

Department of Workers' Claims Litigation Management System



Technical Overview

Kentucky Department of Workers' Claims

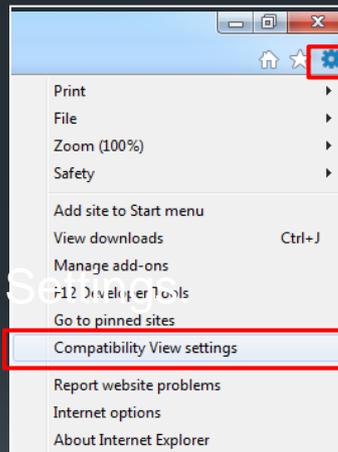


Scope of Litigation Management System

- The Litigation Management System (LMS) provides a simple, online tool for initiating and managing workers' compensation claims. LMS is a paperless alternative for attorneys, or those representing themselves, to initiate workers' compensation claims and submit litigation-related documents.
- Court reporters are able to submit depositions and hearing transcripts.
- Other parties to a claim, such as insurance carriers, employers, medical providers, and claimants, can use LMS to view claim details and monitor activity.

Supported Browsers

We recommend the following Web browsers for navigating LMS: Microsoft® Internet Explorer, Mozilla Firefox, Google Chrome, or Apple Safari. Please ensure the version you have is up to date.



If you are using IE10 or higher and still encounter problems, please verify that your browser is not operating in Compatibility Mode. To verify this, click the gear icon and then select Compatibility View. If problems continue, contact LMS support at LaborKYWCLMS.TechnicalSupport@ky.gov.

Hours of Operation and System Maintenance

Proposed change to 803 KAR 25:010

Section 3. LMS Filings. (1) A document submitted electronically shall be deemed filed on the date filing is completed within the time frames set forth in paragraph (a) of this subsection. The filing party shall receive an electronic notification of the time and date filed.

(a) Pleadings, motions, orders or other documents may be filed utilizing the LMS at any time the LMS is available. Periods of unavailability shall be pre-announced by the department. Inability to file during periods that were previously announced shall not constitute an excuse for a failure to file during a period.

LMS will be “down” for maintenance by the Commonwealth Office of Technology (COT). When the DWC is informed by COT that the system is going to be taken down the DWC will provide notice that the system will be unavailable.

Technical Failure/Effect

803 KAR 25:010

(15) "Technical failure":

(a) Means a failure of the Department of Workers' Claims' hardware, software, and telecommunications facility that results in the impossibility for an external user to submit a filing electronically; and

(b) Does not include malfunctioning of an external user's equipment.

(10) "Jurisdictional deadline" means a deadline set by statute or administrative regulation that the Department of Workers' Claims shall not extend or change.

Section 4. Technical Difficulty: Litigation Management System Unavailability. (1) Jurisdictional Deadlines. A jurisdictional deadline shall not be extended. A technical failure, including a failure of LMS, shall not excuse a failure to comply with a jurisdictional deadline. The filing party shall insure that a document is timely filed to comply with jurisdictional deadlines and, if necessary to comply with those deadlines, the filing party shall file the document conventionally accompanied by a certification of the necessity to do so in order to meet a jurisdictional deadline.

(2) Technical Failures.

(a) If a filing party experiences a technical failure, the document may be filed conventionally, if it is accompanied by a certification, signed by the filing party, with a certification the filing party has attempted to file the document electronically at least twice, with those unsuccessful attempts occurring at least one (1) hour apart. The commissioner may require the document to be accompanied by a disc or CD-ROM that contains the document in PDF format.

(b) A filing party is prejudiced due to a technical failure as defined by Section 1(15) of this administrative regulation, or a filing party who cannot file a time-sensitive document electronically due to unforeseen technical difficulties, other than a one filed under a jurisdictional deadline, may seek relief from an administrative law judge. Parties may also enter into an agreed order deeming a document, other than one (1) filed under a jurisdictional deadline, timely

Dashboard and Claim Detail Screen Functionality

Kentucky Department of Workers' Claims



Below is the landing screen which appears at logon. Information on the Claims a user is associated to are listed and clicking on the claim number for each case will take the user to the claim detail screen for that claim. A user can also click the submit a filing button or the add a claim button to complete those tasks.

Ky.gov An Official Website of the Commonwealth of Kentucky Department of Workers' Claims

Litigation Management System

Welcome, dfsfd ?

My Claims + Add Claim Submit a Filing

Show entries Search:

Claim #	Style	Injury Date	Body Part	ALJ	Remove
2099-00001	TEST ACCOUNT VS GO GO GADGET ARMS	2/1/2017	WHOLE BODY	HON ROBERT L SWISHER	✕
2020-00012	ASDFASKLDF SDFLKASDF VS ASDFKAL	9/27/2016	ANKLE	N/A	✕
2020-00010	RILEY KING VS BUBBA SHRIMP AND MORE & KEMI	7/20/2016	LOWER ARM	JEFF V. LAYSON	✕

LMS Group Claims

Notifications

Admin

By clicking on the notifications tab on the blue menu on the left side of the screen, a user can see any drafts of forms they have saved and notifications of filings in cases to which they are associated. Clicking on the link under document name opens the document.

Ky.gov An Official Website of the Commonwealth of Kentucky Department of Workers' Claims

Welcome, dfsfd ?

Litigation Management System

- LMS Group Claims
- Notifications**
- Admin

My Notifications

My Drafts

Drafts will expire 14 days from the last saved date.

Show entries Search:

Draft Id	Name of Form	Date Draft Created	Date Draft Updated	
42197	APPLICATION FOR RESOLUTION OF INJURY CLAIM	3/26/2018	3/26/2018	

Showing 1 to 1 of 1 entries Previous **1** Next

Filing Notifications

Unseen Only

Show entries Search:

Seen/Unseen	Document Name	Claim Number	Claimant	Date Filed
	MEDICAL WAIVER AND CONSENT FORM	209900001	Test Account	3/26/2018
	MEDICAL WAIVER AND CONSENT FORM	209900001	Test Account	3/26/2018

The claim detail screen shown here contains vital information about the claim that can be accessed using tabs near the middle of your screen. Here we see the document tab that lists electronic copies of all documents filed in the case.

Ky.gov An Official Website of the Commonwealth of Kentucky Department of Workers' Claims

Welcome, dfsfd ?

Litigation Management System

LMS Group Claims

Notifications

Admin

Claim #: 209900001 File Document

Style	TEST ACCOUNT VS GO GO GADGET ARMS	Insurance Carrier Information	
Judge	661 - ROBERT L. SWISHER	Maintenance Type Code	N/A
Date of Injury	2/1/2017	Maintenance Type Code Date	N/A
Disposition	05 - PROOF TIME	Claim Administrator #	N/A
Nature	46 - RUPTURE	Claim Access #	show access #
Body Part	99 - WHOLE BODY		

Documents Participants Participants (cont'd) Accident Insurance

Export Documents Printable list of documents

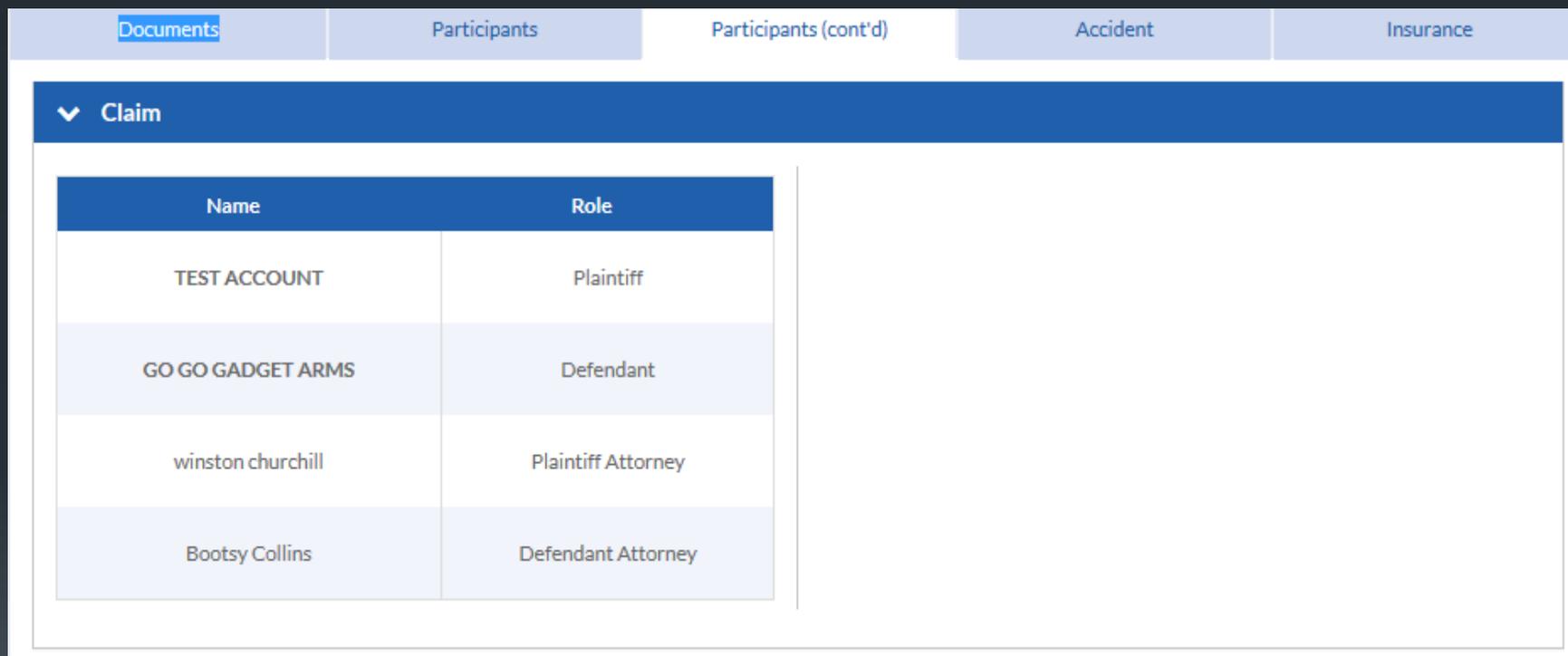
Search:

	Document Id	Document Name	Submitted By	Date Filed
<input type="checkbox"/>	5566748	MEDICAL WAIVER AND CONSENT FORM	Mr COT Server Team (Kentucky Attorney)	3/26/2018
<input type="checkbox"/>	5566747	MEDICAL WAIVER AND CONSENT FORM	Mr COT Server Team (Kentucky Attorney)	3/26/2018

The participants tab displays all participants involved in all styles of a claim and a description of all involvements.

Documents	Participants	Participants (cont'd)	Accident	Insurance
▲ GO GO GADGET ARMS : Defendant				
Address Line 1	5 FIFTH ST			
Address Line 2				
City	FRANKFORT			
State	KY			
Postal Code	40601			
Country	UNITED STATES			
▼ TEST ACCOUNT : Plaintiff				
▼ WINSTON CHURCHILL : Plaintiff Attorney				
▼ BOOTSY COLLINS : Defendant Attorney				

The participants (cont'd) tab allows a user to view claim, appeal, and medical dispute litigations for a claim. The participants specific to each claim and their role can be viewed here.



Name	Role
TEST ACCOUNT	Plaintiff
GO GO GADGET ARMS	Defendant
winston churchill	Plaintiff Attorney
Bootsy Collins	Defendant Attorney

The accident tab provides details about the claimant and the accident.

Documents	Participants	Participants (cont'd)	Accident	Insurance
Claimant: Test Account				
Injured Worker		Injured Worker		
Accident/Injury Description Narrative	They fell	SSN / GCN	***-**-4656	
Nature	RUPTURE	Date of Birth	1/12/1956	
Cause of Injury Description	TERRORISM	Date of Death	Living	
County		Gender	Male	
Accident Site Postal Code	40601	Marital Status	Unknown	
Injury Address	IRVINGTON, KY	Occupation	Gaffer	
Date Reported to DWC	Feb-13-2017			
Date Disability Began				
Date Employer Had Knowledge				
Date Claim Admin Had Knowledge				
Date of Death				

The insurance tab shows insurance carriers and policy numbers connected to the claim.

Documents	Participants	Participants (cont'd)	Accident	Insurance
Carrier/Policy Number	Effective Date	Cancel Date	DC Date	
FEDERAL INS CO 0071630676	8/1/1999	8/1/1999	N/A	
FEDERAL INS CO 0071630677	8/1/1999	N/A	N/A	
FEDERAL INS CO 9971630676	8/1/1998	8/1/1999	N/A	
FEDERAL INS CO 9471630676	8/1/1993	8/1/1998	N/A	
ST PAUL MERCURY INS CO 795ZB0064	8/1/1985	N/A	N/A	
AMERICAN MUTUAL INS CO (BANKRUPT) FWCRC257624014D	7/1/1984	9/8/1985	N/A	

Filing a Claim

Kentucky Department of Workers' Claims



After successfully logging in to LMS and selecting the Submit a Filing button, click on the dropdown list under the File a New Claim heading. The type of application you are directed to depends on the nature of the injury or occupational disease selected from this list.

Choose the type of document you wish to file.

File a New Claim

Start filing a new claim by picking the nature of your injury or disease. Then click next. This will direct you to the appropriate form for your particular claim.

Nature of Injury *

[Continue to Form](#)

Agreements are not being submitted electronically at this time. Please select fatality or the nature of the injury / occupational disease to create an agreement document. Once completed, please print and mail a copy to the Department of Workers' Claims, 657 Chamberlain Ave., Frankfort, KY 40601. Thank you!

File an Agreement

Begin your agreement form by picking the nature of your injury or disease, and then continue to the form. If you have filed a claim, add it to your "My Claims" list and submit an agreement to the claim file.

Employee/plaintiff is deceased

Nature of Injury *

[Continue to Form](#)

File a Motion to Reopen

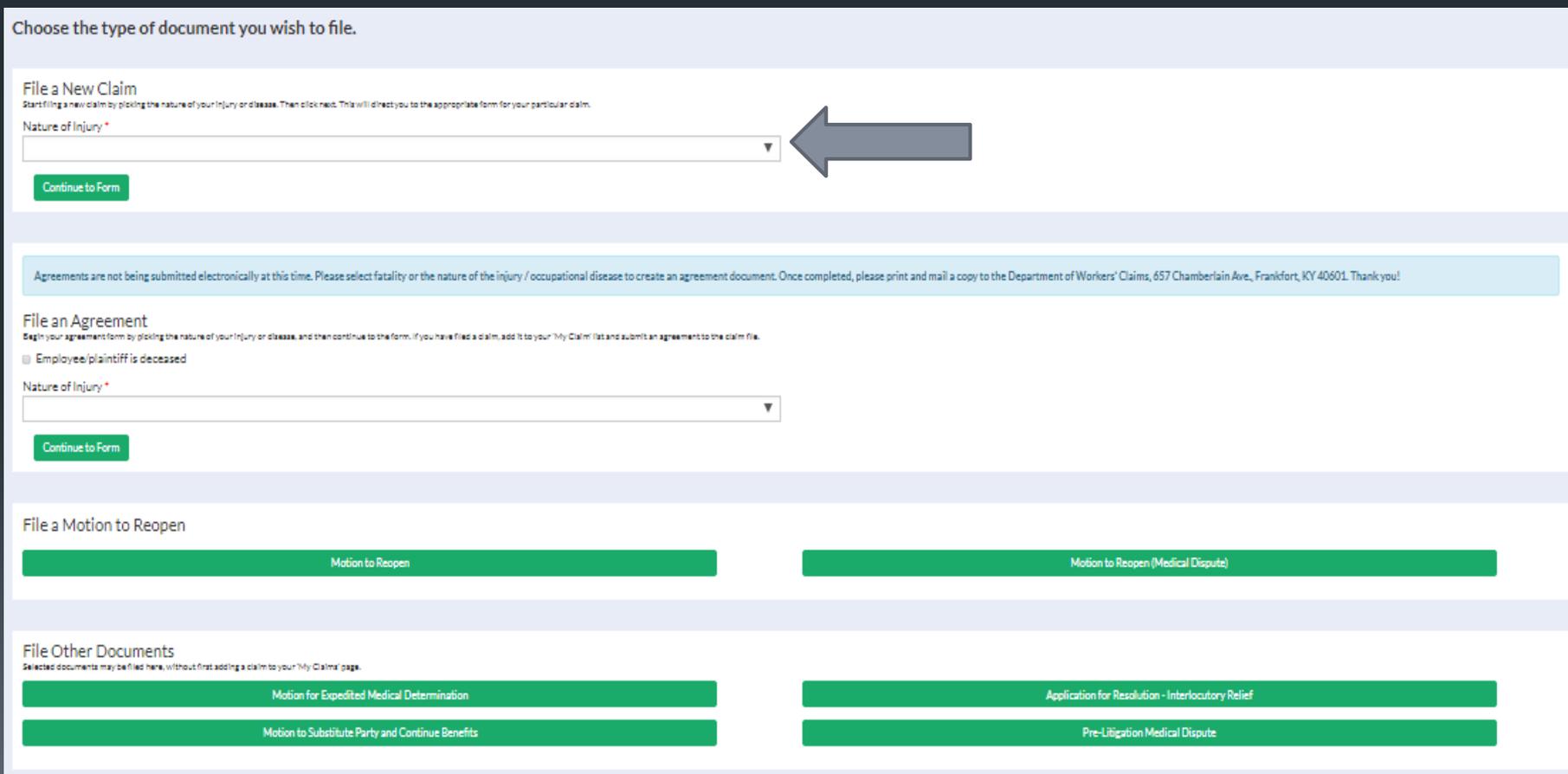
[Motion to Reopen](#) [Motion to Reopen \(Medical Dispute\)](#)

File Other Documents

Selected documents may be filed here, without first adding a claim to your "My Claims" page.

[Motion for Expedited Medical Determination](#) [Application for Resolution - Interlocutory Relief](#)

[Motion to Substitute Party and Continue Benefits](#) [Pre-Litigation Medical Dispute](#)



Because “Strain or Tear” was selected we are taken to an Application for Resolution of Injury Claim and are prompted to enter basic information about the plaintiff.

Application for Resolution of Injury Claim

Step 1 of 7

Plaintiff Information

Title First Name * Middle Last Name * Suffix

Select the type of ID *
 Social Security Number Green Card #

SSN *

Birth Date * mm/dd/yyyy Gender *
 Female Male Undisclosed

Address *

Outside of United States

Postal Code * City/Town * State

Occupation *

Step 2 asks for contact information for the defendant or employer.

Application for Resolution of Injury Claim

Step 2 of 7

Defendant/Employer Information

Business Name *

Address *

Postal Code * City/Town * State

Proceeding to the next screen prompts the user to enter Insurance Carrier information. If this information is not available, simply check No Insurance Information Available and proceed to the next screen.

Application for Resolution of Injury Claim

Step 3 of 7

Insurance Carrier Information

No Insurance Information Available

Business Name

Address

Postal Code*

City/Town*

State

This screen collects information about the injury and any medical treatment provided.

Application for Resolution of Injury Claim

Step 4 of 7

Nature of Injury

Date and Location of accident/ injury:

Date of Injury * mm/dd/yyyy

Postal Code * City/Town * State

Plaintiff states that he/she was injured within the scope and course of employment with defendant employer on the above date and at the above location.

Description of Injury: *

Cause of Injury * Body Part Injured *

When and by what means did the plaintiff give notice of injury to the employer?

Describe medical treatment, if any:

Name and address of physician, whose report will be provided:

Cancel Save & Exit Back Next

The next step collects information about whether an interpreter is needed, whether or not the injured worker is deceased, and other claims that may have been filed previously. If the time limit for filing a claim is close, a supplemental filing containing this information can be submitted as soon as the attorney receives information on the prior claim.

Application for Resolution of Injury Claim

Step 5 of 7

Other Information and Prior Claims

Will an interpreter be needed for the formal hearing? *

No Yes

Injured worker is deceased? *

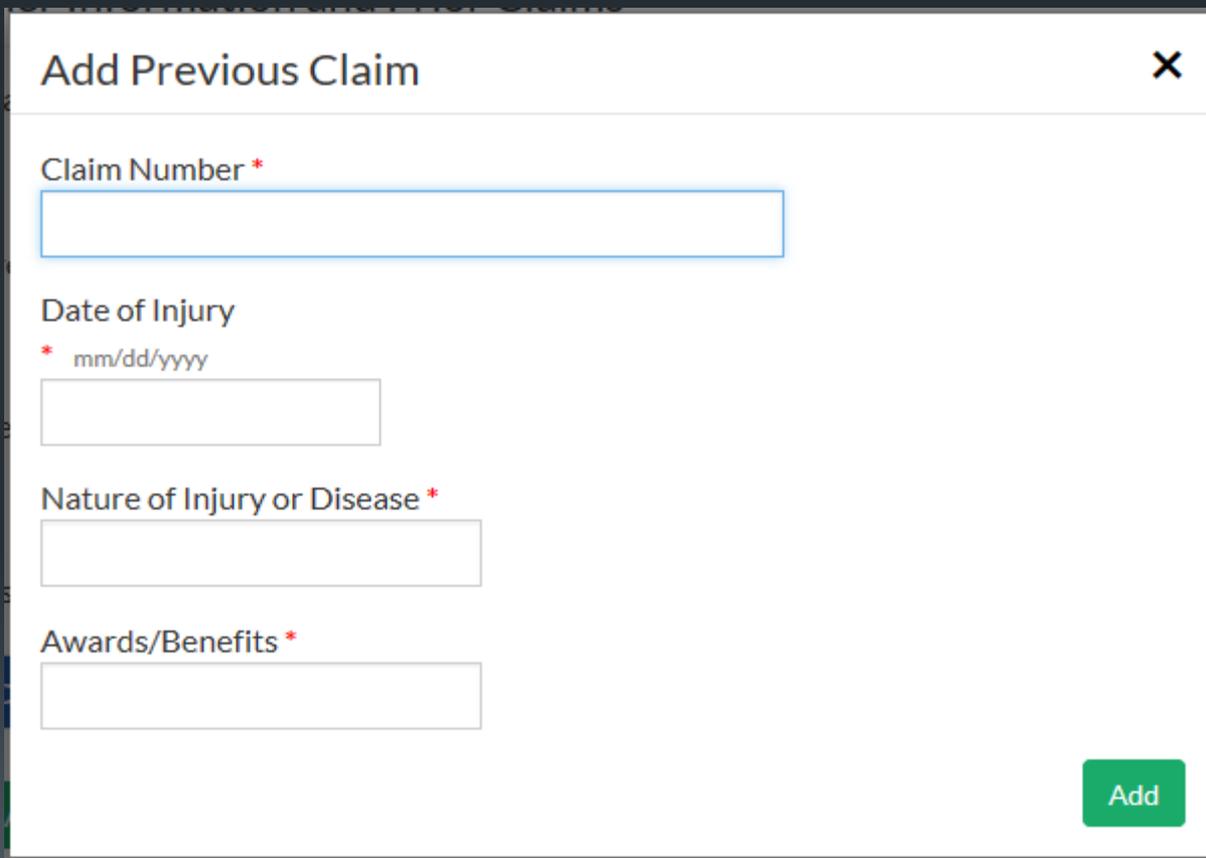
No Yes

Have you previously filed for or received worker's compensation benefits in Kentucky? *

No Yes

If not a Kentucky claim, please provide the state in which you were awarded benefits:

If the user selects the add previous claim button, a window will open prompting the entry of information about that claim. Provide any available information about previous claims here.



The image shows a dialog box titled "Add Previous Claim" with a close button (X) in the top right corner. The dialog contains four text input fields, each with a red asterisk indicating a required field:

- Claim Number ***: A text input field.
- Date of Injury**: A text input field with a placeholder "mm/dd/yyyy" and a red asterisk.
- Nature of Injury or Disease ***: A text input field.
- Awards/Benefits ***: A text input field.

An "Add" button is located in the bottom right corner of the dialog box.

The prior claim information is now shown below. If there are no other prior claims, the user can proceed to the next step.

Application for Resolution of Injury Claim

Step 5 of 7

Other Information and Prior Claims

Will an interpreter be needed for the formal hearing? *

No Yes

Injured worker is deceased? *

No Yes

Have you previously filed for or received worker's compensation benefits in Kentucky? *

No Yes

Please list up to three (3) of your previous filings

Claim Number	Date of Injury	Nature of Injury or Disease	Awards/Benefits	Action
201200543	7/6/2016	Stubbed Toe	2500	

[+ Add Previous Claim](#)

If not a Kentucky claim, please provide the state in which you were awarded benefits:

Additional employment information and whether or not the plaintiff is alleging a safety violation is collected in step 6.

Application for Resolution of Injury Claim

Step 6 of 7

Other Employment Information

Was there concurrent employment at the time of injury? *

No Yes

Has the plaintiff worked since the injury? *

No Yes

Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? *

No Yes

Cancel Save & Exit Back Next

In the final step of the application process the user attests to their identity and the accuracy of the application and attachments. An electronic signature is required to complete the submission process. After these items have been completed, the user may preview and print a copy of the application by clicking Preview Document and may submit their application to DWC by clicking the Finish button.

Application for Resolution of Injury Claim

Step 7 of 7

Attestations

- I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. *
- Plaintiff herein being duly sworn, states that the statements in this application and in Forms 104, 105, and 106, to be separately filed, are true. *

By entering your name below, you are confirming the accuracy of this form to the best of your knowledge:

This form prepared and submitted by: *

(by entering your name in the field above, you are providing your electronic signature)

Relationship to injured worker: *

Cancel

Save & Exit

Back

Preview Document

Finish

Example - Completed Application for Resolution of Injury (Rendered as PDF)

Form 101

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS Application for Resolution of Injury Claim

Claim No. _____

Filed:

via UPS -

Harry B Lyons
Plaintiff

333-22-1111
Social Security Number/Green Card

10/18/1950 F
Birth Date Gender

388 Maple St
Mailing Address

FRANKFORT, KY 40601
City/State/Postal Code

Outside United States

UNITED STATES
Country

BOOKKEEPERS ACCOUNTING & AUDITING CLC
Occupation

vs. ABC Tax Services
Defendant/Employer (business name)

488 S Main St
Mailing Address

FRANKFORT, KY 40601
City/State/Postal Code

KERC
Insurance Carrier

258 W Main St Suite 900
Mailing Address

LEXINGTON, KY 40587
City/State/Postal Code

Additional Defendant Name

Mailing Address

City/State/Postal Code

Reason for Joinder:

Additional Other Defendant

Mailing Address

City/State/Postal Code

Reason for Joinder:

I. Nature of Injury

1. Date and location of accident/injury:

3/27/2015

FRANKFORT, KY 40601

Date of Injury

Location of Injury (City/State/Postal Code)

Plaintiff states that he/she was injured within the scope and course of employment with defendant employer on the above date and at the above location.

2. Describe how the accident/injury occurred:

fell down stairs and injured right knee and left shoulder

Cause of Injury: FALL, SLIP OR TRIP ON STAIRS

3. Body part injured: MULTIPLE BODY PARTS

4. When and by what means did the plaintiff give notice of injury to the employer?

Ms. Lyons told her boss at the time of the injury who called the ambulance to transport Ms. Lyons to the emergency room

5. Describe medical treatment, if any:

ACL repair of right knee; rotator cuff repair of left shoulder

6. Name and address (city/state/postal code) of physician whose report will be provided:

Harry Lockstadt MD

7. Will an interpreter be needed for the formal hearing? (Yes / No) No

If yes, in which language? _____

8. Dependents

Injured worker is deceased? (Yes / No) No

If deceased, dependent information is required for a deceased worker. If work injury resulted in the death of claimant, attach/provide/upload Form F in addition to the Application for Resolution of Claim.

9. Have you previously filed for or received workers' compensation benefits in Kentucky? (Yes / No) Yes

If yes, please provide the following information:

Claim Number	Date of Injury	Nature of Injury/Disease	Awards/Benefits
199484881	5/17/1994	laceration R index finger	settled

If not a Kentucky claim, please provide the state in which you were awarded benefits: _____

10. Was there concurrent employment at the time of injury? (Yes / No) No

11. Name and address of concurrent employer:

Concurrent Employer Name _____

Concurrent Employer City _____

Concurrent Employer State _____ Postal Code _____

12. Has the plaintiff worked since the injury? (Yes / No) Yes

13. Name and address of current employer and description of job currently being performed:

Current Employer Name Mabel's Bookkeeping Service

Current Employer City FRANKFORT

Current Employer State KY Postal Code 40601

14. Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? (Yes / No) No
If yes, submit form SVE within 15 days after filing the Application for Resolution of Claim.

Attestations:

I understand that any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Plaintiff herein being duly sworn, states that the statements in this application and in Form 104, 105, and 106 to be separately filed, are true.

By entering your name below, you are confirming the accuracy of this form to the best of your knowledge.

/s/ Norma Ray Sutton

This form prepared and submitted by

attorney

Relationship to injured worker:

Plaintiff Signature

To file an Application for Resolution of Occupational Disease Claim, we return to the Submit a File screen and select a nature that is consistent with the need to file an Occupational Disease Claim such as Black Lung. The next slides cover the differences between filing an Occupational Disease Claim and an Injury Claim.

Choose the type of document you wish to file.

File a New Claim

Start filing a new claim by picking the nature of your injury or disease. Then click next. This will direct you to the appropriate form for your particular claim.

Nature of Injury*

Continue to Form

Step 4 requests information about the nature of the disease.

Application for Resolution of Occupational Disease Claim

Step 4 of 7

Nature of Occupational Disease

Date and Location of Last Exposure:

Date of Last Exposure *

County (in which injury/fatality occurred) *

Postal Code * City/Town * State

Plaintiff states that he/she became affected by reason of a disease arising out of and in the course of his/her employment.

Identify the occupational disease claimed: *

Nature of the work in which the plaintiff was engaged at the time of exposure:

When and by what means did the plaintiff give notice of occupational disease to the employer?

Name and address of physician, whose report will be provided:

Cancel Save & Exit Back Next

Step 6 collects further employment information including retraining benefit elections, work history, and safety violations.

Application for Resolution of Occupational Disease Claim

Step 6 of 7

Other Employment Information

Are you applying for retraining incentive benefit? *

No Yes

Are you currently engaged in the severance or processing of coal? *

No Yes

Are you currently working in the industry in which the last exposure occurred? *

No Yes

Was there concurrent employment at the time of injury? *

No Yes

Has the plaintiff worked since the injury? *

No Yes

Are you alleging a violation of a safety rule/regulation pursuant to KRS 342.165? *

No Yes

To file a Hearing Loss Application, return to the submit a document screen and select “Hearing Loss or Impairment (Traumatic Only)” from the Nature of Injury drop down under File a New Claim. The next slides explore the differences between filing a Hearing Loss Claim and an Injury Claim.

Choose the type of document you wish to file.

File a New Claim

Start filing a new claim by picking the nature of your injury or disease. Then click next. This will direct you to the appropriate form for your particular claim.

Nature of Injury *

HEARING LOSS OR IMPAIRMENT (TRAUMATIC ONLY)



Continue to Form

Step 4 of the application differs from the previous 2 applications. The ⁴² user is asked to provide information about their hearing loss



Application for Resolution of Hearing Loss Claim

Step 4 of 7

Nature of Occupational Hearing Loss

Date and Location of Exposure/Accident:

Date of Injury * mm/dd/yyyy

Postal Code * City/Town * State

Plaintiff states that he/she was injured within the scope and course of employment with defendant employer on the above date and at the above location.

Describe the nature of the Occupational hearing loss: *

Cause of Hearing Loss *

Notice to employer

To file a Pre-Litigation Medical Dispute, select “Pre-Litigation Medical Dispute” from the submit a filing page.

Choose the type of document you wish to file.

File a New Claim

Start filing a new claim by picking the nature of your injury or disease. Then click next. This will direct you to the appropriate form for your particular claim.

Nature of Injury *

Continue to Form

Agreements are not being submitted electronically at this time. Please select fatality or the nature of the injury / occupational disease to create an agreement document. Once completed, please print and mail a copy to the Department of Workers' Claims, 657 Chamberlain Ave., Frankfort, KY 40601. Thank you!

File an Agreement

Begin your agreement form by picking the nature of your injury or disease, and then continue to the form. If you have filed a claim, add it to your 'My Claim' list and submit an agreement to the claim file.

Employee/plaintiff is deceased

Nature of Injury *

Continue to Form

File a Motion to Reopen

Motion to Reopen

Motion to Reopen (Medical Dispute)

File Other Documents

Selected documents may be filed here, without first adding a claim to your 'My Claims' page.

Motion for Expedited Medical Determination

Application for Resolution - Interlocutory Relief

Motion to Substitute Party and Continue Benefits

Pre-Litigation Medical Dispute



File a “Motion for Expedited Medical Determination” from the submit a filing screen by clicking on the button denoted by the green arrow below.

Choose the type of document you wish to file.

File a New Claim

Start filing a new claim by picking the nature of your injury or disease. Then click next. This will direct you to the appropriate form for your particular claim.

Nature of Injury*

Continue to Form

Agreements are not being submitted electronically at this time. Please select fatality or the nature of the injury / occupational disease to create an agreement document. Once completed, please print and mail a copy to the Department of Workers' Claims, 657 Chamberlain Ave., Frankfort, KY 40601. Thank you!

File an Agreement

Begin your agreement form by picking the nature of your injury or disease, and then continue to the form. If you have filed a claim, add it to your 'My Claim' list and submit an agreement to the claim file.

Employee/plaintiff is deceased

Nature of Injury*

Continue to Form

File a Motion to Reopen

Motion to Reopen

Motion to Reopen (Medical Dispute)

File Other Documents

Selected documents may be filed here, without first adding a claim to your 'My Claims' page.

Motion for Expedited Medical Determination

Application for Resolution - Interlocutory Relief

Motion to Substitute Party and Continue Benefits

Pre-Litigation Medical Dispute



Click the “Application for Resolution – Interlocutory Relief” as indicated by the grey arrow below to file an application for interlocutory relief.

Choose the type of document you wish to file.

File a New Claim

Start filing a new claim by picking the nature of your injury or disease. Then click next. This will direct you to the appropriate form for your particular claim.

Nature of Injury*

Continue to Form

Agreements are not being submitted electronically at this time. Please select fatality or the nature of the injury / occupational disease to create an agreement document. Once completed, please print and mail a copy to the Department of Workers' Claims, 657 Chamberlain Ave., Frankfort, KY 40601. Thank you!

File an Agreement

Begin your agreement form by picking the nature of your injury or disease, and then continue to the form. If you have filed a claim, add it to your 'My Claim' list and submit an agreement to the claim file.

Employee/plaintiff is deceased

Nature of Injury*

Continue to Form

File a Motion to Reopen

Motion to Reopen

Motion to Reopen (Medical Dispute)

File Other Documents

Selected documents may be filed here, without first adding a claim to your 'My Claims' page.

Motion for Expedited Medical Determination

Motion to Substitute Party and Continue Benefits

Application for Resolution - Interlocutory Relief

Pre-Litigation Medical Dispute



Click “Motion to Substitute Party and Continue Benefits” as denoted by the grey arrow below.

Choose the type of document you wish to file.

File a New Claim

Start filing a new claim by picking the nature of your injury or disease. Then click next. This will direct you to the appropriate form for your particular claim.

Nature of Injury*

Continue to Form

Agreements are not being submitted electronically at this time. Please select fatality or the nature of the injury / occupational disease to create an agreement document. Once completed, please print and mail a copy to the Department of Workers' Claims, 657 Chamberlain Ave., Frankfort, KY 40601. Thank you!

File an Agreement

Begin your agreement form by picking the nature of your injury or disease, and then continue to the form. If you have filed a claim, add it to your 'My Claim' list and submit an agreement to the claim file.

Employee/plaintiff is deceased

Nature of Injury*

Continue to Form

File a Motion to Reopen

Motion to Reopen

Motion to Reopen (Medical Dispute)

File Other Documents

Selected documents may be filed here, without first adding a claim to your 'My Claims' page.

Motion for Expedited Medical Determination

Application for Resolution - Interlocutory Relief

Motion to Substitute Party and Continue Benefits

Pre-Litigation Medical Dispute



The next section pertains to filings after a user is associated to a claim. These filings are done by clicking on the file document button in the claim detail screen as shown by the green arrow below.

Claim #: 202000001  [File Document](#)

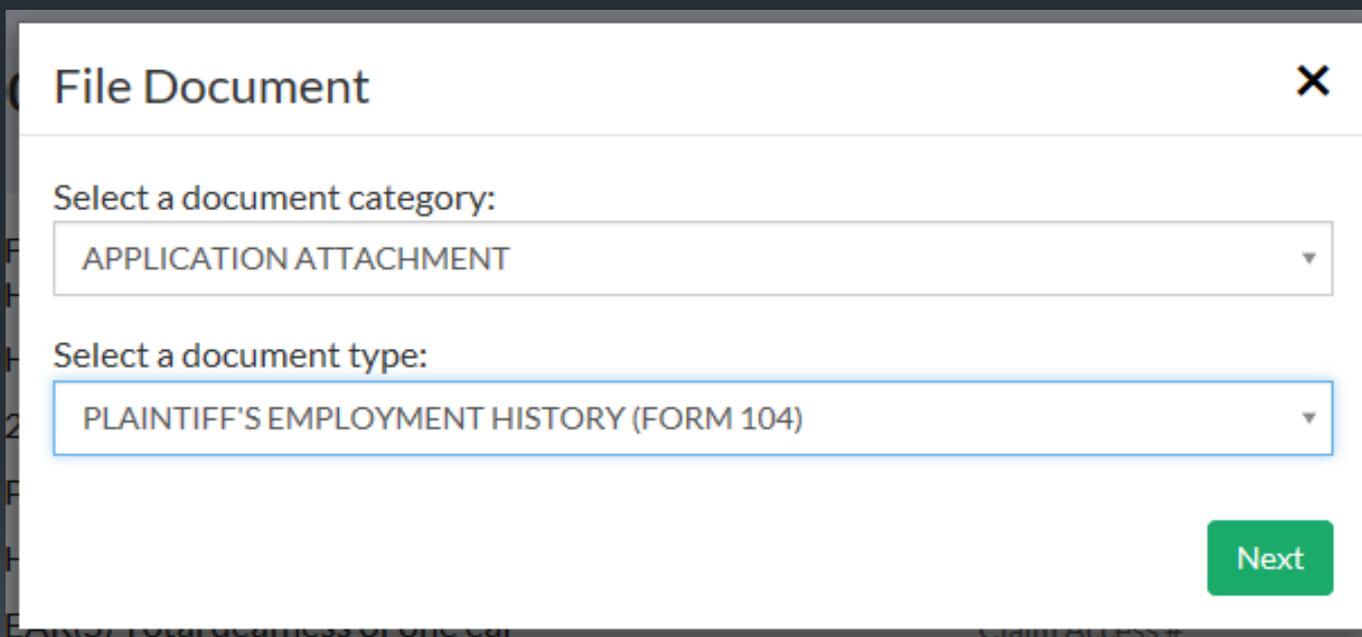
Style	INJURED SALLY VS NATIONAL COMPUTER SYSTEMS	Insurance Carrier Information	
Judge	HON ROBERT L. SWISHER	Maintenance Type Code	N/A
Date of Injury	7/4/2015	Maintenance Type Code Date	N/A
Disposition	SUBMITTED FOR ALJ DECISION	Claim Administrator #	N/A
Nature	LACERATION	Claim Access #	show access #
Body Part	LOWER ARM		

Documents | **Participants** | Participants (cont'd) | Accident | Insurance

[Export Documents](#)

	Code	Type	Document Name	Submitted By	Date Filed
<input type="checkbox"/>	NORP		NOTICE OF REPRESENTATION	LMS Worker (System)	3/10/2016

To file a Form 104, select Application Attachment from the available document categories, then select Plaintiff's Employment History (Form 104) as the document type.



File Document ✕

Select a document category:

APPLICATION ATTACHMENT ▼

Select a document type:

PLAINTIFF'S EMPLOYMENT HISTORY (FORM 104) ▼

Next

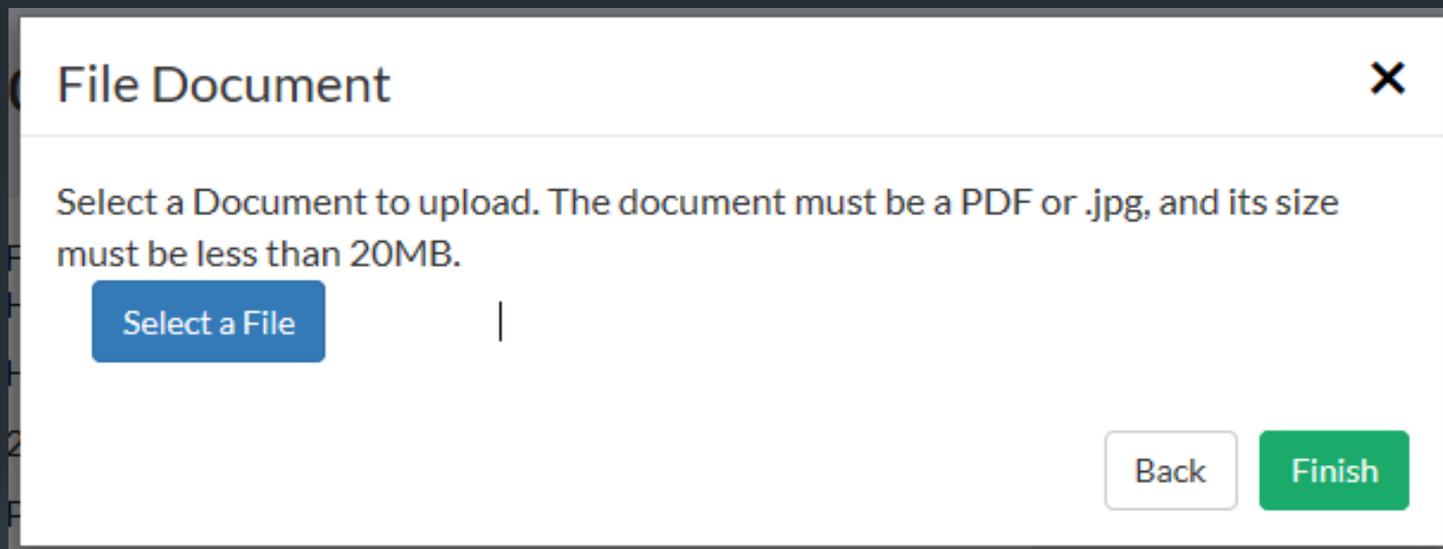
Form 106 is not a web form, it accepts PDF attachments. Click next to proceed.

File Document ✕

Proceed to upload your document on the next step.

[Back](#) [Next](#)

By clicking the Select a File button below, you will be prompted to select a file from your computer to attach to the Form 106. **THE FILE MUST BE IN PDF FORMAT AND MAY NOT BE MORE THAN 20 MB IN SIZE.**



The image shows a screenshot of a web application dialog box titled "File Document". The dialog has a close button (an 'X' icon) in the top right corner. Below the title bar, there is a text instruction: "Select a Document to upload. The document must be a PDF or .jpg, and its size must be less than 20MB." Below this text is a blue button labeled "Select a File". At the bottom right of the dialog, there are two buttons: a white button with a grey border labeled "Back" and a green button labeled "Finish".

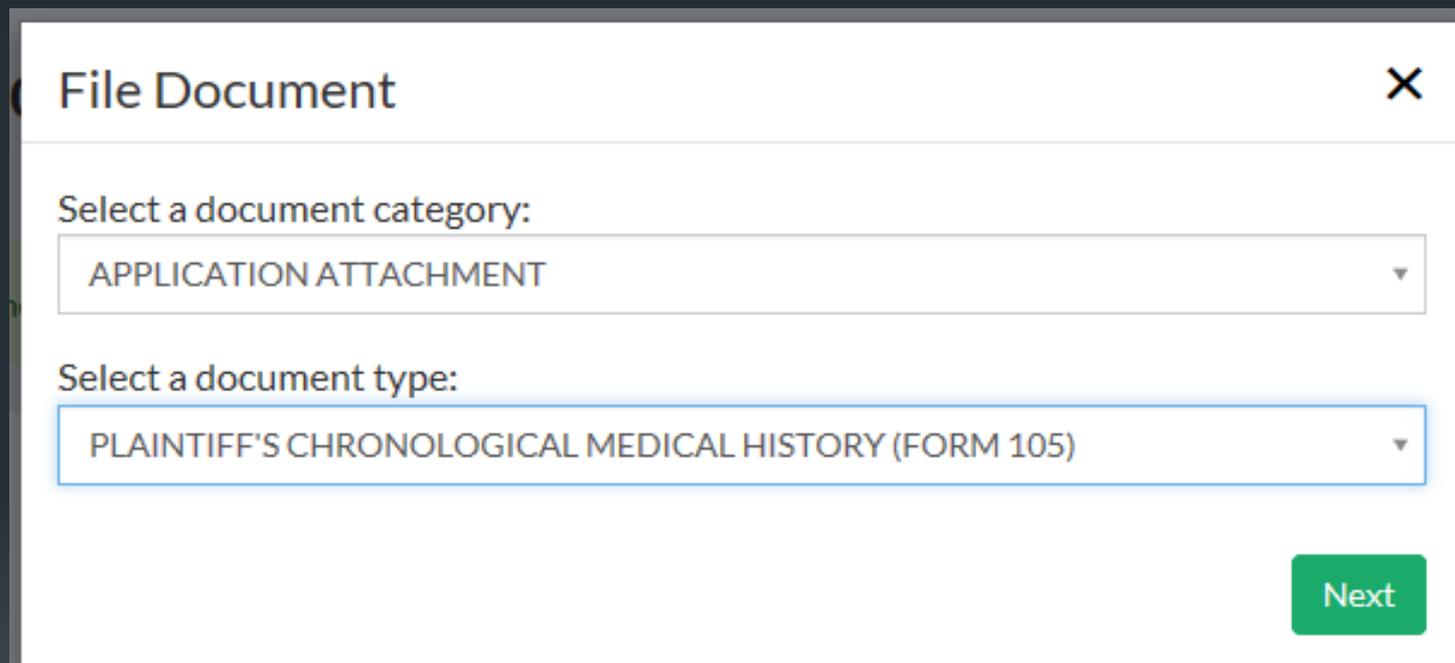
Once the file has been attached, clicking the Finish button will submit the document to DWC.

File Document ✕

Select a Document to upload. The document must be a PDF or .jpg, and its size must be less than 20MB.

0bb576_10420326e31d4d9080c43c4619748a1f.pdf

To file a Form 105, select Application Attachment from the available document categories, then select Plaintiff's Chronological Medical History (Form 105) as the document type.



The screenshot shows a 'File Document' dialog box with a close button (X) in the top right corner. It contains two dropdown menus. The first dropdown is labeled 'Select a document category:' and has 'APPLICATION ATTACHMENT' selected. The second dropdown is labeled 'Select a document type:' and has 'PLAINTIFF'S CHRONOLOGICAL MEDICAL HISTORY (FORM 105)' selected. A green 'Next' button is located in the bottom right corner of the dialog box.

File Document

Select a document category:

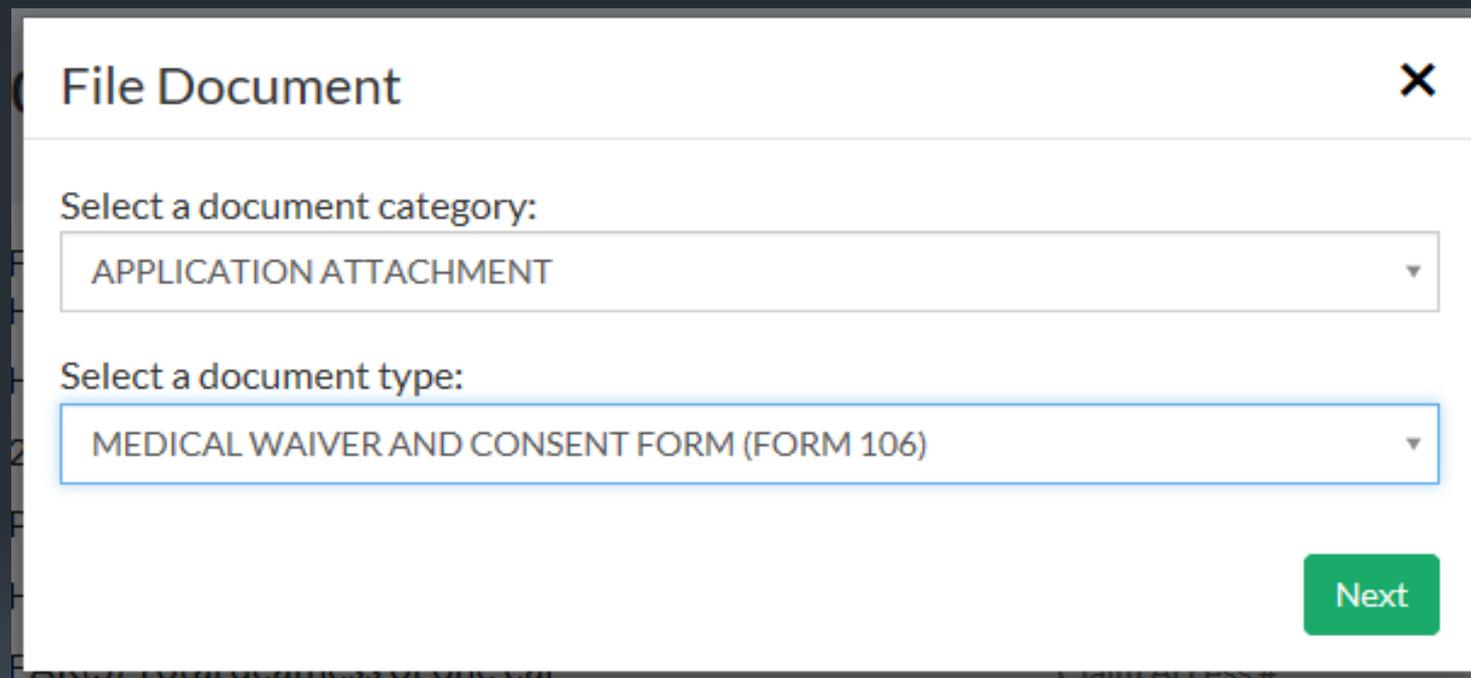
APPLICATION ATTACHMENT

Select a document type:

PLAINTIFF'S CHRONOLOGICAL MEDICAL HISTORY (FORM 105)

Next

To file a Form 106, select Application Attachment from the available document categories, then select Medical Waiver and Consent Form (Form 106) as the document type.



The screenshot shows a 'File Document' dialog box with a close button (X) in the top right corner. It contains two dropdown menus. The first dropdown is labeled 'Select a document category:' and has 'APPLICATION ATTACHMENT' selected. The second dropdown is labeled 'Select a document type:' and has 'MEDICAL WAIVER AND CONSENT FORM (FORM 106)' selected. A green 'Next' button is located at the bottom right of the dialog box.

File Document ✕

Select a document category:

APPLICATION ATTACHMENT ▼

Select a document type:

MEDICAL WAIVER AND CONSENT FORM (FORM 106) ▼

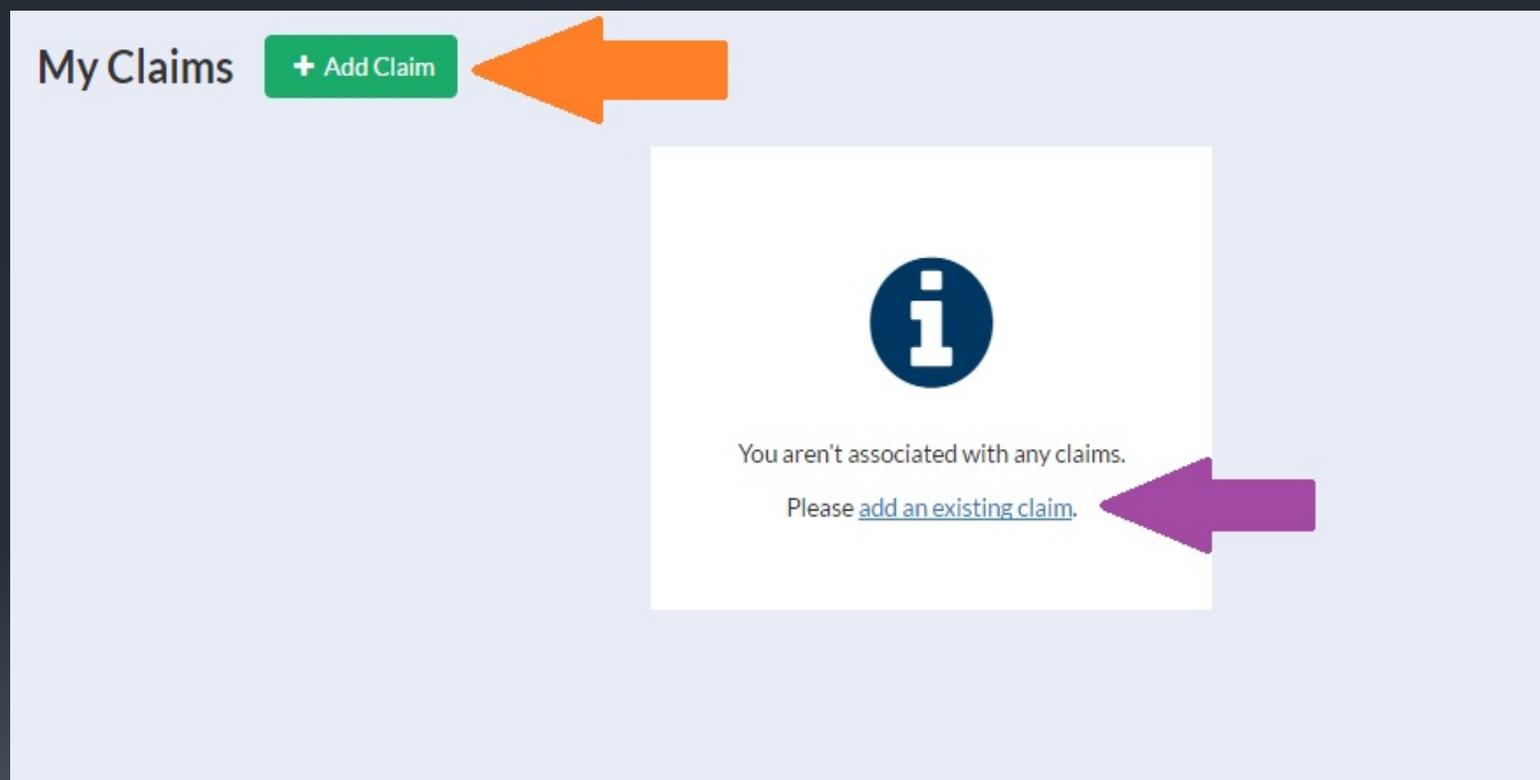
Next

Filing a Notice of Representation and Claim Denial

Kentucky Department Of Workers' Claims



To file a Notice of Representation, either of the options below can be selected from the landing screen in LMS.



The add a claim button will bring up the add a claim window where a claim and access number can be entered.

Add a Claim ✕

To join as a party or representative to a claim you must be a named party and have an Access Number.

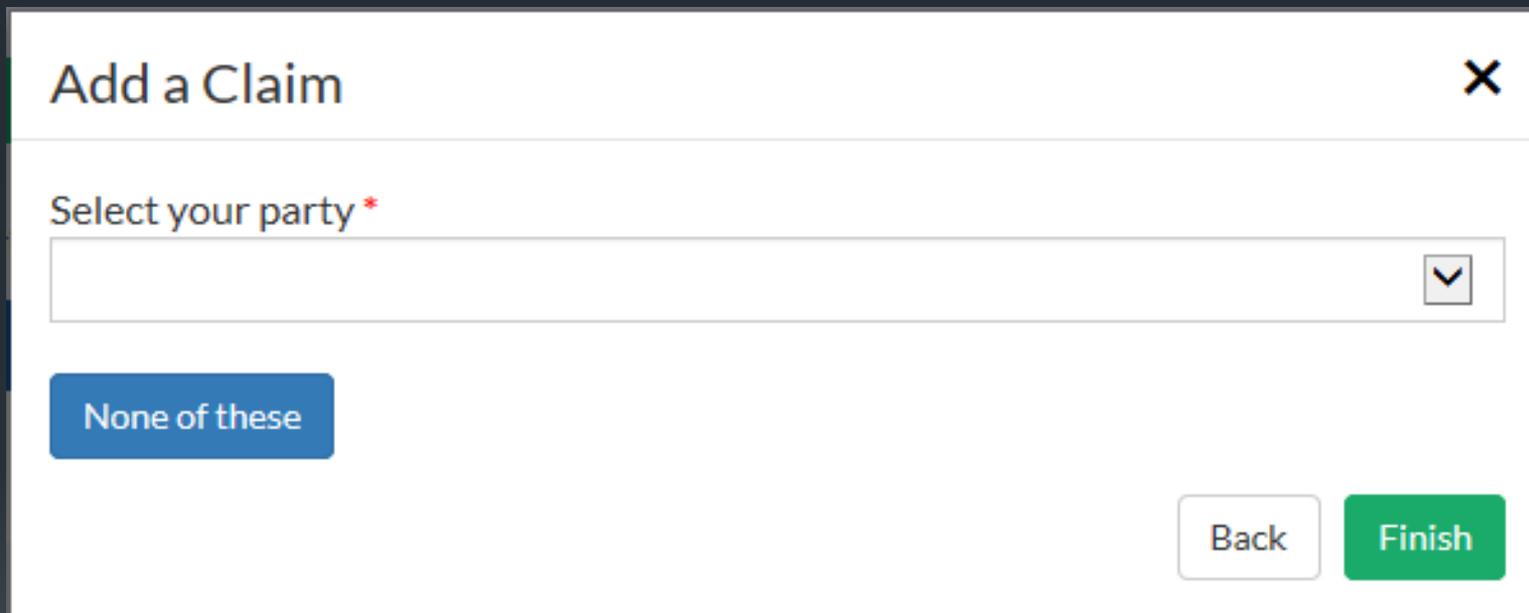
Claim Number *

Access Number *

You can also [file a new claim](#), submitting all documentation electronically.

[Next](#)

If the party you need to associate with is not listed in the parties drop down, click the “None of These.”



The image shows a dialog box titled "Add a Claim" with a close button (X) in the top right corner. Below the title bar, there is a label "Select your party *" followed by a dropdown menu. The dropdown menu is currently empty, showing only a downward-pointing arrow icon. Below the dropdown menu, there is a blue button labeled "None of these". At the bottom right of the dialog box, there are two buttons: a white button labeled "Back" and a green button labeled "Finish".

If you are counsel for a party listed on this screen, select your party and click Continue to Form to file the Notice of Representation (NOR) form.

If you are associating to this claim as counsel for an existing party, you must file a notice of representation. Please select which party you represent, if any:

- VALCANO PROTECTION LLC
- KALAMAZOO TIGER HOUSING
- FUNKMASTER FLEX
- HANDY MANNY
- HANDY MANNY
- BOB THE BUILDER
- None of these

[Continue to Form](#)

The notice of representation form will populate with the information provided by the attorney at registration and ask for an electronic signature.

Form NOR

Step 1 of 3

Attorney Name and Address

Enter your name and address as parties should address filings.

First Name or Name of your Organization * ×

Last Name

Address *

Postal Code * City/Town * State

Electronic Signature *

(by entering your name in the field above, you are providing your electronic signature)

The list below allows for the designation of the manner of service. Parties can be served by mail, email, LMS, in person or not served at all.

Form NOR

Step 2 of 3

Presented To

<input type="text"/>	▼	VALCANO PROTECTION LLC
<input type="text"/>	▼	KALAMAZOO TIGER HOUSING
<input type="text"/>	▼	FUNKMASTER FLEX
<input type="text"/>	▼	WINSTON CHURCHILL
<input type="text"/>	▼	BOB THE BUILDER
<input type="text"/>	▼	HANDY MANNY
<input type="text"/>	▼	HANDY MANNY
<input type="text"/>	▼	BOB THE BUILDER

[+ Add Recipient](#)

[Cancel](#) [Back](#) [Next](#)

On this screen, you can confirm the service chosen and if you choose,⁶¹ preview and save a copy of your notice. Clicking the finish button submits the form to DWC. The following slide shows an example of a system generated Notice of Representation.

Form NOR

Step 2 of 3

Presented To

Served by mail	<input type="checkbox"/>	GEORGE CLINTON
Served by email	<input type="checkbox"/>	BILL BILLINGSLEY
Served via LMS	<input type="checkbox"/>	UNINSURED EMPLOYERS FUND
Not served	<input type="checkbox"/>	UNINSURED EMPLOYERS FUND
Served	<input checked="" type="checkbox"/>	ROYCE D. ROLLES

[+ Add Recipient](#)

[Cancel](#) [Back](#) [Next](#)

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
CLAIM NO. 2020-00008

BEFORE:

GEORGE CLINTON

PLAINTIFF/EMPLOYEE

VS

NOTICE OF REPRESENTATION

BILL BILLINGSLEY

DEFENDANT/EMPLOYER(S)

Comes tes har and gives notice of representation on behalf
of BILL BILLINGSLEY in the above referenced claim. All relevant
correspondence and pleadings should be served on counsel in the following
fashion:

 tes har
 14 oak

 Frankfort, KY 40601

Respectfully submitted,
 /s/ tes har

Once a claim has been successfully associated to, it will appear on your landing page under “My Claims.” By clicking on the claim number, you will be able to view details about the claim.

My Claims [+ Add Claim](#)

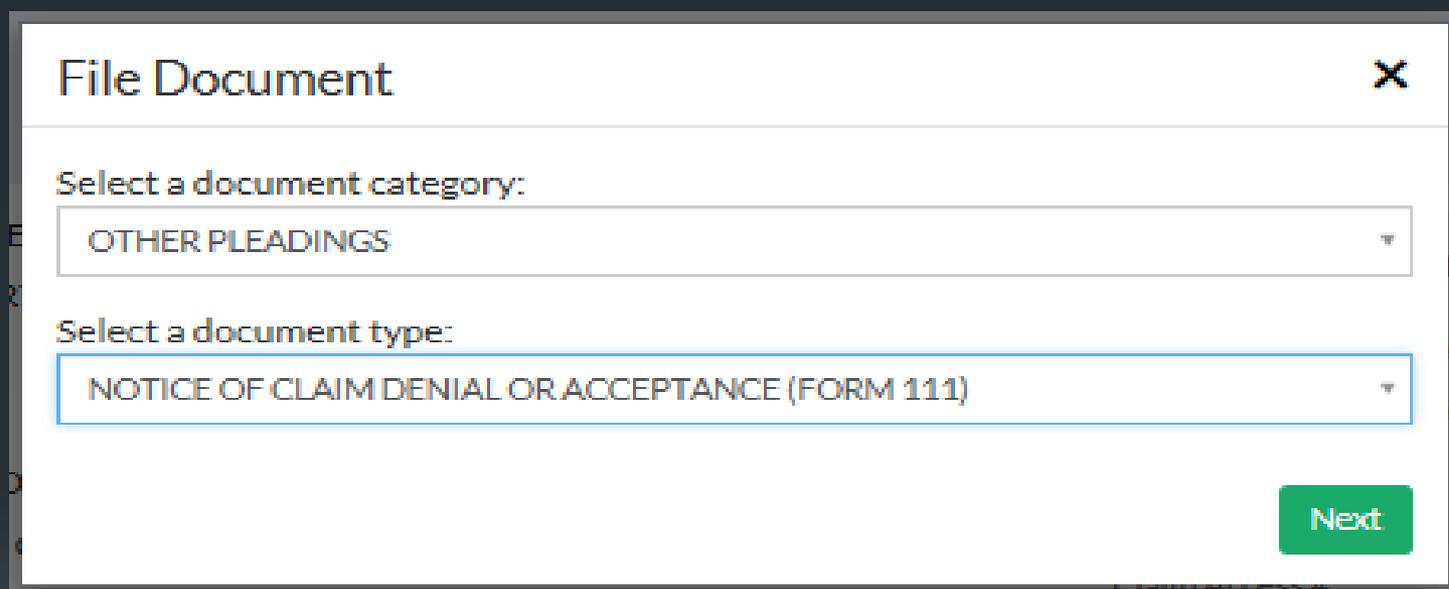
Show entries

Claim #	Style	Injury Date	Body Part	ALJ
2020-00004	GARTH BROOKS VS NATIONAL COMPUTER SYSTEMS INC	2/8/2016	EYE(S)	N/A

Showing 1 to 1 of 1 entries

Previous **1** Next

To file a Notice of Claim Denial or Acceptance (Form 111), select Other Pleadings from the available document categories, then select Notice of Claim Denial or Acceptance (Form 111) as the document type.



The screenshot shows a 'File Document' dialog box with a close button (X) in the top right corner. It contains two dropdown menus. The first dropdown is labeled 'Select a document category:' and has 'OTHER PLEADINGS' selected. The second dropdown is labeled 'Select a document type:' and has 'NOTICE OF CLAIM DENIAL OR ACCEPTANCE (FORM 111)' selected. A green 'Next' button is located at the bottom right of the dialog box.

File Document ✕

Select a document category:

OTHER PLEADINGS ▾

Select a document type:

NOTICE OF CLAIM DENIAL OR ACCEPTANCE (FORM 111) ▾

Next

Form 111 is a web form that accepts information from a user and generates a PDF document that can be filed with the DWC. Below is the first screen with the claim accepted option selected. The next slide shows available options when the claim denied option is selected.

Form 111 - Notice of Claim Denial or Acceptance

Step 1 of 4

Defendant filing this form *

D. Fendant

Insurance Carrier *

C. Arrier

This claim is accepted as compensable in its entirety

This claim is denied

Cancel Save & Exit Next

Form 111 - Notice of Claim Denial or Acceptance

Step 1 of 4

Defendant filing this form *

D. Fendant

Insurance Carrier *

C. Arrier

- This claim is accepted as compensable in its entirety
- This claim is denied

The claim is denied for the following reasons (select at least one or all that apply): *

- There is a dispute concerning the amount of compensation owed to the plaintiff
- Plaintiff was not employed by defendant on the date of alleged injury
- Plaintiff's last injurious exposure to the risks of the occupational disease alleged did not occur in the employment of this defendant
- The plaintiff did not give due and timely notice to employer of the alleged occupational disease
- The alleged injury did not arise out of and in the course of employment
- Plaintiff has not contracted the occupational disease alleged
- The plaintiff did not give due and timely notice to employer of the injury
- The claim is barred by limitations
- Other reason for denial

Cancel

Save & Exit

Next

Step 2 of Form 111 shows employer admission options.

Form 111 - Notice of Claim Denial or Acceptance

Step 2 of 4

The following are admitted by the employer (select all that apply):

- Plaintiff's alleged work event was covered under the Workers' Compensation Act.
- The work event occurred on
- Plaintiff reported the work event on
- Plaintiff returned to work.
Plaintiff continues to work for this employer.
 No Yes
- Temporary total disability income benefits were paid as the result of the injury.
- Medical expenses have been paid as the result of this injury.

Special answers and summaries are entered in Step 3.

Form 111 - Notice of Claim Denial or Acceptance

Step 3 of 6

Special Answer: The Defendant/Employer for its special answers asserts the following as a bar to recovery in whole or part in accordance with 803 KAR 25:010 Section 6 (2)(d)1. (Select all that apply):

- KRS 342.035(3), unreasonable failure to follow medical advice;
- KRS 342.165, safety violation, need to submit Form SVC within 15 days;
- KRS 342.316(7) or KRS 342.335, false statement on employment application;
- KRS 342.395, voluntary rejection of KRS Chapter 342;
- KRS 342.610(3), voluntary intoxication or self-infliction of injury;
- KRS 342.710(5), refusal to accept rehabilitation services; or
- Running of periods of limitations or repose under KRS 342.185, 342.270, 342.316, or other applicable statute;
- Injury resulted from "horseplay";

Provide a brief summary of the basis for each special answer listed:

Please attach any additional supporting documentation here:

 **Attach File**

Maximum of 5 attachments

An attestation of form accuracy and an electronic signature are required to complete Step 4. Here you may preview and save or print a copy of your form in PDF format. Selecting finish will submit your document to DWC. An example of a completed Form 111 is shown on the next slide.

Form 111 - Notice of Claim Denial or Acceptance

Step 4 of 6

By entering my full name below, I attest that this form is accurate and complete to the best of my knowledge.

Signature *

Title

(by entering your name in the field above, you are providing your electronic signature)

Submitter Address:

Phone:

Email Address:

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS

Notice of Claim Denial or Acceptance

Before ALJ: HON. ROBERT L. SWISHER

Claim No. 202000003

FUNKMASTER FLEX

Plaintiff/Employee

vs.

KALAMAZOO TIGER HOUSING

Defendant/Employer

Comes the defendant, D. Fendant, as insured by C. Annier, and in response to the Application for Resolution of Claim, states as follows:

1. This claim is accepted as compensable in its entirety.
- x 2. This claim is denied for the following reasons:
 - (a) There is a dispute concerning the amount of compensation owed to the plaintiff.
 - (b) Plaintiff was not employed by defendant on the date of alleged injury.
 - (c) Plaintiff's last injurious exposure to the risks of the occupational disease alleged did not occur in the employment of this defendant.
 - x (d) The plaintiff did not give due and timely notice to employer of the alleged occupational disease.
 - (e) The alleged injury did not arise out of and in the course of employment.
 - (f) Plaintiff has not contracted the occupational disease alleged.
 - (g) The plaintiff did not give due and timely notice to employer of the injury.
 - (h) The claim is barred by limitations.
 - (i) Other reason for denial.
3. The following are admitted by the employer:
 - x Plaintiff's alleged work event was covered under the Workers' Compensation Act.
 - x The work event occurred on 4/5/2016
Date
 - x Plaintiff reported the work event on 4/5/2016
Date

- Plaintiff returned to work for this employer and does does not continue to work for this employer.
- Temporary total disability income benefits were paid as the result of the injury.
- Medical expenses have been paid as the result of this injury.

4. **Special Answer:** The Defendant/Employer for its special answers asserts the following as a bar to recovery in whole or part in accordance with 803 KAR 25:010 Section 6 (2)(d)1.:

- | | | |
|-------------------------------------|---|---|
| <input checked="" type="checkbox"/> | * | KRS 342.035(3), unreasonable failure to follow medical advice; |
| <input type="checkbox"/> | * | KRS 342.165, safety violation, need to submit a Form SVC within 15 days; |
| <input type="checkbox"/> | * | KRS 342.316(7) or KRS 342.335, false statement on employment application; |
| <input type="checkbox"/> | * | KRS 342.395, voluntary rejection of KRS Chapter 342; |
| <input checked="" type="checkbox"/> | * | KRS 342.610(3), voluntary intoxication or self-infliction of injury; |
| <input type="checkbox"/> | * | KRS 342.710(5), refusal to accept rehabilitation services; or |
| <input type="checkbox"/> | * | Running of periods of limitations or repose under KRS 342.185, 342.270, 342.316, or other applicable statute; |
| <input type="checkbox"/> | * | Injury resulted from "horseplay"; |
| <input type="checkbox"/> | * | Other |

Provide a brief summary of the basis for each special answer listed:
See attached

Notice: Any person who knowingly and with intent to defraud another person, files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material to the action commits a fraudulent act, which is a crime.

Being duly sworn, the undersigned states that the statements in this form are true and correct to the best of my knowledge and belief. This the 5 day of July 2016.

/s/ D. Fendant
Atty for Defendant
Signature _____ Title _____
25 sdlfakdf lexington, Kentucky 40505
Address _____
(526) 325-8741
Phone Number _____



2

/ 2



Asserting a Safety Violation

Kentucky Department of Workers' Claims



To submit a document to an established claim in LMS through the claim detail screen by clicking on the file document button.

Claim #: 202000001 

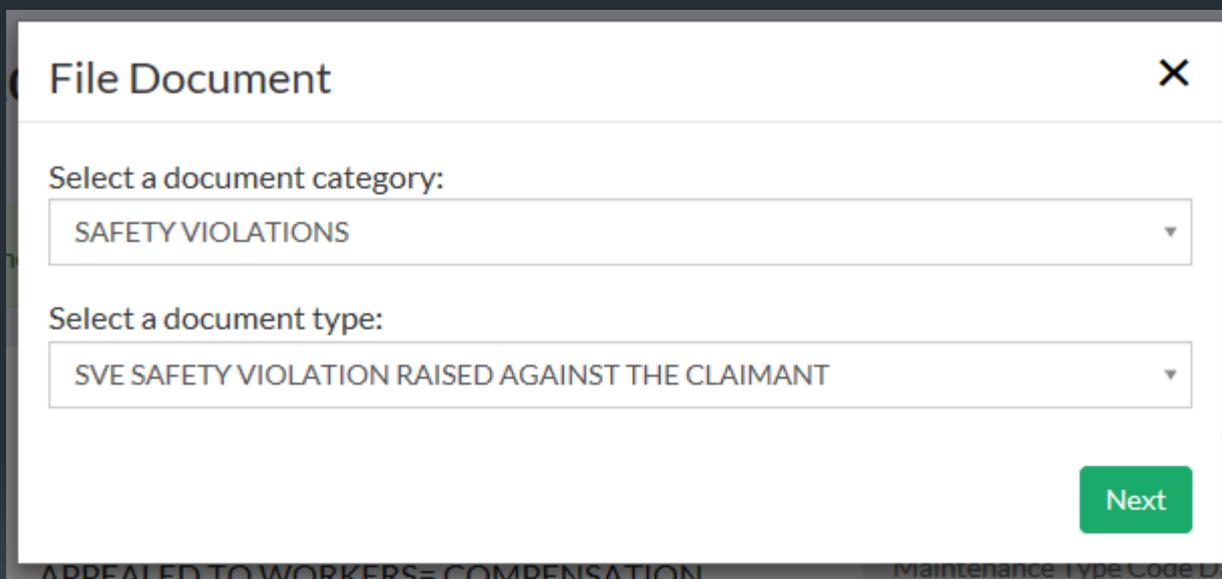
Style	INJURED SALLY VS NATIONAL COMPUTER SYSTEMS
Judge	HON ROBERT L. SWISHER
Date of Injury	7/4/2015
Disposition	SUBMITTED FOR ALJ DECISION
Nature	LACERATION
Body Part	LOWER ARM

Insurance Carrier Information

Maintenance Type Code	N/A
Maintenance Type Code Date	N/A
Claim Administrator #	N/A

Claim Access # [show access #](#)

To file an SVE, select Safety Violations from the available document categories, then select SVE Safety Violation Raised Against the Claimant as the document type. The following slide shows the SVE form.



The screenshot shows a 'File Document' form with two dropdown menus. The first dropdown is labeled 'Select a document category:' and has 'SAFETY VIOLATIONS' selected. The second dropdown is labeled 'Select a document type:' and has 'SVE SAFETY VIOLATION RAISED AGAINST THE CLAIMANT' selected. A green 'Next' button is located at the bottom right of the form.

File Document ×

Select a document category:

SAFETY VIOLATIONS ▼

Select a document type:

SVE SAFETY VIOLATION RAISED AGAINST THE CLAIMANT ▼

Next

Form SVE - Safety Violation Raised against the Claimant

For the alleged safety violation to KRS 342.165, state the safety rule(s), regulation(s), or statute(s) the employee is alleged to have failed to follow or obey *

If it is to be alleged the employee intentionally failed to use a safety appliance furnished by the employer, state the safety appliance

State the facts as to how the alleged failure by the employee to use a safety appliance furnished by the employer or to obey a safety rule, regulation, statute or order caused, in any degree, the accident to occur *

The following attachments should be submitted, if applicable and available:

- Accident report
- OSHA, MSHA or other report of investigation
- Any safety manual, employee handbook or other document provided to the employee by the employer relative to the use of the subject safety appliance, rule, regulation, statute or order

 Attach File

Maximum of 5 attachments

By entering your name below, you are confirming under penalty of perjury the accuracy of this form *

Cancel

Save & Exit

Next

To file an SVC, select Safety Violations from the available document categories, then select SVC Safety Violation Raised Against the Employer as the document type. The following slide shows the SVC form.



The screenshot shows a web form titled "File Document" with a close button (X) in the top right corner. The form contains two dropdown menus. The first dropdown is labeled "Select a document category:" and has "SAFETY VIOLATIONS" selected. The second dropdown is labeled "Select a document type:" and has "SVC SAFETY VIOLATION RAISED AGAINST THE EMPLOYER" selected. A green "Next" button is located at the bottom right of the form. At the bottom of the slide, the text "Claim Access #:" is partially visible.

File Document ×

Select a document category:

SAFETY VIOLATIONS ▾

Select a document type:

SVC SAFETY VIOLATION RAISED AGAINST THE EMPLOYER ▾

Next

Claim Access #:

Form SVC - Safety Violation Raised against the Employer

For the alleged safety violation to KRS 342.165, state the safety rule(s), regulation(s), or statute(s) alleged to have been violated by the employer *

State the facts as to how the alleged failure of the employer to comply with the rule(s), regulation(s) or statute(s) referred to in answers to the previous section caused or contributed to, in any degree, the accident to occur: *

The following attachments should be submitted, if applicable and available:

- Accident report
- OSHA, MSHA or other report of investigation
- Citation for safety penalty by a government agency

 Attach File

Maximum of 5 attachments

This form prepared and submitted by: *

(by entering your name in the field above, you are providing your electronic signature)

Submitter is: *

- Plaintiff
 Plaintiff's Attorney

Cancel

Save & Exit

Next

Associating to a Claim/ Business Groups

Kentucky Department Of Workers' Claims

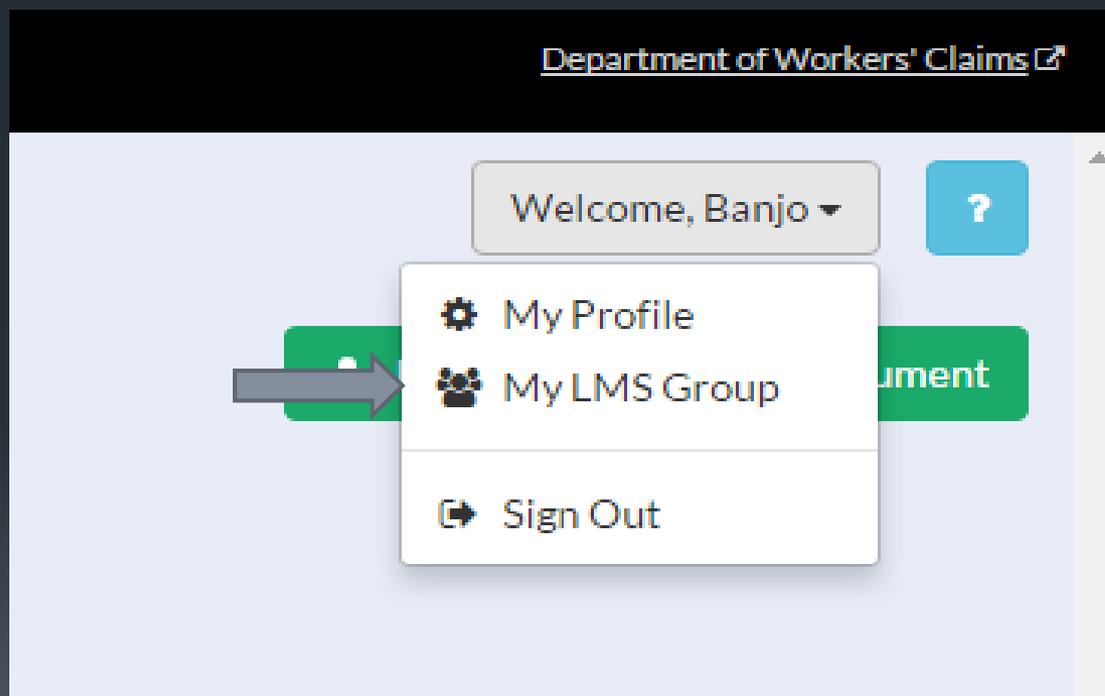


LMS allows law firms and other organizations to set up business groups. Establishing a group allows members to view claims to which they are associated and assign claims for work purposes.

- Group creation and management is handled by Site Administrators. Site Administrators are responsible for the upkeep of the business group including case assignment, adding and removing group members, and associating the group to claims.
- For attorney groups, the site administrator should be a managing partner of the firm with a bar ID.
- Once the group is established, the Site Administrator may designate up to five other Site Administrators to assist with managing the group.

- Court reporters cannot be added to LMS groups.
- Other organizations can also set up LMS groups using the “Other” role. Attorneys can be added to an LMS “Other” Group by accepting the invitation sent by the site admin but will not be able to file pleadings. Users already in the system as attorneys cannot be added to an “Other” group.
- A user (email address) can only be associated with one group at any given time. Should a user need to be in more than one business group, they will need to use a separate email account for each group they wish to be a part of.
- If you have additional questions or need assistance with business group creation and management, please email:
LaborKYWCLMS.TechnicalSupport@ky.gov

After logging into LMS, to create a group, click on the downward-pointing arrow next to your name in the upper right corner of the screen. Select My LMS Group.



If the user is registered as an attorney, they will be prompted to create an LMS Group for attorneys or a law firm.

LMS Group Creation

Step 1 of 3

The logged in user will become the Site Administrator to manage claims and users for the LMS group. Please select the appropriate type of group you are registering from the list.

The Site Administrator will have the permissions to alter business/entity profile information, add users, remove users, create additional Site Administrators for the business.

Attorney Group/Law Firm

Next

Users will next be prompted to enter contact information, a FEIN or Tax ID number, and information about the person responsible for the group. A user in the attorney role is required to provide a Bar ID.

LMS Group Creation

Step 2 of 3

Business Information:

Business Name *

Address *

City/Town * State * Zip Code *

Phone * Fax

FEIN/Tax ID * Confirm FEIN/Tax ID *

Managing Partner Information:

Title First Name * Middle Last Name *

Bar ID Confirm Bar ID

The final step of creating an LMS Group is to accept the terms and conditions and click finish.

LMS Group Creation

Step 3 of 3

LITIGATION MANAGEMENT SYSTEM TERMS AND CONDITIONS

Terms and Conditions as of January 1, 2016

These terms and conditions pertain to the Kentucky Department of Workers' Claims ("DWC") hosted online Litigation Management System ("LMS"). By using LMS, you are expressly, without reservation, indicating your consent to the following terms and conditions. Failure to comply with these terms and conditions shall subject the user and his or her organization to termination of access to and use of LMS as well as to other penalties.

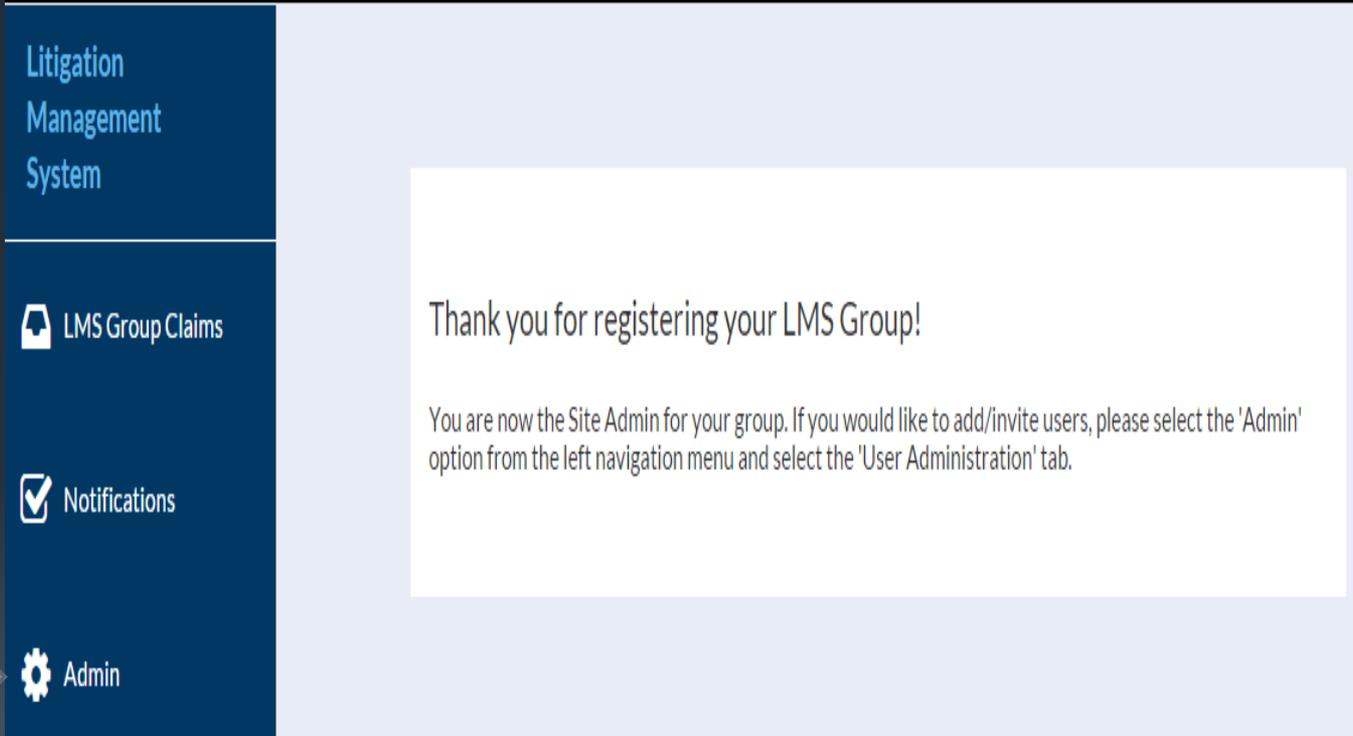
SUBMITTING FILINGS VIA LMS

A. Time of Filing. A record submitted to DWC via LMS is considered filed only when it is loaded onto the DWC's servers. Thus, a record submitted at 10:59 p.m. on day 1, but loaded onto the servers at 6:00 a.m. on day 2, is considered filed on day 2. You will receive confirmation of a successful transmission at the time of filing.

Check this box to accept the Terms and Conditions *

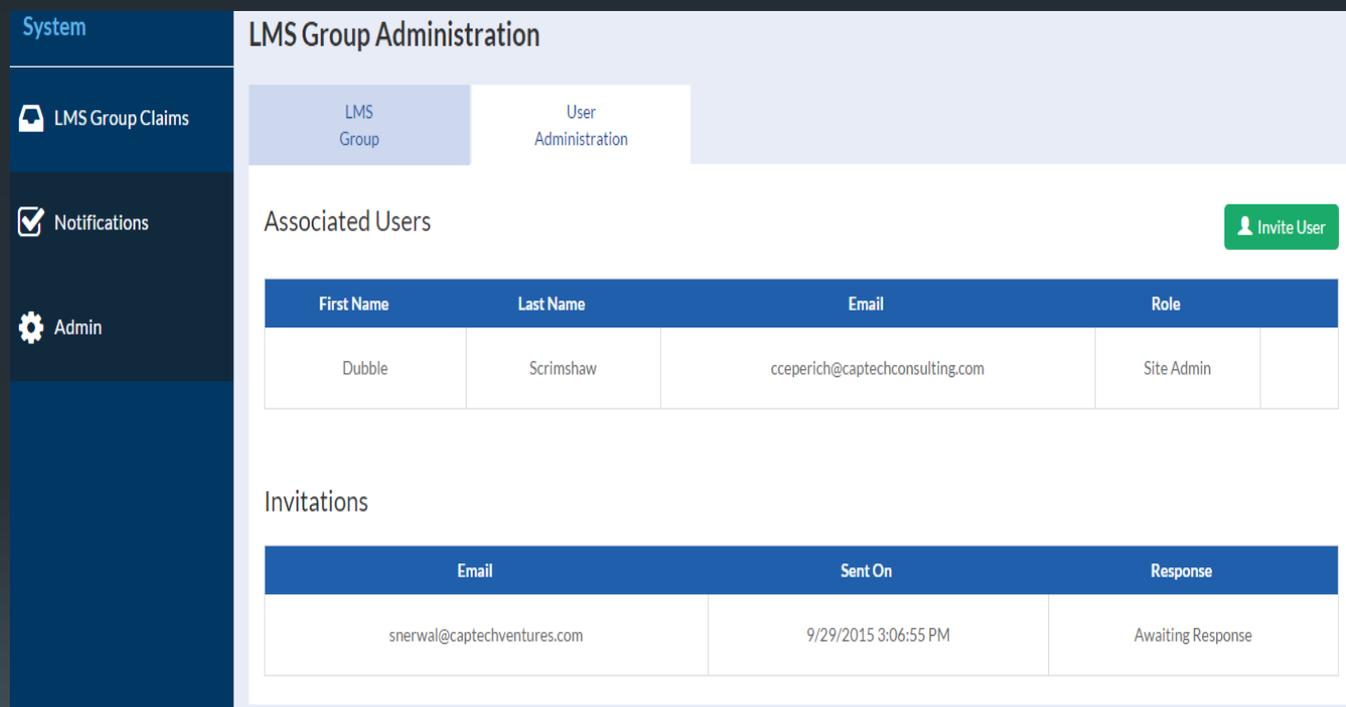
Back Finish

The final step of creating an LMS Group is to accept the terms and conditions and click finish. Note the new icon in the left menu called Admin. Administration of your LMS group happens there.



The screenshot displays the LMS Management System interface. On the left is a dark blue navigation menu with the following items: "Litigation Management System" (text only), "LMS Group Claims" (with a document icon), "Notifications" (with a checkmark icon), and "Admin" (with a gear icon). A grey arrow points to the "Admin" menu item. The main content area is light blue and contains a white message box with the text: "Thank you for registering your LMS Group! You are now the Site Admin for your group. If you would like to add/invite users, please select the 'Admin' option from the left navigation menu and select the 'User Administration' tab."

On the LMS Group Administration page, the Site Administrator can invite users to the group by clicking the invite user button.



The screenshot displays the LMS Group Administration interface. On the left is a dark blue sidebar with navigation options: System, LMS Group Claims, Notifications, and Admin. The main content area is titled 'LMS Group Administration' and features two tabs: 'LMS Group' (selected) and 'User Administration'. Below the tabs, there is an 'Associated Users' section with a table listing users and an 'Invite User' button. The 'Associated Users' table has columns for First Name, Last Name, Email, and Role. Below this is an 'Invitations' section with a table listing invitation details, including Email, Sent On, and Response.

LMS Group Administration

LMS Group Administration

LMS Group Administration

Associated Users [Invite User](#)

First Name	Last Name	Email	Role
Dubble	Scrimshaw	cceperich@captechconsulting.com	Site Admin

Invitations

Email	Sent On	Response
snerwal@captechventures.com	9/29/2015 3:06:55 PM	Awaiting Response

Entering an email address triggers an invitation email to be sent to the address provided.

Add User ✕

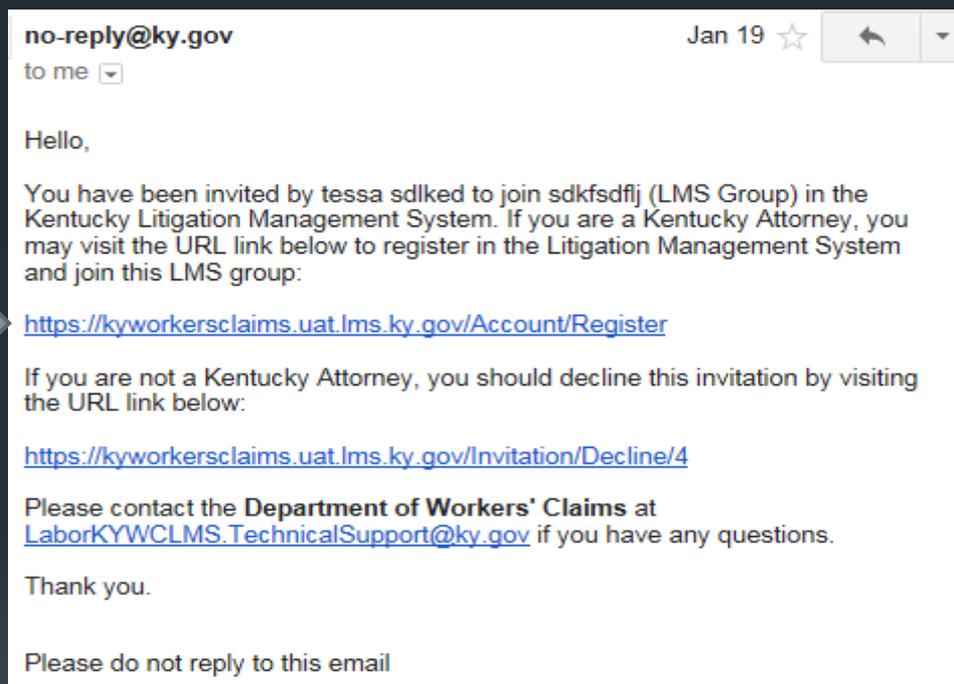
Please provide the email address of the user you would like to invite to join your group. The user will be sent the invitation to join. If the email address provided is not registered with LMS, the user will complete a registration and be added to your group once they complete the registration.

Email *

Confirm Email *

[Add User / Send Invite](#)

This is what an LMS Group invitation email looks like. We are currently working on clarifying the language so attorney support staff are not discouraged from registering.



If you are a site administrator, you will be able to toggle back and forth between claims the group is associated to and claims assigned individually to the site administrator. From the LMS Group Claims screen, the administrator will be able to assign claims to members of the group.

LMS Group Claims [+ Add Claim](#) [My Claims](#) [Submit a Filing](#)

Show entries

Claim #	Style	Injury Date	Body Part	ALJ	Assigned To	
2020-00003	FUNKMASTER FLEX VS KALAMAZOO TIGER HOUSING	2/1/2016	EAR(S) Total deafness of one ear	N/A	Unassigned	Assign

Motion to Reopen/ Medical Disputes

Kentucky Department Of Workers' Claims



From the “Submit a Filing” page, click on the “Motion to Reopen” button to file a motion to reopen.

Choose the type of document you wish to file.

File a New Claim
Start filing a new claim by picking the nature of your injury or disease. Then click next. This will direct you to the appropriate form for your particular claim.

Nature of Injury *

[Continue to Form](#)

Agreements are not being submitted electronically at this time. Please select fatality or the nature of the injury / occupational disease to create an agreement document. Once completed, please print and mail a copy to the Department of Workers' Claims, 657 Chamberlain Ave., Frankfort, KY 40601. Thank you!

File an Agreement
Begin your agreement form by picking the nature of your injury or disease, and then continue to the form. If you have filed a claim, add it to your "My Claims" list and submit an agreement to the claim file.

Employee/plaintiff is deceased

Nature of Injury *

[Continue to Form](#)

File a Motion to Reopen

[Motion to Reopen](#) 

[Motion to Reopen \(Medical Dispute\)](#)

File Other Documents
Selected documents may be filed here, without first adding a claim to your "My Claims" page.

[Motion for Expedited Medical Determination](#)

[Application for Resolution - Interlocutory Relief](#)

[Motion to Substitute Party and Continue Benefits](#)

[Pre-Litigation Medical Dispute](#)

Step one requests plaintiff information.

Motion to Reopen

Step 1 of 6

Plaintiff Information

Title First Name* Middle Last Name* Suffix

Phone*

Select the type of ID* Social Security Number Green Card #

Green Card #*

Birth Date* mm/dd/yyyy Gender* Female Male

Address*

Outside of United States

Postal Code* City/Town* State

Occupation*

Cancel Save & Exit Next

Step 2 collects defendant/employer information.

Motion to Reopen

Step 2 of 8

Defendant/Employer Information

Business Name *

Address *

Postal Code * City/Town * State

Step 3 collects carrier information.

Motion to Reopen

Step 3 of 8

Insurance Carrier Information

No Insurance Information Available

Business Name

Address

Postal Code *

City/Town *

State

Step 4 collects information about the nature of injury.

Motion to Reopen

Step 4 of 8

Nature of Injury

Date of Injury/Last Exposure *

Cause of Injury *

Body Part Injured *

Nature of Injury *

Cancel Save & Exit Back Next

Step 5 collects information about the reason(s) for reopening.

Motion to Reopen

Step 5 of 8

Claim Information

What claim number do you want to reopen? *

Plaintiff/Employee in this claim: *

Defendant/Employer in this claim: *

What grounds for reopening apply? (check all that apply)

- Change of disability shown by objective medical evidence
- Fraud
- Mistake
- Newly discovered evidence
- Conforming the award to employee's work status for injuries after 12-12-96
- Reducing a permanent total disability award when employee returns to work

Explain:

Have you previously filed a motion to reopen this claim? *

- Yes
- No

NOTE: Pursuant to KRS 342.125(3) no party may file a motion to reopen within one (1) year of any previous motion to reopen by the same party.

Cancel Save & Exit Back Next

Step 6 provides the opportunity to attach any relevant documents.

Motion to Reopen

Step 6 of 8

Attachments

Which of the following documents are attached in support of this motion (check all that apply)?

- Affidavit(s) of employee / other witnesses
- Medical report
- A current medical release Form 106, signed and witnessed
- A copy of the Opinion and Award, Settlement, Agreed Order, or Agreed Resolution sought to be reopened
- Utilization report

 Attach File

Maximum of 5 attachments

Cancel Save & Exit Back Next

Step 7 collects information for the certificate of service.

Motion to Reopen

Step 7 of 8

Certificate of Service

I certify the original of the foregoing document was filed with the Department of Workers' Claims, 657 Chamberlin Avenue, Frankfort, Kentucky 40601 by either U.S. Mail or electronically through the Department of Workers' Claims Litigation Management System and copies served on the persons or entities given below:

Attorney for Employer or Insurance Carrier, if applicable:

Name

Address

City State Postal Code

Employer or Insurance Carrier:

Name

Address

City State Postal Code

Other Parties, if applicable:

Name

Address

City State Postal Code

Special Fund, if applicable:

Name

Address

City State Postal Code

Cancel Save & Exit Back **Next**

Step 8 collects an electronic signature and contact information from the filer.

Motion to Reopen

Step 8 of 8

Attestation

By providing my electronic signature, I attest that the statements above and in an attached Form 106 are true and accurate to the best of my knowledge.

Electronic signature *

Address

City State Postal Code

Phone: EmailAddress:

Cancel Save & Exit Back Preview Document Finish

To file a Motion to Reopen on a Medical Dispute, click on the “Motion to Reopen(Medical Dispute)” from the “Submit a Filing” page.

Choose the type of document you wish to file.

File a New Claim

Start filing a new claim by picking the nature of your injury or disease. Then click next. This will direct you to the appropriate form for your particular claim.

Nature of Injury*

Continue to Form

Agreements are not being submitted electronically at this time. Please select fatality or the nature of the injury / occupational disease to create an agreement document. Once completed, please print and mail a copy to the Department of Workers' Claims, 657 Chamberlain Ave., Frankfort, KY 40601. Thank you!

File an Agreement

Begin your agreement form by picking the nature of your injury or disease, and then continue to the form. If you have filed a claim, add it to your "My Claims" list and submit an agreement to the claim file.

Employee/plaintiff is deceased

Nature of Injury*

Continue to Form

File a Motion to Reopen

Motion to Reopen



Motion to Reopen (Medical Dispute)

File Other Documents

Selected documents may be filed here, without first adding a claim to your "My Claims" page.

Motion for Expedited Medical Determination

Application for Resolution - Interlocutory Relief

Motion to Substitute Party and Continue Benefits

Pre-Litigation Medical Dispute

Step 1 collects basic plaintiff information.

Motion to Reopen / Medical Dispute

Step 1 of 10

Plaintiff Information

Title First Name* Middle Last Name* Suffix

Phone*

Select the type of ID* Social Security Number Green Card # Green Card #*

Birth Date* mm/dd/yyyy Gender* Female Male

Address*

Outside of United States

Postal Code* City/Town* State

Occupation*

Step 2 collects Defendant/Employer information.

Motion to Reopen / Medical Dispute

Step 2 of 10

Defendant/Employer Information

Business Name *

Address *

Postal Code * City/Town * State

Add Defendant

Cancel Save & Exit Back Next

Step 3 collects carrier information.

Motion to Reopen / Medical Dispute

Step 3 of 10

Insurance Carrier Information

No Insurance Information Available

Business Name

Address

Postal Code*

City/Town*

State

Cancel Save & Exit Back Next

Step 4 collects information about the nature of the injury.

Motion to Reopen / Medical Dispute

Step 4 of 10

Nature of Injury

Date of Injury* mm/dd/yyyy

Cause of Injury* Body Part Injured* Nature of Injury*

Cancel Save & Exit Back **Next**

Step 4 is where medical provider information is entered. Entry of at least one provider is required. The next screen shows the pop-up where medical provider details are entered

Motion to Reopen / Medical Dispute

Step 5 of 10

Medical Providers

Name	Street Address	Remove
------	----------------	--------

+ Add Medical Provider

Cancel Save & Exit Back Next

Add Medical Provider ✕

Business Name *

Address

Postal Code * City/Town * State

Step 6 collects information specifically about the medical dispute.

Motion to Reopen / Medical Dispute

Step 6 of 10

Applicant Info

Identify which party is applying for the medical dispute: *

Has a workers' compensation claim been filed with the Department of Workers' Claims? *

No Yes

Has a utilization review been completed? *

No Yes

The dates on which each disputed statement for services first received by the employer, insurance carrier, or any agent thereof is as follows:

Description	Date Received	Remove
+ Add Dispute Statement		

The nature of this dispute can briefly be described as follows (Please include all facts necessary for relief sought and attach copies of any supporting medical documentation): *

Has an award or settlement previously been entered on this claim? *

No Yes

Step 7 collects information about the reason(s) for reopening.

Motion to Reopen / Medical Dispute

Step 7 of 10

Claim Information

What claim number do you want to reopen? *

Plaintiff/Employee in this claim: *

Defendant/Employer in this claim: *

What grounds for reopening apply? (check all that apply)

- Change of disability shown by objective medical evidence
- Fraud
- Mistake
- Newly discovered evidence
- Conforming the award to employee's work status for injuries after 12-12-96
- Reducing a permanent total disability award when employee returns to work

Explain:

Have you previously filed a motion to reopen this claim? *

- Yes
- No

NOTE: Pursuant to KRS 342.125(3) no party may file a motion to reopen within one (1) year of any previous motion to reopen by the same party.

Cancel Save & Exit Back Next

Relevant documents can be uploaded in step 8. If you are filing a Medical dispute reopening, please do not attach a motion to reopen here.

Motion to Reopen / Medical Dispute

Step 8 of 10

Upload Documents

The following documents are attached:

- Copy of the final utilization review decision
- Physician opinion supporting utilization review decision
- Medical bill audit, if any
- Copies for disputed statements for services
- Supporting medical documentation

For reopening a claim to contest this medical treatment, the following additional items are attached:

- Motion to Reopen
- Affidavit(s)
- Medical report
- Current medical release Form 106 signed and witnessed
- A copy of the Opinion and Award, Settlement, Agreed Order or Agreed Resolution sought to be responded

Maximum of 5 attachments

Step 9 requests certificate of service information.

Motion to Reopen / Medical Dispute

Step 9 of 10

Certificate of Service

I certify the original of the foregoing document was filed with the Department of Workers' Claims, 657 Chamberlin Avenue, Frankfort, Kentucky 40601 by either U.S. Mail or electronically through the Department of Workers' Claims Litigation Management System and copies served on the persons or entities given below:

Attorney for Employer or Insurance Carrier, if applicable:

Name

Address

City State Postal Code

Employer or Insurance Carrier:

Name

Address

City State Postal Code

Other Parties, if applicable:

Name

Address

City State Postal Code

Special Fund, if applicable:

Name

Address

City State Postal Code

Cancel Save & Exit Back **Next**

Step 10 collects additional submission info and an electronic signature.

Motion to Reopen / Medical Dispute

Step 10 of 10

Submission Info

Submitting Party

Name *

Role *

Address

Postal Code * City/Town * State

A copy of this file has been sent to the following recipients:

- fdgsdfs fdgdfd (employee)
- sdfasdfad (employer)
- (insurance carrier)
- asofasdfasdfadsf (medical provider)

Add additional recipients:

Name	Remove
<input type="text"/>	

[+ Add Recipient](#)

Signature *

Please enter your full name.

Phone: Email Address:

Settlement Agreements

Kentucky Department of Workers' Claims



Please Note that we are only accepting settlement agreements on paper at this time.

A solution is in the works and will be implemented soon but for now, keep sending in your settlement agreements on paper!

You can use the process described in the next few slides to fill out a settlement agreement form that can be printed and sent in to DWC.

To file a settlement agreement, select the nature of injury under the “File an Agreement” section of the submit a filing page and click “Continue to Form.”

Choose the type of document you wish to file.

File a New Claim

Start filing a new claim by picking the nature of your injury or disease. Then click next. This will direct you to the appropriate form for your particular claim.

Nature of Injury *

Continue to Form

Agreements are not being submitted electronically at this time. Please select fatality or the nature of the injury / occupational disease to create an agreement document. Once completed, please print and mail a copy to the Department of Workers' Claims, 657 Chamberlain Ave., Frankfort, KY 40601. Thank you!

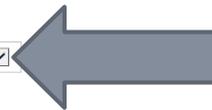
File an Agreement

Begin your agreement form by picking the nature of your injury or disease, and then continue to the form. If you have filed a claim, add it to your 'My Claim' list and submit an agreement to the claim file.

Employee/plaintiff is deceased

Nature of Injury *

Continue to Form



File a Motion to Reopen

Motion to Reopen

Motion to Reopen (Medical Dispute)

File Other Documents

Selected documents may be filed here, without first adding a claim to your 'My Claims' page.

Motion for Expedited Medical Determination

Application for Resolution - Interlocutory Relief

Motion to Substitute Party and Continue Benefits

Pre-Litigation Medical Dispute

Step 1 of the form collects personal information from the plaintiff.

AGREEMENT AS TO COMPENSATION

Step 1 of 10

Plaintiff Information

Title First Name* Middle Last Name* Suffix

Select the type of ID* Social Security Number Green Card # SSN*

Birth Date* mm/dd/yyyy Gender* Female Male Undisclosed

Address*

Outside of United States

Postal Code* City/Town* State

Occupation*

Step 2 collects defendant information.

AGREEMENT AS TO COMPENSATION

Step 2 of 10

Defendant/Employer Information

Business Name *

Address *

Postal Code * City/Town * State

Step 3 prompts the user for insurance information if any.

AGREEMENT AS TO COMPENSATION

Step 3 of 10

Insurance Carrier Information

No Insurance Information Available

Business Name

Address

Postal Code*

City/Town*

State

Cancel Save & Exit Back Next

Step 4 requires information of the nature of injury.

AGREEMENT AS TO COMPENSATION

Step 4 of 10

Nature of Injury

Date of Injury * mm/dd/yyyy

Where did the injury occur?

Postal Code *

City/Town *

State

Description

Cause of Injury *

Nature of Injury *

Body Part Injured *

Step 5 collects medical information – expenses and impairments.

AGREEMENT AS TO COMPENSATION

Step 5 of 10

Medical Information

Medical expenses paid *

\$

Date of last medical payment mm/dd/yyyy

Medical expenses unpaid or contested

\$

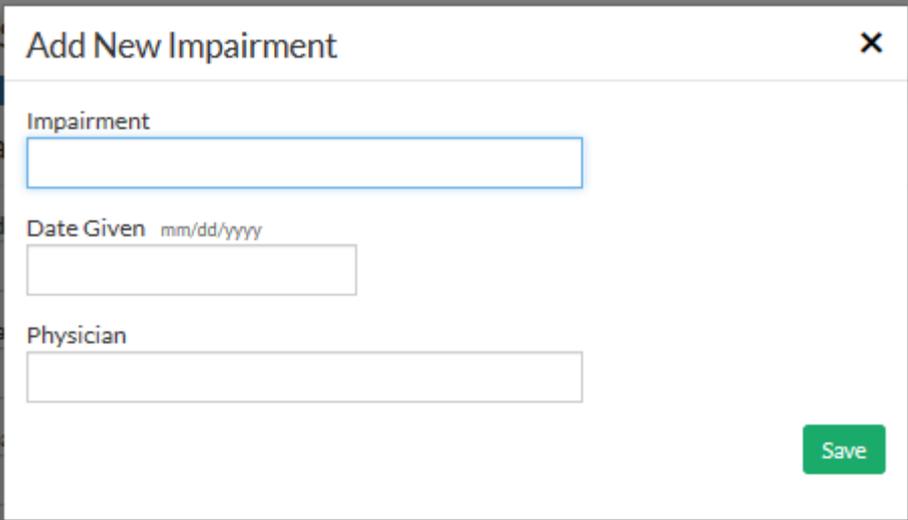
Surgery performed:

Yes No

What range of impairments were considered in reaching a settlement? (may be N/A)

Impairment Percentage	Date Given	Physician	Remove
<div style="display: flex; align-items: center; margin-bottom: 10px;">+ Add Impairment</div> <p>Diagnosis:</p> <input style="width: 240px; height: 30px;" type="text"/>			

Clicking the “Add New Impairment” button pops open the screen below where information for each impairment can be entered.



The screenshot shows a modal window titled "Add New Impairment" with a close button (X) in the top right corner. The form contains three input fields: "Impairment", "Date Given" (with a placeholder "mm/dd/yyyy"), and "Physician". A green "Save" button is located in the bottom right corner of the form.

Add New Impairment ×

Impairment

Date Given mm/dd/yyyy

Physician

Save

Step 6 collects work and wage information about the plaintiff.

AGREEMENT AS TO COMPENSATION

Step 6 of 10

Work Information

Does plaintiff/employee qualify for increased benefits under KRS 342.730 (1)(c)1 or 2? *

Yes No

Has the plaintiff/employee filed for Social Security Disability or Supplemental Security Income benefits? *

Yes No

Type of work at time of injury: *

Average Weekly Wage at time of injury: *

\$

N/A

Wages upon returning to work: *

\$

Post-injury return-to-work date: mm/dd/yyyy *

Type of work performed after injury:

Type of work performed at time of settlement:

Cancel Save & Exit Back Next

Benefit and Settlement Information is collected in Step 7. The popup screens for Disability Payment, Benefit Calculation and Settlement Term Entry are shown on the next 3 slides.

AGREEMENT AS TO COMPENSATION

Step 7 of 10

Benefit and Settlement Information

Amount and duration of temporary total disability paid to date:

Start Date	End Date	\$ per Week	# of Weeks	Total	Remove
+ Add Disability Payment					

For each lump sum or periodic income benefit agreed to, show your calculation below:

Type	Start Date	Payment Amount	# of Weeks	PV	Total	Edit/Remove
+ Add Benefit Calculation						

Total of Lump Sum and Income Benefits
\$

Are the following waivers included in the settlement?

Waiver or buyout of past medical benefits
 Yes No

Waiver or buyout of future medical benefits
 Yes No

(If yes, attach copy of most current medical report or office note from treating physician)

Waiver of vocational rehabilitation
 Yes No

Waiver of right to reopen
 Yes No

Total of Waivers
\$

Monetary terms of settlement:

Beginning Date	Payment Amount	Frequency	# of Payments	Total Value	Remove
+ Add Settlement Term					

Total settlement
\$

If settlement terms provide for a lump sum representing weekly benefits less than \$100, does claimant have adequate source of income during disability?
 Yes No

Cancel Save & Exit Back Next

Add New Disability Payment ✕

Start Date * mm/dd/yyyy

End Date * mm/dd/yyyy

Amount per Week *
\$

of weeks *

Total *
\$

Add New Benefit Calculation ✕

Payment Schedule *	Weekly Payment Rate *
<input type="text"/>	<input type="text"/>
Responsible Party *	Impairment Rating *
<input type="text"/>	<input type="text"/>
Payment Frequency	Grid Factor *
<input type="text"/>	<input type="text"/>
Beginning Date <small>mm/dd/yyyy</small>	Multiplier *
<input type="text"/>	<input type="text"/>
	Payment Amount
	<input type="text"/>
	Number of weeks (for periodic income benefit)
	<input type="text"/>
	Present value (for lump sum payments)
	<input type="text"/>
	Total
	<input type="text"/>

Add New Settlement Term ✕

Beginning Date mm/dd/yyyy

Payment Amount
\$

Payment Frequency

Number of Payments

Total Value
\$

Step 8 allows the user to add any additional information they may have regarding the settlement.

AGREEMENT AS TO COMPENSATION

Step 8 of 10

Other Information

If additional information is pertinent to settlement, explain, (Attach additional pages if necessary)

Other responsible parties against whom further proceedings are reserved:

 Attach File

Maximum of 5 attachments

Step 9 prompts the user to attest to whether or not they are represented by counsel.

AGREEMENT AS TO COMPENSATION

Step 9 of 10

PreAttestations

Represented By Attorney

I, the claimant, am represented by an attorney.

I, the claimant, understand that I have a right to obtain an attorney of my choice to review this agreement, and by signing below I acknowledge that I have waived that right. By waiving that right, I understand I will be held to the same standard as an attorney and this agreement will be enforceable as if represented by an attorney.

The final step collects information about parties and capturing an electronic signature attesting to the accuracy of the information contained in the form. The user may view and save a copy of the completed form by clicking “Preview Document.” Clicking the finish button will submit the document to the Department of Worker’s Claims.

AGREEMENT AS TO COMPENSATION

Step 10 of 10

Attestations

Parties to this agreement:

Attorney or representative of claimant

Attorney or representative of employer

Other participating parties:

Name	Role
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

By entering your name below, you are confirming under penalty of perjury the accuracy of this form. That it accurately represents the agreement entered into by the parties above.

This form prepared and submitted by: *

(By entering your name in the field above, you are providing your electronic signature)

Relationship to injured worker: *

Cancel Save & Exit Back Preview Document Finish

Submitting Motions, Notices and Briefs

Kentucky Department of Workers' Claims



Document submission is a huge benefit of the LMS system. Using this feature allows almost instantaneous feedback. Submitting a document to a claim in the system allows the document to be displayed immediately under the documents tab on the claim detail screen.

Alternatively, once an ALJ issues an order, it can be immediately reviewed on the LMS system.

By filing documents electronically, resource usage and postage are reduced.

Submit a document to an established claim in LMS through the claim detail screen by clicking on the file document button. All of the documents in this portion of the presentation are submitted in this way.

Claim #: 202000001 

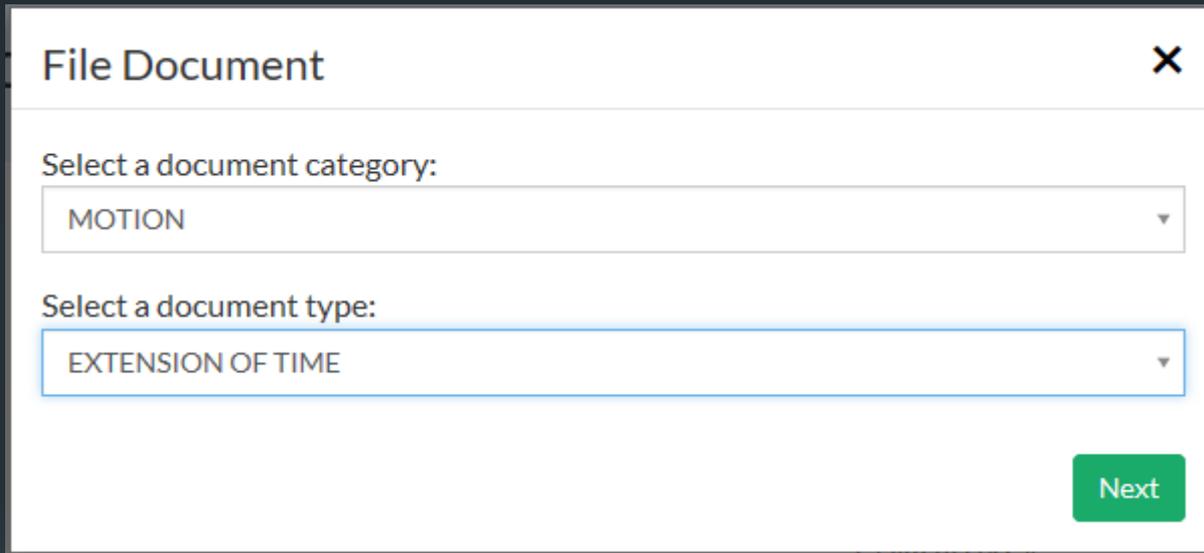
Style	INJURED SALLY VS NATIONAL COMPUTER SYSTEMS
Judge	HON ROBERT L. SWISHER
Date of Injury	7/4/2015
Disposition	SUBMITTED FOR ALJ DECISION
Nature	LACERATION
Body Part	LOWER ARM

Insurance Carrier Information

Maintenance Type Code	N/A
Maintenance Type Code Date	N/A
Claim Administrator #	N/A

Claim Access # [show access #](#)

To file a motion for extension of time select “Motion” from the available document categories and “Extension of Time” from document types.



The image shows a 'File Document' dialog box with a close button (X) in the top right corner. It contains two dropdown menus. The first dropdown is labeled 'Select a document category:' and has 'MOTION' selected. The second dropdown is labeled 'Select a document type:' and has 'EXTENSION OF TIME' selected. A green 'Next' button is located at the bottom right of the dialog box.

File Document ×

Select a document category:

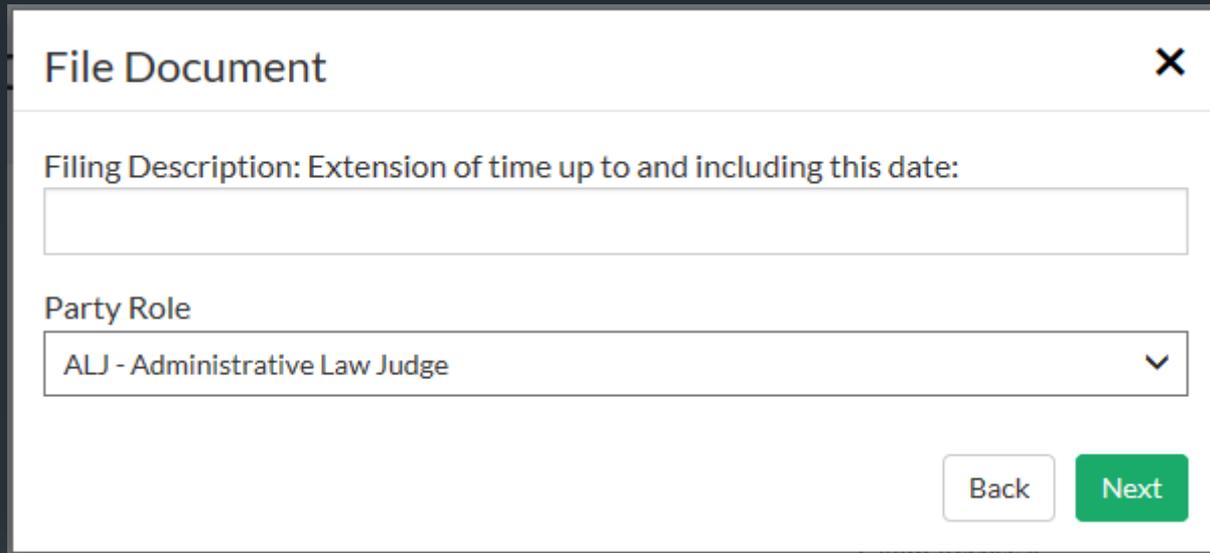
MOTION ▾

Select a document type:

EXTENSION OF TIME ▾

Next

On the next screen the user will enter the date they are requesting for extension and their role in the claim.



The screenshot shows a web form titled "File Document" with a close button (X) in the top right corner. The form contains two main sections: "Filing Description: Extension of time up to and including this date:" followed by a text input field, and "Party Role" followed by a dropdown menu. The dropdown menu is currently set to "ALJ - Administrative Law Judge" and has a downward arrow icon. At the bottom right of the form, there are two buttons: "Back" and "Next".

File Document ✕

Filing Description: Extension of time up to and including this date:

Party Role

ALJ - Administrative Law Judge ▼

Back Next

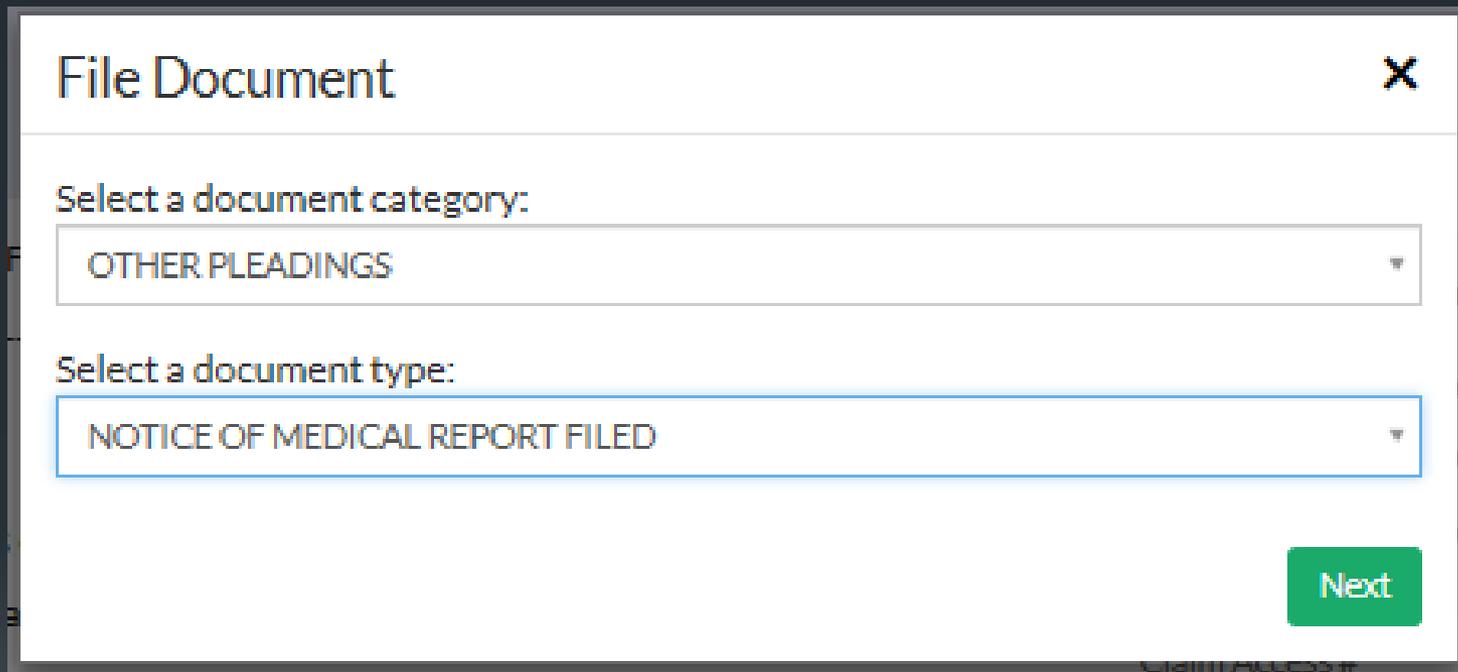
By clicking the Select a File button below, the user will be prompted to select a file from their computer to attach to the Motion for Extension of Time. Please note that the file must be in PDF or .jpg format and may not be more than 20 MB in size. Once the file has been attached, clicking the Finish button will submit the document to DWC.

File Document ✕

Select a Document to upload. The document must be a PDF or .jpg, and its size must be less than 20MB.

0bb576_10420326e31d4d9080c43c4619748a1f.pdf

To file a Medical Report, select Other Pleadings from the available document categories, then select Notice of Medical Report Filed as the document type. **Please note that medical report submissions are limited by statute to two per claim.**



File Document ✕

Select a document category:

OTHER PLEADINGS ▾

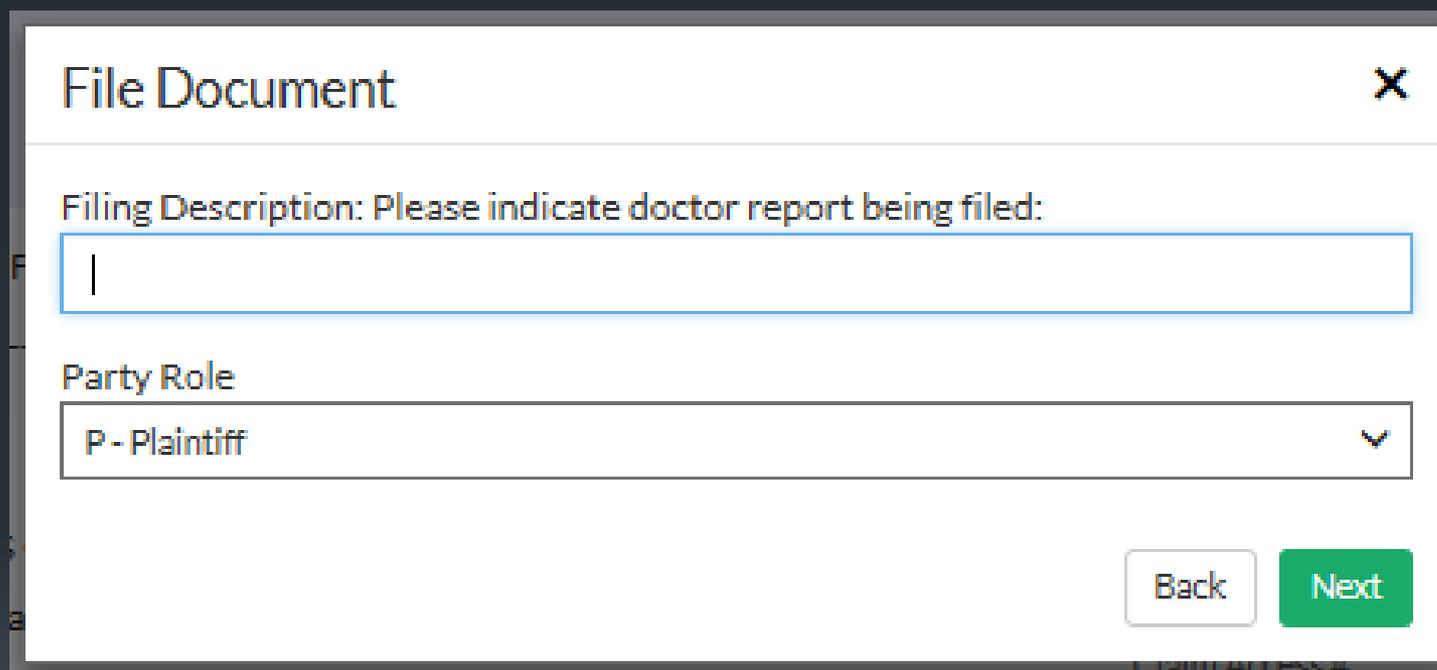
Select a document type:

NOTICE OF MEDICAL REPORT FILED ▾

[Next](#)

Claim Access #

Enter the name of the report into the first field of this window and choose the appropriate party role.



The screenshot shows a window titled "File Document" with a close button (X) in the top right corner. Below the title bar, there is a label "Filing Description: Please indicate doctor report being filed:" followed by a text input field containing a vertical bar cursor. Below this is a "Party Role" dropdown menu with "P - Plaintiff" selected and a downward arrow. At the bottom right, there are two buttons: "Back" (white with black text) and "Next" (green with white text). A partially visible label "Claim/Access #" is at the bottom right of the window.

File Document ✕

Filing Description: Please indicate doctor report being filed:

|

Party Role

P - Plaintiff ▼

Back Next

Claim/Access #

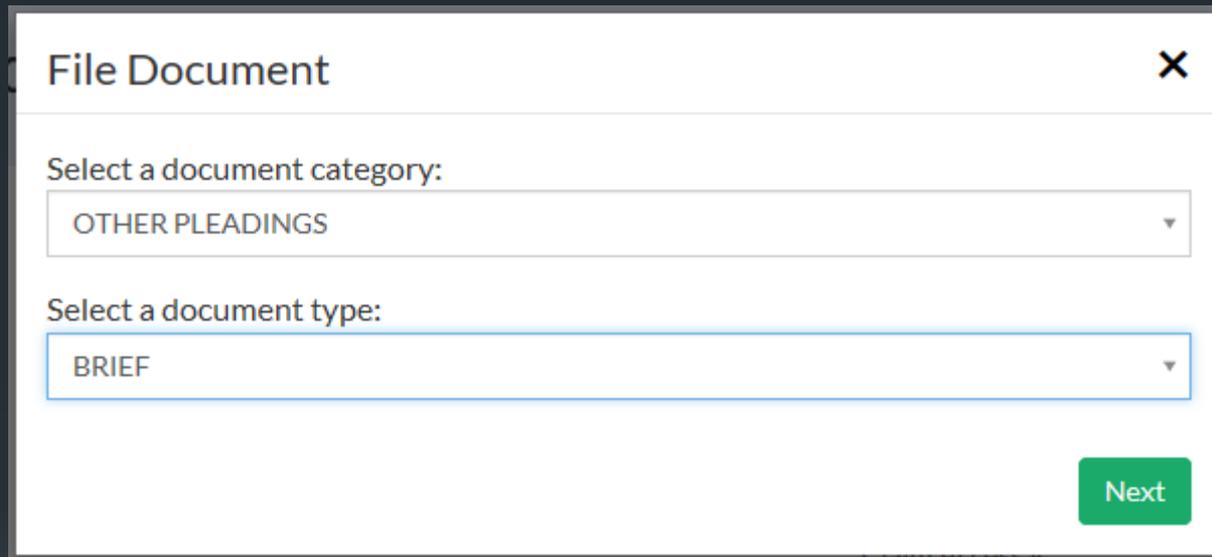
By clicking the Select a File button below, you will be prompted to select a file from your computer to attach to the Notice of Medical Report Filed. Please note that the file must be in PDF or .jpg format and may not be more than 20 MB in size. Once the file has been attached, clicking the Finish button will submit the document to DWC.

File Document ✕

Select a Document to upload. The document must be a PDF or .jpg, and its size must be less than 20MB.

0bb576_10420326e31d4d9080c43c4619748a1f.pdf

To file a brief select “Other Pleadings” from the available document categories. Select “Brief” from the available document types.



The image shows a 'File Document' dialog box with a close button (X) in the top right corner. It contains two dropdown menus. The first dropdown is labeled 'Select a document category:' and has 'OTHER PLEADINGS' selected. The second dropdown is labeled 'Select a document type:' and has 'BRIEF' selected. A green 'Next' button is located at the bottom right of the dialog box.

File Document

Select a document category:

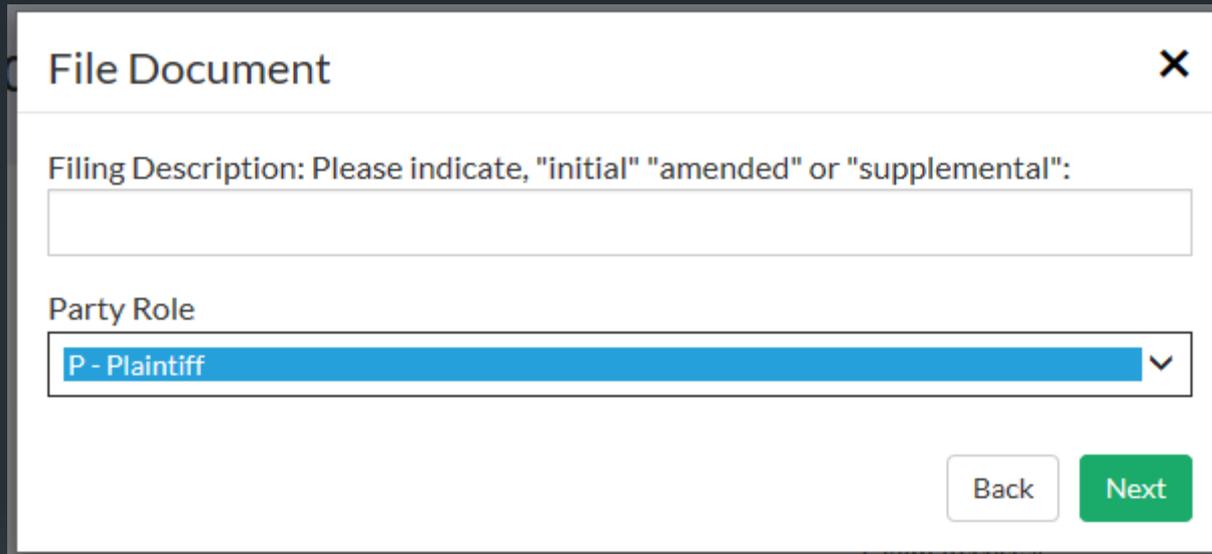
OTHER PLEADINGS

Select a document type:

BRIEF

Next

Next the user is prompted to indicate the type of brief being filed and supply their role in the claim.



The screenshot shows a web form titled "File Document" with a close button (X) in the top right corner. Below the title, there is a text input field labeled "Filing Description: Please indicate, 'initial' 'amended' or 'supplemental':". Underneath this is a "Party Role" dropdown menu with "P - Plaintiff" selected. At the bottom right, there are two buttons: "Back" and "Next".

File Document

Filing Description: Please indicate, "initial" "amended" or "supplemental":

Party Role

P - Plaintiff

Back Next

By clicking the Select a File button below, you will be prompted to select the Brief file from your computer to attach. Please note that the file must be in PDF or .jpg format and may not be more than 20 MB in size. Once the file has been attached, clicking the Finish button will submit the document to DWC.

File Document ✕

Select a Document to upload. The document must be a PDF or .jpg, and its size must be less than 20MB.

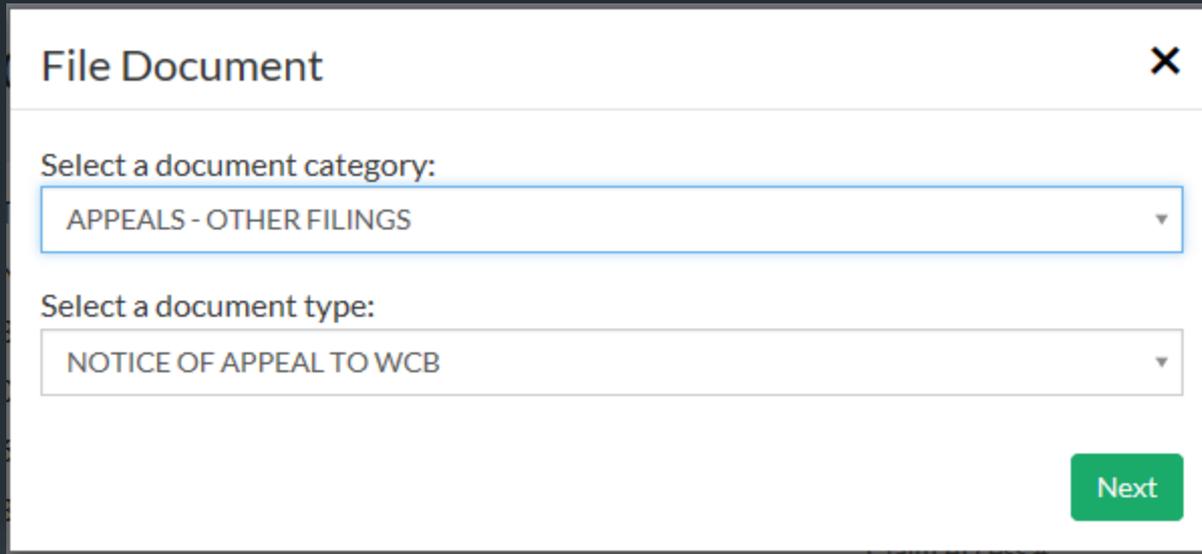
0bb576_10420326e31d4d9080c43c4619748a1f.pdf

Appealing to the Workers' Compensation Board – Notices, Motions, and Briefs

Kentucky Department of Workers' Claims



To file a Notice of Appeal to the Workers' Compensation Board, select "Appeals – Other Filings" from document type.



File Document ✕

Select a document category:

APPEALS - OTHER FILINGS ▼

Select a document type:

NOTICE OF APPEAL TO WCB ▼

[Next](#)

Claim/Access #

The next screen prompts the user for the date of the next work day and their role in the case.



The screenshot shows a web form titled "File Document" with a close button (X) in the top right corner. The form contains two main sections:

- Next Work Day:** A text input field containing the date "7/8/2016".
- Petitioner/Respondent:** A dropdown menu with "Petitioner" selected and a downward arrow on the right.

At the bottom right of the form, there are two buttons: a white "Back" button and a green "Next" button. Below the form, the text "Claim Access #" is partially visible.

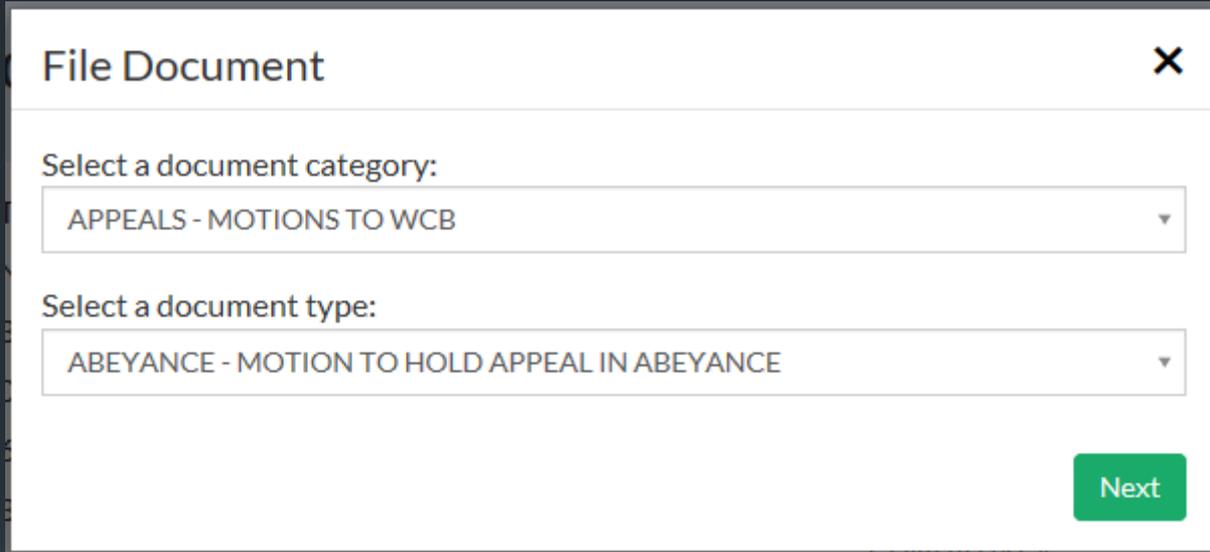
By clicking the Select a File button below, you will be prompted to select the Notice file from your computer to attach. Please note that the file must be in PDF or .jpg format and may not be more than 20 MB in size. Once the file has been attached, clicking the Finish button will submit the document to DWC.

File Document ✕

Select a Document to upload. The document must be a PDF or .jpg, and its size must be less than 20MB.

0bb576_10420326e31d4d9080c43c4619748a1f.pdf

To file a Motion to Hold Appeal in Abeyance select “Appeals – Motions to WCB” from the available document categories and “Abeyance – Motion to Hold Appeal in Abeyance” from the available document types.



The screenshot shows a 'File Document' dialog box with a close button (X) in the top right corner. It contains two dropdown menus. The first dropdown is labeled 'Select a document category:' and has 'APPEALS - MOTIONS TO WCB' selected. The second dropdown is labeled 'Select a document type:' and has 'ABEYANCE - MOTION TO HOLD APPEAL IN ABEYANCE' selected. A green 'Next' button is located at the bottom right of the form.

File Document ✕

Select a document category:

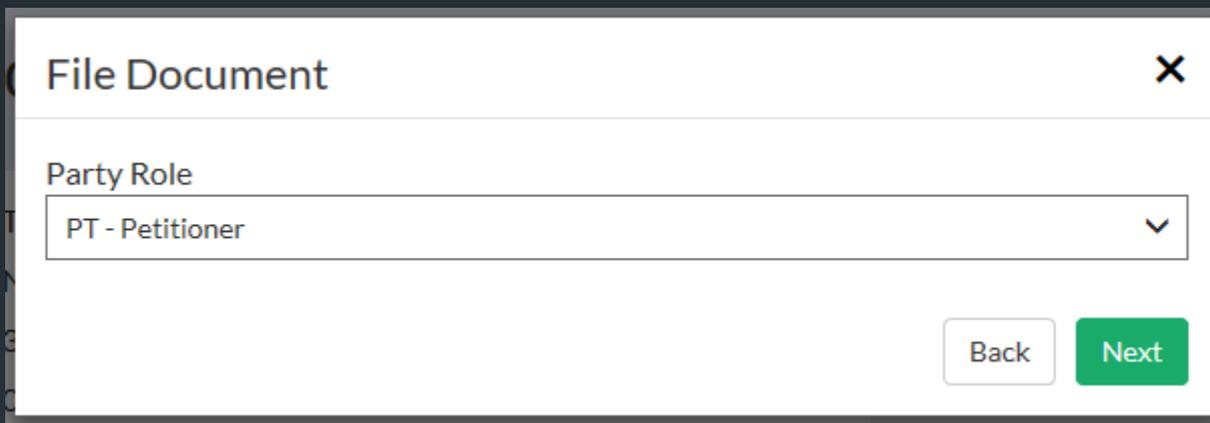
APPEALS - MOTIONS TO WCB ▾

Select a document type:

ABEYANCE - MOTION TO HOLD APPEAL IN ABEYANCE ▾

Next

The next screen requires the user to select their role in the claim.



The screenshot shows a web form titled "File Document" with a close button (X) in the top right corner. Below the title is a dropdown menu labeled "Party Role" with the selected option "PT - Petitioner" and a downward arrow. At the bottom right of the form are two buttons: "Back" and "Next".

File Document ✕

Party Role

PT - Petitioner ▾

Back Next

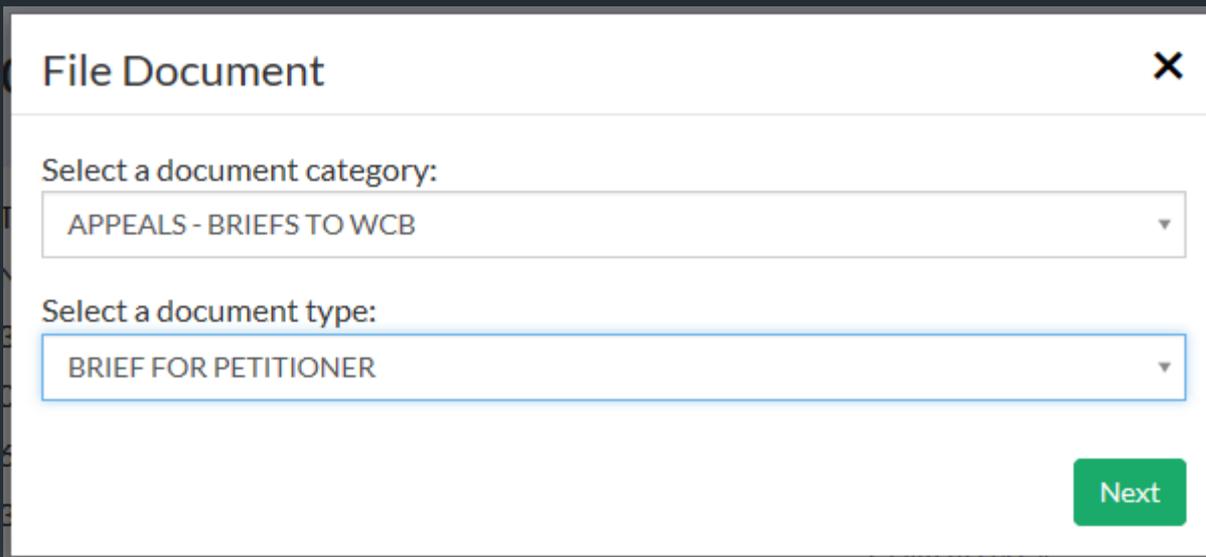
By clicking the Select a File button below, you will be prompted to select the Motion file from your computer to attach. Please note that the file must be in PDF or .jpg format and may not be more than 20 MB in size. Once the file has been attached, clicking the Finish button will submit the document to DWC.

File Document ✕

Select a Document to upload. The document must be a PDF or .jpg, and its size must be less than 20MB.

0bb576_10420326e31d4d9080c43c4619748a1f.pdf

To file a Brief to the Workers' Compensation Board, select the "Appeals – Briefs to WCB" document category and the "Brief for Petitioner" document type.



The screenshot shows a 'File Document' window with a close button (X) in the top right corner. Below the title bar, there are two dropdown menus. The first dropdown is labeled 'Select a document category:' and has 'APPEALS - BRIEFS TO WCB' selected. The second dropdown is labeled 'Select a document type:' and has 'BRIEF FOR PETITIONER' selected. A green 'Next' button is located at the bottom right of the form.

File Document ✕

Select a document category:

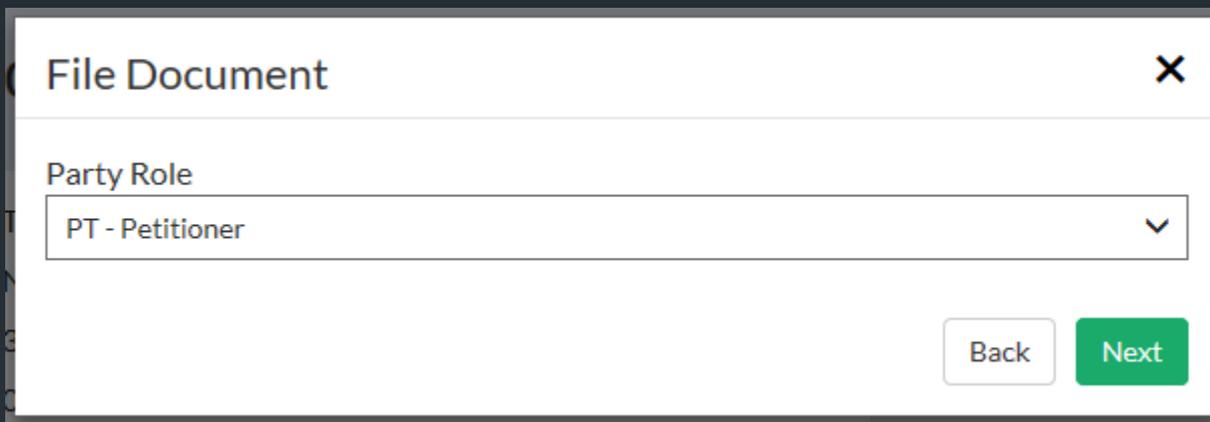
APPEALS - BRIEFS TO WCB ▾

Select a document type:

BRIEF FOR PETITIONER ▾

Next

The user must next identify their role in the claim.



The image shows a screenshot of a software interface titled "File Document". It features a dropdown menu labeled "Party Role" with the option "PT - Petitioner" selected. Below the dropdown are two buttons: "Back" and "Next". The "Next" button is highlighted in green, indicating it is the active or recommended action.

By clicking the Select a File button below, you will be prompted to select the Brief file from your computer to attach. Please note that the file must be in PDF or .jpg format and may not be more than 20 MB in size. Once the file has been attached, clicking the Finish button will submit the document to DWC.

File Document ✕

Select a Document to upload. The document must be a PDF or .jpg, and its size must be less than 20MB.

0bb576_10420326e31d4d9080c43c4619748a1f.pdf



THANK YOU!

QUESTIONS?

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