Approved February 20, 1992
Date

MINUTES OF THE House COMMITTEE ON Labor and Industry.

The meeting was called to order by Representative Anthony Hensley at
Chairperson

9:02 a.m./~~p.m.~~ on February 13, 1992 in room 526-S of the Capitol.

All members were present except:

Rep. Hayzlett - excused
Rep. Sluiter - excused

Committee staff present:

Jerry Donaldson, Principal Analyst
Jim Wilson, Revisor of Statutes
Barbara Dudney, Committee Secretary

Conferees appearing before the committee:

Pat Nichols, Kansas Trial Lawyers Assn.
Tom E. Hammond, attorney at law, Render, Kamas and Hammond, Wichita.
Joe Furjanic, Exec. Dir., Kansas Chiropractic Assn.

The meeting was called to order at 9:02 a.m., by the chairman, Rep. Anthony Hensley.

Chairman Hensley stated that the purpose of the meeting was to hear testimony from the opponents of House Bills no. 2872 and 2873. He reiterated that these two bills were introduced by the committee at the request of the Kansas Chamber of Commerce and Industry (KCCI). He explained that the first conferee would also speak in opposition to House Bill No. 2871, which had been heard by the committee on Tuesday, February 11th.

The chairman introduced Pat Nichols, representing the Kansas Trial Lawyers Association (KTLA). Mr. Nichols stated that the KTLA opposes House Bill No. 2871 because it provides duplicative benefits to insurance carriers (attachment #1). He also spoke against House Bill No. 2872, stating that it is his belief the bill is not necessary since K.S.A. 21-3904 already prohibits the presentation of a false claim with intent to defraud a public officer authorized to allow such claim. On House Bill No. 2873, Mr. Nichols stated various reasons for opposing the bill. He said he would provide the committee written testimony on House Bills. no. 2872 and 2873 in the near future. He then answered questions from committee members.

The next conferee was Tom E. Hammond, attorney at law, Render, Kamas and Hammond, Wichita. Mr. Hammond informed the committee that he was testifying at the request of the Kansas AFL-CIO. He said the AFL-CIO opposes House Bill No. 2872 because the language in the bill is too vague and would increase litigation and expense. He noted that the bill could be unconstitutional because it applies only to employees. He suggested that the bill be amended to also include employers and insurance carriers.

Mr. Hammond stated that House Bill No. 2873 would violate the compromise reached in 1987 between labor and industry to the detriment of injured workers. He said the committee should look to three major areas to cut costs in the workers' compensation system: (1) improve workplace safety, (2) reduce vocational rehabilitation and medical management costs, and (3) reduce medical treatment costs (attachment #2).

Joe Furjanic, Executive Director, Kansas Chiropractic Association, distributed and read written testimony on House Bill No. 2872. In his testimony, Mr. Furjanic stated that he was a member of the KCCI's workers' compensation task force that worked on the bill. He said the task force reached a consensus that any workers' compensation "fraud" should include claimants, doctors, attorneys, employers and insurance carriers. He questioned why the bill in its present form did not include employers and insurance carriers, particularly after the task force had recommended to include "all the players in the system" (attachment #3).

Chairman Hensley asked Terry Leatherman, KCCI lobbyist, to respond to Mr. Furjanic's statement. Mr. Leatherman said that House Bill No. 2872 was drafted as he had directed Jim Wilson, committee revisor, to draft it. He stated that he would have no objection if the committee amended the bill to include employers and insurance carriers, which he said would more closely reflect the task force's recommendation.

MINUTES OF THE House COMMITTEE ON Labor and Industry,

room 526-S, Statehouse, at 9:02 a.m./p.m. on February 13, 1992

The chairman entertained a motion to approve the minutes of previous committee meetings. Rep. Bob Grant moved to approve the minutes of the February 3, 4 and 5, 1992 meetings. The motion was seconded by Rep. Tim Carmody. Motion carried.

The chairman announced that two remaining proponents of House Bills no. 2872 and 2873 would give testimony on Monday, February 17, 1992. He said that at the same meeting the committee will hear a response concerning all bills previously heard from Bill Morrissey, acting Director, Kansas Division of Workers' Compensation. He said the rest of next week will be devoted to hearings on House Bill No. 3023.

The meeting was adjourned at 10:05 a.m.

GUEST LIST

COMMITTEE: House Labor and Industry DATE: Feb. 13, 1992

NAME	ADDRESS	COMPANY/ORGANIZATION
Bill Morrissey	Topeka	KDHR/Work Comp
Terry Leatherman	Topeka	KCCI
George Welch	Topeka	State Self Ins.
Billy Newman	Topeka	State Self Ins.
Wes Friesen	N Newton	W.J.F. Ins.
Larry Magill	Topeka	Ind. Ins. Agents of Ks.
Tom Hammond	Wichita	AFL-CIO
Thomas Hammond	Wichita	
Tom Whitaker	Topeka	Ks Motor Carriers Assn
John Peters	Tpk	Beech Aircraft
Harry D. Helser	Wichita	Ks AFL-CIO
Wayne Maichel	Topeka	" " "
Christopher Dean	Emporia	Rep. Tim Carmody/Intern
Joe Furjanic	Topeka	KCA
Steve Jones	Wichita	Boeing
Tom Slattery	Top	AGC of Ks
Ron Smith	"	Ks Bar

KANSAS
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TESTIMONY

of the

KANSAS TRIAL LAWYERS ASSOCIATION

regarding

HB 2871 - Subrogation

HB 2871 is a reaction to the McGranahan decision and purports to restore allegedly lost subrogation rights to insurance companies who have paid benefits pursuant to workers' compensation cases.

The McGranahan decision did not change the existing law - it clarified and confirmed basic principles of the doctrine of subrogation. "Subrogation is the right of one who has paid an obligation which another should have paid to be indemnified by the other." This is a quote from Neises v. Solomon State Bank, 236 Kan. at page 779. In basic terms, when a person receives benefits from one party and later receives payment for those same benefits from another, the law sometimes allows the first party a "right of subrogation" to the extent of the benefits they paid, and requires that those benefits be repaid.

KTLA opposes this bill because it allows insurance companies to collect liens for benefits which they have never paid. Further, it unconstitutionally discriminates against workers compensation claimants; other persons in similar situations are required to honor subrogation liens only to the extent that monies are received for benefits which have actually been paid.

The troublesome language in the proposed bill is contained at the end of the inserted material, "Whether that recovery duplicates workers' compensation benefits or not." From the quote and discussion above, it is apparent that this language clearly goes against the fundamental principle of subrogation; that the claims may be asserted and collected where another pays for the same benefits. The ramifications are troublesome. The Workers' Compensation Act does not compensate claimants for all of their losses, therefore, a lien should not extend to all of their recovery where different items of loss are compensated.

Consider an employee driving his own vehicle who is injured in an auto accident. The broad language of the proposal would provide for subrogation against the property damage loss; "The employer shall be subrogated to any recovery....against any person obligated to pay.... other damages resulting from an accidental injury for which the employer has paid...." Similar to property damage, the loss of the value of the services provided by the injured spouse has long been recognized as an

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appropriate element of damage in a personal injury case, but not in a workers' compensation case. The wife who is required to hire the mowing, car repair, home maintenance, etc., or the husband who must contract for housekeeping services previously provided by the injured spouse can recover in tort actions, but receives nothing under workers' compensation. As such, it would be inequitable to strip the accident victim of these additional monies received for uncompensated loss.

No good reason exists to differentiate subrogation claims in a workers' compensation setting from those elsewhere in the law. Other claimants in subrogation cases are confined to duplicative benefits or benefits specifically connected with the transaction at issue. Under-insured, un-insured motorist carriers are subrogated by K.S.A. 40-284(f), "To the extent of such payment and any settlement under the under-insured motorist coverage". Personal injury protection benefit providers are subrogated by K.S.A. 443113a(1992 supp.), "To the extent of duplicative benefits". Kansas SRS is subrogated under K.S.A. 39-719)a(1992 supp.), to the extent that medical expenses are the third party's obligation. In none of these situations is the lien claimant allowed to reach benefits which are not duplicative.

Subrogation is also allowed in a commercial law setting, but is confined, once again, to benefits or amounts actually paid. See K.S.A. 84-4-407 which provides that banks which erroneously make wrongful payments on drafts are subrogated in that transaction, not in all trans-actions with the same maker.

There is no justification for extending to workers' compensation insurance carriers alleged rights of subrogation beyond those allowed in the law for other similarly situated providers of benefits. Subrogation by definition is limited to duplicate benefits received; the McGranahan decision confirms this.

There is no need to amend K.S.A. 44-504. The McGranahan decision only confirmed existing law. The statute provides that the employer may intervene and participate if they so desire. The principles of subrogation dictate fundamental fairness; no subrogation claims exist for benefits which have never been paid. Since that is the effect of HB 2871, it should be rejected by this committee.

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TESTIMONY

of the

KANSAS TRIAL LAWYERS ASSOCIATION

before the

HOUSE LABOR & INDUSTRY COMMITTEE

regarding HB 2872 and HB 2873

On behalf of the Kansas Trial Lawyers Association and the injured workers they represent, I rise in opposition to both bills.

The first bill, HB 2872, purports to be an anti-fraud statute, but is simply duplicative of other legislative provisions now in place. Of course, no one in our organization or anywhere is in favor of or supports fraudulent claims to either secure or deny compensation. However, current legislation is adequate. The perjury statute K.S.A. (1991 supp.) 21-3805, prohibits the same conduct sought to be reached here. In addition, there is another criminal statute prohibiting this same type of conduct, K.S.A. 21-3904 prohibits the presentation of a false claim with intent to defraud a public officer authorized to allow such a claim.

The legislation is also objectionable because there are no reciprocal provisions. In my own practice, I have encountered within the last sixty days false statements by employers to the effect that they did not have insurance or that the claimant was not entitled to benefits because of a pre-existing condition. Thus, it seems likely that whatever abuse exists probably occurs on both sides of the case. This legislation makes no provisions whatsoever to deal with fraud or false statement by the employer or his representatives.

The final problem has to do with the legislation of criminal acts. Ordinarily, our citizens are entitled to have adequate knowledge of what conduct is going to be punished. This statute fails to do so; the language, "or knowingly fails to disclose a material fact" is vague and does not give a worker or the respondent an adequate opportunity to anticipate, and thus avoid, criminal misconduct.

The changes proposed by HB 2873 should be declined by this committee. The first change purports to restrict unauthorized medical allowance. This allowance is given to the injured worker for examination, diagnosis, or treatment; no impairment rating can be given without an examination and diagnosis. Further, disability assessments now center on the injured worker's ability to return to gainful employment. Thus, physical restrictions are crucial. Employer's doctors are traditionally conservative from the claimant's perspective, and therefore, the claimant should be entitled to have a diagnosis and examination by his own physician.

The second proposed change would prohibit permanent total disability awards for employees who were receiving retirement benefits of any kind. Permanent total benefits are paid for life. If the person has retired, there is not much exposure for the period of those payments. In addition, most workers have earned and paid for those retirement benefits as conditions of their employment all of their working life. It would be grossly unfair to strip them away or, in the alternative, to deny bodily compensation to people who are so injured that they are, in the language of subsection 2 of the statute, "completely and permanently incapable of engaging in <u>any type</u> of substantial and gainful employment". The blind, the lame, the crippled would receive nothing as a result of their disability under this proposed change.

The third change seeks to undo the rebuttable presumption created as a result of a long and arduous process in the enactment of the original legislation in 1987. It seeks to prohibit work disability of the worker has "the ability" to engage in work at comparable wages. Some hypothetical "ability" is small solace to the worker who is not earning any money. Until the Supreme Court tells us how this provision is to be interpreted, no action should be taken by the Committee. We do not know if there is a problem in how this statute will be interpreted. No consideration should be given to amending the statute until there is a definitive interpretation of its meaning.

The final provision of HB 2873 provides that preliminary awards may be appealed. The only beneficiary of such a decision will be defense counsel in these cases. Transaction costs for workers compensation cases will increase as will the bureaucracy. Thirty to forty preliminary hearings are held each month by each of the state's workers compensation judges. There will be an enormous number of such appeals since the disgruntled claimant will have the right to insist his counsel pursue one, and the insurance company will lose only its attorney's fees by seeking to reverse the decision. If only 1/4 of those preliminary hearings held each month are appealed and each appeal can be disposed of within four hours (an exceedingly optimistic assessment), three additional assistant directors will have to be hired to process <u>only those appeals</u>. The costs are enormous.

What evidence exists to indicate that overall costs would be lowered by allowing appeals from preliminary hearings? I know of none. Rather, I think it likely that as often as the respondent would be successful in reversing a preliminary hearing award, and thus denying the claimant the benefits ordered, claimants would be successful in reversing denials at a preliminary hearings, and thus reinstating those same benefits. Again, in the end, the guaranteed beneficiaries of this change are the defense counsel and those individuals fortunate enough to be hired as assistant directors to process the onslaught of litigation.

KTLA suggests that HB 2872 be rejected since it merely duplicates existing law, fails to provide reciprocal penalties for knowing misrepresentations by employers and, by language "knowingly fails to disclose" fails to give fair warning of prohibited conduct to both sides. HB 2873 should be rejected since these changes will only increase the cost of workers' compensation, will bring no benefit to either side, and would only result in further confusion regarding the state of the law in this area.

TESTIMONY IN OPPOSITION

TO HOUSE BILLS 2872 & 2873

Tom E. Hammond
of RENDER, KAMAS & HAMMOND

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Attachment #2-1

My name is Tom Hammond and I am a partner in the firm of Render, Kamas & Hammond. I represent injured workers in workers compensation claims. I am testifying at the request of the Kansas AFL-CIO in opposition to House Bills 2872 and 2873.

House Bill No. 2872 (HB 2872) creates a new criminal theft and fraud provision in a workers compensation setting. The language of the proposed statute is overly broad and vague and if passed would result in a tremendous increase in litigation and expense. The language is also unconstitutional because of denial of equal protection. Interestingly, the proposed language does not make it a crime for employers or their insurance companies to use the same "illegal" tactics to reduce or prevent recovery of benefits.

The proposed statute would be used to discourage claims and would limit the number of people who file workers compensation cases. The language in the proposed Bill stating any person who "knowingly fails to disclose a material fact", is so broad that doctors, lawyers and many employers would potentially fall under this statute. This overly broad language would result in a tremendous increase the bureaucracy in the workers compensation system and would therefore add tremendous additional cost to employers and taxpayers.

We feel that the present criminal statutes concerning fraud, theft and perjury in Kansas are more than sufficient to cover the type of allegations complained of by the proponents of this Bill. We request you vote against HB 2872.

House Bill 2873 (HB 2873) would circumvent the 1987

compromise between labor and industry, all to the detriment of injured workers. The real purpose for the changes in HB 2873 is to deny injured workers benefits and discourage them from having access to the workers compensation system. The passage of any portion of HB 2873 will result in increased cost, additional bureaucracy and increased appeals and litigation.

The first material change in HB 2873 occurs on Page 6 and deals with a change in the unauthorized medical provision of the Workers Compensation Act. The 1987 compromise provided the present language and was placed in the Act to allow employees the opportunity to obtain second opinions from other doctors which they were not in a position to pay for. The proposed change would prevent employees from using their unauthorized medical to obtain different opinions concerning the amount of functional impairment they have because of their injuries.

At the present time, employers and insurance companies completely control the medical system under the Workers Compensation Act. The employer has the right to select any doctor of their choice to treat the injured worker. Many times this process results in a doctor being chosen not for his expertise but simply because of the fact that he gives low impairment ratings, finds many injuries to be non-work related and/or does not put very many restrictions on an injured worker.

If the law was changed so that injured workers would have the right to choose their own physician and therefore choose someone they trust, there would be no need for the unauthorized

medical statute at all. However, if employers insist in keeping the present unfair system where they are in total control of the medical services, it is essential that the unauthorized medical provision remain the same.

In fact, most injured people cannot obtain a complete diagnosis and evaluation of their condition for the $350.00 that is presently provided for in the statute, let alone actually receive treatment. We urge that you oppose this change in the unauthorized medical provision of HB 2873.

The next change proposed in HB 2873 is on Page 7 and will provide an offset affecting the benefits of retired totally disabled workers. Besides being of questionable constitutional validity, this change penalizes injured workers who wind up being permanently totally disabled as a result of work related injuries. A person that is permanently totally disabled not only is unable to work but also has significant physical problems with which they have trouble functioning on a daily basis. This change would prevent injured workers from obtaining any money for the injuries they have suffered to their body let alone taking into account the fact that they are no longer able to work. We would urge that this section be voted against.

The next material change proposed in HB 2873 is on Page 9 and deals with the change in the present permanent partial general bodily disability definition. The proposed language in HB 2873 is a direct attempt to circumvent the 1987 compromise that was worked out between labor and industry. In actuality the

language proposed would place back into the statute the irrebuttable presumption that was taken out of the statute by this committee.

HB 2873 would also place into the statute the provision "has the ability to engage" in any work for comparable wage. The result of this change would be a substantial increase in the number of litigated workers compensation cases. Thereby increasing the cost to employers and taxpayers because of the need for additional bureaucracy to handle these changes.

The present statute has not been fully interpreted by the Kansas Supreme Court. It is therefore ludicrous to change the statute prior to having the benefit of the Supreme Court's interpretation. A premature change in the statute nullifies all existing traditional interpretations and all parties will be starting over without any judicial guidance. It will again be three or four years before we reach the stage we are presently at concerning interpretation of the statute. No change in the statute should be considered until we have a final interpretation by the Kansas Supreme Court and we know what we are changing.

The preliminary hearing statute of the present law has been the heart of the Workers Compensation Act. The purpose of the Workers Compensation Act has always been to get injured workers who are unable to work immediate medical treatment and compensation for their family to live on. The passing of HB 2873 would change the law so that all preliminary hearings are appealable thereby further delaying financial relief to injured

workers and their families (See Page 11, HB 2873).

The reason for the proposed change in the preliminary hearing statute in HB 2873 is to deny injured workers benefits they are entitled to and to starve out injured workers so that they go back to work sooner than they should. The change in the statute will result in many injured workers being denied benefits until any appeal process is completed.

In the last year in the Wichita area, the two Administrative Law Judges have averaged over 100 preliminary hearings and motions per month. If just all of the Wichita preliminary hearing cases were appealed into the Director's office there would be a need to hire at least two or three additional Assistant Directors just to handle the cases heard in Wichita. If you compound this figure by the number of judges throughout the state you can see the net cost to the state and taxpayers of this provision would be tremendous.

In addition to the cost to taxpayers, the litigation cost in most cases will rise significantly. Respondents who now voluntarily pay benefits will take many more cases to hearing and many more cases will be appealed. This will result in more cases being litigated which will mean that the cost of litigation and workers compensation insurance premiums will increase. The net effect of the preliminary hearing statute would be to dramatically increase the cost of workers compensation insurance for employers and for the taxpayers of Kansas.

In conclusion, HB 2873 is a proposal made by industry to

deny injured workers benefits and to prevent injured workers from having proper access to the system. The proposed changes will result in increased litigation and appeals which will raise insurance premiums and also drastically increase the state budget for the Division of Workers Compensation.

All persons involved in workers compensation agree the two major places to cut costs are: 1) the vocational rehabilitation and medical management field which has tremendously increased the cost of workers compensation, and 2) the escalating cost of medical treatment. These are the problems that need to be addressed by this Committee, not the provisions in HB 2873 and HB 2872 which would drastically affect the rights of injured workers and ultimately lead to them being on some other type of public assistance.

Until we have some type of final decisions out of the Kansas Supreme Court it is impossible to know what our present statute actually means. It is ludicrous for us to change the present statute until we know what it means. We therefore request that you oppose HB 2873 and HB 2872.

Kansas Chiropractic ASSOCIATION

FEBRUARY 13, 1992

JOE FURJANIC

HOUSE LABOR AND INDUSTRY COMMITTEE

TESTIMONY ON HB 2872

Mr. Chairman and members of the committee:

I am Joe Furjanic, Executive Director of the Kansas Chiropractic Association. Thank you for the opportunity to speak to you regarding HB 2872.

Yesterday, Mr. Leatherman, Burkholder and Korte spoke to you on behalf of the KCCI to explain their support of HB 2872. For the last several months a KCCI Workers Compensation task force met to attempt to analyze the work comp system, identify problem areas within the system and then make recommendations to the Legislature. Mr. Burkholdere and Korte were on the committee. I too was on this committee.

HB 2872 may or may not be the answer to fraud within the workers compensation system. It may be that part of the problem, at least regarding health care providers, is already covered in K.S.A.44-510 (a) (12). Also it may be that there are claimants committing fraud upon the system. Mr. Korte, who works for one of the largest employers in the state, did give an 1987 example of a claimant receiving $1,800 he shouldn't have.

Discussion in the KCCI committee centering on fraud was not only concerned with claimants, doctors and attorneys. The

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concensus of the KCCI committee also was to include employers and insurance carriers under any new fraud statute. As I recall, committee discussion was to recommend that any "person", including employers or insurance carriers who fraudulently withhold, decrease, deny or in any way prevent workers compensation benefits would be covered under the proposed workers compensation fraud statue. Somewhere between the KCCI committee and this committee the second part of this statute was lost.

I would suggest one of two things regarding this bill. Either include all the players in the system under a fraud statue or kill this bill in its present form.

I will attempt to answer questions from the committee.

"Workers' Compensation—A Salute to the Trial Lawyers of Kansas," Gary L. Jordan, 10 J.K.T.L.A. No. 6, 9 (1987).
"Should You Take A Chiropractor To Court?", Steven M. Dickson, J.K.T.L.A., Vol. XIII, No. 3, 19, 20 (1990).

Attorney General's Opinions:
County extension council; extension agent and other employees status under tort claims and workers compensation acts. 84-56.
Performance of community service. 86-149.
Doctors of chiropractic cannot use the term "chiropractic physician." 87-42.

CASE ANNOTATIONS

199. Self-employed persons and individual employers not intended to be covered by act as employees. Allen v. Mills, 11 K.A.2d 415, 417, 418, 724 P.2d 143 (1986).

200. Cited; proof required of employer to be relieved of liability for hiring or retaining handicapped employee (44-1567) examined. Denton v. Sunflower Electric Co-op, 12 K.A.2d 262, 264, 269, 740 P.2d 98 (1987).

201. Cited; tests to determine liability of principal contractor for injury to employee of independent contractor (44-503) examined. Thompson v. Harold Thompson Trucking, 12 K.A.2d 449, 457, 748 P.2d 430 (1987).

202. Nature of claimant's burden of proof to establish right to compensation award stated. Hughes v. Inland Container Corp., 247 K. 407, 410, 789 P.2d 1011 (1990).

44-510. Medical compensation; powers of director; schedules of maximum fees; advisory panel; unjustified treatment or excessive fees, remedies, penalties; utilization and peer review; judgments for services fees, prohibited, stayed; hepatitis preventive care. Except as otherwise provided therein, medical compensation under the workers compensation act shall be as follows:

(a) It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, and apparatus, and transportation to and from the home of the injured employee to a place outside the community in which such employee resides, and within such community if the director in the director's discretion so orders, including transportation expenses computed in accordance with subsection (a) of K.S.A. 44-515 and amendments thereto, as may be reasonably necessary to cure and relieve the employee from the effects of the injury.

(1) The director shall prepare and adopt rules and regulations which establish a schedule for the state approved by the advisory panel, or schedules approved by the advisory panel which are limited to defined localities, fixing the maximum fees for medical, surgical, hospital, dental, nursing, vocational rehabilitation or any other treatment or services provided or ordered by health care providers and rendered to employees under this section. Each such schedule shall include provisions and review procedures for exceptional cases involving extraordinary medical procedures or circumstances and shall include costs and charges for medical records and testimony.

(2) The schedules of maximum fees shall be reasonable, shall promote health care cost containment and efficiency with respect to the workers compensation health care delivery system, and shall be sufficient to ensure availability of such reasonably necessary treatment, care and attendance to each injured employee to cure and relieve the employee from the effects of the injury.

(3) (A) In every case, all fees, transportation costs and charges under this section and all costs and charges for medical records and testimony shall be subject to approval by the director and shall be limited to such as are fair, reasonable and necessary.

(B) There is hereby created an advisory panel to assist the director in establishing schedules of maximum fees as required by this section. The panel shall consist of the commissioner of insurance and seven members appointed as follows: (i) One person shall be appointed by the Kansas medical society, (ii) one member shall be appointed by the Kansas association of osteopathic medicine, (iii) one member shall be appointed by the Kansas hospital association, (iv) one member shall be appointed by the Kansas chiropractic association, and (v) three members appointed by the secretary. One member appointed by the secretary shall be a representative of employers recommended to the secretary by the Kansas chamber of commerce and industry. One member appointed by the secretary shall be a representative of employees recommended to the secretary by the Kansas AFL-CIO. One member appointed by the secretary shall be a representative of entities providing vocational rehabilitation services pursuant to K.S.A. 44-510g and amendments thereto. Each appointed member shall be appointed for a term of office of two years which shall commence on July 1 of the year of appointment.

(C) The panel shall annually review and approve the schedules of maximum fees for such reasonably necessary treatment, care and attendance to each injured employee to cure and relieve the employee from the effects of the injury. All fees and other charges paid for such treatment, care and attendance, including

3-3

treatment, care and attendance provided by any health care provider, hospital or other entity providing health care services, shall not exceed the amounts prescribed by the schedules of maximum fees established under this section or the amounts authorized pursuant to the provisions and review procedures prescribed by the schedules for exceptional cases. A health care provider, hospital or other entity providing health care services shall be paid either such health care provider, hospital or other entity's usual charge for the treatment, care and attendance or the maximum fees as set forth in the applicable schedule, whichever is less. In reviewing and approving the schedules of maximum fees, the panel shall consider the following:

(i) The levels of fees for similar treatment, care and attendance imposed by other health care programs or third-party payors in the locality in which such treatment or services are rendered;

(ii) The impact upon cost to employers for providing a level of fees for treatment, care and attendance which will ensure the availability of treatment, care and attendance required for injured employees;

(iii) The potential change in workers compensation insurance premiums or costs attributable to the level of treatment, care and attendance provided; and

(iv) The financial impact of the schedule of maximum fees upon health care providers and health care facilities and its effect upon their ability to make available to employees such reasonably necessary treatment, care and attendance to each injured employee to cure and relieve the employee from the effects of the injury.

(D) Members of the advisory panel attending meetings of the advisory panel, or attending a subcommittee of the advisory panel authorized by the advisory panel, shall be paid subsistence allowances, mileage and other expenses as provided in K.S.A. 75-3223 and amendments thereto.

(4) Any contract or any billing or charge which any health care provider, hospital, person, or institution enters into with or makes to any patient for services rendered in connection with injuries covered by the workers compensation act or a fee schedule adopted under this section, which is or may be in excess of or not in accordance with such act or fee schedule is unlawful, void and unenforceable as a debt.

(5) The director shall have jurisdiction to hear and determine all disputes as to such charges and interest due thereon and shall prescribe procedural rules to be followed by the parties to such disputes. In the event of any controversy arising under this section, payments shall not be delayed for any amounts not in dispute or controversy. Acceptance by any provider of services of a payment amount under this section which is less than the full amount charged for the services, shall not affect the right to have a review of the claim for the outstanding or remaining amounts.

(6) If the director finds, after utilization review and peer review, that a health care provider or health care facility has made excessive charges or provided or ordered unjustified treatment, services, hospitalization or visits, the health care provider or health care facility shall not receive payment pursuant to this section from an insurance carrier, employer or employee for the excessive fees or unjustified treatment, services, hospitalization or visits and such health care provider or health care facility shall repay any fees or charges collected therefor.

(7) The director shall develop and implement, or contract with a qualified entity to develop and implement, utilization review and peer review procedures relating to the services rendered by a health care provider, which services are paid for in whole or in part pursuant to this section. The director may contract with a private foundation or organization to provide utilization review, as appropriate, of entities providing health care services pursuant to this section.

(8) By accepting payment pursuant to this section for treatment or services rendered to an injured employee, a health care provider or health care facility shall be deemed to consent to submitting all necessary records to substantiate the nature and necessity of the service or charge and other information concerning such treatment to utilization review and peer review under this section. Such health care provider shall comply with any decision of the director pursuant to subsection (a)(9).

(9) If it is determined by a peer review committee that a health care provider improperly overutilized or otherwise rendered or ordered unjustified medical treatment or services or that the fees for such treatment or services were excessive, the director may order the health care provider to show cause why the health care provider should not be required to

repay the amount which was paid for rendering or ordering such treatment or services and shall provide the health care provider a hearing thereon if requested. If a hearing is not requested within 30 days of receipt of the order and the director decides to proceed with the matter, a hearing shall be conducted and if a prima facie case is established a final order shall be issued by the director. If the final order is adverse to the health care provider, the director shall provide a report to the licensing board of the health care provider with full documentation of any such determination, except that no such report shall be provided until after judicial review if the order is appealed. Any order of the director under this section shall be subject to review in accordance with the act for judicial review and civil enforcement of agency actions in the district court for Shawnee county.

(10) Except as provided by K.S.A. 60-437 and amendments thereto, all reports, information, statements, memoranda, proceedings, findings and records submitted to the director for the purposes of this section, including any records of peer review committees, shall be privileged and shall not be subject to discovery, subpoena, or other means of legal compulsion for release to any person or entity and shall not be admissible in evidence in any judicial or administrative proceeding, except those authorized pursuant to this section.

(11) A health care provider or health care facility may not improperly charge or overcharge a workers compensation insurer or charge for services which were not provided, for the purpose of obtaining additional payment.

(12) Any violation of the provisions of this section which is willful or which demonstrates a pattern of improperly charging or overcharging workers compensation insurers constitutes grounds for the director to impose a civil fine not to exceed $5,000. Any civil fine imposed under this section shall be subject to review in accordance with the act for judicial review and civil enforcement of agency actions in the district court for Shawnee county. All moneys received for civil fines imposed under this section shall be deposited in the state treasury to the credit of the workers compensation fund.

(b) Any health care provider, nurse, physical therapist, any entity providing medical, physical or vocational rehabilitation services or providing reeducation or training pursuant to K.S.A. 44-510g and amendments thereto, medical supply establishment, surgical supply establishment, ambulance service or hospital who accept the terms of the workers compensation act by providing services or material thereunder shall be bound by the fees approved by the director and no injured employee or dependent of a deceased employee shall be liable for any charges above the amounts approved by the director. If the employer has knowledge of the injury and refuses or neglects to reasonably provide the benefits required by this section, the employee may provide the same for such employee, and the employer shall be liable for such expenses subject to the regulations adopted by the director. No action shall be filed in any court by a health care provider or other provider of services under this section for the payment of an amount for medical services or materials provided under the workers compensation act and no other action to obtain or attempt to obtain or collect such payment shall be taken by a health care provider or other provider of services under this section, including employing any collection service, until after final adjudication of any claim for compensation for which an application for hearing is filed with the director under K.S.A. 44-534 and amendments thereto. In the case of any such action filed in a court prior to the date an application is filed under K.S.A. 44-534 and amendments thereto, no judgment may be entered in any such cause and the action shall be stayed until after the final adjudication of the claim. In the case of an action stayed hereunder, any award of compensation shall require any amounts payable for medical services or materials to be paid directly to the provider thereof plus an amount of interest at the rate provided by statute for judgments. No period of time under any statute of limitation, which applies to a cause of action barred under this subsection, shall commence or continue to run until final adjudication of the claim under the workers compensation act.

(c) If the services of the health care provider furnished as provided in subsection (a) are not satisfactory to the injured employee, the director may authorize the appointment of some other health care provider subject to the limitations set forth in this section and the rules and regulations adopted by the director. Without application or approval, an employee may consult a health care provider of the employee's choice for the purpose of examination, diagnosis or treatment, but the employer shall only be liable for the fees and charges of such

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health care provider up to a total amount of $350.

(d) An injured employee whose injury or disability has been established under the workers compensation act may rely, if done in good faith, solely or partially on treatment by prayer or spiritual means in accordance with the tenets of practice of a church or religious denomination without suffering a loss of benefits subject to the following conditions:

(1) The employer or the employer's insurance carrier agrees thereto in writing either before or after the injury;

(2) the employee submits to all physical examinations required by the workers compensation act;

(3) the cost of such treatment shall be paid by the employee unless the employer or insurance carrier agrees to make such payment;

(4) the injured employee shall be entitled only to benefits that would reasonably have been expected had such employee undergone medical or surgical treatment; and

(5) the employer or insurance carrier that made an agreement under paragraph (1) or (3) of this subsection may withdraw from the agreement on 10 days' written notice.

(e) In any employment to which the workers compensation act applies, the employer shall be liable to each employee who is employed as a duly authorized law enforcement officer, ambulance attendant, mobile intensive care technician, fireman or firefighter, including any person who is serving on a volunteer basis in such capacity, for all reasonable and necessary preventive medical care and treatment for hepatitis to which such employee is exposed under circumstances arising out of and in the course of employment.

History: L. 1927, ch. 232, § 10; L. 1931, ch. 217, § 1; L. 1939, ch. 213, § 2; L. 1947, ch. 288, § 1; L. 1951, ch. 305, § 1; L. 1953, ch. 244, § 1; L. 1955, ch. 250, § 4; L. 1957, ch. 293, § 2; L. 1959, ch. 220, § 1; L. 1961, ch. 243, § 1; L. 1963, ch. 275, § 1; L. 1967, ch. 280, § 4; L. 1968, ch. 102, § 3; L. 1970, ch. 190, § 2; L. 1974, ch. 203, § 9; L. 1977, ch. 174, § 2; L. 1979, ch. 156, § 3; L. 1980, ch. 146, § 1; L. 1981, ch. 203, § 1; L. 1987, ch. 187, § 3; L. 1987, ch. 188, § 1; L. 1990, ch. 183, § 2; L. 1991, ch. 144, § 3; July 1.

Cross References to Related Sections:

Payment of medical compensation when compensability is not an issue on review, see 44-551 and 44-556.

Law Review and Bar Journal References:

"Unauthorized Medical: A Changing Concept," Vol. IX, No. 3, J.K.T.L.A. 8 (1985).

"Workers' Compensation—A Salute to the Trial Lawyers of Kansas," Gary L. Jordan, 10 J.K.T.L.A. No. 6, 9 (1987).

Attorney General's Opinions:

Workers compensation advisory panel; medical compensation; powers; panel members. 90-131.

Workers compensation advisory panel; members; powers. 91-2.

Workers compensation; schedules of maximum fees; advisory panel; contracts with private entities; information. 91-36.

CASE ANNOTATIONS

228. Subsection (c) permits employee dissatisfied with approved physician to ask for new one or select his own. Murphy v. IBP, Inc., 240 K. 141, 148, 727 P.2d 465 (1986).

229. Cited; discharge for absence due to work-related injury held retaliatory; tort action independent of collective bargaining agreement. Coleman v. Safeway Stores, Inc., 242 K. 804, 805, 752 P.2d 645 (1988).

44-510a.

CASE ANNOTATIONS

7. Cited; effect of prior 100% permanent partial disability rating on second injury claim examined. Baxter v. L.T. Walls Constr. Co., 241 K. 588, 590, 738 P.2d 445 (1987).

44-510b. Compensation where death results from injury; compensation upon remarriage; apportionment; burial expenses; limitations on compensation; annual statement by surviving spouse. Where death results from injury, compensation shall be paid as provided in K.S.A. 44-510 and amendments thereto, and as follows:

(a) If an employee leaves any dependents wholly dependent upon the employee's earnings at the time of the accident, all compensation benefits under this section shall be paid to such dependent persons. Such dependents shall be paid weekly compensation, except as otherwise provided in this section, in a total sum to all such dependents, equal to 66⅔% of the average gross weekly wage of the employee at the time of the accident, computed as provided in K.S.A. 44-511 and amendments thereto, but in no event shall such weekly benefits exceed, nor be less than, the maximum and minimum weekly benefits provided in K.S.A. 44-510c and amendments thereto, subject to the following:

(1) If the employee leaves a surviving legal spouse or a wholly dependent child or children, or both, who are eligible for benefits under this section, then all death benefits shall be paid to such surviving spouse or children, or both, and no benefits shall be paid to any other wholly or partially dependent persons.