HOUSE OF REPRESENTATIVES

KENTUCKY GENERAL ASSEMBLY AMENDMENT FORM

2018 REGULAR SESSION

Amend printed copy of **HB 2**

On page 1, line 3, through page 61, line 11, delete in its entirety and insert in lieu thereof:

"➔Section 1. KRS 342.0011 is amended to read as follows:

As used in this chapter, unless the context otherwise requires:

(1) "Injury" means any work-related traumatic event or series of traumatic events, including cumulative trauma, arising out of and in the course of employment which is the proximate cause producing a harmful change in the human organism evidenced by objective medical findings. "Injury" does not include the effects of the natural aging process, and does not include any communicable disease unless the risk of contracting the disease is increased by the nature of the employment. "Injury" when used generally, unless the context indicates otherwise, shall include an occupational disease and damage to a prosthetic appliance, but shall not include a psychological, psychiatric, or stress-related change in the human organism, unless it is a direct result of a physical injury;

(2) "Occupational disease" means a disease arising out of and in the course of the employment;

(3) An occupational disease as defined in this chapter shall be deemed to arise out of the employment if there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is performed and the occupational disease, and which can be seen to have followed as a natural incident to the work as a result of the exposure occasioned by the nature of the

Amendment No. HFA 3 Rep. Rep. Jill York

Committee Amendment Signed:

Floor Amendment LRC Drafter: Manno, Andrew

Adopted: Date:

Rejected: Doc. ID: XXXX

employment and which can be fairly traced to the employment as the proximate cause. The occupational disease shall be incidental to the character of the business and not independent of the relationship of employer and employee. An occupational disease need not have been foreseen or expected but, after its contraction, it must appear to be related to a risk connected with the employment and to have flowed from that source as a rational consequence;

(4) "Injurious exposure" shall mean that exposure to occupational hazard which would, independently of any other cause whatsoever, produce or cause the disease for which the claim is made;

(5) "Death" means death resulting from an injury or occupational disease;

(6) "Carrier" means any insurer, or legal representative thereof, authorized to insure the liability of employers under this chapter and includes a self-insurer;

(7) "Self-insurer" is an employer who has been authorized under the provisions of this chapter to carry his own liability on his employees covered by this chapter;

(8) "Department" means the Department of Workers' Claims in the Labor Cabinet;

(9) "Commissioner" means the commissioner of the Department of Workers' Claims under the direction and supervision of the secretary of the Labor Cabinet;

(10) "Board" means the Workers' Compensation Board;

(11) (a) "Temporary total disability" means the condition of an employee who has not reached maximum medical improvement from an injury and has not reached a level of improvement that would permit a return to employment;

(b) ***"Temporary partial disability" means the condition of an employee who has not reached maximum medical improvement, but has reached a level of improvement that would permit the employee with medically imposed employment restrictions to return to some form of modified employment, with the same employer, but at lesser***

earnings than the employee earned at the time of the injury;

(c) "Permanent partial disability" means the condition of an employee who, due to an injury, has a permanent disability rating but retains the ability to work; and

(d) ~~[(c)]~~ "Permanent total disability" means the condition of an employee who, due to an injury, has a permanent disability rating and has a complete and permanent inability to perform any type of work as a result of an injury, except that total disability shall be irrebuttably presumed to exist for an injury that results in:

1. Total and permanent loss of sight in both eyes;
2. Loss of both feet at or above the ankle;
3. Loss of both hands at or above the wrist;
4. Loss of one (1) foot at or above the ankle and the loss of one (1) hand at or above the wrist;
5. Permanent and complete paralysis of both arms, both legs, or one (1) arm and one (1) leg;
6. Incurable insanity or imbecility; or
7. Total loss of hearing;

(12) "Income benefits" means payments made under the provisions of this chapter to the disabled worker or his dependents in case of death, excluding medical and related benefits;

(13) "Medical and related benefits" means payments made for medical, hospital, burial, and other services as provided in this chapter, other than income benefits;

(14) "Compensation" means all payments made under the provisions of this chapter representing the sum of income benefits and medical and related benefits;

(15) "Medical services" means medical, surgical, dental, hospital, nursing, and medical rehabilitation services, medicines, and fittings for artificial or prosthetic devices;

(16) "Person" means any individual, partnership, limited partnership, limited liability company,

firm, association, trust, joint venture, corporation, or legal representative thereof;

(17) "Wages" means, in addition to money payments for services rendered, the reasonable value of board, rent, housing, lodging, fuel, or similar advantages received from the employer, and gratuities received in the course of employment from persons other than the employer as evidenced by the employee's federal and state tax returns;

(18) "Agriculture" means the operation of farm premises, including the planting, cultivation, producing, growing, harvesting, and preparation for market of agricultural or horticultural commodities thereon, the raising of livestock for food products and for racing purposes, and poultry thereon, and any work performed as an incident to or in conjunction with the farm operations, including the sale of produce at on-site markets and the processing of produce for sale at on-site markets. It shall not include the commercial processing, packing, drying, storing, or canning of such commodities for market, or making cheese or butter or other dairy products for market;

(19) "Beneficiary" means any person who is entitled to income benefits or medical and related benefits under this chapter;

(20) "United States," when used in a geographic sense, means the several states, the District of Columbia, the Commonwealth of Puerto Rico, the Canal Zone, and the territories of the United States;

(21) "Alien" means a person who is not a citizen, a national, or a resident of the United States or Canada. Any person not a citizen or national of the United States who relinquishes or is about to relinquish his residence in the United States shall be regarded as an alien;

(22) "Insurance carrier" means every insurance carrier or insurance company authorized to do business in the Commonwealth writing workers' compensation insurance coverage and includes the Kentucky Employers Mutual Insurance Authority and every self-insured group operating under the provisions of this chapter;

(23) (a) "Severance or processing of coal" means all activities performed in the Commonwealth at underground, auger, and surface mining sites; all activities performed at tipple or processing plants that clean, break, size, or treat coal; and all activities performed at coal loading facilities for trucks, railroads, and barges. Severance or processing of coal shall not include acts performed by a final consumer if the acts are performed at the site of final consumption.

(b) "Engaged in severance or processing of coal" shall include all individuals, partnerships, limited partnerships, limited liability companies, corporations, joint ventures, associations, or any other business entity in the Commonwealth which has employees on its payroll who perform any of the acts stated in paragraph (a) of this subsection, regardless of whether the acts are performed as owner of the coal or on a contract or fee basis for the actual owner of the coal. A business entity engaged in the severance or processing of coal, including but not limited to administrative or selling functions, shall be considered wholly engaged in the severance or processing of coal for the purpose of this chapter. However, a business entity which is engaged in a separate business activity not related to coal, for which a separate premium charge is not made, shall be deemed to be engaged in the severance or processing of coal only to the extent that the number of employees engaged in the severance or processing of coal bears to the total number of employees. Any employee who is involved in the business of severing or processing of coal and business activities not related to coal shall be prorated based on the time involved in severance or processing of coal bears to his total time;

(24) "Premium" for every self-insured group means any and all assessments levied on its members by such group or contributed to it by the members thereof. For special fund assessment purposes, "premium" also includes any and all membership dues, fees, or other

payments by members of the group to associations or other entities used for underwriting, claims handling, loss control, premium audit, actuarial, or other services associated with the maintenance or operation of the self-insurance group;

(25) (a) "Premiums received" for policies effective on or after January 1, 1994, for insurance companies means direct written premiums as reported in the annual statement to the Department of Insurance by insurance companies, except that "premiums received" includes premiums charged off or deferred, and, on insurance policies or other evidence of coverage with provisions for deductibles, the calculated cost for coverage, including experience modification and premium surcharge or discount, prior to any reduction for deductibles. The rates, factors, and methods used to calculate the cost for coverage under this paragraph for insurance policies or other evidence of coverage with provisions for deductibles shall be the same rates, factors, and methods normally used by the insurance company in Kentucky to calculate the cost for coverage for insurance policies or other evidence of coverage without provisions for deductibles, except that, for insurance policies or other evidence of coverage with provisions for deductibles effective on or after January 1, 1995, the calculated cost for coverage shall not include any schedule rating modification, debits, or credits. The cost for coverage calculated under this paragraph by insurance companies that issue only deductible insurance policies in Kentucky shall be actuarially adequate to cover the entire liability of the employer for compensation under this chapter, including all expenses and allowances normally used to calculate the cost for coverage. For policies with provisions for deductibles with effective dates of May 6, 1993, through December 31, 1993, for which the insurance company did not report premiums and remit special fund assessments based on the calculated cost for coverage prior to the reduction for deductibles, "premiums received" includes the

initial premium plus any reimbursements invoiced for losses, expenses, and fees charged under the deductibles. The special fund assessment rates in effect for reimbursements invoiced for losses, expenses, or fees charged under the deductibles shall be those percentages in effect on the effective date of the insurance policy. For policies covering leased employees as defined in KRS 342.615, "premiums received" means premiums calculated using the experience modification factor of each lessee as defined in KRS 342.615 for each leased employee for that portion of the payroll pertaining to the leased employee.

(b) "Direct written premium" for insurance companies means the gross premium written less return premiums and premiums on policies not taken but including policy and membership fees.

(c) "Premium," for policies effective on or after January 1, 1994, for insurance companies means all consideration, whether designated as premium or otherwise, for workers' compensation insurance paid to an insurance company or its representative, including, on insurance policies with provisions for deductibles, the calculated cost for coverage, including experience modification and premium surcharge or discount, prior to any reduction for deductibles. The rates, factors, and methods used to calculate the cost for coverage under this paragraph for insurance policies or other evidence of coverage with provisions for deductibles shall be the same rates, factors, and methods normally used by the insurance company in Kentucky to calculate the cost for coverage for insurance policies or other evidence of coverage without provisions for deductibles, except that, for insurance policies or other evidence of coverage with provisions for deductibles effective on or after January 1, 1995, the calculated cost for coverage shall not include any schedule rating modifications, debits, or credits. The cost for coverage calculated under this paragraph by insurance

companies that issue only deductible insurance policies in Kentucky shall be actuarially adequate to cover the entire liability of the employer for compensation under this chapter, including all expenses and allowances normally used to calculate the cost for coverage. For policies with provisions for deductibles with effective dates of May 6, 1993, through December 31, 1993, for which the insurance company did not report premiums and remit special fund assessments based on the calculated cost for coverage prior to the reduction for deductibles, "premium" includes the initial consideration plus any reimbursements invoiced for losses, expenses, or fees charged under the deductibles.

(d) "Return premiums" for insurance companies means amounts returned to insureds due to endorsements, retrospective adjustments, cancellations, dividends, or errors;

(26) "Insurance policy" for an insurance company or self-insured group means the term of insurance coverage commencing from the date coverage is extended, whether a new policy or a renewal, through its expiration, not to exceed the anniversary date of the renewal for the following year;

(27) "Self-insurance year" for a self-insured group means the annual period of certification of the group created pursuant to KRS 342.350(4) and 304.50-010;

(28) "Premium" for each employer carrying his own risk pursuant to KRS 342.340(1) shall be the projected value of the employer's workers' compensation claims for the next calendar year as calculated by the commissioner using generally-accepted actuarial methods as follows:

(a) The base period shall be the earliest three (3) calendar years of the five (5) calendar years immediately preceding the calendar year for which the calculation is made. The commissioner shall identify each claim of the employer which has an injury date or date of last injurious exposure to the cause of an occupational disease during each one

(1) of the three (3) calendar years to be used as the base, and shall assign a value to each claim. The value shall be the total of the indemnity benefits paid to date and projected to be paid, adjusted to current benefit levels, plus the medical benefits paid to date and projected to be paid for the life of the claim, plus the cost of medical and vocational rehabilitation paid to date and projected to be paid. Adjustment to current benefit levels shall be done by multiplying the weekly indemnity benefit for each claim by the number obtained by dividing the statewide average weekly wage which will be in effect for the year for which the premium is being calculated by the statewide average weekly wage in effect during the year in which the injury or date of the last exposure occurred. The total value of the claims using the adjusted weekly benefit shall then be calculated by the commissioner. Values for claims in which awards have been made or settlements reached because of findings of permanent partial or permanent total disability shall be calculated using the mortality and interest discount assumptions used in the latest available statistical plan of the advisory rating organization defined in Subtitle 13 of KRS Chapter 304. The sum of all calculated values shall be computed for all claims in the base period;

(b) The commissioner shall obtain the annual payroll for each of the three (3) years in the base period for each employer carrying his own risk from records of the department and from the records of the Office of Employment and Training, Education and Workforce Development Cabinet. The commissioner shall multiply each of the three (3) years of payroll by the number obtained by dividing the statewide average weekly wage which will be in effect for the year in which the premium is being calculated by the statewide average weekly wage in effect in each of the years of the base period;

(c) The commissioner shall divide the total of the adjusted claim values for the three (3) year base period by the total adjusted payroll for the same three (3) year period. The

value so calculated shall be multiplied by 1.25 and shall then be multiplied by the employer's most recent annualized payroll, calculated using records of the department and the Office of Employment and Training data which shall be made available for this purpose on a quarterly basis as reported, to obtain the premium for the next calendar year for assessment purposes under KRS 342.122;

(d) For November 1, 1987, through December 31, 1988, premium for each employer carrying its own risk shall be an amount calculated by the board pursuant to the provisions contained in this subsection and such premium shall be provided to each employer carrying its own risk and to the funding commission on or before January 1, 1988. Thereafter, the calculations set forth in this subsection shall be performed annually, at the time each employer applies or renews its application for certification to carry its own risk for the next twelve (12) month period and submits payroll and other data in support of the application. The employer and the funding commission shall be notified at the time of the certification or recertification of the premium calculated by the commissioner, which shall form the employer's basis for assessments pursuant to KRS 342.122 for the calendar year beginning on January 1 following the date of certification or recertification;

(e) If an employer having fewer than five (5) years of doing business in this state applies to carry its own risk and is so certified, its premium for the purposes of KRS 342.122 shall be based on the lesser number of years of experience as may be available including the two (2) most recent years if necessary to create a three (3) year base period. If the employer has less than two (2) years of operation in this state available for the premium calculation, then its premium shall be the greater of the value obtained by the calculation called for in this subsection or the amount of security required by the commissioner pursuant to KRS 342.340(1);

(f) If an employer is certified to carry its own risk after having previously insured the risk, its premium shall be calculated using values obtained from claims incurred while insured for as many of the years of the base period as may be necessary to create a full three (3) year base. After the employer is certified to carry its own risk and has paid all amounts due for assessments upon premiums paid while insured, the employer shall be assessed only upon the premium calculated under this subsection;

(g) "Premium" for each employer defined in KRS 342.630(2) shall be calculated as set forth in this subsection; and

(h) Notwithstanding any other provision of this subsection, the premium of any employer authorized to carry its own risk for purposes of assessments due under this chapter shall be no less than thirty cents ($0.30) per one hundred dollars ($100) of the employer's most recent annualized payroll for employees covered by this chapter;

(29) "SIC code" as used in this chapter means the Standard Industrial Classification Code contained in the latest edition of the Standard Industrial Classification Manual published by the Federal Office of Management and Budget;

(30) "Investment interest" means any pecuniary or beneficial interest in a provider of medical services or treatment under this chapter, other than a provider in which that pecuniary or investment interest is obtained on terms equally available to the public through trading on a registered national securities exchange, such as the New York Stock Exchange or the American Stock Exchange, or on the National Association of Securities Dealers Automated Quotation System;

(31) "Managed health care system" means a health care system that employs gatekeeper providers, performs utilization review, and does medical bill audits;

(32) "Physician" means physicians and surgeons, psychologists, optometrists, dentists, podiatrists, and osteopathic and chiropractic practitioners acting within the scope of their

license issued by the Commonwealth;

(33) "Objective medical findings" means information gained through direct observation and testing of the patient applying objective or standardized methods;

(34) "Work" means providing services to another in return for remuneration on a regular and sustained basis in a competitive economy;

(35) "Permanent impairment rating" means percentage of whole body impairment caused by the injury or occupational disease as determined by the "Guides to the Evaluation of Permanent Impairment";

(36) "Permanent disability rating" means the permanent impairment rating selected by an administrative law judge times the factor set forth in the table that appears at KRS 342.730(1)***(c)***~~[(b)]~~; and

(37) "Guides to the Evaluation of Permanent Impairment" means, except as provided in KRS 342.262:

(a) The fifth edition published by the American Medical Association; and

(b) For psychological impairments, Chapter 12 of the second edition published by the American Medical Association.

➔Section 2. KRS 342.020 is amended to read as follows:

(1) In addition to all other compensation provided in this chapter, the employer shall pay for the cure and relief from the effects of an injury or occupational disease the medical, surgical, and hospital treatment, including nursing, medical, and surgical supplies and appliances, as may reasonably be required at the time of the injury and thereafter during disability, or as may be required for the cure and treatment of an occupational disease. The employer's obligation to pay the benefits specified in this section shall continue for so long as the employee is disabled regardless of the duration of the employee's income benefits. In the absence of designation of a managed health care system by the employer, the employee

may select medical providers to treat his injury or occupational disease. Even if the employer has designated a managed health care system, the injured employee may elect to continue treating with a physician who provided emergency medical care or treatment to the employee. The employer, insurer, or payment obligor acting on behalf of the employer, shall make all payments for services rendered to an employee directly to the provider of the services within thirty (30) days of receipt of a statement for services. The commissioner shall promulgate administrative regulations establishing conditions under which the thirty (30) day period for payment may be tolled. The provider of medical services shall submit the statement for services within forty-five (45) days of the day treatment is initiated and every forty-five (45) days thereafter, if appropriate, as long as medical services are rendered. Except as provided in subsection (4) of this section, in no event shall a medical fee exceed the limitations of an adopted medical fee schedule or other limitations contained in KRS 342.035, whichever is lower. The commissioner may promulgate administrative regulations establishing the form and content of a statement for services and procedures by which disputes relative to the necessity, effectiveness, frequency, and cost of services may be resolved.

(2) Notwithstanding any provision of the Kentucky Revised Statutes to the contrary, medical services and treatment provided under this chapter shall not be subject to copayments or deductibles.

(3) Employers may provide medical services through a managed health care system. The managed health care system shall file with the Department of Workers' Claims a plan for the rendition of health care services for work-related injuries and occupational diseases to be approved by the commissioner pursuant to administrative regulations promulgated by the commissioner.

(4) All managed health care systems rendering medical services under this chapter shall

include the following features in plans for workers' compensation medical care:

(a) Copayments or deductibles shall not be required for medical services rendered in connection with a work-related injury or occupational disease;

(b) The employee shall be allowed choice of provider within the plan;

(c) The managed health care system shall provide an informal procedure for the expeditious resolution of disputes concerning rendition of medical services;

(d) The employee shall be allowed to obtain a second opinion, at the employer's expense, from an outside physician if a managed health care system physician recommends surgery;

(e) The employee may obtain medical services from providers outside the managed health care system, at the employer's expense, when treatment is unavailable through the managed health care system;

(f) The managed health care system shall establish procedures for utilization review of medical services to assure that a course of treatment is reasonably necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee; and

(g) Statements for services shall be audited regularly to assure that charges are not duplicated and do not exceed those authorized in the applicable fee schedules.

(h) A schedule of fees for all medical services to be provided under this chapter which shall not be subject to the limitations on medical fees contained in this chapter.

(i) Restrictions on provider selection imposed by a managed health care system authorized by this chapter shall not apply to emergency medical care.

(5) Except for emergency medical care, medical services rendered pursuant to this chapter shall

be under the supervision of a single treating physician or physicians' group having the authority to make referrals, as reasonably necessary, to appropriate facilities and specialists. The employee may change his designated physician one (1) time and thereafter shall show reasonable cause in order to change physicians.

(6) When a compensable injury or occupational disease results in the amputation of an arm, leg, or foot, or the loss of hearing, or the enucleation of an eye or loss of teeth, the employer shall pay for, in addition to the other medical, surgical, and hospital treatment enumerated in subsection (1) and this subsection, a modern artificial member and, where required, proper braces as may reasonably be required at the time of the injury and thereafter during disability.

(7) Upon motion of the employer, with sufficient notice to the employee for a response to be filed, if it is shown to the satisfaction of the administrative law judge by affidavits or testimony that, because of the physician selected by the employee to treat the injury or disease, or because of the hospital selected by the employee in which treatment is being rendered, that the employee is not receiving proper medical treatment and the recovery is being substantially affected or delayed; or that the funds for medical expenses are being spent without reasonable benefit to the employee; or that because of the physician selected by the employee or because of the type of medical treatment being received by the employee that the employer will substantially be prejudiced in any compensation proceedings resulting from the employee's injury or disease; then the administrative law judge may allow the employer to select a physician to treat the employee and the hospital or hospitals in which the employee is treated for the injury or disease. No action shall be brought against any employer subject to this chapter by any person to recover damages for malpractice or improper treatment received by any employee from any physician, hospital, or attendant thereof.

(8) An employee who reports an injury alleged to be work-related or files an application for adjustment of a claim shall execute a waiver and consent of any physician-patient, psychiatrist-patient, or chiropractor-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding any other provision in the Kentucky Revised Statutes, any physician, psychiatrist, chiropractor, podiatrist, hospital, or health care provider shall, within a reasonable time after written request by the employee, employer, workers' compensation insurer, special fund, uninsured employers' fund, or the administrative law judge, provide the requesting party with any information or written material reasonably related to any injury or disease for which the employee claims compensation.

(9) When a provider of medical services or treatment, required by this chapter, makes referrals for medical services or treatment by this chapter, to a provider or entity in which the provider making the referral has an investment interest, the referring provider shall disclose that investment interest to the employee, the commissioner, and the employer's insurer or the party responsible for paying for the medical services or treatment, within thirty (30) days from the date the referral was made.

(10) (a) A medical fee schedule in workers' compensation is justified, in part, to guarantee and speed the payment of medical services; therefore, notwithstanding subsection (4) of this section, if an employer, its insurance carrier, or any other entity on behalf of the employer files a challenge to a medical bill or service, and it is determined that the bill or service is appropriately payable pursuant to this section, the fee to be paid, whether by fee schedule, administrative regulation, or in some other manner shall be increased thirty percent (30%).

(b) If the employee whose treatment resulted in the challenge is represented by an attorney in the dispute, the attorney shall be entitled to a fee of thirty percent (30%)

of the total amount of the medical bill or cost for the medical service found payable, not to exceed three thousand five hundred dollars ($3,500). This attorney fee shall be deducted from the payment made to the medical provider, and is exclusive of the attorney fee provided in Section 7 of this Act.

➔Section 3. KRS 342.035 is amended to read as follows:

(1) Periodically, the commissioner shall promulgate administrative regulations to adopt a schedule of fees for the purpose of ensuring that all fees, charges, and reimbursements under KRS 342.020 and this section shall be fair, current, and reasonable and shall be limited to such charges as are fair, current, and reasonable for similar treatment of injured persons in the same community for like services, where treatment is paid for by general health insurers. In determining what fees are reasonable, the commissioner may also consider the increased security of payment afforded by this chapter. On or before November 1, 1994, and on July 1 every two (2) years thereafter, the schedule of fees contained in administrative regulations promulgated pursuant to this section shall be reviewed and updated, if appropriate. Within ten (10) days of April 4, 1994, the commissioner shall execute a contract with an appropriately qualified consultant pursuant to which each of the following elements within the workers' compensation system are evaluated; the methods of health care delivery; quality assurance and utilization mechanisms; type, frequency, and intensity of services; risk management programs; and the schedule of fees contained in administrative regulation. The consultant shall present recommendations based on its review to the commissioner not later than sixty (60) days following execution of the contract. The commissioner shall consider these recommendations and, not later than thirty (30) days after their receipt, promulgate a regulation which shall be effective on an emergency basis, to effect a twenty-five percent (25%) reduction in the total medical costs within the program.

(2) No provider of medical services or treatment required by this chapter, its agent, servant, employee, assignee, employer, or independent contractor acting on behalf of any medical provider, shall knowingly collect, attempt to collect, coerce, or attempt to coerce, directly or indirectly, the payment of any charge, for services covered by a workers' compensation insurance plan for the treatment of a work-related injury or occupational disease, in excess of that provided by a schedule of fees, or cause the credit of any employee to be impaired by reason of the employee's failure or refusal to pay the excess charge. In addition to the penalty imposed in KRS 342.990 for violations of this subsection, any individual who sustains damages by any act in violation of the provisions of this subsection shall have a civil cause of action in Circuit Court to enjoin further violations and to recover the actual damages sustained by the individual, together with the costs of the lawsuit, including a reasonable attorney's fee.

(3) Where these requirements are furnished by a public hospital or other institution, payment thereof shall be made to the proper authorities conducting it. No compensation shall be payable for the death or disability of an employee if his or her death is caused, or if and insofar as his disability is aggravated, caused, or continued, by an unreasonable failure to submit to or follow any competent surgical treatment or medical aid or advice.

(4) The commissioner shall, by December 1, 1994, promulgate administrative regulations to adopt a schedule of fees for the purpose of regulating charges by medical providers and other health care professionals for testimony presented and medical reports furnished in the litigation of a claim by an injured employee against the employer. The workers' compensation medical fee schedule for physicians, 803 KAR 25:089, having an effective date of February 9, 1995, shall remain in effect until July 1, 1996, or until the effective date of any amendments promulgated by the commissioner, whichever occurs first, it being determined that this administrative regulation is within the statutory grant of authority,

meets legislative intent, and is not in conflict with the provisions of this chapter. The medical fee schedule and amendments shall be fair, current, and reasonable and otherwise comply with this section.

(5) (a) To ensure compliance with subsections (1) and (4) of this section, the commissioner shall promulgate administrative regulations by December 31, 1994, which require each insurance carrier, self-insured group, and self-insured employer to certify to the commissioner the program or plan it has adopted to ensure compliance.

(b) In addition, the commissioner shall periodically have an independent audit conducted by a qualified independent person, firm, company, or other entity hired by the commissioner, in accordance with the personal service contract provisions contained in KRS 45A.690 to 45A.725, to ensure that the requirements of subsection (1) of this section are being met. The independent person, firm, company, or other entity selected by the commissioner to conduct the audit shall protect the confidentiality of any information it receives during the audit, shall divulge information received during the audit only to the commissioner, and shall use the information for no other purpose than the audit required by this paragraph.

(c) The commissioner shall promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, self-insured group, or self-insured employer pursuant to this chapter. ***Utilization review required under administrative regulations may be waived if the insurance carrier, self-insured group, or self-insured employer agrees that the recommended medical treatment is medically necessary and appropriate or if the injured employee elects not to proceed with the recommended medical treatment.***

(d) Periodically, or upon request, the commissioner shall report to the Interim Joint Committee on Labor and Industry of the Legislative Research Commission or to the

corresponding standing committees of the General Assembly, as appropriate, the degree of compliance or lack of compliance with the provisions of this section and make recommendations thereon.

(e) The cost of implementing and carrying out the requirements of this subsection shall be paid from funds collected pursuant to KRS 342.122.

(6) The commissioner may promulgate administrative regulations incorporating managed care or other concepts intended to reduce costs or to speed the delivery or payment of medical services to employees receiving medical and related benefits under this chapter.

(7) For purposes of this chapter, any medical provider shall charge only its customary fee for photocopying requested documents. However, in no event shall a photocopying fee of a medical provider or photocopying service exceed fifty cents ($0.50) per page. In addition, there shall be no charge for reviewing any records of a medical provider, during regular business hours, by any party who is authorized to review the records and who requests a review pursuant to this chapter.

(8) (a) The commissioner shall develop or adopt practice parameters or guidelines for clinical practice for use by medical providers under this chapter. The commissioner may adopt any parameters for clinical practice as developed and updated by the federal Agency for Health Care Policy Research, or the commissioner may adopt other parameters for clinical practice which are developed by qualified bodies, as determined by the commissioner, with periodic updating based on data collected during the application of the parameters.

(b) Any provider of medical services under this chapter who has followed the practice parameters or guidelines developed or adopted pursuant to this subsection shall be presumed to have met the appropriate legal standard of care in medical malpractice cases regardless of any unanticipated complication that may thereafter develop or be

discovered.

(9) (a) Notwithstanding any other provision of law to the contrary, the medical fee schedule adopted under subsection (4) of this section shall require all worker's compensation insurance carriers, worker's compensation self-insured groups, and worker's compensation self-insured employers to provide coverage and payment for surgical first assisting services to registered nurse first assistants as defined in KRS 216B.015.

(b) The provisions of this subsection apply only if reimbursement for an assisting physician would be covered and a registered nurse first assistant who performed the services is used as a substitute for the assisting physician. The reimbursement shall be made directly to the registered nurse first assistant if the claim is submitted by a registered nurse first assistant who is not an employee of the hospital or the surgeon performing the services.

➔Section 4. KRS 342.040 is amended to read as follows:

(1) Except as provided in KRS 342.020, no income benefits shall be payable for the first seven (7) days of disability unless disability continues for a period of more than two (2) weeks, in which case income benefits shall be allowed from the first day of disability. All income benefits shall be payable on the regular payday of the employer, commencing with the first regular payday after seven (7) days after the injury or disability resulting from an occupational disease, with interest at the rate of six percent (6%) per annum on each installment from the time it is due until paid, except that if the administrative law judge determines that a denial, delay, or termination in the payment of income benefits was without reasonable foundation, the rate of interest shall be twelve percent (12%) per annum. In no event shall income benefits be instituted later than the fifteenth day after the employer has knowledge of the disability or death. Income benefits shall be due and payable not less often than semimonthly. If the employer's insurance carrier or other party

responsible for the payment of workers' compensation benefits should terminate or fail to make payments when due, that party shall notify the commissioner of the termination or failure to make payments and the commissioner shall, in writing, advise the employee or known dependent of right to prosecute a claim under this chapter.

(2) If overdue temporary total ***or temporary partial*** disability income benefits are recovered in a proceeding brought under this chapter by an attorney for an employee, or paid by the employer after receipt of notice of the attorney's representation, a reasonable attorney's fee for these services may be awarded. The award of attorney's fees shall be paid by the employer if the administrative law judge determines that the denial or delay was without reasonable foundation. No part of the fee for representing the employee in connection with the recovery of overdue temporary total ***or temporary partial*** disability benefits withheld without reasonable foundation shall be charged against or deducted from benefits otherwise due the employee.

(3) All retraining incentive benefits awarded pursuant to KRS 342.732 shall be payable on the regular payday of the employer, commencing with the second regular payday after the award of the retraining incentive benefit by the administrative law judge becomes final. Retraining incentive benefits shall be due and payable not less often than semimonthly.

(4) Upon written request of the employee, all payments of compensation shall be mailed to the employee at his or her last known address.

➔Section 5. KRS 342.125 is amended to read as follows:

(1) Upon motion by any party or upon an administrative law judge's own motion, an administrative law judge may reopen and review any award or order on any of the following grounds:

(a) Fraud;

(b) Newly-discovered evidence which could not have been discovered with the exercise

of due diligence;

(c) Mistake;~~[and]~~

(d) Change of disability as shown by objective medical evidence of worsening or improvement of impairment due to a condition caused by the injury since the date of the award or order***; or***

(e) Additional temporary total or temporary partial disability benefits.

(2) No claim which has been previously dismissed or denied on the merits shall be reopened except upon the grounds set forth in this section.

(3) Except for reopening solely for determination of the compensability of medical expenses, fraud, or conforming the award as set forth in KRS 342.730(1)(c)2., or for reducing a permanent total disability award when an employee returns to work, or seeking temporary total disability ***or temporary partial disability*** benefits during the period of an award, no claim shall be reopened more than four (4) years following the date of the original award or order granting or denying benefits, and no party may file a motion to reopen within one (1) year of any previous motion to reopen by the same party.

(4) Reopening and review under this section shall be had upon notice to the parties and in the same manner as provided for an initial proceeding under this chapter. Upon reopening, the administrative law judge may end, diminish, or increase compensation previously awarded, within the maximum and minimum provided in this chapter, or change or revoke a previous order. The administrative law judge shall immediately send all parties a copy of the subsequent order or award. Reopening shall not affect the previous order or award as to any sums already paid thereunder, and any change in the amount of compensation shall be ordered only from the date of filing the motion to reopen. No employer shall suspend benefits during pendency of any reopening procedures except upon order of the administrative law judge.

(5) (a) Upon the application of the affected employee, and a showing of progression of his previously-diagnosed occupational pneumoconiosis resulting from exposure to coal dust and development of respiratory impairment due to that pneumoconiosis and two (2) additional years of employment in the Commonwealth wherein the employee was continuously exposed to the hazards of the disease, the administrative law judge may review an award or order for benefits attributable to coal-related pneumoconiosis under KRS 342.732. An application for review under this subsection shall be made within one (1) year of the date the employee knew or reasonably should have known that a progression of his disease and development or progression of respiratory impairment have occurred. Review under this subsection shall include a review of all evidence admitted in all prior proceedings.

(b) Benefits awarded as a result of a review under this subsection shall be reduced by the amount of retraining incentive benefits or income benefits previously awarded under KRS 342.732. The amount to be deducted shall be subtracted from the total amount awarded, and the remaining amount shall be divided by the number of weeks, for which the award was made, to arrive at the weekly benefit amount which shall be apportioned in accordance with the provisions of KRS 342.316.

(6) In a reopening or review proceeding where there has been additional permanent partial disability awarded, the increase shall not extend the original period, unless the combined prior disability and increased disability exceeds fifty percent (50%), but less than one hundred percent (100%), in which event the awarded period shall not exceed five hundred twenty (520) weeks, from commencement date of the original disability previously awarded. The law in effect on the date of the original injury controls the rights of the parties.

(7) Where an agreement has become an award by approval of the administrative law judge, and

a reopening and review of that award is initiated, no statement contained in the agreement, whether as to jurisdiction, liability of the employer, nature and extent of disability, or as to any other matter, shall be considered by the administrative law judge as an admission against the interests of any party. The parties may raise any issue upon reopening and review of this type of award which could have been considered upon an original application for benefits.

(8) The time limitation prescribed in this section shall apply to all claims irrespective of when they were incurred, or when the award was entered, or the settlement approved. However, claims decided prior to December 12, 1996, may be reopened within four (4) years of the award or order or within four (4) years of December 12, 1996, whichever is later, provided that the exceptions to reopening established in subsections (1) and (3) of this section shall apply to these claims as well.

➔Section 6. KRS 342.316 is amended to read as follows:

(1) (a) The employer liable for compensation for occupational disease shall be the employer in whose employment the employee was last exposed to the hazard of the occupational disease. During any period in which this section is applicable to a coal mine, an operator who acquired it or substantially all of its assets from a person who was its operator on and after January 1, 1973, shall be liable for, and secure the payment of, the benefits which would have been payable by the prior operator under this section with respect to miners previously employed in the mine if it had not been acquired by such later operator. At the same time, however, this subsection does not relieve the prior operator of any liability under this section. Also, it does not affect whatever rights the later operator might have against the prior operator.

(b) The time of the beginning of compensation payments shall be the date of the employee's last injurious exposure to the cause of the disease, or the date of actual

disability, whichever is later.

(2) The procedure with respect to the giving of notice and determination of claims in occupational disease cases and the compensation and medical benefits payable for disability or death due to the disease shall be the same as in cases of accidental injury or death under the general provisions of this chapter, except that notice of claim shall be given to the employer as soon as practicable after the employee first experiences a distinct manifestation of an occupational disease in the form of symptoms reasonably sufficient to apprise the employee that he or she has contracted the disease, or a diagnosis of the disease is first communicated to him or her, whichever shall first occur.

(3) The procedure for filing occupational disease claims shall be as follows:

(a) The application for resolution of claim shall set forth the complete work history of the employee with a concise description of injurious exposure to a specific occupational disease, together with the name and addresses of the employer or employers with the approximate dates of employment. The application shall also include at least one (1) written medical report supporting his or her claim. This medical report shall be made on the basis of clinical or X-ray examination performed in accordance with accepted medical standards and shall contain full and complete statements of all examinations performed and the results thereof. The report shall be made by a duly-licensed physician. The commissioner shall promulgate administrative regulations which prescribe the format of the medical report required by this section and the manner in which the report shall be completed.

1. For coal-related occupational pneumoconiosis claims, each clinical examination shall include a chest X-ray interpretation by a National Institute of Occupational Safety and Health (NIOSH) certified "B" reader. The chest X-ray upon which the report is made shall be filed with the application as well as spirometric tests

when pulmonary dysfunction is alleged.

2. For other compensable occupational pneumoconiosis claims, each clinical examination shall include a chest X-ray examination and appropriate pulmonary function tests.

(b) To be admissible, medical evidence offered in any proceeding under this chapter for determining a claim for occupational pneumoconiosis resulting from exposure to coal dust shall comply with accepted medical standards as follows:

1. Chest X-rays shall be of acceptable quality with respect to exposure and development and shall be indelibly labeled with the date of the X-ray and the name and Social Security number of the claimant. Physicians' reports of X-ray interpretations shall: identify the claimant by name and Social Security number; include the date of the X-ray and the date of the report; classify the X-ray interpretation using the latest ILO Classification and be accompanied by a completed copy of the latest ILO Classification report. Only interpretations by National Institute of Occupational Safety and Health (NIOSH) certified "B" readers shall be admissible.

2. Spirometric testing shall be conducted in accordance with the standards recommended in the "Guides to the Evaluation of Permanent Impairment" and the 1978 ATS epidemiology standardization project with the exception that the predicted normal values for lung function shall not be adjusted based upon the race of the subject. The FVC or the FEV1 values shall represent the largest of such values obtained from three (3) acceptable forced expiratory volume maneuvers as corrected to BTPS (body temperature, ambient pressure and saturated with water vapor at these conditions) and the variance between the two (2) largest acceptable FVC values shall be either less than five percent (5%)

of the largest FVC value or less than one hundred (100) milliliters, whichever is greater. The variance between the two (2) largest acceptable FEV1 values shall be either less than five percent (5%) of the largest FEV1 value or less than one hundred (100) milliliters, whichever is greater. Reports of spirometric testing shall include a description by the physician of the procedures utilized in conducting such spirometric testing and a copy of the spirometric chart and tracings from which spirometric values submitted as evidence were taken.

3. The commissioner shall promulgate administrative regulations pursuant to KRS Chapter 13A as necessary to effectuate the purposes of this section. The commissioner shall periodically review the applicability of the spirometric test values contained in the "Guides to the Evaluation of Permanent Impairment" and may by administrative regulation substitute other spirometric test values which are found to be more closely representative of the normal pulmonary function of the coal mining population.
4. The procedure for determination of occupational disease claims shall be as follows:
    a. Immediately upon receipt of an application for resolution of claim, the commissioner shall notify the responsible employer and all other interested parties and shall furnish them with a full and complete copy of the application.
    b. The commissioner shall assign the claim to an administrative law judge and, except for coal workers' pneumoconiosis claims, shall promptly refer the employee to such physician or medical facility as the commissioner may select for examination. The report from this examination shall be provided to all parties of record. The employee shall not be referred by the

commissioner for examination within two (2) years following any prior referral for examination for the same disease.

c. Except for coal workers' pneumoconiosis claims, within forty-five (45) days following the notice of filing an application for resolution of claim, the employer or carrier shall notify the commissioner and all parties of record of its acceptance or denial of the claim. A denial shall be in writing and shall state the specific basis for the denial. In coal workers' pneumoconiosis claims, the employer's notice of claim denial or acceptance shall be filed within thirty (30) days of the issuance by the commissioner of the notice of the consensus reading unless the consensus is that the miner has not developed coal workers' pneumoconiosis category 1/0 or greater. In the event the consensus procedure is exhausted without consensus being established, the employer's notice of claim denial or acceptance shall be filed within thirty (30) days of the commissioner notification to the administrative law judge that consensus has not been reached.

d. Within forty-five (45) days of assignment of a coal workers' pneumoconiosis claim to an administrative law judge, the employer shall cause the employee to be examined by a physician of the employer's choice and shall provide to all other parties and file with the commissioner the X-ray interpretation by a "B" reader. The examination of the employee shall include spirometric testing if pulmonary dysfunction is alleged by the employee in the application for resolution of a claim. The commissioner shall determine whether the X-ray interpretations filed by the parties are in consensus.

e. If the readings are not in consensus, the commissioner shall forward both films, masking information identifying the facility where the X-ray was obtained and the referring physician, consecutively to three (3) "B" readers selected randomly from a list maintained by the commissioner for interpretation. Each "B" reader shall select the highest quality film and report only the interpretation of that film. The commissioner shall determine if two (2) of the X-ray interpretations filed by the three (3) "B" readers selected randomly are in consensus. If consensus is reached, the commissioner shall forward copies of the report to all parties as well as notice of the consensus reading which shall be considered as evidence. If consensus is not reached, the administrative law judge shall decide the claim on the evidence submitted.

f. "Consensus" is reached between two (2) chest X-ray interpreters when their classifications meet one (1) of the following criteria: each finds either category A, B, or C progressive massive fibrosis; or findings with regard to simple pneumoconiosis are both in the same major category and within one (1) minor category (ILO category twelve (12) point scale) of each other.

g. The administrative law judge shall conduct such proceedings as are necessary to resolve the claim and shall have authority to grant or deny any relief, including interlocutory relief, to order additional proof, to conduct a benefit review conference, or to take such other action as may be appropriate to resolve the claim.

h. Unless a voluntary settlement is reached by the parties, or the parties agree otherwise, the administrative law judge shall issue a written determination

within sixty (60) days following a hearing. The written determination shall address all contested issues and shall be enforceable under KRS 342.305.

5. The procedure for appeal from a determination of an administrative law judge shall be as set forth in KRS 342.285.

(4) (a) The right to compensation under this chapter resulting from an occupational disease shall be forever barred unless a claim is filed with the commissioner within three (3) years after the last injurious exposure to the occupational hazard or after the employee first experiences a distinct manifestation of an occupational disease in the form of symptoms reasonably sufficient to apprise the employee that he or she has contracted the disease, whichever shall last occur; and if death results from the occupational disease within that period, unless a claim therefor be filed with the commissioner within three (3) years after the death; but that notice of claim shall be deemed waived in case of disability or death where the employer, or its insurance carrier, voluntarily makes payment therefor, or if the incurrence of the disease or the death of the employee and its cause was known to the employer. However, the right to compensation for any occupational disease shall be forever barred, unless a claim is filed with the commissioner within five (5) years from the last injurious exposure to the occupational hazard, except that, in cases of radiation disease**,** ~~[or]~~asbestos-related disease, ***or a type of cancer specified in KRS 61.315(11)(b),*** a claim must be filed within twenty (20) years from the last injurious exposure to the occupational hazard.

(b) Income benefits for the disease of pneumoconiosis resulting from exposure to coal dust or death therefrom shall not be payable unless the employee has been exposed to the hazards of such pneumoconiosis in the Commonwealth of Kentucky over a continuous period of not less than two (2) years during the ten (10) years immediately

preceding the date of his or her last exposure to such hazard, or for any five (5) of the fifteen (15) years immediately preceding the date of such last exposure.

(5) The amount of compensation payable for disability due to occupational disease or for death from the disease, and the time and manner of its payment, shall be as provided for under the general provisions of the Workers' Compensation Act, but:

(a) In no event shall the payment exceed the amounts that were in effect at the time of the last injurious exposure;

(b) The time of the beginning of compensation payments shall be the date of the employee's last injurious exposure to the cause of the disease, or the date of actual disability, whichever is later; and

(c) In case of death where the employee has been awarded compensation or made timely claim within the period provided for in this section, and an employee has suffered continuous disability to the date of his or her death occurring at any time within twenty (20) years from the date of disability, his or her dependents, if any, shall be awarded compensation for his or her death as provided for under the general provisions of the Workers' Compensation Act and in this section, except as provided in KRS 342.750(6).

(6) If an autopsy has been performed, no testimony relative thereto shall be admitted unless the employer or its representative has available findings and reports of the pathologist or doctor who performed the autopsy examination.

(7) No compensation shall be payable for occupational disease if the employee at the time of entering the employment of the employer by whom compensation would otherwise be payable, falsely represented himself or herself, in writing, as not having been previously disabled, laid-off, or compensated in damages or otherwise, because of the occupational disease, or failed or omitted truthfully to state to the best of his or her knowledge, in answer

to written inquiry made by the employer, the place, duration, and nature of previous employment, or, to the best of his or her knowledge, the previous state of his or her health.

(8) No compensation for death from occupational disease shall be payable to any person whose relationship to the deceased, which under the provisions of this chapter would give right to compensation, arose subsequent to the beginning of the first compensable disability, except only for after-born children of a marriage existing at the beginning of such disability.

(9) Whenever any claimant misconceives his or her remedy and files an application for adjustment of claim under the general provisions of this chapter and it is subsequently discovered, at any time before the final disposition of the cause, that the claim for injury, disability, or death which was the basis for his or her application should properly have been made under the provisions of this section, then the application so filed may be amended in form or substance, or both, to assert a claim for injury, disability, or death under the provisions of this section, and it shall be deemed to have been so filed as amended on the date of the original filing thereof, and compensation may be awarded that is warranted by the whole evidence pursuant to the provisions of this chapter. When amendment of this type is submitted, further or additional evidence may be heard when deemed necessary. Nothing this section contains shall be construed to be or permit a waiver of any of the provisions of this chapter with reference to notice of time for filing of a claim, but notice of filing a claim, if given or done, shall be deemed to be a notice of filing of a claim under provisions of this chapter, if given or done within the time required by this subsection.

(10) When an employee has an occupational disease that is covered by this chapter, the employer in whose employment he or she was last injuriously exposed to the hazard of the disease, and the employer's insurance carrier, if any, at the time of the exposure, shall alone be liable therefor, without right to contribution from any prior employer or insurance carrier, except as otherwise provided in this chapter.

(11) (a) For claims filed on or before June 30, 2017, income benefits for coal-related occupational pneumoconiosis shall be paid fifty percent (50%) by the Kentucky coal workers' pneumoconiosis fund as established in KRS 342.1242 and fifty percent (50%) by the employer in whose employment the employee was last exposed to the hazard of that occupational disease.

(b) Income benefits for coal-related occupational pneumoconiosis for claims filed after June 30, 2017, shall be paid by the employer in whose employment the employee was last exposed to the hazards of coal workers' pneumoconiosis.

(c) Compensation for all other occupational disease shall be paid by the employer in whose employment the employee was last exposed to the hazards of the occupational disease.

(12) A concluded claim for benefits by reason of contraction of coal workers' pneumoconiosis in the severance or processing of coal shall bar any subsequent claim for benefits by reason of contraction of coal workers' pneumoconiosis, unless there has occurred in the interim between the conclusion of the first claim and the filing of the second claim at least two (2) years of employment wherein the employee was continuously exposed to the hazards of the disease in the Commonwealth.

(13) For coal-related occupational pneumoconiosis claims, the consensus procedure shall apply to all claims which have not been assigned to an administrative law judge prior to July 15, 2002. The consensus classification shall be presumed to be the correct classification of the employee's condition unless overcome by clear and convincing evidence. If an administrative law judge finds that the presumption of correctness of the consensus reading has been overcome, the reasons shall be specially stated in the administrative law judge's order.

➔Section 7. KRS 342.320 is amended to read as follows:

(1) All fees of attorneys and physicians, and all charges of hospitals under this chapter, shall be subject to the approval of an administrative law judge pursuant to the statutes and administrative regulations.

(2) In an original claim, attorney's fees for services under this chapter on behalf of an employee shall be subject to the following maximum limits:

(a) ***For attorney-client employment contracts entered into and signed after July 14, 2000, but before the effective date of this Act,*** twenty percent (20%) of the first twenty-five thousand dollars ($25,000) of the award, fifteen percent (15%) of the next ten thousand dollars ($10,000), and five percent (5%) of the remainder of the award, not to exceed a maximum fee of twelve thousand dollars ($12,000). This fee shall be paid by the employee from the proceeds of the award or settlement; and

(b) ***For attorney-client employment contracts entered into and signed on or after the effective date of this Act, twenty percent (20%) of the first fifty thousand dollars ($50,000) of the award and ten percent (10%) of the remainder of the award, not to exceed a maximum fee of twenty-two thousand dollars ($22,000). This fee shall be paid by the employee from the proceeds of the award or settlement***~~[Attorney-client employment contracts entered into and signed after July 14, 2000, shall be subject to the conditions of paragraph (a) of this subsection]~~.

(3) ***All attorneys shall file with the commissioner, with notice to the other party or parties, a notarized affidavit detailing the amount of fees charged and the basis for the fee calculation used***~~[In approving an allowance of attorney's fees, the administrative law judge shall consider the extent, complexity, and quality of services rendered, and in the case of death, the Remarriage Tables of the Dutch Royal Insurance Institute]~~. An ***administrative law judge may order a refund or reduction in the amount of the*** attorney's fee~~[may be denied or reduced]~~ upon proof of solicitation by the attorney. However, this provision shall

not be construed to preclude advertising in conformity with standards prescribed by the Kentucky Supreme Court.

(4) No attorney's fee in any case involving benefits under this chapter shall be paid until the ***affidavit for the*** fee is ***filed with the commissioner as required in subsection (3) of this section***~~[approved by the administrative law judge]~~, and any contract for the payment of attorney's fees otherwise than as provided in this section shall be void. The ***notarized affidavit for the***~~[motion for approval of an]~~ attorney's fee shall be submitted within thirty (30) days following finality of the claim. Except when the attorney's fee is to be paid by the employer or carrier, the attorney's fee shall be paid in one (1) of the following ways:

(a) The employee may pay the attorney's fee out of his or her personal funds or from the proceeds of a lump-sum settlement; or

(b) ***If the award or settlement calls for weekly payments, then the employer or carrier shall issue the payment of the attorney's fee***~~[The administrative law judge, upon request of the employee, may order the payment of the attorney's fee]~~ in a lump sum directly to the attorney of record and deduct the attorney's fee from the weekly benefits payable to the employee in equal installments over the duration of the award or until the attorney's fee has been paid, commuting sufficient sums to pay the fee.

(5) At the commencement of the attorney-client relationship, the attorney shall explain to the employee the methods by which this section provides for the payment of the attorney's fee, and the employee shall select the method in which the attorney's fee is to be paid. His or her selection and statement that he or she fully understands the method to be used shall be submitted ***to the commissioner*** by his or her attorney, on a notarized form signed by the employee, ***within thirty (30) days following the finality of the claim***~~[at the time the motion for approval of the attorney's fee is submitted]~~. The commissioner shall develop the format and content of the form to be used pursuant to this section. The form to be used shall list on

its face all options permitted in this section for the payment of an attorney's fees and contain an explanation in nontechnical language of each method.

(6) The General Assembly declares that by the enactment of KRS 342.316(3), it is the legislative intent to encourage settlement and prompt administrative handling of those claims and thereby reduce expenses to claimants for compensation under the provisions of KRS 342.316, and the administrative law judge shall give due regard to this legislative intent in the handling of uncontested claims ~~[and the allowance of attorney's fees therein]~~.

(7) In a claim that has been reopened pursuant to the provisions of this chapter, an attorney's fee may be ***charged***~~[awarded by the administrative law judge]~~ subject to the limits set forth in subsection (2) of this section ***and subsection (10) of Section 2 of this Act***.~~[In awarding the attorney's fee, the administrative law judge shall consider the factors set forth in subsection (3) of this section.]~~ If no additional amount is recovered upon reopening, no attorney's fee shall be awarded. No attorney's fee shall be allowed~~[or approved]~~ exceeding the amounts provided in subsection (2)(a) of this section applicable to any additional amount recovered.

(8) ~~[Attorney's fees for representing employers in proceedings under this chapter pursuant to contract with the employer shall be subject to approval of the administrative law judge in the same manner as prescribed for attorney representation of employees.]~~Employer attorney's fees are subject to the limitation of ***twenty-two***~~[twelve]~~ thousand dollars ***($22,000)***~~[($12,000)]~~ maximum fees**,** except that fees for representing employers shall not be dependent upon the result achieved. Employer attorney's fees may be paid on a periodic basis while a claim is adjudicated and the payments need not be ***filed***~~[approved]~~ until the claims resolution process is completed. All such~~[approved]~~ fees shall be paid by the employer and in no event shall exceed the amount the employer agreed by contract to pay.

➔Section 8. KRS 342.730 is amended to read as follows:

(1) Except as provided in KRS 342.732, income benefits for disability shall be paid to the employee as follows:

(a) For temporary or permanent total disability, sixty-six and two-thirds percent (66-2/3%) of the employee's average weekly wage but not more than one hundred ***thirty*** percent ***(130%)***~~[(100%)]~~ of the state average weekly wage and not less than twenty percent (20%) of the state average weekly wage as determined in KRS 342.740 during that disability. Nonwork-related impairment and conditions compensable under KRS 342.732 and hearing loss covered in KRS 342.7305 shall not be considered in determining whether the employee is totally disabled for purposes of this subsection.

(b) ***For temporary partial disability, the difference between sixty-six and two-thirds percent (66-2/3%) of the employee's average weekly wage at the time of injury and sixty-six and two-thirds percent (66-2/3%) of the weekly wage the employee earns after the injury, subject to the limitations set forth in paragraph (a) of this subsection for a period not to exceed twenty-six (26) weeks.***

(c) For permanent partial disability, sixty-six and two-thirds percent (66-2/3%) of the employee's average weekly wage but not more than ***ninety***~~[seventy-five]~~ percent ***(90%)***~~[(75%)]~~ of the state average weekly wage as determined by KRS 342.740, multiplied by the permanent impairment rating caused by the injury or occupational disease as determined by the "Guides to the Evaluation of Permanent Impairment," times the factor set forth in the table that follows:

AMA Impairment	Factor
0 to ***20%***~~[5%]~~	***1.50***~~[0.65~~
~~6 to 10%~~	~~0.85~~
~~11 to 15%~~	~~1.00~~

~~16 to 20%~~	~~1.00]~~
21 to 25%	***1.75***~~[1.15]~~
26 to 30%	***2.00***~~[1.35]~~
31 to 35%	***2.25***~~[1.50]~~
36% and above	***2.50***~~[1.70]~~

Any temporary total ***or temporary partial*** disability period within the maximum period for permanent, partial disability benefits shall extend the maximum period but shall not make payable a weekly benefit exceeding that determined in subsection (1)(a) ***or (b)*** of this section***, whichever is applicable***. Notwithstanding any section of this chapter to the contrary, there shall be no minimum weekly income benefit for permanent partial disability and medical benefits shall be paid for the duration of the disability.

(c) 1. If, due to an injury, an employee does not retain the physical capacity to return to the type of work that the employee performed at the time of injury, the benefit for permanent partial disability shall be multiplied by three (3) times the amount otherwise determined under paragraph (b) of this subsection, but this provision shall not be construed so as to extend the duration of payments; or

2. If an employee returns to work at a weekly wage equal to or greater than the average weekly wage at the time of injury, the weekly benefit for permanent partial disability shall be determined under paragraph (b) of this subsection for each week during which that employment is sustained. During any period of cessation of that employment, temporary or permanent, for any reason, with or without cause, payment of weekly benefits for permanent partial disability during the period of cessation shall be two (2) times the amount otherwise payable under paragraph (b) of this subsection. This provision shall not be

construed so as to extend the duration of payments.

3. Recognizing that limited education and advancing age impact an employee's post-injury earning capacity, an education and age factor, when applicable, shall be added to the income benefit multiplier set forth in paragraph (c)1. of this subsection. If at the time of injury, the employee had less than eight (8) years of formal education, the multiplier shall be increased by four-tenths (0.4); if the employee had less than twelve (12) years of education or a high school Equivalency diploma, the multiplier shall be increased by two-tenths (0.2); if the employee was age sixty (60) or older, the multiplier shall be increased by six-tenths (0.6); if the employee was age fifty-five (55) or older, the multiplier shall be increased by four-tenths (0.4); or if the employee was age fifty (50) or older, the multiplier shall be increased by two-tenths (0.2).

4. Notwithstanding the provisions of KRS 342.125, a claim may be reopened at any time during the period of permanent partial disability in order to conform the award payments with the requirements of subparagraph 2. of this paragraph.

(d) For permanent partial disability, if an employee has a permanent disability rating of fifty percent (50%) or less as a result of a work-related injury, the compensable permanent partial disability period shall be four hundred twenty-five (425) weeks, and if the permanent disability rating is greater than fifty percent (50%), the compensable permanent partial disability period shall be five hundred twenty (520) weeks from the date the impairment or disability exceeding fifty percent (50%) arises. Benefits payable for permanent partial disability shall not exceed ninety-nine percent (99%) of sixty-six and two-thirds percent (66-2/3%) of the employee's average weekly wage as determined under KRS 342.740 and shall not exceed seventy-five percent (75%) of the state average weekly wage, except for benefits payable pursuant to paragraph (c)1.

of this subsection, which shall not exceed one hundred percent (100%) of the state average weekly wage, nor shall benefits for permanent partial disability be payable for a period exceeding five hundred twenty (520) weeks, notwithstanding that multiplication of impairment times the factor set forth in paragraph (b) of this subsection would yield a greater percentage of disability.

(e) For permanent partial disability, impairment for nonwork-related disabilities, conditions previously compensated under this chapter, conditions covered by KRS 342.732, and hearing loss covered in KRS 342.7305 shall not be considered in determining the extent of disability or duration of benefits under this chapter.

(2) The period of any income benefits payable under this section on account of any injury shall be reduced by the period of income benefits paid or payable under this chapter on account of a prior injury if income benefits in both cases are for disability of the same member or function, or different parts of the same member or function, and the income benefits payable on account of the subsequent disability in whole or in part would duplicate the income benefits payable on account of the pre-existing disability.

(3) Subject to the limitations contained in subsection (4) of this section, when an employee, who has sustained disability compensable under this chapter, and who has filed, or could have timely filed, a valid claim in his or her lifetime, dies from causes other than the injury before the expiration of the compensable period specified, portions of the income benefits specified and unpaid at the individual's death, whether or not accrued or due at his or her death, shall be paid, under an award made before or after the death, for the period specified in this section, to and for the benefit of the persons within the classes at the time of death and in the proportions and upon the conditions specified in this section and in the order named:

(a) To the widow or widower, if there is no child under the age of eighteen (18) or

incapable of self-support, benefits at fifty percent (50%) of the rate specified in the award; or

(b) If there are both a widow or widower and such a child or children, to the widow or widower, forty-five percent (45%) of the benefits specified in the award, or forty percent (40%) of those benefits if such a child or children are not living with the widow or widower; and, in addition thereto, fifteen percent (15%) of the benefits specified in the award to each child. Where there are more than two (2) such children, the indemnity benefits payable on account of two (2) children shall be divided among all the children, share and share alike; or

(c) If there is no widow or widower but such a child or children, then to the child or children, fifty percent (50%) of the benefits specified in the award to one (1) child, and fifteen percent (15%) of those benefits to a second child, to be shared equally. If there are more than two (2) such children, the indemnity benefits payable on account of two (2) children shall be divided equally among all the children; or

(d) If there is no survivor in the above classes, then the parent or parents wholly or partly actually dependent for support upon the decedent, or to other wholly or partly actually dependent relatives listed in paragraph (g) of subsection (1) of KRS 342.750, or to both, in proportions that the commissioner provides by administrative regulation.

(e) To the widow or widower upon remarriage, up to two (2) years, benefits as specified in the award and proportioned under paragraphs (a) or (b) of this subsection, if the proportioned benefits remain unpaid, to be paid in a lump sum.

(4) All income benefits payable pursuant to this chapter shall terminate as of the date upon which the employee [qualifies for normal old-age Social Security retirement benefits under the United States Social Security Act, 42 U.S.C. secs. 301 to 1397f, or two (2) years after the employee's injury or last exposure, whichever last occurs. In

like manner all income benefits payable pursuant to this chapter to spouses and dependents shall terminate when such spouses and dependents qualify for benefits under the United States Social Security Act by reason of the fact that the worker upon whose earnings entitlement is based would have qualified for normal old-age Social Security retirement benefits.

(5) All income benefits pursuant to this chapter otherwise payable for temporary total**,** ***temporary partial,*** and permanent total disability shall be offset by unemployment insurance benefits paid for unemployment during the period of temporary total***, temporary partial,*** or permanent total disability.

(6) All income benefits otherwise payable pursuant to this chapter shall be offset by payments made under an exclusively employer-funded disability or sickness and accident plan which extends income benefits for the same disability covered by this chapter, except where the employer-funded plan contains an internal offset provision for workers' compensation benefits which is inconsistent with this provision.

(7) If an employee receiving a permanent total disability award returns to work, that employee shall notify the employer, payment obligor, insurance carrier, or special fund as applicable.

➔Section 8. KRS 342.735 is amended to read as follows:

(1) The commissioner shall promulgate administrative regulations to expedite the payment of temporary total ***and temporary partial*** disability and medical expense benefits.

(2) The commissioner may promulgate administrative regulations incorporating managed care intended to reduce costs or to speed the delivery or payment of medical services to employees receiving medical and related benefits under this chapter.

(3) The commissioner shall promulgate administrative regulations pursuant to KRS Chapter 13A establishing an expedited method for resolving medical issues prior to the filing of a claim with the Department of Workers' Claims. The administrative regulations shall permit

an employee or other interested party, prior to the filing of a claim, to request a determination by an administrative law judge on medical issues relating to the reasonableness or appropriateness of the proposed medical care or relating to the obligation of the employer or the employer's insurance carrier to make payment of contested medical bills. However, the employee has the burden of proof to show the medical expenses are related to the injury, reasonable and necessary prior to an application of benefits being filed and before an award or order of benefits. Thereafter, the burden is upon the employer. The respondent to the moving party shall be given ten (10) days to answer a request for an expedited determination of medical issues, and the administrative law judge shall issue a ruling within seven (7) days thereafter. The interested parties shall be provided a form to provide to the medical care provider and the completed form filed with the department and served upon the respondent shall initiate the time for response and determination."