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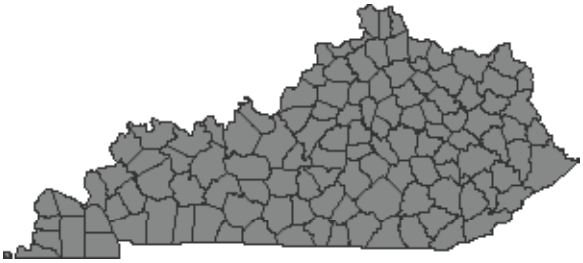
KENTUCKY WORKERS' COMPENSATION LAW



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ADMINISTRATIVE: Claims for workers' compensation benefits are administered by the Kentucky Department of Workers' Claims (DWC). The DWC oversees approximately 80,0000 employers and 1.7 million employees. This agency currently consists of 15 Administrative Law Judges (ALJ) who handle the adjudication of claims, a Workers' Compensation Board which handles appeals, and Specialists who answer general questions from the public, including employees, employers, and carriers. Once a decision is rendered by an ALJ and is appealed to the Workers' Compensation Board, further appeals can be made to the Court of Appeals and the Supreme Court as a matter of right.

PAYMENT OF BENEFITS: Temporary total disability benefits become due when an employee is unable to work for more than seven days, and benefits are owed until the employee reaches MMI or a level of improvement that permits a return to customary employment. If more than two weeks are missed, then benefits are payable for the first seven days. K.R.S.342.040.

AVERAGE WEEKLY WAGE: An employee's average weekly wage is computed based upon the highest 13 week quarter of wages during the 52 weeks prior to date of injury, if paid based upon an hourly wage. Overtime hours are included in the computation, but at the regular hourly rate. If the employee worked fewer than 13 weeks prior to date of injury, wages of a similarly situated employee must be used. K.R.S. 342.140.

TEMPORARY TOTAL DISABILITY RATE: Temporary Total Disability benefits are 66 2/3% of the employee's AWW, subject to minimum and maximum caps as set forth in Benefits Schedule, which is updated annually.

PERMANENT PARTIAL DISABILITY:
Permanent Partial Disability benefits are based on statutory formulas utilizing 5th Edition AMA Guides impairment ratings and multiplying factors. The compensation rate for PPD is 66 2/3% of the employee's AWW, subject to maximum cap as set forth in Benefits Schedule (nominimum for PPD). The weekly benefit for PPD is capped at 99% of 66 2/3% of the employee's AWW, but not more than maximum cap set forth in BenefitsSchedule (for DOI from and after 7/14/18, cap is 82.5% of the state AWW, except where the employee does not retain the physical capacity to return to preinjury work, in which case the cap increases to 110% of the state AWW). Here are the steps for calculating PPD:

1. Determine the correct average weekly wage for the employee. This should have already been reduced to a Form AWW- 1;
2. Multiply the employee's average weekly wage by 66 2/3%, and compare to maximum rates for year of injury, to determine compensation rate;
3. Multiply the impairment rating by the grid factor in table below, to arrive at disability rating;
4. Multiply the disability rating by the compensation rate, to determine a weekly benefit rate;
5. Determine applicability of multipliers (see below);
6. Multiply the weekly benefit rate by 425 weeks, if the disability rating is 50% or less, or by 520 weeks, if greater than 50%. This is the value of the claim if paid on a periodic basis. All income benefits terminate at age seventy (70), or four (4) years after the date of injury, whichever is later. The four-year minimum includes any periods of TTD paid.

If paid as a lump sum, there is a discount for present value of the settlement per the Present Worth Table (2.75% if weekly benefit is ≤$40 or 2.25% if the weekly benefit is >$40). For a 425 week award, the discounted weeks are 380.6478 (≤ $40) or 388.2302 (>$40).

CAUTION: These values were in effect as of 1/1/23. The present value table changes yearly, so be sure to utilize the most current table, which may be found on the DWC website.

AMA IMPAIRMENT RATING	ENHANCEMENT FACTOR
0-5%	.65
6-10%	.85
11-20%	1.00
21-25%	1.15
26-30%	1.35
31-35%	1.50
36% AND ABOVE	1.70

MULTIPLIERS:
If the Employee Does Not Retain the Physical Capacity to Return to Preinjury Work: If the employee does not retain the physical capacity to return to work, and does not return to other employment at equal or greater wages for the indefinite future, then the weekly benefit determined in Step 4 above is multiplied by three, with enhancements based on advanced age and limited education, as follows:

AGE ON DOI	3.0+
50-54	0.2
55-59	0.4
60 OR OLDER	0.6

EDUCATION LEVEL	3.0+
< 8 YEARS	0.4
< 12 YEARS (OR GED)	0.2

EXAMPLE: The employee has a loss of physical capacity to perform her pre-injury work. She is 60 years old and has a 10th grade education. The weekly benefit would be multiplied by 3.8, adding a .6 for age and a .2 for education to the 3-multiplier.

If The Employee Returns to Work at Equal Or Greater Wages: If the employee returns to work at an equal or greater wage than the AWW, but there is a period of cessation of such employment, then the weekly benefit as determined in Step 4 above is multiplied by two. This multiplier only applies during the period of cessation of employment at equal or greater wages, and can revert back to the original weekly benefit rate upon return to employment at equal or greater wages.

PERMANENT TOTAL DISABILITY: Determination made when employee has a permanent impairment rating, and also has a complete and permanent inability to return to work as a result of a work injury. K.R.S. 342.0011(11)(c). Income benefits payable at 66 2/3% of employee's average weekly wage until such time as the employee reaches the age of seventy (70) or four (4) years after the employee's injury, whichever occurs later. K.R.S.342.730(1) & (4). Subject to same maximum & minimum as TTD benefits.

MEDICAL TREATMENT: Employer is obligated to provide medical treatment, including any medical, surgical, prescription, or hospital expenses related to the recovery of the Employee from the work related injury. K.R.S. 342.020. The obligation does not terminate upon ending of payment of income benefits. For dates of injury from and after 7/14/18, there is a 15-year limit on medicals in cases of PPD, subject to extension on application by the employee. Employee must complete a Form 113 Notice of Designated Physician and return it to the Claim Administrator within ten days of receipt. Employee may change his/her choice of physician one time without consent of the Claim Administrator, which may not be unreasonably withheld. **This does not include a referral to a specialist by the designated treating physician.**

COMMONLY USED FORMS:

- Form IA-1-First Report of Injury
- Form IA-2-Subsequent Report of Injury (to report cessation or non-payment of TTD, denial of claim after IA-1 already filed, and other events)
- Form 101-Application for Resolution of Injury Claim (Initiates Litigation - 45 days to respond)
- Form 106-Medical Waiver and Consent
- Form 110-Settlement Agreement
- Form 113-Designated Physician Form
- Form 114-Request for Reimbursement of Medical Costs/Transportation Expenses

LIMITATIONS OF ACTIONS: Employees must file an Application for Resolution of Claim within two years of the date of injury, or the date of the last voluntary payment of TTD benefits, whichever i s later. For cumulative trauma claims, the employee must give notice and file the Form 101 within two (2) years from the date the employee is told by a physician that the trauma is work related. The cumulative trauma claim can be filed no later than five (5) years after the last work related exposure to the cumulative trauma. K.R.S. 342.185.

REOPENINGS: May be had upon a showing **BY ANY PARTY** that there has been a 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; newly discovered evidence which could not have been discovered with the exercise of due diligence; mistake; or fraud. No motion to reopen may be filed more than four years following the original order granting benefits, and a subsequent order does not extend the time to reopen or restart the four (4) year period. No party may file a motion to reopen if that party has filed a petition within one year previous to the most recent petition. K.R.S. 342.125.

APPEALS: A party shall file a Petition for Reconsideration within fourteen (14) days of the filing of a final Order or Award of an Administrative Law Judge.

Final ALJ decisions are subject to review by the Workers' Compensation Board. A Notice of Appeal must be filed with the Office of Workers' Claims within thirty (30) days of the date a final award, order or decision is rendered by an ALJ.

A party has the right to appeal the decision of the Workers' Compensation Board to the Kentucky Court of Appeals and further appeal to the Kentucky Supreme Court. Workers' compensation differs from other civil litigation because it is a statutory right for further appeal rather than discretionary by the Court.

MEDICAL FEE DISPUTES: Medical Fee Disputes are governed by 803 KAR 25:012, which states: "A dispute regarding payment, nonpayment, reasonableness, necessity, or work-relatedness of a medical expense, treatment, procedure, statement or service which has been rendered or will be rendered under KRS Chapter 342 shall be resolved by an Administrative Law Judge following the filing of a Medical Dispute."

The Medical Fee Dispute may be filed by an employee, employer, carrier or medical provider. If an Application for Resolution of Injury Claim has been settled or previously litigated, a Motion to Reopen must accompany the Medical Fee Dispute.

Following resolution of a claim, a medical payment obligor shall either tender payment or file a Medical Fee Dispute within thirty (30) days following receipt of a completed statement for services, which includes a request for authorization.

UTILIZATION REVIEW: Unless the claim is denied as non-compensable, in good faith, medical services "reasonably" related to the claim shall be subject to utilization review if:

(1) A medical provider requests preauthorization of a medical treatment or procedure;
(2) Notification of a surgical procedure or resident placement pursuant to an 803 KAR 25:096 treatment plan is received;
(3) The total medical costs cumulatively exceed $3,000;
(4) The total lost work days cumulatively exceed thirty (30) days; or
(5) An arbitrator or Administrative Law Judge orders a review.

Initiation of Utilization Review tolls the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(1). The thirty (30) day period commences on the date of the "final" utilization review decision. Physician review for purposes of addressing causation does not toll the thirty (30) day period for challenging or paying medical expenses.