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A Climate Ripe for Abuse: The Role of Kentucky's Workers' Compensation Law in Perpetuating Drug Abuse in the Appalachian Region

BY STACY E. MILLER*

ABSTRACT

There are many loopholes in Kentucky's workers' compensation legislation that create an opportunity for the enterprising to divert narcotics prescriptions to illegal use. Among those loopholes is the state's utilization review program, which does not review workers' compensation patients' medical regimens for alternatives to treatment using narcotic painkillers. In addition, many employees may select their own treating physician with minimal employer interference. This unconstrained freedom gives employees the means of selecting physicians who are amenable to prescribing narcotics unnecessarily or excessively. Finally, the current program makes no attempt to monitor narcotic painkiller distribution to individual employees or by individual doctors. Therefore the deviant can work in virtual anonymity under the current system. These, and other oversights, make Kentucky's workers' compensation program particularly susceptible to abuse in counties plagued by high levels of unemployment and low levels of education. This article will explore the current administration of Kentucky's workers' compensation program and will offer proposals for making this program more resistant to abuse by those who would manipulate it in order to acquire narcotics prescriptions for illegal use.

I. A CLIMATE RIPE FOR ABUSE

Standing with his hands clasped in front of him, the white-haired, ruddy-faced [Dr.] Procter¹ told District Judge Henry Wilhoit . . . that

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he and four other doctors he hired at his South Shore [Kentucky] clinic routinely prescribed narcotics to hundreds of addicts between 1996 and 2002 [H]e would at times see 80 or more patients a day, prescribing pain pills after limited, if any, medical examinations. He also admitted prescribing more than 1.5 million tablets of Schedule II and III controlled substances Procter said his medical practice evolved from . . . mostly workers' compensation injuries, to about 95 percent pain-pill patients by 1998.²

Eastern Kentucky is known for high levels of prescription drug abuse due to the diversion of pharmaceutical prescriptions to illegal use.³ Hydrocodone⁴ distribution in Kentucky is the second highest in the nation, more than twice the national average.⁵ In fact, "[e]nough hydrocodone came into Martin, Johnson and parts of Lawrence counties in 2001 to provide each adult there with 89 pills at the standard dose of 7.5 milligrams."⁶ The federal Drug Enforcement Agency ("DEA") considers diverted prescription drugs to be "the most underestimated of [Kentucky's] drug problems."⁷ DEA reports state that during 2002 "8,719 dosage units of diverted pharmaceutical drugs were seized . . . in Kentucky."⁸ In fact, "Eastern Kentucky counties led the nation in per capita narcotics distribution in 1998, 1999 and 2000."⁹ With "nearly half

the author would like to thank her family—Terry and Linda Sole, Kelly Odom, and Johnny and Janice Miller—for their tireless encouragement and love.

¹ Dr. David Procter, formerly an Eastern Kentucky physician, was indicted in early 2003 on "three felony charges—one of conspiring to distribute controlled substances and two of prescribing controlled substances without a legitimate purpose." Gil Gideon, *Doctor Pleads Guilty in Drug Case, E. Kentucky Physician Served Addicts, Was Sometimes Paid in Sex*, COURIER-JOURNAL (Louisville), Apr. 29, 2003, at A1, 2003 WL 18828770.

² *Id.*

³ See DEA, DRUGS AND DRUG ABUSE, STATE FACTSHEET, KENTUCKY, at <http://www.usdoj.gov/dea/pubs/states/Kentucky.html> [hereinafter DEA KENTUCKY FACTSHEET].

⁴ See *infra* notes 86–91 and accompanying text.

⁵ DEA KENTUCKY FACTSHEET, *supra* note 3. In 2001, 11,409 grams of hydrocodone were distributed per 100,000 Kentucky residents, compared to the national average of 5614 grams per 100,000 residents. *Id.*

⁶ *Painkillers Story Erred in Amount Per Adult*, LEXINGTON HERALD-LEADER, Jan. 21, 2003, at B1.

⁷ DEA KENTUCKY FACTSHEET, *supra* note 3.

⁸ *Id.*

⁹ Linda J. Johnson, *Eastern Kentucky: Painkiller Capital*, LEXINGTON HERALD-LEADER, Jan. 19, 2003, at A1.

a ton of painkillers” coming into the region, the quantity of narcotics averaged “0.0078 pounds per adult.”¹⁰

The kinds of prescription drugs that are most often diverted to illicit use in Kentucky are narcotic painkillers such as Lorcet, Lortab and Vicodin.¹¹ These drugs are intended to treat pain resulting from traumatic injuries, like those often covered by workers’ compensation insurance. These drugs “all share the same key ingredient: hydrocodone, [which is] an opium derivative.”¹² The hydrocodone-based pills are more popular in Appalachia than the highly publicized OxyContin¹³ because such prescriptions tend to be refillable, they have a lower street value, and are less regulated.¹⁴

The devastating effect of prescription drugs in Eastern Kentucky is evidenced by the large quantities of people requesting treatment for substance abuse.¹⁵ “The number of people seeking residential treatment for painkiller addiction . . . nearly tripled from 1998 through 2001, and the wait for admission to one of the region’s five community treatment centers can take several months.”¹⁶ In early 2003 “every person in Mountain [Comprehensive Care’s] . . . Layne House in Prestonsburg [was] a recovering prescription drug addict.”¹⁷

There are many factors that render this area of the Commonwealth particularly susceptible to abusing and trafficking painkiller narcotics.¹⁸ First, the Appalachian region has a higher degree of unemployment than the rest of the state.¹⁹ During the recent recession, unemployment rates in

¹⁰ *Painkillers Story Erred in Amount Per Adult*, *supra* note 6.

¹¹ *Id.* Linda Johnson, *Lesser-Known Favorites Cheap, Abundant*, LEXINGTON HERALD-LEADER, Jan. 21, 2003, at A8.

¹² *Id.*

¹³ “OxyContin is a Schedule II narcotic and is normally prescribed as an analgesic for cancer and severe arthritis patients.” DEA KENTUCKY FACTSHEET, *supra* note 3. “OxyContin pills range from 20–80 milligrams worth of narcotic, and their active ingredient is slightly more potent than hydrocodone.” Johnson, *supra* note 11.

¹⁴ Johnson, *supra* note 11.

¹⁵ See generally Johnson, *supra* note 9; DEA KENTUCKY FACTSHEET, *supra* note 3.

¹⁶ Johnson, *supra* note 9; see also DEA KENTUCKY FACTSHEET, *supra* note 3 (noting a 288% increase in the number of narcotics abusers seeking treatment in Eastern Kentucky from 1998 to 2001).

¹⁷ Johnson, *supra* note 9.

¹⁸ For purposes of this note, the term “painkiller narcotics” refers to OxyContin, Roxycontin, Oxycodone, Lorcet, Lortab, Percocet, Percodan, Hydrocodone, Vicodin, and other potentially addictive painkiller narcotics.

¹⁹ Jim Jordan, *Recession No Cause for Depression*, LEXINGTON HERALD-LEADER, Sept. 22, 2002, at A6, 2002 WL 24680578.

several Eastern Kentucky counties were in “double digits,” while figures for Central Kentucky hovered around three to four percent.²⁰ This high degree of unemployment has caused many Eastern Kentucky residents to view programs like workers’ compensation as a kind of “social-welfare.”²¹ Coal mine operators, for example, have noticed “big jumps in workers’ compensation claims after layoffs—an indication, they said, that workers treat the system as a safety net in areas where jobs are scarce.”²²

Perhaps because of their elevated levels of unemployment, many inhabitants of Eastern Kentucky maintain an unconventional perspective on disability, social security insurance (“SSI”) and other welfare programs.²³ Having observed several generations of family members drawing disability income, many view disability and SSI as acceptable alternatives to or supplements for traditional employment income.²⁴ Residents “learn to describe their symptoms in a way that guarantees they will get a government check,” and they learn it from a very young age.²⁵ As one native noted, “[p]arents are particularly aggressive about claiming disability checks for their children.”²⁶ They even go as far as demanding that “their healthy children be placed in special-education classes to lend credibility to the children’s forthcoming SSI applications Sometimes, parents even coach their children to act slow-witted or disruptive to support claims of learning disabilities.”²⁷ Parents’ efforts in this regard have been fruitful, as children now account for “13 percent of Kentucky’s SSI recipients.” That number is “up from 6 percent in 1990.”²⁸

This chronic disability mindset is so prevalent in Eastern Kentucky and other Appalachian communities that it supports products designed to

²⁰ *Id.* For example, in 2000 unemployment was at 14 percent in Magoffin county and at 15.8 and 10.6 percent in Lewis and Letcher counties, respectively. U.S. Census Bureau, County and City Book: 2000 323 (13th ed. 2000).

²¹ Bill Estep, *Top Areas in Workers’ Comp All in Coalfields*, LEXINGTON HERALD-LEADER, June 29, 1996, at C1.

²² *Id.*

²³ See generally John Cheves, *Disability Claims Are on the Rise in Kentucky*, LEXINGTON HERALD-LEADER, Aug. 25, 2002, at A1, 2002 WL 26061850; Bill Estep & Tom Lasseter, *Moonshine Mentality*, LEXINGTON HERALD-LEADER, Feb. 3, 2003, at A8, 2003 WL 2466814.

²⁴ See Cheves, *supra* note 23 (“Families learn that disability is a way of life, ‘passed down from generation to generation”).

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.* (observations of Appalachian educators).

²⁸ *Id.*

help residents with their claims. Typical of this commercialization of disability is the “how-to” manual, which outlines the procedure one should follow to achieve success in a disability claim. One such manual, *What Every Disability Claimant Should Know!*, can be purchased in Appalachian stores for a mere \$5.95 and “urges applicants to appeal their cases until they win a check.”²⁹

The vigorous market for prescription drugs, the lack of stigma surrounding disability and social security claims, the high levels of unemployment, and low levels of education³⁰ all contribute to making workers’ compensation programs ripe for abuse in Eastern Kentucky. The current workers’ compensation legislation³¹ requires employers to provide palliative treatment³² to claimants regardless of the treatment’s effectiveness in curing the injury, and provides claimants with the opportunity to “doctor shop,” thereby maximizing their prospects for obtaining narcotics prescriptions.³³ Moreover, workers’ compensation regulations provide for no monitoring of pharmaceuticals dispensed as a result of the program.³⁴ This note proposes that the Kentucky workers’ compensation program should, in the interest of public policy, be altered to provide three things: 1) greater scrutiny of narcotic painkiller distribution; 2) prospective employer control to challenge narcotic painkiller prescriptions; and 3) diminished employee authority to select treating physicians.

The following sections will discuss the level of participation in workers’ compensation programs in Eastern Kentucky as compared with the rest of the state;³⁵ the current administration of the workers’

²⁹ *Id.*

³⁰ 72.5% of Kentuckians age 25 or older have no greater than a high school education. ALMANAC OF THE 50 STATES 141 (Louise L. Hornor ed., 2003).

³¹ Kentucky’s workers’ compensation laws are located in KY. REV. STAT. ANN. [hereinafter K.R.S.] ch. 342 (Michie 2004).

³² Palliative treatment is that treatment which “[relieves] pain or [alleviates] a problem without dealing with the underlying cause.” NEW OXFORD AMERICAN DICTIONARY 1231 (2001).

³³ See *infra* note 123–25 and accompanying text.

³⁴ Outside of workers’ compensation regulations, Kentucky does have a drug-tracking program called the Kentucky All Schedule Prescription Electronic Reporting System (“KASPER”). A recent law has expanded the use of KASPER to determine geographic areas where prescription drug abuse might be a problem.” Previously, KASPERs database could only be accessed in response to a particular complaint. Karla Ward, *Law Adds Access to Drug Database*, LEXINGTON HERALD-LEADER, Apr. 14, 2004, at B1. The KASPER program is beyond the scope of this note.

³⁵ See *infra* Part II.

compensation program,³⁶ and finally propose adjustments to the current legislation and regulations designed to curb abuse of painkiller narcotics dispensed pursuant to the Kentucky workers' compensation program.³⁷

II. WORKERS' COMPENSATION PARTICIPATION IN KENTUCKY: AN INTRA-STATE GEOGRAPHICAL COMPARISON

First, the analysis begins with a look at a select group of Eastern Kentucky counties.³⁸ In fiscal year 2003–2004,³⁹ 186 First Reports of Injury (“FROIs”) ⁴⁰ were filed in Magoffin County, out of a total labor force of 5031 workers.⁴¹ At 3.70%, this incidence of injury reports is more than twice the average for the rest of the state.⁴² Interestingly, there were 160 claims made in Magoffin County in fiscal year 2003–2004.⁴³ “In Kentucky, not every work-related injury is a claim; only cases in which there are disagreements that cannot be resolved (i.e. contesting payment of benefits, [or] a question of the extent of disability) become claims.”⁴⁴ Magoffin County’s claims-to-FROI ratio was 86.02%, four times the state average of 20.49%, indicating that Magoffin County workers are particularly litigious in their pursuit of workers’ compensation benefits.⁴⁵

Examination of other Eastern Kentucky counties produced similar results. In Johnson County, the FROI-to-labor-force ratio was equal to the state average, but the claims-to-FROIs ratio was roughly twice the

³⁶ See *infra* Part III.

³⁷ See *infra* Part IV.

³⁸ Johnson, Lawrence, Martin, Magoffin, Owsley, and Pike counties are examined herein because they are representative of the issues described in Part I.

³⁹ Kentucky Office of Workers’ Claims, Annual Report Fiscal Year 2003–2004, 19 (2004).

⁴⁰ An FROI is “[t]he initial report of a workplace injury that involves lost time.” Kentucky Office of Workers’ Claims, *Workers’ Compensation Guidebook* 47 (2002), [hereinafter OWC Guidebook].

⁴¹ See *infra* Appendix A (citing information taken from the Kentucky Office of Workers’ Claims, *supra* note 39, at 18–20).

⁴² See *infra* Appendix A (4.46% of Harlan’s employees had FROIs, which is more than twice the state average of 2.00%).

⁴³ See *id.*

⁴⁴ OWC Guidebook, *supra* note 40, at 46.

⁴⁵ See *infra* Appendix A.

state average.⁴⁶ In Lawrence County, the FROI-to-labor-force ratio was actually below state average, and yet its claims-to-FROIs ratio was 56.10%—more than twice the state average.⁴⁷ In other words, these counties had an average number of injury reports, but the number of claims filed in which the employee challenged the benefits coverage was well above normal.

In other Eastern Kentucky counties, both the number of injuries reported and the number of claims filed were also significantly above average. For example, in Martin County the FROI-to-labor-force ratio was more than seven times the state average.⁴⁸ Pike County's FROI-to-labor-force ratio was one and a half times the state average and its claims ratio was three times the state average.⁴⁹ The Owsley County figures were the lowest in the test group, with a FROI-to-labor-force ratio below average and a claims ratio that was only slightly above state average.⁵⁰

In contrast, the figures for the two counties with the highest number of workers were near the state average for FROIs, but below average in the number of claims filed.⁵¹ Jefferson County has 372,219 employees, the highest in the state.⁵² Yet, despite the greater number of employees, only 2.07% of its labor force filed FROIs, and only 13.97% of its FROIs turned into claims.⁵³ Similarly, Fayette County has 141,070 employees, but only 1.90% of them filed FROIs, and a mere 16.24% of those FROIs became claims. Thus, a scant 0.3% of Fayette County workers filed a workers' compensation claim and then contested their award in some way.⁵⁴ This tiny percentage is in sharp contrast to Martin County, where more than three percent of all FROI filers contested their award and created a claim.⁵⁵

⁴⁶ Johnson County's percentage of FROIs to workers was 2.89%, and the percentage of claims to FROIs was 36.23%. *See id.*

⁴⁷ *See id.*

⁴⁸ *See id.*

⁴⁹ *See id.*

⁵⁰ *See id.*

⁵¹ *See id.*

⁵² *See id.* The next closest county is Fayette, with 141,070 total employees. Office of Workers' Claims, *supra* note 39, at 18.

⁵³ *See infra* Appendix A.

⁵⁴ In Fayette County there were 436 claims and 141,070 employees. The percentage of claims to total labor force, therefore, was 0.309%. *See infra* Appendix A.

⁵⁵ In Martin County, there were 125 claims and 3699 employees; thus, the ratio of claims to the total labor force was 3.379%. *See infra* Appendix A.

After looking at these sample counties, there is an obvious disparity between the use of workers' compensation benefits in Eastern Kentucky and use of such benefits in the state's two most populous counties.⁵⁶ These figures indicate that in Eastern Kentucky a greater number of injuries are reported⁵⁷ and a significantly greater number of claims filed than in Fayette and Jefferson counties, or in the rest of the state.⁵⁸

This is not a recent phenomenon. A 1996 newspaper article examining the workers' compensation program found its use to be much higher in the state's coal-producing counties, which are located predominantly in Eastern Kentucky.⁵⁹ The article reported that in "three Eastern Kentucky counties, the total amount of workers' compensation awarded was more than 1,000 percent above the state average in the [preceding] four years, . . . [and] the top 10 counties in lost-wage awards were all in the state's eastern coalfield."⁶⁰ The article went on to note that "[i]n Pike County . . . an average of \$74 million in benefits was awarded each year from April 1992 to April 1996," while in Fayette County the yearly average during the same period was a much lower \$13.8 million.⁶¹ These numbers become even more skewed when one bears in mind the size discrepancy between these counties' workforces.⁶²

The article's findings generally correlate with Appalachia's attitude towards disability claims.⁶³ The unusually high number of Eastern Kentucky claims challenging workers' compensation benefits awards may be a direct result of the encouragement residents receive to pursue disability claims until the maximum award is achieved.⁶⁴ Regardless, the high degree of workers' compensation use in the region is a prime source for narcotics prescriptions, which may be abused either directly by the patient-employee or indirectly by individuals to whom the employee has illegally sold the narcotics.

⁵⁶ See *supra* notes 38–55 and accompanying text.

⁵⁷ See *supra* notes 38–55 and accompanying text.

⁵⁸ See *supra* notes 38–55 and accompanying text.

⁵⁹ Estep, *supra* note 21.

⁶⁰ *Id.* (using a "county-by-county comparison of workers' compensation awards completed [in June 1996] by the [Kentucky] Department of Workers' Claims").

⁶¹ Estep, *supra* note 21.

⁶² *Id.* Pike County employs 26,725 workers; in contrast, the Fayette County workforce is 146,703 strong. See *infra* Appendix A.

⁶³ See notes 23–30 and accompanying text.

⁶⁴ See notes 23–30 and accompanying text.

III. CURRENT WORKERS' COMPENSATION ADMINISTRATION IN KENTUCKY

A. *The Purpose and Goals of Workers' Compensation Legislation*

The Office of Workers' Claims ("OWC") is the state agency responsible for administering workers' compensation regulations in Kentucky. Its purpose is "to promote safe, healthful, and quality working environments for employees and employers."⁶⁵ In furtherance of that purpose, the agency lists several goals in its mission statement. One such goal is a desire "[t]o provide the public and policy makers with accurate and current indicators of program performance [and] [t]o anticipate changes in the program environment and respond appropriately."⁶⁶ These are admirable goals which align the OWC's purpose. However, liberal judicial interpretation of the current legislation and regulations, as well as the insufficiency of the current system to monitor the use and distribution of painkiller narcotics, prevents the OWC from attaining its objectives. These shortcomings will be illuminated at greater length in the following sections.

B. *The Use of Managed Care Networks to Administer Workers' Compensation Medical Benefits to Claimants*

1. *Physician Selection*

There are two options available to employers for providing claimants with medical benefits pursuant to a workers' compensation program. The first option is to participate in a "managed health care system," and the second is to administer claims independently of such a system.⁶⁷ When an employer elects to participate in a managed care network, the injured employee must choose his primary treating physician (the "gatekeeper" physician) from a list of approved providers.⁶⁸ Only in a limited number of circumstances may the employee acquire a primary treating physician

⁶⁵ OWC Guidebook, *supra* note 40, at 4.

⁶⁶ *Id.*

⁶⁷ K.R.S. § 342.020(1) (Michie 2004).

⁶⁸ 803 KY. ADMIN. REGS. [hereinafter K.A.R.] 25:119 § 9(1) (2003); OWC Guidebook, *supra* note 40, at 39.

from outside the network.⁶⁹ This system allows employers to have some control over which physicians employees may see for their injuries.⁷⁰

2. Medical Benefits

Workers' compensation statutes provide for injured employees to receive treatment for the "cure and relief from the effects of" a work-related injury.⁷¹ The statute officially defines "injury" to be "any work related traumatic event or series of 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."⁷² The injury must be incurred "while performing normal duties during regular working hours."⁷³

Psychological injuries are also included within the definition of a compensable injury.⁷⁴ In *Coleman v. Emily Enterprises, Inc.*, the Kentucky Supreme Court found that "an event that involves physical trauma may be viewed as a 'physical injury' without regard to whether the harmful change that directly results is physical, psychological, psychiatric, stress-related, or a combination thereof."⁷⁵ The court did stress, however, that where the injury claimed is "psychological, psychiatric, or stress-related, it must *directly* result from a physically traumatic event."⁷⁶

The physical trauma requirement is somewhat helpful in narrowing the scope of compensable injuries, but it is considerably weakened by the court's ultimate holding in *Coleman*. Despite reaffirming the causation requirement, the court extended coverage of workers' compensation benefits to anxiety and depression about the pending workers' compensation case, even though these psychological problems were not a

⁶⁹ OWC Guidebook, *supra* note 40, at 39. The circumstances in which the employee may choose a physician from outside the network include: emergency care, a referral to an outside physician, when treatment cannot be obtained from an in-network physician, and to obtain a second opinion following a recommendation for surgery. 803 K.A.R. 25:110 § 4(3), 9(1)-(2).

⁷⁰ The employer does not have complete control over the claimant's choice of physician because the regulations require the employer to include different types of physicians in the network.

⁷¹ K.R.S. § 342.020.

⁷² § 342.011.

⁷³ OWC Guidebook, *supra* note 40, at 13.

⁷⁴ *Coleman v. Emily Enters., Inc.*, 58 S.W.3d 459, 462 (Ky. 2001).

⁷⁵ *Id.*

⁷⁶ *Id.* (emphasis added).

direct result of the claimant's back injury.⁷⁷ In so holding, the court stated, "[t]he general rule is that all of the injurious consequences that flow from a work-related physical injury and that are not attributable to an unrelated cause are compensable."⁷⁸ This overly broad definition of "injury" expands the number of permissible claims which are treatable with addictive drugs to include psychological claims that are not directly related to the injury, and that are inherently difficult to verify.⁷⁹ Thus, the *Coleman* definition only exacerbates the prescription drug abuse problem in workers' compensation cases by making it easier for claimants to obtain prescriptions for addictive narcotics to treat psychological conditions such as depression or anxiety.

3. Covered Medical Treatments

As stated earlier, employers are required to pay for the "cure and relief" of an employee's work-related injury.⁸⁰ The Kentucky Court of Appeals, in *National Pizza Co. v. Curry*, has interpreted "cure and relief" to mean "cure *and/or* relief."⁸¹ As a result, "the employer of one determined to have incurred a work-related disability [is required] to pay for any reasonable and necessary medical treatment for relief whether or not the treatment has any curative effect."⁸² The employee is permitted to seek "medical, surgical and hospital treatment," which includes any supplies and medications required to treat the injury.⁸³ In addition, "[t]he employer's obligation to pay . . . shall continue for so long as the employee is disabled regardless of the duration of the employee's income benefits."⁸⁴ Therefore, once an employee receives a disability rating

⁷⁷ *Id.* at 463. Justice Cooper's dissent astutely observes that the court has jumbled the meanings of direct and proximate causation. *Id.* (Cooper, J., dissenting). Although stating the general rule that "where the harmful change is psychological, psychiatric, or stress-related, it must directly result from a physically traumatic event," the court applied the proximate result test generally used for non-psychological injuries in reaching its conclusion. *Id.*

⁷⁸ *Id.* at 462–63 (citing *Beech Creek Coal Co. v. Cox*, 237 S.W.2d 56 (Ky. 1951)).

⁷⁹ "The growing majority [of Kentucky's SSI recipients] complain of mental illness, which officials say is far harder to confirm than blindness or a broken back." Cheves, *supra* note 23.

⁸⁰ K.R.S. § 342.020(1) (Michie 2004).

⁸¹ *Nat'l Pizza Co. v. Curry*, 802 S.W.2d 949, 951 (Ky. Ct. App. 1991) (emphasis added).

⁸² *Id.*

⁸³ K.R.S. § 342.020(1).

⁸⁴ *Id.*

under the workers' compensation program, the employer is obligated to pay for palliative pharmaceutical coverage, among other things, for the duration of the employee's disability, regardless of whether that treatment actually cures the employee's condition.⁸⁵

Several common painkiller narcotic ingredients are used to treat pain resulting from injuries for which an employer might be responsible under the workers' compensation laws. For example, hydrocodone is an "opium-like compound" used to relieve moderate to moderately severe pain.⁸⁶ Hydrocodone is similar to codeine and is considered a narcotic analgesic.⁸⁷ Hydrocodone is found in a number of brand name painkiller narcotics such as Lorcet, Lortab, and Vicodin. These three are some of the most commonly diverted pharmaceutical drugs in Eastern Kentucky.⁸⁸ Another medication commonly prescribed in Eastern Kentucky is the notorious pain drug OxyContin.⁸⁹ All of these painkiller narcotics are habit-forming⁹⁰ and constitute the bulk of illicit pharmaceutical use in Eastern Kentucky.⁹¹

4. Reporting

Managed care programs are required to file annual reports with the commissioner of workers' compensation.⁹² With respect to

⁸⁵ See *id.*; *Nat'l Pizza Co.*, 802 S.W.2d at 951.

⁸⁶ DRUG ABUSE HANDBOOK 37 (Steven B. Karch, M.D. ed., CRC Press 1998); see also DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 71 (N.B. Saunders Co. 2000).

⁸⁷ DRUG ABUSE HANDBOOK, *supra* note 86, at 37, 558. "Codeine is one of the substances found in opium." *Id.* at 557.

⁸⁸ Lance Williams, *Ky. Tylox Cases Highlight Big Illegal-Drug Problem*, LEXINGTON HERALD-LEADER, Oct. 11, 1999, at A1; see also Johnson, *supra* note 11.

⁸⁹ See Johnson, *supra* note 11. OxyContin is made from oxycodone, an addictive pharmaceutical opiate. See *Oxycontin Prescriber Convicted*, LEXINGTON HERALD-LEADER, Feb. 20, 2002, at A1; DRUG ABUSE HANDBOOK, *supra* note 86, at 37.

⁹⁰ DRUG ABUSE HANDBOOK, *supra* note 86, at 37.

⁹¹ DEA KENTUCKY FACTSHEET, *supra* note 3.

⁹² 803 K.A.R. 25:110 § 11 (2003). Reports must include the following information:

- (1) [the] number of employees treated by the managed care plan;
- (2) [the] number of work-related injuries . . . ;
- (3) a breakdown . . . of injuries . . . ;
- (4) total medical costs;
- (5) [the] average medical cost per injured employee by type of injury;
- (6) average medical cost per diseased employee by type of disease;
- (7) breakdown of medical cost elements as to type of physician utilized, hospital costs, drug costs and other costs;
- (8) the number of grievances filed, and summary of action taken;
- (9) [and the] number of days for which an employee has been released from work.

pharmaceutical usage, there is no requirement that the managed care program report the incidents of painkiller narcotic prescriptions dispensed pursuant to a workers' compensation program.⁹³ This means that the OWC does not keep records on the distribution and utilization of painkiller narcotics dispensed pursuant to a workers' compensation treatment plan.⁹⁴ Reporting requirements regarding the amount of money spent by employers in providing claimants with painkiller narcotics are also conspicuously absent.⁹⁵ There is only the general requirement that employers report their total medical costs broken down into the broad categories of "type of physician used, [overall] drug costs and other costs."⁹⁶

5. Utilization Review

A managed care network must have a system in place for performing utilization review.⁹⁷ Utilization review is defined as an "[e]valuation by the payment obligor of the medical appropriateness and necessity of medical care and services for the purpose of recommending payments for compensable injuries or diseases."⁹⁸ Utilization review is designed to be a system of cost containment⁹⁹ and "serves the purpose of determining whether payment is warranted."¹⁰⁰ In practice, utilization review should "ensure that an effective treatment plan is implemented and that over-utilization of services is avoided."¹⁰¹

For a managed care network to be certified by the workers' compensation commissioner,¹⁰² it must contain "[m]echanisms for utilization review which shall prevent inappropriate, excessive, or

⁹³ *Id.*

⁹⁴ *Id.*; Letter from Carla H. Montgomery, Assistant General Counsel, Office of Workers' Claims, to the author (October 28, 2003) (on file with author) (stating that these were not records that the OWC "keep[s] or has available").

⁹⁵ See 803 K.A.R. 25:110 § 11.

⁹⁶ *Id.*

⁹⁷ *Id.* § 4(5).

⁹⁸ OWC Guidebook, *supra* note 40, at 49; see also 803 K.A.R. 25:190 § 1(6); E-town Quarry v. Goodman, 12 S.W.3d 708 (Ky. Ct. App. 2000); Dep't of Workers' Claims, Utilization Review ¶ 1, at <http://labor.ky.gov/dwc/ur.htm>.

⁹⁹ OWC Guidebook, *supra* note 40, at 38.

¹⁰⁰ Marcy D. Ches & Stuart A. Cooke, *Status Report on Utilization Review and Medical Bill Audit in Non-Managed Care 3* (Oct. 1997), at <http://labor.ky.gov/dwc/pdf-file-misc/ur-txt.pdf>.

¹⁰¹ *Id.*

¹⁰² "All managed care plans must be certified by the commissioner." 803 K.A.R. 25:110 § 2(1) (2004).

medically unnecessary medical services.”¹⁰³ In particular, the network’s system of review must have a process for demonstrating that: “a course of treatment is reasonably necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is [sic] appropriate; [and that] pharmaceuticals are not unnecessarily prescribed.”¹⁰⁴ The standard of review is “inappropriate, excessive, or medically unnecessary . . . in accordance with prevailing standards in the medical community of which the plan provider is a member.”¹⁰⁵

By law, employers are *required* to submit cases for utilization review when: “a medical provider requests pre-authorization . . . ; notification of a surgical procedure . . . is received; the total medical costs cumulatively exceed \$3000; the total lost work days cumulatively exceed thirty (30) days; or an . . . administrative law judge orders a review.”¹⁰⁶ When utilization review is requested, the claim is evaluated by a “physician, registered nurse, licensed practical nurse, medical records technician or other personnel, who through training and experience, is qualified to issue decisions on medical necessity or appropriateness.”¹⁰⁷ The review is retrospective and thus does not constitute “pre-certification”,¹⁰⁸ that is, by the time review takes place, medical services have already been furnished to the injured employee.¹⁰⁹

Recordkeeping is an essential part of utilization review. Each workers’ compensation insurance carrier must demonstrate that their utilization review program has a recordkeeping component that meets regulations in order for their managed care plan to be certified.¹¹⁰ Each must maintain a records database which includes: “each instance of utilization review; . . . the extent of the review; the conclusions of the reviewer; and the action, if any, taken as a result of the review.”¹¹¹ Each carrier is required to maintain this database for a minimum of two years.¹¹²

¹⁰³ *Id.* § 4(5).

¹⁰⁴ K.R.S. § 342.020(4)(f) (Michie 2004).

¹⁰⁵ 803 K.A.R. 25:110 § 4(5)(a).

¹⁰⁶ *Id.* at 25:190 § 5 (2003); OWC Guidebook, *supra* note 40, at 39.

¹⁰⁷ 803 K.A.R. 25:190 § 6(1) (2003).

¹⁰⁸ Ches & Cooke, *supra* note 100, at 16; Dep’t of Workers Claims, Utilization Review ¶ 11, at <http://labor.ky.gov/dwc/ur.htm>.

¹⁰⁹ Dep’t of Workers’ Claims, Utilization Review ¶ 11.

¹¹⁰ 803 K.A.R. 25:190 § 4(9).

¹¹¹ *Id.* § 4(9)(a).

¹¹² *Id.* § 4(9)(b).

C. *The Administration of Workers' Compensation Medical Benefits to Claimants by Employers Who Do Not Participate in a Managed Care Network*

1. *Physician Selection*¹¹³

One of the principal differences between programs that use a managed care network and programs that do not is the manner in which employees may select their gatekeeper physician.¹¹⁴ Under a managed care scheme, the injured employee is required to select a physician from within the finite list of in-network providers.¹¹⁵ When an employer does not participate in a managed care program, the injured employee is free to select “without interference from the employer” whomever he pleases to be his gatekeeper physician.¹¹⁶ This has been described by the OWC as one of the employee’s “rights.”¹¹⁷

Once the employee has selected a gatekeeper physician, he is required to give notice to the employer or payment obligor of the gatekeeper’s name and contact information.¹¹⁸ The employee gives such notice by filling out a “Form 113” and tendering it to the employer.¹¹⁹ Once the form is submitted, the gatekeeper physician is officially designated and the workers’ compensation insurance card bearing the gatekeeper’s name is issued.¹²⁰ Thereafter, the employee can change the physician designation only once without permission from the employer or an administrative law judge.¹²¹ The employee may continue treatment with his chosen gatekeeper until the employer “makes some showing of unreasonableness or non-necessity of the treatment.”¹²²

¹¹³ Physician selection is the only area that differs significantly between a managed care and a non-managed care workers’ compensation program; thus, it is the only area that will be addressed in this section. In all other respects, the programs are similar and face the same difficulties except that when an employer elects to participate in a managed care network, all treatment and utilization review reporting is done from within the network.

¹¹⁴ 803 K.A.R. 25:096 § 3.

¹¹⁵ *Id.* at 25:119 § 9(1); OWC Guidebook, *supra* note 40, at 39.

¹¹⁶ OWC Guidebook, *supra* note 40, at 14, 36; 803 K.A.R. 25:096 § 3.

¹¹⁷ OWC Guidebook, *supra* note 40, at 14, 36.

¹¹⁸ 803 K.A.R. 25:096 § 3.

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ OWC Guidebook, *supra* note 40, at 14, 36.

¹²² *Nat’l Pizza Co., v. Curry*, 802 S.W.2d 949, 950 (Ky. Ct. App. 1991).

Because it is the employee who ultimately fills out the Form 113,¹²³ it is improbable that an employer would know how many physicians the employee has visited before finally making a selection. This degree of freedom in selecting a treating physician creates another area where workers' compensation programs are vulnerable to abuse by drug seekers. Under the current system, a claimant can easily "doctor shop," going from physician to physician until one is found who will prescribe painkiller narcotics immediately without exhausting all other non-addictive alternatives.¹²⁴ In its Kentucky report, the DEA notes that "Lorcet, Lortab, Percocet, Percodan, Xanax and OxyContin are readily available [in Kentucky], and [t]he primary sources for most of these pharmaceuticals are 'doctor shoppers.'"¹²⁵

Another problem created by this physician selection system is that in rural areas, with a limited number of physicians available, injured employees usually turn to their family doctors for care. This is problematic on several levels. First, as observed by Asa Hutchinson, former director of the DEA, "[w]ith family doctors, especially in rural areas, 'you wouldn't have the same level of expertise in pain management as you would with the pain-management specialists.'"¹²⁶ Despite this lack of expertise, however, "family doctors [are] the busiest prescribers of pain pills for everything from backaches to car-crash injuries."¹²⁷ When workers' compensation claimants use their family doctors to treat their work-related injuries, they will likely receive treatment from an individual who is inexperienced at prescribing non-addictive types of curative and pain management treatment.¹²⁸

A second problem with allowing injured employees to select their own physicians is that in the small rural communities of Eastern Kentucky there is a great deal of social pressure to conform to the culture of tolerance towards prescription drug abuse and trafficking.¹²⁹ Prosecutors, for example, have bemoaned the extreme difficulty of prosecuting even open-and-shut drug trafficking cases in many Eastern

¹²³ See 803 K.A.R. 25:096 § 3.

¹²⁴ Another common meaning for "doctor shopping" is to go from doctor to doctor, collecting prescriptions for painkiller narcotics from each and getting them filled. Bill Estep, *Medicaid has Role in Drug Trade*, LEXINGTON HERALD-LEADER, Dec. 28, 2003, at A1.

¹²⁵ DEA KENTUCKY FACTSHEET, *supra* note 3.

¹²⁶ Charles B. Camp, *Millions Sold, Office by Office*, LEXINGTON HERALD-LEADER, Aug. 17, 2003, at A1.

¹²⁷ *Id.*

¹²⁸ See *id.*

¹²⁹ See Estep & Lasseter, *supra* note 23.

Kentucky counties.¹³⁰ They say, “[i]n small counties such as Owsley, where the population is less than 5,000, it’s difficult to pick an unbiased jury Too many people know one another or are related.”¹³¹ Jurors who have refused to convict known drug traffickers have cited this prevailing social pressure as the principal reason for not convicting the defendant.¹³²

It does not take a huge inferential leap to guess that the pressure upon small town doctors to unnecessarily dispense painkiller narcotics is also very strong.¹³³ In small counties such as Owsley, it is probable that doctors see many, if not all, members of the same family. Not conforming—either by exposing patients’ attempts to acquire painkiller narcotics for illicit purposes, or by refusing to dispense drugs in sufficient quantities—could cost a rural physician the business of not only the injured employee, but of that employee’s entire family. Fear of retaliation is also a factor which may influence physicians to dispense painkiller narcotics, just as it is a factor influencing jury decisions in drug trafficking cases.¹³⁴

IV. PROPOSED ADJUSTMENTS TO THE CURRENT WORKERS’ COMPENSATION STATUTES AND REGULATIONS

A. *Why Change Is Necessary*

There are several aspects of the current workers’ compensation administration that are problematic from the employer’s perspective, and can be linked to the prescription drug abuse problem in Eastern Kentucky.¹³⁵ While Kentucky has a policy of discouraging drug abuse,¹³⁶ the state requires employers to pay for painkiller narcotics to treat injured employees. Further, the state fails to monitor drug use and distribution

¹³⁰ *See id.*

¹³¹ *Id.*

¹³² *See id.* In one open-and-shut Owsley County case, a member of the hung jury that was unable to convict a Tylox trafficker stated that he feared retaliation against his father if he convicted the defendant. *Id.* In that same case, “17 people of 51 in the jury pool were excused from jury service because they knew [the defendant] or her family or were related to her.” *Id.*

¹³³ *See id.*

¹³⁴ *See generally id.* (noting that jurors in drug trafficking cases in Eastern Kentucky often are reluctant to return guilty verdicts for fear of retaliation).

¹³⁵ *See supra* Part III.

¹³⁶ Kentucky Cabinet for Health Services, at http://chs.ky.gov/publichealth/drug_control.htm.

within the workers' compensation program or to arm employers with more than a right to challenge the medical appropriateness of these prescriptions. By failing to do these things, the state violates public policy and prevents the OWC from fulfilling its workers' compensation goals. Further, the state should take all possible precautions before mandating that employers pay for addiction-forming treatments for work-related injuries. Finally, it is wholly inequitable to require employers to subsidize rehabilitation for employees who became addicted to painkiller narcotics under a treatment plan without also giving employers a way to prevent the addiction in the first place.¹³⁷ For the all of these policy reasons, changes must be made to Kentucky's workers' compensation laws.

B. Proposals

1. *Tightening the Existing Statutory Language*

As currently interpreted by Kentucky courts, the definition of "compensable injury" is overbroad.¹³⁸ It includes not only injuries resulting from a specific traumatic event, but also injuries that are the result of "cumulative trauma."¹³⁹ As a result, there is "no traumatic injury . . . required in order to recover compensation" in Kentucky.¹⁴⁰ The current statutory language has opened the door for judicial interpretations, such as *Coleman*, to extend the definition of "compensable injury" beyond those injuries which are the direct result of a work-related traumatic event, evidenced by objective medical proof.¹⁴¹ As discussed above, courts have construed "compensable injury" to include psychological injuries which result from the traumatic event.¹⁴²

Other states have chosen more precise language to define "compensable injury." Louisiana, for example, explicitly limits its

¹³⁷ *Coleman v. Emily Enters.*, 58 S.W.3d 459, 462–63 (citing *Beech Creek Coal Co. v. Cox*, 237 S.W.2d 56 (Ky. 1951)) ("The general rule is that all of the injurious consequences that flow from a work-related physical injury and that are not attributable to an unrelated cause are compensable."). Drug addiction and other problems stemming from the treatment of a workers' compensation injury are inherently included in the definition of a compensable injury under the ruling of this case. *See id.*

¹³⁸ *Id.* at 462–63. *see also supra* notes 74–79 and accompanying text.

¹³⁹ K.R.S. § 342.0011(1) (Michie 2004).

¹⁴⁰ MODERN WORKERS COMPENSATION § 108:3 (West 2003).

¹⁴¹ *See Coleman*, 58 S.W.3d at 462.

¹⁴² *Id.* at 463–64 (Cooper, J., dissenting).

definition to injuries that occur in a qualifying accident.¹⁴³ Louisiana defines such an injury as “an . . . identifiable, precipitous event happening suddenly or violently, with or without human fault, and *directly* producing *at the time* objective findings of an injury which is *more* than simply a gradual deterioration or progressive degeneration.”¹⁴⁴ Missouri also goes much further than Kentucky, explicitly narrowing the list of compensable injuries to those that are the direct result of a work-related accident.¹⁴⁵ The Missouri statute states that “[a]n injury is compensable if it is clearly work related. An injury is clearly work related if work was a substantial factor in the cause of the resulting medical condition or disability. An injury is not compensable merely because work was a triggering or precipitating factor.”¹⁴⁶

The Louisiana and Missouri statutes exhibit tighter statutory language that leaves minimal room for liberal judicial interpretation. Similarly, if Kentucky altered its definition of “compensable injury” and explicitly prohibited compensation for injuries that are not the proximate cause of a traumatic event the result would be a more manageable category of compensable injuries. A tighter definition of compensable injury will make it more difficult for drug seekers, who have “learned how to describe their injuries in a way that guarantees [them] a . . . check,”¹⁴⁷ to receive compensation for claims that are hard to verify or are only distantly related to a legitimate injury.

In addition to refining the definition of “compensable injury,” the legislature should institute a more finite duration of treatment under a workers’ compensation program. At present, any claimant with at least a one percent disability rating¹⁴⁸ is entitled to receive medical treatment for as long as they are disabled.¹⁴⁹ Limiting the duration of treatment to six months regardless of disability rating, as Arkansas has done, would discourage individuals from choosing this route to obtain painkiller

¹⁴³ LA. REV. STAT. ANN. § 23:1021 (West 2003) (cited in MODERN WORKERS COMPENSATION § 108:9 n.49).

¹⁴⁴ *Id.* (emphasis added).

¹⁴⁵ MO. REV. STAT. § 287.020(2) (2003) (cited in MODERN WORKERS COMPENSATION § 108:9 n.49).

¹⁴⁶ *Id.*

¹⁴⁷ Cheves, *supra* note 23.

¹⁴⁸ “AMA impairment ratings [are] [u]sed by [the] treating physician to describe [the] percentage of body functional impairment caused by injury or occupational disease.” OWC Guidebook, *supra* note 40, at 46.

¹⁴⁹ K.R.S. § 342.020(1) (Michie 2003).

narcotics for illicit purposes.¹⁵⁰ Another option is to cap the amount of money an employer is obligated to expend on any one injury for an employee. For example, Arkansas caps coverage at \$10,000 for a single injury when the period eligibility has not yet expired.¹⁵¹

2. *Adding Narcotics Reporting Requirements to the Regulations*

Presently there are no pharmaceutical reporting requirements within the workers' compensation administrative regulations, except for a requirement that employers generally report their pharmaceutical costs for the year.¹⁵² In order to effectively monitor distribution and utilization of narcotics pursuant to a workers' compensation program, the state must amend its present reporting requirements to include, at a minimum, the number of narcotics prescriptions by county and by type of drug. It might also be beneficial to report utilization reviews which concerned narcotic prescriptions, also by county and type of drug. These measures will help to identify areas of the state susceptible to narcotics abuse or over-prescription. If necessary, the level of reporting could even extend to the number of narcotics prescriptions dispensed to workers' compensation patients, organized by prescribing doctor. Such extreme measure would specifically identify problem individuals—both patients and doctors—who are abusing the system. Because of the nature of narcotics abuse, reports should be made more frequently—perhaps monthly or quarterly—in order for the OWC to respond to potential incidents of abuse in a timely manner.¹⁵³

¹⁵⁰ See ARK. CODE ANN. § 11-9-509 (Michie 2003) (cited in MODERN WORKERS COMPENSATION § 202:33 n.36). The Arkansas workers' compensation code limits duration of coverage to:

- (1) Six (6) months if the claimant lost no compensable time from work as a result of his or her injury;
- (2) Six (6) months following the return to work by an injured employee who has been receiving authorized medical or hospital or other services or treatment;
- (3) Ten thousand dollars (\$10,000) aggregate for all authorized medical, hospital, and other services and treatment, including any amounts paid under subdivisions (1) and (2) of this section.

Id.

¹⁵¹ See *id.* (capping coverage at \$10,000 for a single injury when the period of eligibility has not yet expired).

¹⁵² 803 K.A.R. 25:110 § 11(7) (2003).

¹⁵³ Various other reports required by regulation tend to be submitted annually. See *id.* § 11.

3. *Using Existing and New Information Technology to Monitor Narcotics Distribution*

The OWC currently uses an reporting system called the Electronic Data Interchange, or EDI.¹⁵⁴ The system was initially used to transmit FROIs; now its use has been extended to facilitate the reporting requirements for various segments of program administration.¹⁵⁵ If the legislature amends its reporting requirements to include reports on the types and quantities of narcotics distributed to workers' compensation claimants, the cost of adding these reports to the EDI system should be minimal. With technology already in place, this would simply be another application for it.

In addition to monitoring narcotics distribution through regular reporting, both employers and the OWC would benefit from having the ability to scrutinize narcotics distribution in real time. Several commercial pharmaceutical distribution and management companies can do this with an interactive online database.¹⁵⁶ They track distribution using a prescription card which they issue to workers' compensation claimants. The claimants must present the card when filling their prescriptions in order to have the medication costs covered by their workers' compensation insurance. Use of the card to fill a prescription will initiate a search within the interactive database "to check for potential drug interactions, to review prescriptions for medical appropriateness to the workers' compensation injury and to prevent duplicate prescriptions from multiple providers and prescribers."¹⁵⁷

There is an additional benefit to this type of system. Not only are pharmacy databases linked together, but employers are able to access the system directly. Because of this, "[p]rescription claims [can] be processed and adjudicated online *before* the medication is dispensed, thus eliminating the need to audit or deny a pharmacy claim after the prescription has been dispensed."¹⁵⁸ In addition, employers would have the power "to activate or terminate the claimant's eligibility online in

¹⁵⁴ Kentucky Department of Workers' Claims, *Annual Report Fiscal Year 2000–2001* 35 (2001), available at <http://www.comped.net/comped/pdf/annrpt01.pdf>. The system has been operational since 1996. *Id.*

¹⁵⁵ *Id.* "Subsequent Reports of Injury, Proof of Coverage and Medical Bill Reporting have been added to the list of electronic reporting [using EDI]." *Id.*

¹⁵⁶ See *Tmesys Inc. to Manage Pharmacy Services for PCS' Workers' Compensation Claimants*, MANAGED PHARM. REP., May 19, 1997, 1997 WL 8905558.

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

real time, design dispensing guidelines and drug plans, and authorize or deny specific medications and prescribers based on a group or patient-specific level.”¹⁵⁹

This type of system would give employers more prospective control over narcotics distribution than is currently afforded by utilization review. The real-time system would enable employers to challenge the use of narcotics in treatment before the patient can become addicted to the medication or can divert the prescription to illicit use. This approach also has a built-in protection for the employee in that prescription drug claims would be adjudicated in a timely manner, without making an employee wait an unreasonably long time before receiving a necessary medication. Finally, this system has the benefit of allowing administrators to monitor narcotics distribution patterns of the *provider* as well as of the patient. This heightened level of scrutiny should discourage physicians from prescribing narcotics unnecessarily or excessively, even if it does not discourage the patients from trying to obtain the prescriptions.

4. *Adjusting Utilization Review Regulations*

The purpose of utilization review is to evaluate “medical necessity and appropriateness of treatment and services,”¹⁶⁰ in order to propose payments for compensable injuries.¹⁶¹ But it is difficult for the institution to meet this goal when all review is performed retrospectively.¹⁶² A 1997 report on the status of utilization review found that “retrospective utilization review does not work because the bills have often been paid before the case is flagged for review.”¹⁶³ The report suggested several ways to increase the effectiveness of utilization review. First, the OWC should “require utilization review to begin upon the occurrence of an injury.”¹⁶⁴ Such prospective review would enable employers to catch inappropriate distribution of narcotics before they reached the employee, and it would afford employers a timely opportunity to challenge the use of narcotics when other non-addictive treatments have not yet been exhausted. The report also recommended that utilization review be “of a

¹⁵⁹ *Id.*

¹⁶⁰ OWC Guidebook, *supra* note 40, at 38.

¹⁶¹ 803 K.A.R. 25:190 § 1(6) (2003).

¹⁶² Ches & Cooke, *supra* note 100, at 16.

¹⁶³ *Id.* at 15.

¹⁶⁴ *Id.*

treatment plan, rather than . . . of each individual medical procedure.”¹⁶⁵ This more holistic approach would provide a comprehensive review of treatment that would be more equitable for both the employee and the gatekeeper physician.

An alternative to the report’s suggestion is to add a sixth criterion to the list of events which trigger utilization review.¹⁶⁶ That criterion would require that utilization review be performed every time painkiller narcotics are prescribed for an employee. But because of the unique nature of narcotics, review should be performed according to an equally unique standard. Instead of reviewing claims for medical necessity and appropriateness to the injury, it would be more appropriate for reviewers of narcotics prescriptions to determine whether there is a feasible, non-addictive alternative. Alternatives should be examined to establish whether they are comparable in price and effectiveness to the original treatment plan laid out by the gatekeeper or specialist provider. In most instances, painkiller narcotics are an appropriate treatment, but they are rarely the *only* treatment option. And, while narcotics may be suitable, their addictive side effects may do more harm to the employee than good.

5. *Restricting Employee Choice in Selecting the Gatekeeper Physician*

An enormous pitfall for employers who do not participate in a managed care network is their inability to control the employee’s choice of a gatekeeper physician. Surreptitious employees can easily manipulate the system by doctor shopping before filling out a Form 113. The Commissioner’s 1997 status report on utilization review drew attention to the problem of doctor shopping is a problem when employees are not limited by a managed care network.¹⁶⁷ The report suggested a fairly simple solution to this problem: “eliminate Form 113 and replace it with a preauthorization card which must be presented to each physician by the patient. On this card it should state that no services will be paid unless preauthorized.”¹⁶⁸ Another solution is to mandate that all Kentucky employers participate in a certified workers’ compensation managed care network. The cost to smaller employers might be high, but the state’s interest in curbing prescription drug abuse and diversion is significant enough to justify the extra cost.

¹⁶⁵ *Id.*

¹⁶⁶ 803 K.A.R. 25:190 § 5.

¹⁶⁷ Ches & Cooke, *supra* note 100, at 19–21.

¹⁶⁸ *Id.* at 21.

V. CONCLUSION

Among the Office of Workers' Claims' objectives is a desire to "provide the public and policy makers with accurate and current indicators of program performance [and] [t]o anticipate changes in the program environment and respond appropriately."¹⁶⁹ Without a more developed and accurate reporting system to monitor the narcotics prescribed pursuant to workers' compensation regulations, it is difficult for the OWC to meet this goal. Agency officials are unable to respond specifically to the prescription drug abuse problem when they have no method for uncovering which counties have above average incidents of narcotics use and which prescribers are responsible for high numbers of narcotics prescriptions.¹⁷⁰

In addition, the agency's goal of "promot[ing] safe, healthful and quality working environments for employees and employers"¹⁷¹ is further thwarted by liberal judicial interpretation of the workers' compensation statutes.¹⁷² The overbroad definition of "compensable injury," as it is currently defined by Kentucky courts, creates an environment ripe for manipulation. Employees are able to make claims of psychological and other injuries that are increasingly distant from the occurrence of an actual traumatic event. This broad interpretation makes effective and safe administration of workers' compensation claims difficult, and creates opportunities to abuse the system. To aid the OWC's efforts to effectively administer Kentucky workers' compensation legislation in a way that promotes safety and health, the state legislature needs to tighten the statutory language to limit coverage to a narrower and more easily verifiable definition of "compensable injury" and perhaps put caps on the duration and cost of medical treatment.¹⁷³

Employers have a vested interest in ensuring that their employees make a full recovery from workers' compensation injuries. Recoveries mean individuals are returning to work and that the cost of providing medical and other workers' compensation benefits are down for those employees. Because of this vested interest in effectively treating their employees, employers are perhaps in the best position to curb abuse of narcotics prescribed for work-related injuries.

¹⁶⁹ See OWC Guidebook, *supra* note 40, at 4; see also *supra* Part III.A.

¹⁷⁰ See *supra* Part IV.B.b.

¹⁷¹ See *supra* Part III.A.

¹⁷² See *supra* Part III.B.b.

¹⁷³ See *supra* Part IV.B.a.

Employers should be given more power to prospectively monitor narcotics prescriptions dispensed to their employees, and to adjudicate issues relating to such prescriptions. Changes to utilization review requirements and standards of review are one way to help employers take an effective stance against drug abuse;¹⁷⁴ another approach is to take advantage of interactive online pharmaceutical monitoring systems.¹⁷⁵ Finally, employers may help to prevent drug abuse by exercising greater control over gatekeeper physician selection.¹⁷⁶

Eastern Kentucky suffers from a substantial prescription drug crisis. There is a great deal of social pressure to traffic painkillers and other narcotics, and a great degree of tolerance for the drugs' abuse; some people in that region learn very early how to successfully claim a disability check.¹⁷⁷ When a state is dealing with this kind of mentality it must be very careful how it structures its workers' compensation and other disability insurance programs. Currently, Kentucky's workers' compensation legislation and administration contain many loopholes that create multiple opportunities for narcotics abuse and diversion. If there is any hope of curbing the rampant abuse of this system, all such programs must be tightened and closely monitored. The state has a responsibility to close these loopholes for abuse and to carefully preserve program resources for those who truly deserve them.

¹⁷⁴ See *supra* Part IV.B.d.

¹⁷⁵ See *supra* Part IV.B.c.

¹⁷⁶ See *supra* Part IV.B.e.

¹⁷⁷ See *supra* Parts I, II.

APPENDIX A

WORKERS' COMPENSATION UTILIZATION: A COMPARISON OF SELECT
KENTUCKY COUNTIES

COUNTY	TOTAL LABOR FORCE	FROIS	% FROIS TO LABOR FORCE	CLAIMS	% CLAIMS TO FROIS
Fayette	141,070	2684	1.90%	436	16.24%
Jefferson	372,219	7721	2.07%	1079	13.97%
Johnson	9588	172	1.79%	71	41.28%
Lawrence	5531	41	0.74%	23	56.10%
Magoffin	5031	186	3.70%	160	86.02%
Martin	3699	480	12.98%	125	26.04%
Owsley	1788	15	0.84%	4	26.67%
Pike	25,717	733	2.85%	489	66.71%
State	1,956,401	35,015	1.79%	7174	20.49%

* This graph is taken in select parts directly from the chart provided in Kentucky Office of Workers' Claims, *Annual Report Fiscal Year 2003-2004*, 18-20 (2004), at <http://www.comped.net/comped/pdf/annrpt01.pdf>.