FAIR CLAIMS PRACTICES AND A "LITTLE BIT OF ETHICS"

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There has been, for quite some time, a lack of understanding of and a great deal of misinformation disseminated concerning the law concerning unfair claims settlement practices, also known as "bad faith", and how it relates to workers compensation matters in general as well as medical disputes. Hopefully the following information will shed some light on the issue for you as you navigate the minefield of managing workers compensation claims as a self-insured.

UNFAIR CLAIMS PRACTICE

Contrary to popular belief, and what some individuals will tell you, there is significant specificity in the Kentucky statutes and regulations relating to unfair claims settlement practices. The statutory authority, KRS 342.267, reads as follows:

> **342.267 Unfair claims settlement practices -- Penalties.**
> If an insurance carrier, self-insured group, or **self-insured employer** providing workers' compensation coverage engages in claims settlement practices in violation of this chapter, or the provisions of KRS 304.12-230, the commissioner of the Department of Workers' Claims shall fine the insurance company, self-insured group, or self-insured employer the sum of **one thousand dollars ($1,000) to five thousand dollars ($5,000) for each violation** and if they have a pattern of violations, the commissioner **may revoke the certificate of self-insurance** or request the commissioner of insurance to revoke the certificate of authority of the insurance carrier or the self-insured group. (Emphasis added)

Pursuant to the enabling statutory authority, regulations have been promulgated to enable the Department of Workers Claims (DWC) to properly deal with unfair claims settlement practice. Relevant portions of the regulations are as follows:

803 KAR 25:240. Workers' compensation unfair claims settlement practices.

Section 2. File and Record Documentation.

(1) Each carrier's claim files and files held by an agent of the carrier shall be subject to examination by the executive director or the executive director's designee.

(2) Each carrier or agent of the carrier shall maintain claim data that is readily accessible and retrievable for examination.

(3) Documentation shall be contained in each claim file:

(a) Detailing the activities of each carrier and any agent of the carrier; and

(b) Detailing the foundations for the decision of the carrier or agent of the carrier upon material matters of the claim.

(4) Each document within a claim file shall be noted as to date received, date processed, or date mailed.

(5) For a carrier which does not maintain hard copy files, claim files shall be capable of duplication to legible hard copy.

(6) A claim file shall be maintained for a period not less than five (5) years following the creation of the material or the completion of the purpose for which it was created, whichever shall occur last.

Section 3. Notice of Policy Provisions and Information.

(1) A carrier shall provide adequate notice with regard to policy provisions and information with regard to coverage and benefits.

(2) Failure of a carrier to provide the notice required by KRS 342.610(6) in the form prescribed by 803 KAR 25:200 shall constitute an unfair claims settlement practice.

Section 4. Duty to Investigate.

Upon notice of a work-related injury, a carrier shall diligently investigate a claim for facts warranting the extension or denial of benefits.

Section 5. Standards for Prompt and Timely Actions.

(1) After receipt of notice of a work-related injury necessitating medical care or causing lost work days, a carrier shall as soon as practicable advise an injured employee of acceptance or denial of the claim.

(2) A carrier shall provide to the employee in writing the specific reasons for denial of a claim.

(3) A carrier shall inform an employee of additional information needed for the claim to be accepted.

(4) A carrier shall meet the time constraints for accepting and paying workers' compensation claims established in KRS Chapter 342 and applicable administrative regulations.

Section 6. Standards for Fair and Equitable Settlement.

(1) A carrier shall attempt in good faith to promptly pay a claim in which liability is clear;
(2) A carrier shall not misrepresent pertinent facts or law with regard to a claim;
(3) A carrier shall not compel an employee to institute formal proceedings with the Office of Workers' Claims to recover benefits where liability is clear;
(4) A carrier shall not offer a settlement which is substantially less than the reasonable value of a claim;
(5) A carrier shall not threaten to file or invoke a policy of filing appeals for the purpose of compelling a settlement for less than a workers' compensation award or benefit review determination; and
(6) A carrier shall not require an employee to obtain information which is accessible to the carrier.

So, what does all that legal mumbo-jumbo mean to you, a self-insured, as a practical matter? Here are some helpful hints. You are subject to the same legal requirements as a "carrier" under the Kentucky Workers Compensation Act. (KRS 342.0011[6].) Don't misinterpret the statute or the regulations mentioning only "carriers". All this law applies directly to you as a self-insured.

DOCUMENTATION AND INSPECTION---Your files are subject to examination by the Commissioner of the DWC or the Commissioner's "designee"- someone the Commissioner sends to look at your record. We can go to your office to look at your records concerning workers compensation matters. You are required to document, in each claim file, your activities relating to that workers compensation matter and provide details concerning the foundations of your decision upon material matters in the claim. You must maintain those files for five (5) years following their creation or the completion of the purpose for which the file was created.

NOTICE TO EMPLOYEES---You are required to notify your employees of their rights under the Kentucky Workers Compensation Act and how to go about initiating the claim. A copy of the notice required to be posted is attached at the end of this section.

DUTY TO INVESTIGATE---When an employee notifies you of the work-related injury you must diligently investigate the claim. You are under an obligation to determine the facts sufficient for decision on your part as to whether to expand benefits or deny benefits. (Also, remember your duty to document.)

PROMPT AND TIMELY ACTION---Kentucky law requires that, a after work-related injury which requires medical care or causes lost time, you must advise the injured employee as soon as practicable whether you will accept or deny the claim. If you decide to deny the claim, you must provide the employee with a written statement specifying the reasons you are denying the claim. If you determine that you do not have enough information for a decision on acceptance or denial of a claim, you must tell the employee what additional information you need to make a decision.

FAIR AND EQUITABLE SETTLEMENT---It is incumbent upon an employer to promptly pay a claim in which liability is clear. You cannot misrepresent pertinent facts or statements of the law regarding the claim. You are forbidden from compelling an employee to institute formal proceedings (file a claim) with the DWC to recover benefits where liability is clear.

In managing the claim, you cannot require the injured worker to obtain information which is accessible to you. You cannot offer a settlement which is substantially less than a reasonable of value the claim. (You can't "lowball" the injured worker.) In the same vein, you can't threaten to appeal for purposes of compelling a settlement for less than an award from an ALJ. (You can't "threaten to starve out" the injured worker.)

MEDICAL FEE DISPUTES---As in all other aspects of human existence in the United States of America, medical care has become THE major portion of the workers compensation dollar. It is what is most expensive for the employer side of the equation and takes up approximately two thirds of each workers compensation

dollar. The American public, including injured workers in Kentucky, have come to believe that medical science can keep them young, functional and pain free. Americans, with the advent of employer and/or government provided healthcare, have also simply become accustomed to going to the doctor more often. Some injured workers who have received "free" medical care for several months are inclined to continue going to the doctor. Some health care providers, recognizing that the workers compensation medical fee schedule provides more money more quickly for the same medical care have become accustomed to seeking payment for the services there rather than from ordinary healthcare.

All of this has resulted in the development of the procedure which has become known as "the medical fee dispute". For the purposes of this discussion, it will be assumed that the claim is accepted as a compensable work-related injury or occupational disease. Unless you have received approval for a managed healthcare system, the injured worker may select the medical provider to treat his or her injury or occupational disease. Most of the medical care with which you are or will be involved will be subject to the utilization review process. You must submit the medical issue to the utilization review process. Thereafter, you must make payment for services rendered directly to the provider within thirty (30) days of receipt of the statement for the services UNLESS you initiate a medical fee dispute. (KRS 342.020 governs the payment of medical expenses. The utilization review process is governed by 803 KAR 25:190, a copy of which is attached to this outline.)

Medical fee disputes are governed by 803 KAR 25:012, a copy of which is attached to this outline. This form of litigation has developed into a subspecialty which now occupies a major portion of the work of ALJs in Kentucky. In fiscal year 1990-1991, 124 medical fee disputes were filed with the DWC. By fiscal year 2009-2010 (the most recent fiscal year for which we have complete statistics) 1728 medical fee disputes were filed.

By the time you are engaged in a medical fee dispute process, you will surely be represented by an attorney and the intricacies of the medical fee dispute process are not germane to this discussion. It is sufficient that you have a copy of the

regulations. What is more important to this discussion is what you do leading up to and deciding to initiate a medical fee dispute.

So, how can you steer clear of a bad faith claim during the initial stages of what becomes a medical fee dispute? Well, first of all, make sure you understand the unfair claims settlement practice regulations as they relate to medical issues. Then apply those requirements to your procedure of dealing with your employees who suffer a work related injury or contract an occupational disease.

DOCUMENTATION AND INSPECTION—File all notices required by KRS 342.038 and KRS 342.039 (copies are attached). If one of your employees gives notice of a work-related injury or occupational disease and is absent from work for more than one day as a result of the injury or disease, you are required to notify the DWC and file a "First Report of Injury". Meticulously document every such notice and your filing of that notice.

NOTICE TO EMPLOYEES—Make sure you have posted the notice regarding your status as a self-insured with information employees will need in the event they suffer a work-related injury or contract an occupational disease. POST THIS NOTICE IN A CONSPICUIOUS PLACE WHERE ALL EMPLOYEES WILL SEE AND BE MADE AWARE OF THEIR RIGHTS UNDER THE KENTUCKY WORKERS COMPENSATION ACT. Failure to do so may be considered an unfair claims settlement practice.

If immediate medical care is necessary, make sure that medical care is provided. If you are participating in a managed care plan, be certain that the name of your plan, the plan's representative and the telephone number at which the plan can be contacted are all identified on the workers compensation notice. Make certain that the employee claiming the necessity of medical care from a work-related injury or occupational disease is provided with information concerning medical providers in your managed care plan. Immediately provide the employee

with a list of approved medical providers in the managed care program who will see and treat the employee.

If an employee requests information as to how to recover for a workers compensation injury or disease, don't hide that information or even hesitate in responding to the inquiry. Don't mislead employees concerning their rights and/or your obligations under the Kentucky Workers Compensation Act. Document your response and your actions following the request for information.

DUTY TO INVESTIGATE—As soon as you are informed of the occurrence of an injury or the discovery of an occupational disease, begin a diligent investigation of all the facts relating to the potential claim. This is not only the law, it just makes good sense. It is extremely important that you gather as much information as possible while the information is still fresh in the minds of those having knowledge of the incident or the claim. Take statements. Take pictures and/or videos. If the employee's information is accurate and the need for medical care is apparent, make sure it is promptly provided. Document your activities in the investigation of the potential claim.

PROMPT AND TIMELY ACTION—Once you have gathered all the information necessary to make a decision concerning your position on claim, pull the trigger and make that decision. Make the decision based on a pragmatic analysis of your responsibility under the Kentucky Worker's Compensation Act, not what you may THINK you can get away with. Don't play games. The injured employee may be dumber than a box of rocks but you have no idea with whom the person may discuss the matter and whether or not that other person is knowledgeable concerning workers compensation matters. The employee may be married to the third cousin of the most active plaintiff's lawyer in the next county. If you're trying to snooker the poor soul, it may very well come back to bite your company in the wallet.

As soon as you have reached that decision, immediately tell the employee whether you will accept the claim or deny the claim. Don't beat around the bush hoping the matter will go away—it won't. If you decide to deny the claim, do it promptly and give the employee a written statement specifying the reasons you are denying the claim and the facts upon which you base the denial. If you have not reached a decision because you haven't gathered enough information, tell the employee what additional information you need. If that information is accessible to you, don't tell the employee he or she must go off in search of the information and return it to you. Under Kentucky law, it is your responsibility. Document all this activity, including the conversations you have with your employee who is about to become a claimant.

FAIR AND EQUITABLE SETTLEMENT—Again, don't play games. Whether or not you agree with Kentucky law, you as a self-insured employer are required to promptly pay a claim in which liability is clear. Perhaps more importantly, Kentucky law prohibits the employer side from offering a settlement which is substantially less than a reasonable value of THAT particular claim.

If you remember and fully comply with the statutory and regulatory mandates concerning medical coverage of compensable conditions and unfair claims practices, you'll probably never be summoned to Frankfort for one of the unfortunate sessions with Commissioner Lovan. Commissioner Lovan is a lovely person…most of the time. However, he is DEADLY SERIOUS concerning unfair claims settlement practice actions. If you've ever been summoned for one of those sessions, you (and your employer's wallet) probably won't soon forget it.

WHAT CONSTITUTES A "BAD FAITH" VIOLATION
i.e.—WHAT IS AN UNFAIR CLAIMS SETTLEMENT PRACTICE

The statute governing unfair claims settlement practices, KRS 342.267, was passed as part of House Bill 1 in 1996, a major revision of Kentucky Workers Compensation Act which was effective December 12, 1996. There was no "guiding delineation" of exactly what amounted to an unfair claims settlement practice until the governing regulation, 803 KAR 25:240, was promulgated and became effective February 18, 1999. The workers compensation community has now dealt with the defined process for almost 13 years. There are now examples of what type of activity has landed employers/insurers in hot water.

Complaints filed with the DWC are processed through the General Counsel's office. In FY 2012-13 and FY 2013-14, 109 UCP cases were opened by the DWC. The good news is, most of those cases do not result in citations and civil penalties (fines). Some of the complaints are groundless but, unfortunately, many are not. The bad news is fines issued by the Commissioner range from $1,000 to $5.000 PER VIOLATION. In FY 2012-13 $78,000 in civil penalties resulted and in the most recently completed fiscal year, $88,750 in civil penalties resulted. That would average $1,549.82 per case. Keep in mind, however, not every case resulted in a penalty so the ones in which penalties were issued were much higher than the "average". Regardless of the size of your workers compensation budget, that is certainly a very significant amount of money to simply give away without receiving something of some tangible benefit for in return.

Of course, not all of the violations which resulted in fines related solely to issues concerning medical care. Examples range from hiding coverage to lying about the employer's responsibility and/or the content of the statutory and regulatory provisions. In addition to those, here are some other examples of complaints which resulted in fines:

- Denying or failing to authorize medical treatment (often cited)

- Not appealing an ALJ award but refusing to pay for office visits
- Failure to file a first report of injury (often cited)
- Attempting to alter off work status
- Forcing claimant to file a formal claim (indemnity & medical benefits)
- Failure to inform claimant of acceptance or denial of claim
- Failure to pay out-of-pocket medical expenses
- Value to promptly pay medical expenses (often cited)
- Lying about the employer's responsibility and/or the law
- Offering to settle a legitimate claim ONLY with waiver of future medical expense benefits
- Sending the plaintiff for an IME (to a defense only doctor who diagnosed a herniated lumbar disc and recommended surgery) then doing NOTHING thereby forcing plaintiff to initiate a claim…Then failing to file a Form 111…Then doing NOTHING during proof time… Then refusing to settle when the only evidence in the record was from defendant's doctor (who diagnosed a herniated lumbar disc and recommended surgery)

If you contemplate adjusting/managing claims assigned to you in any way that is even REMOTELY SIMILAR to the examples above, be sure to put 657 Chamberlin Aveenue, Frankfort, KY, 40601, in your car's GPS system. You'll be making a trip to the Commissioner's office.

ETHICAL REQUIREMENTS FOR CLAIMS MANAGERS

As previously noted, even though you manage claims for a self-insured entity, you are subject to the same legal requirements as a "carrier" under the Kentucky Workers Compensation Act. (KRS 342.0011[6].) Insurance adjusters must now be licensed in Kentucky to adjust claims. Kentucky's licensing requirement contains a continuing education requirement. The regulation requiring continuing education for adjusters/claims managers includes a requirement that any "…continuing

education course ***shall contribute directly***, at a professional level, ***to the competence of the licensee [in the subject of] ethics"***. (Kentucky Administrative Regulations [KAR], emphasis added.) However, we have been unable to find any "code", "rules", "statement" or description of requirements for ethical conduct by insurance adjusters/claims managers. Therefore, in order to present some substantive ideas for the claims adjustment side of the audience, we will draw heavily from the Florida administrative code section relating to ethics and adjusting claims. Citations to the Florida administrative code are preceded with "FAC".

As attorneys have a requirement to be diligent, so also do claims managers.

FAC 69B-220.201.

(f) An adjuster, upon undertaking the handling of a claim, shall act with dispatch and due diligence in achieving a proper disposition of the claim.

In a seriously injured worker's situation, the most important initial aspect is often adequate medical care. The worker is fearful at the prospect of not being able to recover and return to work and be able to provide for his/her family. The worker, in the vast majority of the situations, has a very limited understanding of both the medical as well as the medical benefit aspects of his/her dilemma. Those workers are in a very vulnerable position and the individual who is adjusting/managing that worker's claim seemingly holds the worker's future in his or her hands. It is imperative that the adjuster/claims manager proceed with diligence and not frustrate or delay the process of the delivery of needed medical care. The following comments indicate why that is beneficial not only to the injured worker, but to the adjuster/claims manager.

There is also unethical obligation for claims managers (and EVERYONE dealing with workers compensation matters) to exhibit candor for the tribunal. The Florida regulation reads as follows:

FAC 69B-220.201.

(d) An adjuster shall make truthful and unbiased reports of the facts after making a complete investigation.

(e) An adjuster shall handle every adjustment and settlement with honesty and integrity, and allow a fair adjustment or settlement to all parties without any remuneration to himself except that to which he is legally entitled.

For everyone, the statutory and regulatory requirement is as follows:

KRS 342.267
803 KAR 25:240 Section 6. Standards for Fair and Equitable Settlement.

(2) A carrier shall not misrepresent pertinent facts or law with regard to a claim;

The presentation of misleading or fallacious statements concerning the proceedings, compliance with discovery requests, settlement negotiations, your employer's position concerning the litigation, etc. violates these rules. A legal argument based on a knowingly false representation of the law constitutes dishonesty toward the ALJ as does presenting knowingly false evidence.

Not all injured workers are liars and not all employee representatives tell the truth. There is a tendency for employer representatives to mistrust injured workers and give unquestioned credit to other employer representatives (supervisors, etc.). When the issue with which you're dealing comes down to an issue of credibility of the injured worker versus another employer representative, look behind the statements of the principles for common sense, logical sequences of events and common occurrences. Don't automatically believe or disbelieve any of the statements and do your best to find out who is telling the truth. If possible, talk to more than one employer representative. That way, you can insure that your side is not UNWITTINGLY failing in its responsibility of **CANDOR TOWARD THE TRIBUNAL**.

One of the ethical requirements for attorneys is" COMPETENCE". The requirement requires "the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation". There is no similar statement relating to competence Florida code relating to adjusters. However, Kentucky has a continuing education requirement for claims managers implies a requirement that claims managers be competent. To be competent, you must know the law. Familiarize yourself with Chapter 342 the Kentucky Revised Statutes AND

Chapter 803 of the Kentucky Administrative Code. Pay particular attention to the following regulations as they relate to medical expenses:

803 KAR 25:012. Resolution of medical disputes.

803 KAR 25:089. Workers' compensation medical fee schedule for physicians.

803 KAR 25:091. Workers' compensation hospital fee schedule.

803 KAR 25:092. Workers' compensation pharmacy fee schedule.

803 KAR 25:096. Selection of physicians, treatment plans and statements for medical services.

803 KAR 25:110. Workers' compensation managed health care plans.

803 KAR 25:190. Utilization review and medical bill audit.

803 KAR 25:240. Workers' compensation unfair claims settlement practices.

If you are not familiar with the statutory and regulatory authority governing Kentucky workers compensation matters, you are not competent to manage medical matters or to litigate medical fee disputes.

It also helps to simply know a little medicine. Anyone involved in medical matters which sometimes give rise to medical fee disputes should also know a little medicine. A practicing attorney whose client complains that the employer/carrier will not approve an MRI recommended by his treating family physician, it helps to know a little bit about low back injuries. Example: the client settled his low back strain/sprain case two years ago for a 3.25% permanent partial disability with medical left open and has treated with the family physician ever since. He complained that the pain is still in his low back but doesn't radiate down his hips or into his legs. What should the attorney tell him? Well, in all likelihood, that MRI will not be found to be reasonably necessary because there is no clinical evidence of radiculopathy or any other neurological signs and symptoms. This is probably a battle neither the attorney nor the client wants to fight.

On the other hand, a claims manager adjusting the claim of the same injured worker but with these added facts: the strain/sprain case was settled only six months ago, was related to the area between the L4 and S1 levels and the employee now has a foot drop. The MRI will be in the neighborhood of $500 to $750. APPROVE THE REQUEST!

If you haven't done so in your career, attend medical/legal seminars, particularly ones which address issues of anatomy, cervical spine injuries, lumbar spine injuries, shoulder injuries and injuries of the knee. In this business, you have to know a little medicine.

Also, **KNOW THE MEDICAL COMMUNITY.** When you are making decisions regarding the delivery of needed medical care, it is always good to know the medical community-- the doctors, the diagnostic centers, the hospitals. The medical community, like the insurance community, the legal community, industry, education, the news media, government and all aspects of the human existence, consist of individuals and entities which display a wide variety of skill levels, credibility levels, consistency, ethics, honesty and morality. The world is full of wonderful practitioners of the healing arts, the legal arts and the adjusting arts. However, the medical community, the legal community and the insurance community each also has its fair shares of sociopaths. If at all possible, get to know the players so you know which players fall in which categories.

If Marcus Welby, M.D., recommends an MRI, the request probably shouldn't be denied, even if the carrier's utilization review examiner recommends denial. Just because the UR opinion finds the recommended treatment not reasonably necessary does NOT mean it cannot be paid if it appears to be a reasonable request from a reasonable medical practitioner or facility. If you are the claims manager, learn to make these types of decisions in order to be competent.

ADVICE FROM TWO OF THE "OLD DUDES OF WORKERS COMPENSATION"

Here are some things that you won't find in any statute or regulation. This is simply advice from a guys who have been involved in Kentucky workers compensation for almost a combined 70 years. We hope the advice is helpful to you in your management/adjustment of claims.

1. **This isn't about you.** Don't become enamored with the power you can exercise over the claimants! Do your job as if no one (other than your mother) will ever know what action you have taken. Being able to "show that guy something" might seem like a good idea in the heat of anger over a comment he made, but it may very well come back to haunt you later. Remember that, while some of the claimants are overstating their injury (or even faking), most of them aren't. Most of them are afraid of you and/or the system and afraid of what may happen to them, their job, and their family while they can't work. **DON'T DO SOMETHING OF WHICH YOUR MOTHER WOULDN'T APPROVE.**

2. **Don't pick a fight over pennies that will cost you dollars.** Of course the reference to "you" is to your company/employer. Often times, a medical fee dispute is the opening salvo that starts the war. Make sure the amount of the money at issue is worth the claim that is likely to follow. Most claimants don't want to file a claim. If they are receiving their TTD (while off work) and their medical expenses are being paid, filing a claim is not in their plan. They just want to get well and go back to work. Don't give them a reason to go see a lawyer and have a claim filed.

3. **The results of MRIs/CT Scans/EMGs/NCVs etc. can prove YOUR position.** Medical technology continues to make great strides in diagnostic testing. If a reasonable treating physician is advocating diagnostic testing for his patient, your claimant, it is probably a reasonable expense that you should NOT deny/contest. If there are not operable lesions or serious injuries, these diagnostic tests will in all likelihood confirm that fact. THAT IS GOOD FOR YOU. If there IS a serious injury, that will be discovered anyway. So don't go to the expense of contesting a procedure that has a chance of proving your position that there is nothing seriously wrong with this claimant.

4. **You MUST submit most medical statements to Utilization Review but you MUST NOT use UR as a litigation tool.** Read, study and get to understand 803 KAR 25:190. It explains in very explicit language what the employer side of

workers compensation MUST do in regard to having medical procedure requests reviewed. The term "utilization review" is defined in the regulation (Sec. 1 [6]) as a review of the medical **necessity** and **appropriateness** of the medical care in question. It has no relation to causation and/or work relatedness. The regulations DON'T require nor authorize the development of a system to or the use of the process to frustrate a claimant (or certain health care providers) in obtaining (or dispensing) necessary medical care. Like the questions in a "push poll", the reviewing practitioners selected or the information sent to the reviewers can be manipulated to reach a desired result rather than to obtain a true answer to a question.

Also, there is ***nothing in the regulation that REQUIRES the filing of a medical fee dispute*** in the event the UR process recommends the denial of expense. If you CHOOSE to file a motion to reopen and a Form 112, that is your prerogative, but don't tell the gathered players at the BRC (especially the ALJ) that "the law required my me to file the MFD". If you choose to pay a bill which you believe will be found compensable that, also, is your prerogative.

5. Review the statutes and regulations BEFORE filing a motion to reopen or a Form 112. The regulations are quite specific and somewhat technical. Since there are fewer (for now anyway) medical fee disputes than other initiating pleadings, they are not as familiar as the run-of-the-mill documents. To make sure you have crossed all your "t's" and dotted all your "i's", go over the law before you file the pleading that will initiate the litigation. If a medical fee dispute is initiated in an improper manner, the consequences can be VERY costly to you and/or your client.

ADDENDUM 1

WORKERS' COMPENSATION NOTICE

COMMONWEALTH OF KENTUCKY

WORKERS' COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers' Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name:

_____

Address:

_____

_

Workers Compensation Carrier
(or third party administrator):

_____

Policy #:_____, effective _____ to

_____

Address:

_____

_

Telephone: _____, Contact Person

_____

EMPLOYEES: IF INJURED – NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS ☐ IS NOT ☐ participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is _____, its representative is _____, phone number _____.

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) day of disability. A CLAIM MUST BE filed with the Department of Workers' Claim WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers' compensation rights are not promptly answered call THE KENTUCKY DEPARTMENT OF WORKERS CLAIMS at 1-800-554-8601 to speak to an Ombudsman or Workers' Compensation Specialist.

EMPLOYER SUPERVISORS – NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

ADDENDUM 2

803 KAR 25:190. Utilization review and medical bill audit.

803 KAR 25:190. Utilization review and medical bill audit.

RELATES TO: KRS Chapter 342

STATUTORY AUTHORITY: KRS 342.035(5), 342.260

NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 provides that the Executive Director of the Office of Workers' Claims shall promulgate administrative regulations necessary to carry on the work of the Office of Workers' Claims, and the executive director may promulgate administrative regulations not inconsistent with the provisions of KRS Chapter 342. KRS 342.035(5) provides that the Executive Director of the Office of Workers' Claims shall promulgate administrative regulations that require each insurance carrier, group self-insurer and individual self-insured employer to certify to the executive director the program

it has adopted to insure compliance with the medical fee schedule provisions of KRS 342.035(1) and (4). KRS 342.035(5) also requires the executive director to promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, group self-insurer or self-insured employer pursuant to KRS Chapter 342. This administrative regulation insures that insurance carriers, group self-insurers, and individual self-insured employers implement a utilization review and audit program.

Section 1. Definitions. (1) "Carrier" is defined by KRS 342.0011(6).

(2) "Executive Director" is defined by KRS 342.0011(9).

(3) "Denial" means a determination by the utilization reviewer that the medical treatment or service under review is not medically necessary or appropriate and, therefore, payment is not recommended.

(4) "Medical bill audit" means the review of medical bills for services which have been provided to assure compliance with adopted fee schedules.

(5) "Preauthorization" means a process whereby payment for a medical service or course of treatment is assured in advance by a carrier.

(6) "Utilization review" means a review of the medical necessity and appropriateness of medical care and services for purposes of recommending payments for a compensable injury or disease.

(7) "Utilization review and medical bill audit plan" means the written plan submitted to the executive director by each carrier describing the procedures governing utilization review and medical bill audit activities.

(8) "Vendor" means a person or entity which implements a utilization review and medical bill audit program for purposes of offering those services to carriers.

Section 2. Utilization Review and Medical Bill Audit Program. (1) The utilization review program shall assure that:

(a) A utilization reviewer is appropriately qualified;

(b) Treatment rendered to an injured worker is medically necessary and appropriate; and

(c) Necessary medical services are not withheld or unreasonably delayed.

(2) The medical bill audit program shall assure that:

(a) A statement or payment for medical goods and services and charges for a deposition, report, or photocopy complies with KRS Chapter 342 and applicable administrative regulations;

(b) A medical bill auditor is appropriately qualified; and

(c) A statement for medical services is not disputed without reasonable grounds.

Section 3. Utilization Review and Medical Bill Audit Plan Approval. (1) A carrier shall fully implement and maintain a utilization review and medical bill audit program.

(2) A carrier shall provide to the executive director a written plan describing the utilization review and medical bill audit program. The executive director shall approve each utilization review and medical bill audit plan which complies with the requirements of this administrative regulation and KRS Chapter 342.

(3) A vendor shall submit to the executive director for approval a written plan describing the utilization review and medical bill audit program. Upon approval, the vendor shall receive written notice from the executive director.

(4) A carrier who contracts with an approved vendor for utilization review or medical bill audit services shall notify the executive director of the contractual arrangement. The contractual arrangement may provide for separate utilization review and medical bill audit vendors.

(5) A plan shall be approved for a period of four (4) years, or until December 31, 2000, whichever is later.

(a) At least ninety (90) days prior to the expiration of the period of approval, a carrier or its approved vendor shall apply for renewal of the approval.

(b) During the term of an approved plan, the executive director shall be notified as soon as practicable of a material change in the approved plan or a change in the selection of a vendor.

Section 4. Utilization Review and Medical Bill Audit Written Plan Requirements. The written utilization review and medical bill audit plan submitted to the executive director shall include the following elements:

(1) A description of the process, policies and procedures whereby decisions shall be made;

(2) A description of the specific criteria utilized in the decision making process, including a description of the specific medical guidelines used as the resource to confirm the medical diagnosis and to provide consistent criteria and practice standards against which care quality and related costs are measured;

(3) A description of the criteria by which claims, medical services and medical bills shall be selected for review;

(4) A description of the qualifications of internal and consulting personnel who shall conduct utilization review and medical bill audit and the manner in which the personnel shall be involved in the review process;

(5) A description of the process to assure that a treatment plan shall be obtained for review by qualified medical personnel if a treatment plan is required by 803 KAR 25:096;

(6) A description of the process to assure that a physician shall be designated by each injured employee as required under 803 KAR 25:096;

(7) A description of the process for rendering and promptly notifying the medical provider and employee of the initial utilization review decision;

(8) A description of the reconsideration process within the structure of the utilization review and medical bill audit program;

(9) An assurance that a database shall be maintained, which shall:

(a) Record:

1. Each instance of utilization review;

2. Each instance of medical bill audit;

3. The name of the reviewer;

4. The extent of the review;

5. The conclusions of the reviewer; and

6. The action, if any, taken as the result of the review;

(b) Be maintained for a period of at least two (2) years; and

(c) Be subject to audit by the executive director, or his agent, pursuant to KRS 342.035(5)(b);

(10) An assurance that a toll free line shall be provided for an employee or medical provider to contact the utilization reviewer. The reviewer or a representative of the reviewer shall be reasonably accessible to an interested party at least five (5) days per week, forty (40) hours per week during normal business hours;

(11) A description of the policies and procedures that shall be implemented to protect the confidentiality of patient information; and

(12) An assurance that the acute low back pain practice parameter adopted by the executive director pursuant to KRS 342.035(8)(a) shall be incorporated in the plan as the standard for evaluating an applicable low back claim. Additional medical guidelines which may be adopted by the executive director pursuant to KRS 342.035(8)(a) shall be incorporated in a utilization review plan.

Section 5. Claim Selection Criteria. (1) Unless the carrier, in good faith, denies the claim as noncompensable, medical services reasonably related to the claim shall be subject to utilization review if:

(a) A medical provider requests preauthorization of a medical treatment or procedure;

(b) Notification of a surgical procedure or resident placement pursuant to an 803 KAR 25:096 treatment plan is received;

(c) The total medical costs cumulatively exceed $3000;

(d) The total lost work days cumulatively exceed thirty (30) days; or

(e) An arbitrator or administrative law judge orders a review.

(2) If applicable, utilization review shall commence when the carrier has notice that a claims selection criteria has been met.

(a) The following requirements shall apply if preauthorization has been requested:

1. The initial utilization review decision shall be communicated to the medical provider and employee within two (2) working days of the initiation of the utilization review process, unless additional information is required. If additional information is required, tender of a single request shall be made within two (2) additional working days.

2. The requested information shall be tendered by the medical provider within ten (10) working days.

3. The initial utilization review decision shall be rendered within two (2) working days following receipt of the requested information.

(b) The following requirements shall apply if retrospective utilization review occurs:

1. The initial utilization review decision shall be communicated to the medical provider and employee within ten (10) days of the initiation of the utilization review process, unless additional information is required. If additional information is required, tender of a single request shall be made within two (2) additional working days.

2. The requested information shall be tendered by the medical provider within ten (10) working days.

3. The initial utilization review decision shall be rendered within two (2) working days following receipt of the requested information.

(3) A medical provider may request an expedited utilization review determination for proposed medical treatment or services, the lack of which could reasonably be expected to lead to serious physical or mental disability or death. The expedited utilization review determination shall be provided within twenty-four (24) hours following a request for expedited review.

(4) Initiation of utilization review shall toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(1). The thirty (30) day period shall commence on the date of the final utilization review decision.

(5) Each medical bill audit shall be initiated within seven (7) days of receipt to assure:

(a) Compliance with applicable fee schedules;

(b) Accuracy; and

(c) That a physician has been designated in accordance with 803 KAR 25:096.

(6) A medical bill audit shall not toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(1).

Section 6. Utilization Review and Medical Bill Audit Personnel Qualifications. (1) Utilization review personnel shall have education, training, and experience necessary for evaluating the clinical issues and services under review. A physician, registered nurse, licensed practical nurse, medical records technician or other personnel, who through training and experience is qualified to issue decisions on medical necessity or appropriateness, shall issue the initial utilization review approval.

(2) A physician shall issue an initial utilization review denial. A physician shall supervise utilization review personnel in making utilization review recommendations. Personnel shall hold the license required by the jurisdiction in which they are employed.

(3) Personnel conducting a medical bill audit shall have the education, training or experience necessary for evaluating medical bills and statements.

Section 7. Written Notice of Denial. (1) Following initial review, a written notice of denial shall:

(a) Be issued to both the medical provider and the employee in a timely manner but no more than ten (10) days from the initiation of the utilization review process;

(b) Be clearly entitled "UTILIZATION REVIEW - NOTICE OF DENIAL"; and

(c) Contain:

1. A statement of the medical reasons for denial;

2. The name, state of licensure and medical license number of the reviewer; and

3. An explanation of utilization review reconsideration rights.

(2) Payment for medical services shall not be denied on the basis of lack of information absent documentation of a good faith effort to obtain the necessary information.

Section 8. Reconsideration. (1) A reconsideration process to appeal an initial decision shall be provided within the structure of utilization review.

(a) A request for reconsideration of the initial utilization review decision shall be made by an aggrieved party within fourteen (14) days of receipt of a written notice of denial.

(b) Reconsideration of the initial utilization review decision shall be conducted by a different reviewer of at least the same qualifications as the initial reviewer.

(c) A written reconsideration decision shall be rendered within ten (10) days of receipt of a request for reconsideration. The written decision shall be clearly entitled "UTILIZATION REVIEW - RECONSIDERATION DECISION". If the reconsideration decision is made by an appropriate specialist or subspecialist, the written decision shall further be entitled "FINAL UTILIZATION REVIEW DECISION".

(d) Those portions of the medical record that are relevant to the reconsideration, if authorized by the patient and in accordance with state or federal law, shall be considered and providers shall be given the opportunity to present additional information.

(2)(a) If a utilization review denial is upheld upon reconsideration and a board eligible or certified physician in the appropriate specialty or subspecialty area, or a chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095 has not previously reviewed the matter, an aggrieved party may request further review by:

1. A board eligible or certified physician in the appropriate specialty or subspecialty; or

2. A chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095.

(b) A written decision shall be rendered within ten (10) days of the request for specialty reconsideration. The specialty decision shall be clearly entitled "FINAL UTILIZATION REVIEW DECISION".

(3) A reconsideration process to appeal an initial decision shall be provided within the structure of medical bill audit.

(a) A request for reconsideration of the medical bill audit decision shall be made by an aggrieved party within fourteen (14) days of receipt of that decision.

(b) Reconsideration shall be conducted by a different reviewer of at least the same qualifications as the initial reviewer.

(c) A written decision shall be rendered within ten (10) days of receipt of a request for reconsideration. The written decision shall be clearly entitled "MEDICAL BILL AUDIT-RECONSIDERATION DECISION".

(d) A request for reconsideration of the medical bill audit decision shall not toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(1). (22 Ky.R. 303; Am. 740; eff. 9-19-95; 23 Ky.R. 1459; 2181; 2489; eff. 12-13-96; 24 Ky.R. 1771; 2124; 2686; eff. 6-15-98; 27 Ky.R. 1893; eff. 3-19-2001; TAm eff. 8-9-2007.)

ADDENDUM 3

803 KAR 25:012. Resolution of medical disputes.

803 KAR 25:012. Resolution of medical disputes.

RELATES TO: KRS 342.020, 342.035, 342.125, 342.260, 342.325, 342.735
STATUTORY AUTHORITY: KRS 342.020, 342.260(1), 342.735(1)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260(1) requires the Executive Director of the Office of Workers' Claims to promulgate administrative regulations necessary to implement KRS Chapter 342. KRS 342.325 requires that a question arising under KRS Chapter 342 which is not settled by agreement of the parties shall be determined by an administrative law judge. KRS 342.735(1) requires the executive director to promulgate administrative regulations to expedite the payment of medical

expense benefits. This administrative regulation establishes a procedure for the resolution of a medical dispute before an administrative law judge.

Section 1. Procedure. (1) 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 Form 112 (Medical Dispute).

(2) Form 112 may be filed by an employee, employer, carrier or medical provider.

(3)(a) The Form 112 shall be accompanied by the following items:

1. Copies of all disputed bills;

2. Supporting affidavit setting forth facts sufficient to show that the movant is entitled to the relief sought;

3. Necessary supporting expert testimony; and

4. The final decision from a utilization review or medical bill audit with the supporting physician opinion.

(b) A single Form 112 may encompass statements, services, or treatment previously rendered as well as future statements, services, or treatment of the same nature or for the same condition, if specifically stated.

(4)(a) If an application for adjustment of claim concerning the injury or disease which is the subject of the dispute has not been filed, copies of the Form 112 and attachments sufficient to serve the other parties, including the employee, employer, and medical provider, shall be filed with the executive director, who shall make service on the named parties.

(b) An opposing party may, within twenty (20) days after service by the executive director, file a response, accompanied by affidavit setting forth facts sufficient to show that the movant is not entitled to the relief sought.

(c) A response shall be served on the executive director and all other parties within the twenty (20) day limit established in paragraph (b) of this subsection.

(d) The dispute shall be assigned to the Frankfort motion docket, where it shall be summarily decided upon the pleadings or assigned for further proceedings before an administrative law judge.

(5) If an application for adjustment of claim is pending concerning the injury or disease which is the subject of the dispute, the movant shall file a Form 112 with the executive director and shall also serve copies on the other parties of record. The movant shall further file a motion to join the medical provider as a party to the claim. This motion shall conform with the requirements of 803 KAR 25:010, Section 4.

(6) Following resolution of a workers' compensation claim by final order, a motion to reopen pursuant to 803 KAR 25:010, Section 4(6), shall be filed in addition to the Form 112.

(a) Unless utilization review has been initiated, the motion to reopen and Form 112 shall be filed within thirty (30) days following receipt of a complete statement for services pursuant to 803 KAR 25:096.

(b) The motion to reopen and Form 112 shall be served on the parties, upon the employee, even if represented by counsel, and upon the medical providers whose services or charges are at issue. If appropriate, the pleadings shall also be accompanied by a motion to join the medical provider as a party.

(c) This dispute shall be assigned to the Frankfort motion docket, where it shall be either summarily decided upon the pleadings, or assigned to an administrative law judge for further proof time and final resolution.

(7)(a) Except as provided by paragraph (b) of this subsection, a Form 112 shall be accompanied by a motion for a partial remand to the administrative law judge assigned to the claim if an appeal is pending before the Workers' Compensation Board concerning the injury or disease which is the subject of the dispute.

(b) If entitlement to medical services is dependent upon resolution of an issue on appeal, the Form 112 shall be accompanied by a motion to the Workers' Compensation Board to hold the Form 112 in abeyance pending a final decision on the appeal.

(8) If the contested expense is subject to utilization review, a medical dispute shall not be filed prior to exhaustion of the utilization review process. The employer or its medical payment obligor shall have thirty (30) days following the final utilization review decision to file a medical dispute.

(9) Repeated filing of identical Form 112's concerning the same subject matter shall not be necessary if an administrative law judge has ruled on both the past expenses and the necessity of future expenses.

(10) A party aggrieved by a decision of the administrative law judge in a medical dispute may appeal to the Workers' Compensation Board by following the procedures established in 803 KAR 25:010, Section 20.

Section 2. In accordance with KRS 342.310, a sanction:

(1) Shall be assessed, as appropriate, if:

(a) An employer or a medical payment obligor challenges a bill without reasonable medical or factual foundation; or

(b) A medical provider, without reasonable foundation, submits a bill for a nonwork-related condition to an employer or its medical payment obligor; and

(2) May be imposed if a movant files a medical dispute prior to exhaustion of the required utilization review or medical bill audit procedures.

Section 3. Expedited Medical Disputes. (1) If a dispute arises requiring expedited determination of the reasonableness, appropriateness or employer's liability for proposed medical care, the lack of which could lead to serious physical or mental disability or death, an employee or employer shall file a written request on Form 120EX to seek an expedited determination. The Form 120EX shall be filed with:

(a) An affidavit of the employee or other witness that the injury or disease which is the subject of the dispute is compensable under KRS Chapter 342 in the format prescribed in Appendix A;

(b) An affidavit of a physician which shall:

1. Explain why failure to obtain or undertake the proposed medical care within forty-five (45) days could lead to serious physical or mental disability or death of the employee;

2. Include:

a. The diagnosis of the patient;

b. The clinical and diagnostic findings upon which the diagnosis is based;

c. The proposed treatment;

d. The reason why immediate initiation of the proposed treatment is necessary; and

e. If feasible, an estimate of the cost of the proposed treatment; and

3. Comply with the format established in Appendix B; and

(c) Other affidavit or authenticated document necessary to demonstrate that the movant is entitled to the relief sought.

(2) If a claim is currently assigned to an administrative law judge, the written request shall be directed to that administrative law judge.

(3) The Form 120EX and attachments shall be filed in triplicate with the executive director who shall serve copies on the named parties.

(a) A respondent to a Form 120EX may file a response within ten (10) days of the date on which the Form 120EX is served by mail. Service shall be deemed complete the third day after mailing by the executive director.

(b) A response shall be accompanied by an affidavit setting forth facts sufficient to demonstrate that the movant is not entitled to the relief sought, and shall be served on the other parties by the respondent.

(4) The administrative law judge may refer the matter to a worker's compensation specialist or an ombudsman to attempt to effectuate a resolution of the dispute.

(5) The administrative law judge to whom a request for expedited determination of medical issues is assigned shall issue a ruling within seven (7) days after expiration of the response time.

Section 4. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Form 112, "Medical Dispute", (June, 2000 Edition), Office of Workers Claims; and

(b) Form 120EX, "Request for Expedited Determination of Medical Issue", (July 14, 1994 Edition), Office of Workers Claims.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of Workers Claims, Monday through Friday, 9 a.m. to 4 p.m., at the following locations:

(a) Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601;

(b) 410 West Chestnut Street, Louisville, Kentucky 40202;

(c) 220B North 8th Street, Paducah, Ke ntucky 42001; or

(d) 107 Coal Hollow Road, Pikeville, Kentucky 41501.

APPENDIX A
AFFIDAVIT OF EMPLOYEE

Affiant, (Name), first being duly sworn, states that the attached Request for Expedited Determination of Medical Issue (Form 120EX) concerns treatment for a condition compensable under the Kentucky Workers' Compensation Act. Affiant further states as follows:

1. Date and time of work-related injury or date on which occupational disease was discovered:

2. Brief description of how injury occurred or how occupational disease was acquired:

3. Date and identity of person to whom notice of injury or occupational disease was given:

4. Medical treatment at issue:

5. Attempts, if any, to obtain approval for contested treatment:

Signature:
STATE OF:
COUNTY OF:

Subscribed and sworn to before me by (name) this (day) day of (month), (year).

Notary Public:
My commission expires:

APPENDIX B
AFFIDAVIT OF PHYSICIAN
EXPEDITED MEDICAL DISPUTE

Affiant (Name), a physician whose area of specialization is (specialization), first being duly sworn, states that the attached Request for Expedited Determination of Medical Issue (Form 120EX) concerns a work-related injury or disease.

(1) The following medical care is required: (describe proposed medical care)

(2) The current working diagnosis is as follows:

(3) The proposed treatment is medically necessary because:

(4) The estimated cost of the proposed treatment is:

Affiant further states that failure of (Name of workers' compensation patient) to obtain or undertake this proposed medical care within the next forty-five (45) days could lead to serious physical or mental disability or death because:

Signature:
W.C. Medical Index No.:
Address:
STATE OF:
COUNTY OF:

Subscribed and sworn to before me by (name) this (day) day of (month), (year).

Notary Public:

My commission expires: (19 Ky.R. 1495; eff. 3-9-93; Am. 21 Ky.R. 569; eff. 10-10-94; 23 Ky.R. 1450; 2173; 2481; eff. 12-13-96; 24 Ky.R. 939; 1260; eff. 12-15-97; 27 Ky.R. 1092; 1486; eff. 12-21-2000; TAm eff. 8-9-2007.)

ADDENDUM 4

KRS 342.038

Employer to keep record of injuries -- Reports required to be filed.

342.038 Employer to keep record of injuries -- Reports required to be filed.

(1) Every employer subject to this chapter shall keep a record of all injuries, fatal or otherwise, received by his employees in the course of their employment. Within one (1) week after the occurrence and knowledge, as provided in KRS 342.185 to 342.200, of an injury to an employee causing his absence from work for more than

one (1) day, a report thereof shall be made to the department in the manner directed
by the commissioner through administrative regulations. An employer's insurance carrier or other party responsible for the payment of workers' compensation benefits shall be responsible for making the report to the Department of Workers' Claims within one week of receiving the notification referred to in subsection (3) of this section.

(2) The report shall contain the name, nature, and location of the business of the employer and name, age, sex, wages, and occupation of the injured employee, and shall state the date and hour of the accident causing the injury, the nature and cause
of the injury, and any other information required by the commissioner.

(3) Every employer subject to this chapter shall report to its workers' compensation insurance carrier or the party responsible for the payment of workers' compensation benefits any work-related injury or disease or alleged work-related injury or disease within three (3) working days of receiving notification of the incident or alleged incident.

(4) Every employer or insurer subject to this chapter shall file additional reports covering specifically voluntary payments and settlements, and any other reports required by the commissioner by administrative regulation for the determination of the promptness of voluntary payment and validity and fairness of agreements. In addition, the commissioner may require additional information as may be necessary to comply with a federal statute or regulation or any state statute.

(5) Upon the termination of the disability of the injured employee, or if the disability
extends beyond a period of sixty (60) days, then also at the expiration of that period, the employer shall make a supplementary report to the commissioner on blanks procured from the department for the purpose.

ADDENDUM 5

KRS 342.039

Filing of detailed claim information by each insurance company, self-insured group, and employer carrying its own risk.

342.039 Filing of detailed claim information by each insurance company, self-insured group, and employer carrying its own risk.

Beginning on January 1, 1995, and pursuant to administrative regulations promulgated under KRS Chapter 13A by the commissioner, each insurance company writing workers' compensation insurance policies in the Commonwealth, every self-insured group, and each employer carrying its own risk shall file in the manner directed by the commissioner, detailed claim information contained in the model regulation developed by the National Association of Insurance Commissioners (NAIC) in conjunction with the International Association of Industrial Accident Boards and Commissions (IAIABC).