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

RELATES TO: KRS Chapter 342
STATUTORY AUTHORITY: KRS 342.020, 342.035, 342.260, 342.320, 342.735
NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 requires the Commissioner of the Department of Workers' Claims to promulgate administrative regulations necessary to carry on the work of the department under KRS Chapter 342. KRS 342.735 requires the commissioner to promulgate administrative regulations to expedite the payment of medical expense benefits. This administrative regulation regulates the selection of physicians and provides for treatment plans under KRS Chapter 342 in order to assure high quality medical care at a reasonable cost.

Section 1. Definitions. (1) "Designated physician" means the physician selected by the employee for treatment pursuant to KRS 342.020(4).

(2) "Emergency care" means:

(a) Medical services required for the immediate diagnosis or treatment of a medical condition that if not immediately diagnosed or treated could lead to a serious physical or mental disability or death; or

(b) Medical services which are immediately necessary to alleviate severe pain.

(3) "Long-term medical care" means:

(a) Medical treatment or medical rehabilitation that is reasonably projected to require a regimen of medical care for a period extending beyond ninety (90) days;

(b) Medical treatment that continues for a period of more than ninety (90) days; or

(c) Medical treatment including the recommendation that the employee not engage in the performance of the employee's usual work for a period of more than sixty (60) days.

(4) "Physician" is defined in KRS 342.0011(32).

(5) "Statement for services" means:

(a) For a nonpharmaceutical bill, a completed Form HCFA 1500, or for a hospital, a completed Form UB-92, with an attached copy of legible treatment notes, hospital admission and discharge summary, or other supporting documentation for the billed medical treatment, procedure, or hospitalization; and

(b) For a pharmaceutical bill, a bill containing the identity of the prescribed medication, the number of units prescribed, the date of the prescription, and the name of the prescribing physician.

(6) "Treatment plan" means a written plan that:

(a) May consist of copies of charts, consultation reports or other written documents maintained by the employee's designated physician discussing symptoms, clinical findings, results of diagnostic studies, diagnosis, prognosis, and the objectives, modalities, frequency, and duration of treatment;

(b) Shall include, as appropriate, details of the course of ongoing and recommended treatment and the projected results; and

(c) May be amended, supplemented or changed as conditions warrant.

Section 2. Employer's Obligation to Supply Kentucky Workers' Compensation Designation and Medical Release Card (Form 113). Within ten (10) days following receipt of notice of a work injury or occupational disease causing lost work time or necessitating continuing medical treatment, the medical payment obligor shall mail a Form 113 to the employee, including a self-addressed, postage prepaid envelope for returning the Form 113. Failure by the medical

payment obligor to timely mail the form shall waive an objection to treatment by other than a designated physician prior to receipt by the employee of the form.

Section 3. Employee Selection of Physician. (1) Except for emergency care, treatment for a work-related injury or occupational disease shall be rendered under the coordination of a single physician selected by the employee. The employee shall give notice to the medical payment obligor of the identity of the designated physician by tendering the completed Form 113, including a written acceptance by the designated physician, within ten (10) days after treatment is commenced by that physician.

(2) Within ten (10) days following receipt of a Form 113 designating a treating physician, the medical payment obligor shall tender a card to the employee, which shall be presented to a medical provider each time that a medical service is sought in connection with the work-related injury or occupational disease.

(3) The card shall serve as notice to a medical provider of the identity of the designated physician, who shall have the sole authority to make a referral to a treatment facility or to a specialist.

(a) The card shall bear the legend "First Designated Physician-Workers' Compensation" and shall further contain the following information:

1. Name and telephone number of the first designated physician;

2. Name, Social Security number, date of birth, and date of work injury or occupational disease and last exposure of the employee; and

3. Name and telephone number of the medical payment obligor.

(b) The reverse side of the first designated physician card shall contain:

1. A notice that treatment shall be performed by or on referral from the first designated physician; and

2. Shall further contain space for the identification and notification of a change of designated physician.

(4) Failure by the medical payment obligor to timely mail the "First Designated Physician" card shall waive an objection to treatment by other than a designated physician prior to receipt by the employee of the card.

(5) The unreasonable failure of an employee to comply with the requirements of this section may suspend all benefits payable under KRS Chapter 342 until compliance by the employee and receipt of the Form 113 by the medical payment obligor has occurred.

Section 4. Change of Designated Physician. (1) Following initial selection of a designated physician, the employee may change designated physicians once without authorization of the employer or its medical payment obligor. Referral by a designated physician to a specialist shall not constitute a change of designated physician unless the latter physician is specifically selected by the employee as the second designated physician.

(2) Within ten (10) days of a decision to change the designated physician, the employee shall complete the back of the first designated physician card and return the card with the name of the second designated physician, including a written acceptance by the second designated physician, to the medical payment obligor, which shall issue a second card within ten (10) days.

(3) The card shall bear the legend "Second Designated Physician-Workers' Compensation" and shall further contain the information required on the first designated physician card. The reverse side of the card shall contain a notice that:

(a) Treatment shall be performed by or on referral from the second designated physician; and

(b) A further change of designated physician shall require the written consent of the employer, its medical payment obligor, arbitrator, or the administrative law judge.

(4) Failure by the medical payment obligor to timely mail the "Second Designated Physician" card shall waive an objection to treatment by other than a designated physician prior to receipt by the employee of the card.

(5) If an employee's two (2) choices of designated physician have been exhausted, he shall not, except as required by medical emergency, make an additional selection of a physician without the written consent of the employer, its medical payment obligor, arbitrator, or the administrative law judge. This consent shall not be unreasonably withheld.

(6) If the employer provides medical services through a managed health care system, it may establish alternate methods for provider selection within the managed health care plan.

Section 5. Treatment Plan. (1) A treatment plan shall be prepared if:

(a) Long-term medical care is required as a result of a work-related injury or occupational disease;

(b) The employee has received treatment with passive modalities, including electronic stimulation, heat or cold packs, massage, ultrasound, diathermy, whirlpool, or similar procedures for a period exceeding sixty (60) days. The treatment plan shall detail the need for the passive treatment, the benefits, if any, derived from the treatment, the risks attendant with termination of the treatment, and the projected period of future treatment; or

(c) An elective surgical procedure or placement into a resident work hardening, pain management, or medical rehabilitation program is recommended. The treatment plan shall set forth specific and measurable performance goals for the employee through the surgery, work hardening, or medical rehabilitation program.

(2) The designated physician shall provide a copy of the treatment plan to the medical payment obligor seven (7) days in advance of an elective surgical procedure or placement into a resident work hardening, pain management, or medical rehabilitation program. In all other instances when a treatment plan is required, a copy of the treatment plan shall be provided within fifteen (15) days following a request by the medical payment obligor. An amendment, supplement, or change to a treatment plan shall be furnished within fifteen (15) days following a request.

(3) Preparation of a treatment plan shall be a necessary part of the care to be rendered and shall be an integral part of the fee authorized in the medical fee schedule for the underlying services. An additional fee shall not be charged for the preparation of a treatment plan or progress report, except for the reasonable cost of photocopying and mailing the records.

Section 6. Tender of Statement for Services. If the medical services provider fails to submit a statement for services as required by KRS 342.020(4) without reasonable grounds, the medical bills shall not be compensable.

Section 7. Written Denial of Statement for Services Prior to the Resolution of Claim. (1) Prior to resolution of a workers' compensation claim by opinion or order of an administrative law judge, the medical payment obligor shall notify the medical provider and employee of its denial of a specific statement for services, or payment for future services from the same provider, in writing within thirty (30) days following receipt of a completed statement for services.

(2) A copy of the denial shall be mailed to the employee, employer, and medical service provider.

(3) The denial shall:

(a) Include a statement of the reasons for denial and a brief synopsis of available utilization

review or medical bill audit procedures with relevant telephone contact numbers; and

(b) Be made for a good faith reason.

(4) Upon receipt of a denial from a medical payment obligor, a medical provider may tender a statement for services to another potential payment source or to the patient.

Section 8. Payment or Challenge to Statement for Services Following Resolution of Claim. (1) Following resolution of a claim by an opinion or order of an arbitrator or administrative law judge, including an order approving settlement of a disputed claim, the medical payment obligor shall tender payment or file a medical fee dispute with an appropriate motion to reopen the claim, within thirty (30) days following receipt of a completed statement for services.

(2) The thirty (30) day period provided in KRS 342.020(4) shall be tolled during a period in which:

(a) The medical provider submitted an incomplete statement for services. The payment obligor shall promptly notify the medical provider of a deficient statement and shall request specific documentation. The medical payment obligor shall tender payment or file a medical fee dispute within thirty (30) days following receipt of the required documentation;

(b) A medical provider fails to respond to a reasonable information request from the employer or its medical payment obligor pursuant to KRS 342.020(4);

(c) The employee's designated physician fails to provide a treatment plan if required by this administrative regulation; or

(d) The utilization review required by 803 KAR 25:190 is pending. The thirty (30) day period for filing a medical fee dispute shall commence on the date of rendition of the final decision from the utilization review. A medical fee dispute filed thereafter shall include a copy of the final utilization review decision and the supporting medical opinions.

(3) An obligation for payment or challenge shall not arise if a statement for services clearly indicates that the services were not performed for a work-related condition.

Section 9. Payment Pursuant to Fee Schedules. (1) If the statement for services contains charges in excess of those provided in the applicable fee schedule established in 803 KAR 25:089, 803 KAR 25:091, and 803 KAR 25:092, the medical payment obligor shall make payment in the scheduled amount and shall serve a written notice of denial setting forth the rea-son for refusal to pay a greater amount.

(2) Following receipt of a final medical bill audit reconsideration decision pursuant to 803 KAR 25:190, the medical provider shall file within thirty (30) days a medical fee dispute in accordance with 803 KAR 25:012 to dispute the amount of payment.

Section 10. Patient Billing. (1) A medical provider may tender a statement for services to a patient once it has received:

(a) A written denial from the medical payment obligor; or

(b) An opinion by an administrative law judge finding that the services were unrelated to a work injury or occupational disease.

(2) The medical provider shall not bill a patient for services which have been found to be unreasonable or unnecessary by an administrative law judge, if the medical provider has been joined as a party to a workers' compensation claim or to a medical fee dispute and has had an opportunity to present contrary evidence.

(3) The medical provider shall not bill a patient for services which have been denied by the payment obligor for failure to submit bills following treatment within forty-five (45) days as required by KRS 342.020 and Section 6 of this administrative regulation.

Section 11. Request for Payment for Services Provided or Expenses Incurred to Secure Medical Treatment. (1) If an individual who is not a physician or medical provider provides compensable services for the cure or relief of a work injury or occupational disease, including home nursing services, the individual shall submit a fully completed Form 114 to the employer or medical payment obligor within sixty (60) days of the date the service is initiated and every sixty (60) days thereafter, if appropriate, for so long as the services are rendered.

(2) Expenses incurred by an employee for access to compensable medical treatment for a work injury or occupational disease, including reasonable travel expenses, out-of-pocket payment for prescription medication, and similar items shall be submitted to the employer or its medical payment obligor within sixty (60) days of incurring of the expense. A request for payment shall be made on a Form 114.

(3) Failure to timely submit the Form 114, without reasonable grounds, may result in a finding that the expenses are not compensable.

Section 12. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Form 113, "Notice of Designated Physician", (March 12, 2003 Edition), Department of Workers' Claims; and

(b) Form 114, "Request for Payment for Services or Reimbursement for Compensable Expenses", (October 30, 2017 Edition), Department of Workers' Claims.

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

(a) Mayo-Underwood Building, 3rd Floor, 500 Mero Street, Frankfort, Kentucky 40601;

(b) Uniplex Building, Suite 304, 126 Trivette Drive, Pikeville, Kentucky 41501; or

(c) Online at "https://labor.ky.gov/comp/Pages/default.aspx". (19 Ky.R. 1498; 1806; 2043; 2246; eff. 3-9-1993; 23 Ky.R. 1455; 2177; 2485; eff. 12-13-1996; 24 Ky.R. 942; eff. 12-15-1997; 2166; 2681; eff. 6-15-1998; TAm eff. 8-9-2007; 46 Ky.R.3015; 47 Ky.R. 544; eff. 12-1-2020.)