AN ACT relating to workers' compensation.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔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 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 Education and Labor Cabinet;

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

(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. For policies with provisions for deductibles with effective dates on or after January 1, 1995, assessments shall be imposed on premiums received as calculated by the deductible program adjustment. 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 covered employees having a co-employment relationship with a professional employer organization and a

client as defined in KRS Chapter 336, "premiums received" means premiums calculated using the experience modification factor of each client as defined in KRS Chapter 336 for each covered employee for that portion of the payroll pertaining to the covered 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. For policies with provisions for deductibles with effective dates on or after January 1, 1995, assessments shall be imposed as calculated by the deductible program adjustment. 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.

(e) "Deductible program adjustment" means calculating premium and premiums received on a gross basis without regard to the following:

1. Schedule rating modifications, debits, or credits;
2. Deductible credits; or
3. Modifications to the cost of coverage from inception through and including any audit that are based on negotiated retrospective rating arrangements, including but not limited to large risk alternative rating options;

(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 Department of Workforce Development, Education and Labor 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 Department of Workforce Development 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) ***"Medical professional" means any physician, audiologist holding a doctorate in audiology, surgeon, psychologist, optometrist, dentist, podiatrist, advanced practice registered nurse, physician assistant, licensed clinical social worker, osteopathic and chiropractic practitioner, any professional authorized to practice medicine as certified by any applicable board or duly licensed in any state, and any retired physician previously authorized to practice in the Commonwealth of Kentucky and who surrendered their license while in good-standing with, and not subject to ongoing investigation for improper practices by, the Kentucky Board of Medical Licensure***~~["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)(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 for the length of time set forth in this section, or as may be required for the cure and treatment of an occupational disease.

(2) In claims resulting in an award of permanent total disability or resulting from an injury described in subsection (9) of this section, 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.

(3) (a) In all permanent partial disability claims not involving an injury described in subsection (9) of this section, the employer's obligation to pay the benefits specified in this section shall continue for seven hundred eighty (780) weeks from the date of injury or date of last exposure.

(b) In all permanent partial disability claims not involving an injury described in subsection (9) of this section, the commissioner shall, in writing, advise the employee of the right to file an application for the continuation of benefits as described in this section. This notice shall be made to the employee seven hundred fifty-four (754) weeks from the date of injury or last exposure.

(c) An employee shall receive a continuation of benefits as described in this

section for additional time beyond the period provided in paragraph (a) of this subsection as long as continued medical treatment is reasonably necessary and related to the work injury or occupational disease if:

1. An application is filed within seventy-five (75) days prior to the termination of the seven hundred eighty (780) week period;
2. The employee demonstrates that continued medical treatment is reasonably necessary and related to the work injury or occupational disease; and
3. An administrative law judge determines and orders that continued benefits are reasonably necessary and related to the work injury or occupational disease for additional time beyond the original seven hundred eighty (780) week period provided in paragraph (a) of this subsection.

(d) If the administrative law judge determines that medical benefits are not reasonably necessary or not related to the work injury or occupational disease, or if an employee fails to make proper application for continued benefits within the time period provided in paragraph (c) of this subsection, any future medical treatment shall be deemed to be unrelated to the work injury and the employer's obligation to pay medical benefits shall cease permanently.

(4) ***(a)*** 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.

(b) 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.

(c) 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.

(d) The commissioner shall promulgate administrative regulations establishing conditions under which the thirty (30) day period for payment may be tolled.

(e) 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. ***Failure to submit the statement for services within forty-five (45) days may render the statement for services ineligible for payment unless determined to be compensable by an administrative law judge. Denial of a claim or a specific expense by an employer shall toll the requirements to submit the statement for services by the provider within the forty-five (45) days of the treatment until an administrative law judge has determined whether the employer is liable for the claim or specified expense.*** ~~[Except as provided in subsection (7) of this section, in]~~

(f) 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.

(g) 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.

(5) 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.

(6) 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.

(7) 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.

(8) 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.

(9) When a compensable injury or occupational disease results in the amputation or partial amputation of an arm, hand, leg, or foot, or the loss of hearing, or the enucleation of an eye or loss of teeth, or permanent total or permanent partial paralysis, 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.

(10) 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.

(11) 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.

(12) 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.

(13) (a) Except as provided in paragraphs (b) and (c) of this subsection, the employer, insurer, or payment obligor shall not be liable for urine drug screenings of patients in excess of:

1. One (1) per year for a patient considered to be low-risk;

2. Two (2) per year for a patient considered to be moderate-risk; and

3. Four (4) per year for patients considered to be high-risk;

based upon the screening performed by the treating medical provider and other pertinent factors.

(b) The employer, insurer, or payment obligor may be liable for urine drug screening at each office visit for patients that have exhibited aberrant behavior documented by multiple lost prescriptions, multiple requests for early refills of prescriptions, multiple providers prescribing or dispensing opioids or opioid substitutes as evidenced by the electronic monitoring system established in KRS 218A.202 or a similar system, unauthorized dosage escalation, or apparent intoxication.

(c) The employer, insurer, or payment obligor may request additional urine drug screenings which shall not count toward the maximum number of drug screenings enumerated in paragraph (a) of this subsection.

(d) The commissioner shall promulgate administrative regulations related to urine drug screenings as part of the practice parameters or treatment guidelines required under KRS 342.035.

(14) (a) As used in this subsection, "practice of pharmacy" has the same meaning as in KRS 315.010.

(b) In addition to all other compensation that may be reimbursed to a pharmacist under this chapter, the employer, insurer, or payment obligor shall be liable for the reimbursement of a pharmacist for a service or procedure at a rate not less than that provided to other nonphysician practitioners if the service or procedure:

1. Is within the scope of the practice of pharmacy;

2. Would otherwise be compensable under this chapter if the service or procedure were provided by a:

a. Physician;

b. Advanced practice registered nurse; or

c. Physician assistant; and

3. Is performed by the pharmacist in strict compliance with laws and administrative regulations related to the pharmacist's license.

➔Section 3. KRS 342.033 is amended to read as follows:

In a claim for benefits, no party may introduce direct testimony from more than two (2) ***medical professionals***~~[physicians]~~ without prior consent from the administrative law judge. The motion requesting additional testimony shall clearly demonstrate the need for such additional testimony. A party may introduce direct testimony from a ***medical professional***~~[physician]~~ through a written medical report. The report shall become a part of the evidentiary record, subject to the right of an adverse party to object to the admissibility of the report and to cross-examine the reporting ***medical professional***~~[physician]~~. The commissioner shall promulgate administrative regulations prescribing the format and content of written medical reports.

➔Section 4. 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***; and***

(e) Consideration of a post-award request for vocational rehabilitation allegedly necessitated by the work injury or disease.

(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 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 original order granting or denying benefits, when such an award or order becomes final and nonappealable, and no party may file a motion to reopen within one (1) year of any previous motion to reopen by the same party. Orders granting or denying benefits that are entered subsequent to an original final award or order granting or denying benefits shall not be considered to be an original order granting or denying benefits under this subsection and shall not extend the time to reopen a claim beyond four (4) years following the date of the final, nonappealable original award or original order.

(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 5. KRS 342.140 is amended to read as follows:

The average weekly wage of the injured employee at the time of the injury or last injurious exposure shall be determined as follows:

(1) If at the time of the injury which resulted in death or disability or the last date of injurious exposure preceding death or disability from an occupational disease:

(a) The wages were fixed by the week, the amount so fixed shall be the average weekly wage;

(b) The wages were fixed by the month, the average weekly wage shall be the monthly wage so fixed multiplied by twelve (12) and divided by fifty-two (52);

(c) The wages were fixed by the year, the average weekly wage shall be the yearly wage so fixed divided by fifty-two (52);

(d) The wages were fixed by the day, hour, or by the output of the employee, the average weekly wage shall be the wage most favorable to the employee computed by dividing by thirteen (13) the wages (not including overtime or premium pay) of said employee earned in the employ of the employer in the

first, second, third, or fourth period of thirteen (13) consecutive calendar weeks in the fifty-two (52) weeks immediately preceding the injury;

(e) ***The wages were determined by the day, hour, or by the output of the employee, and the employee received unemployment benefits pursuant to KRS Chapter 341 during the first, second, third, or fourth period of thirteen (13) consecutive calendar weeks in the fifty-two (52) weeks immediately preceding the injury, the unemployment benefits received shall be added to the wages earned during the thirteen (13) week period and divided by thirteen (13), the average weekly wage shall be the result most favorable to the employee;***

(f) The employee had been in the employ of the employer less than thirteen (13) calendar weeks immediately preceding the injury, his or her average weekly wage shall be computed under paragraph (d), taking the wages (not including overtime or premium pay) for that purpose to be the amount he or she would have earned had he or she been so employed by the employer the full thirteen (13) calendar weeks immediately preceding the injury and had worked, when work was available to other employees in a similar occupation; and

(g) ~~[(f)]~~ The hourly wage has not been fixed or cannot be ascertained, the wage for the purpose of calculating compensation shall be taken to be the usual wage for similar services where the services are rendered by paid employees.

(2) In occupations which are exclusively seasonal and therefore cannot be carried on throughout the year, the average weekly wage shall be taken to be one-fiftieth (1/50) of the total wages which the employee has earned from all occupations during the twelve (12) calendar months immediately preceding the injury.

(3) In the case of volunteer firemen, police, and emergency management agency members or trainees, the income benefits shall be based on the average weekly wage in their regular employment.

(4) If the employee was a minor, apprentice, or trainee when injured, and it is established that under normal conditions his or her wages should be expected to increase during the period of disability, that fact may be considered in computing his or her average weekly wage.

(5) When the employee is working under concurrent contracts with two (2) or more employers and the defendant employer has knowledge of the employment prior to the injury, his or her wages from all the employers shall be considered as if earned from the employer liable for compensation.

(6) The term "wages" as used in this section and KRS 342.143 means, in addition to money payments for services rendered, the reasonable value of board, rent, housing, lodging, and fuel or similar advantage received from the employer, and gratuities received in the course of employment from others than the employer to the extent the gratuities are reported for income tax purposes.

(7) The commissioner shall, from time to time, based upon the best available information, determine by administrative regulation industries which ordinarily do not have a full working day for five (5) days in every week. In those industries, compensation shall be computed at the average weekly wage earned by the employee at the time of injury reckoning wages as earned while working full time. "At full time" as used in this subsection means a full working day for five (5) working days in every week regardless of whether the injured employee actually worked all or part of the time.

➔Section 6. KRS 342.276 is amended to read as follows:

(1) The commissioner shall establish a program to provide an opportunity for mediation of disputes as to the entitlement to benefits under this chapter.

(2) The commissioner shall promulgate administrative regulations ***in accordance with KRS Chapter 13A*** necessary to establish and implement the mediation program, which shall prescribe the qualifications and duties of mediators; a process for the

designation of mediators; procedures for the conduct of mediation proceedings;[~~and~~] the issues which shall be subject to mediation***; and the requirements to demonstrate attempts have been made to reach a settlement and that mediation will be beneficial to resolve the issues***.

(3) Recommendations by mediators are without administrative or judicial authority and are not binding on the parties unless the parties enter into a settlement agreement incorporating the recommendations. Administrative law judges may participate in the mediation process but shall not issue findings or orders as a result of the process unless agreed to by the parties.

➔Section 7. KRS 342.281 is amended to read as follows:

Within fourteen (14) days from the date of the award, order, or decision any party may file a petition for reconsideration of the award, order, or decision of the administrative law judge. The petition for reconsideration shall clearly set out the errors relied upon with the reasons and argument for reconsideration of the pending award, order, or decision. All other parties shall have ten (10) days thereafter to file a response to the petition. The administrative law judge shall be limited in the review to the correction of errors patently appearing upon the face of the award, order, or decision and shall overrule the petition for reconsideration or make any correction within ten (10) days after submission***. After an order on reconsideration has been rendered, subsequent petitions for reconsideration shall not toll or extend the time to file an appeal unless the petition for reconsideration is filed to correct an order on reconsideration***.

➔Section 8. KRS 342.310 is amended to read as follows:

(1) If any administrative law judge, the board, or any court before whom any proceedings are brought under this chapter determines that such proceedings have been brought, prosecuted, or defended without reasonable ground, he or it may assess the whole cost of the proceedings which shall include actual expenses but not be limited to the following: court costs, travel expenses, deposition costs, physician

expenses for attendance fees at depositions, attorney fees, and all other out-of-pocket expenses upon the party who has so brought, prosecuted, or defended them.

(2) If any administrative law judge, the board, or any court before whom any proceedings are brought under this chapter determines that a party has committed acts in violation of KRS 342.335(1) or (2), that party may be ordered to make restitution for any compensation paid as a result of the commission of such acts.

(3) If an administrative law judge determines a medical dispute was frivolously filed, or filed for the purpose of harassment by an employer, its third-party administrator, or the responsible insurer, attorney's fees may be assessed in an amount of no less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000).

➔Section 9. KRS 342.315 is amended to read as follows:

(1) For workers who have had injuries or occupational hearing loss, the commissioner shall contract with the University of Kentucky**,**~~[and]~~ the University of Louisville**,** ***and the University of Pikeville*** medical schools to evaluate workers. For workers who have become affected by occupational diseases, the commissioner shall contract with the University of Kentucky**,**~~[and]~~ the University of Louisville***, and the University of Pikeville*** medical schools, or other ***medical professionals***~~[physicians]~~ otherwise duly qualified as "B" readers who are licensed in the Commonwealth and are board-certified pulmonary specialists. Referral for evaluation may be made whenever a medical question is at issue***. An audiologist holding a doctorate in audiology may perform a hearing loss evaluation. Medical professionals affiliated with the University of Kentucky, the University of Louisville, and the University of Pikeville medical schools may perform hearing loss evaluations***.

(2) The ***medical professionals***~~[physicians]~~ and institutions performing evaluations pursuant to this section shall render reports encompassing their findings and

opinions in the form prescribed by the commissioner. Except as otherwise provided in KRS 342.316, the clinical findings and opinions of the designated evaluator shall be afforded presumptive weight by administrative law judges and the burden to overcome such findings and opinions shall fall on the opponent of that evidence. When administrative law judges reject the clinical findings and opinions of the designated evaluator, they shall specifically state in the order the reasons for rejecting that evidence.

(3) The commissioner or an administrative law judge may, upon the application of any party or upon his own motion, direct appointment by the commissioner, pursuant to subsection (1) of this section, of ***an*** ~~[a medical]~~ evaluator to make any necessary medical examination of the employee. Such medical evaluator shall file with the commissioner within fifteen (15) days after such examination a written report. The ***appointed*** ~~[medical]~~ evaluator appointed may charge a reasonable fee not exceeding fees established by the commissioner for those services.

(4) Within thirty (30) days of the receipt of a statement for the evaluation, the employer or carrier shall pay the cost of the examination. Upon notice from the commissioner that an evaluation has been scheduled, the insurance carrier shall forward within seven (7) days to the employee the expenses of travel necessary to attend the evaluation at a rate equal to that paid to state employees for travel by private automobile while conducting state business.

(5) Upon claims in which it is finally determined that the injured worker was not the employee at the time of injury of an employer covered by this chapter, the special fund shall reimburse the carrier for any evaluation performed pursuant to this section for which the carrier has been erroneously compelled to make payment.

(6) Not less often than annually the designee of the secretary of the Cabinet for Health and Family Services shall assess the performance of the medical schools and render findings as to whether evaluations conducted under this section are being rendered

in a timely manner, whether examinations are conducted in accordance with medically recognized techniques, whether impairment ratings are in conformity with standards prescribed by the "Guides to the Evaluation of Permanent Impairment," and whether coal workers' pneumoconiosis examinations are conducted in accordance with the standards prescribed in this chapter.

(7) The General Assembly finds that good public policy mandates the realization of the potential advantages, both economic and effectual, of the use of telehealth. The commissioner may, to the extent that he or she finds it feasible and appropriate, require the use of telehealth, as defined in KRS 211.332, in the independent medical evaluation process required by this chapter.

➔Section 10. 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 ***medical professional***~~[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. ***Reports by medical professionals*** ~~[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. If it is shown that the spirometric testing is not valid due to inadequate cooperation or poor effort on the part of the claimant, the claimant's right to take or prosecute any proceedings under this chapter shall be suspended until the refusal or obstruction ceases. No compensation shall be payable for the period during which the refusal or obstruction continues.

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 shall promptly refer the employee to a duly qualified ***medical professional who is board certified in the area concerning the alleged occupational disease, and in the case of claims for coal workers' pneumonoconiosis to a*** "B" reader ***medical professional***~~[physician]~~ who is licensed in the Commonwealth and is a board-certified pulmonary specialist as set forth pursuant to KRS 342.315 and 342.794(1). 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. The commissioner shall develop a procedure to annually audit the performance of ***medical professionals***~~[physicians]~~ and facilities that are selected to perform examinations pursuant to this section. The audit shall include an evaluation of the ***medical professional***~~[physician]~~ and facility with respect to the timeliness and completeness of the reports and the frequency at which the ***medical professional's***~~[physician's]~~ classification of an X-ray differs from those of the other ***medical professions***~~[physicians]~~ of that X-ray. The commissioner shall remove a ***medical professional***~~[physician]~~ or facility from selection consideration if the ***medical professional***~~[physician]~~ or facility consistently renders incomplete or untimely reports or if the ***X-ray***~~[physician's]~~ interpretations~~[of X-rays]~~ are not in conformity with the readings of other ***medical professionals***~~[physicians]~~ of record at least fifty percent (50%) of the time. The report required under this

subdivision shall be provided to the Interim Joint Committee on Economic Development and Workforce Investment on or before July 1, 2019, and on or before July 1 of each year thereafter.

d. In coal workers' pneumoconiosis claims, if the ***medical professional*** ~~[physician]~~ selected by the commissioner interprets an X-ray as positive for complicated coal workers' pneumoconiosis, the commissioner shall refer the employee to the facility at which the claimant was previously evaluated for a computerized tomography scan in order to verify the findings. The computerized tomography scan shall be interpreted by the facility and a report shall be filed with the commissioner. The employer, insurer, or payment obligor shall pay the cost of the examination pursuant to the medical fee schedule. The administrative law judge may rely upon the findings in the report in accepting or rejecting ILO radiographic evidence of the disease required under KRS 342.732 for benefit determination.

e. 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.

f. 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.

g. 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.

h. Within thirty (30) days of the receipt of the statement for the evaluation, the employer, insurer, or payment obligor shall pay the cost of the examination. Upon notice from the commissioner that an evaluation has been scheduled, the employer, insurer, or payment obligor shall forward the expenses of travel necessary to attend the evaluation at the state employee reimbursement rates to the employee within seven (7) days. However, if the employee has alleged a pulmonary dysfunction but has not filed spirometric evidence as required by paragraph (a) of this subsection at the time the evaluation is scheduled by the commissioner, the employee will be responsible for fifty percent (50%) of the cost of the evaluation.

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, 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.

➔Section 11. KRS 342.320 is amended to read as follows:

(1) All fees of attorneys and ***medical professionals*** ~~[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 July 14, 2018, 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 July 14, 2018, twenty percent (20%) of the first twenty-five thousand dollars ($25,000) of the award, fifteen percent (15%) of the next twenty-five thousand dollars ($25,000), and ten percent (10%) of the remainder of the award, not to exceed a maximum fee of eighteen thousand dollars ($18,000). This fee shall be paid by the employee from the proceeds of the award or settlement.

(3) 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 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 fee is 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 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) 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 by his or her attorney, on a notarized form signed by the employee, 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) In a claim that has been reopened pursuant to the provisions of this chapter, an attorney's fee may be awarded by the administrative law judge subject to the limits set forth in subsection (2) of this section. 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.

(7) 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 eighteen thousand dollars ($18,000) 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 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 12. KRS 342.794 is amended to read as follows:

(1) The commissioner shall maintain a list of duly qualified "B" reader ***medical professionals who***~~[physicians who are licensed in the Commonwealth and]~~ are board-certified pulmonary specialists, currently certified by the National Institute of Occupational Safety and Health (NIOSH) who have agreed to perform pulmonary examinations, interpret chest X-rays, and review other medical evidence pursuant to KRS 342.316 for a fee to be fixed by the commissioner and paid by the Kentucky coal workers' pneumoconiosis fund or the carrier, whichever is the appropriate

payment obligor, the provisions of KRS 342.1242 notwithstanding, for claims filed on or before June 30, 2017, and by the employer for claims filed after June 30, 2017.

(2) "'B' reader" means a ***medical professional***~~[physician]~~ who has demonstrated proficiency in evaluating chest roentgenograms for roentgenographic quality and in the use of the ILO classification for interpreting chest roentgenograms for pneumoconiosis and other diseases by taking and passing a specially designed proficiency examination given on behalf of the National Institute of Occupational Safety and Health (NIOSH) or by the Appalachian Laboratory for Occupational Safety and Health (ALOSH), or successors.

(3) "Board-certified pulmonary specialist" means a ***medical professional***~~[physician]~~ licensed in the Commonwealth who is board-certified in internal medicine with a certification in the subspecialty of pulmonary medicine by the American Board of Internal Medicine.