CHAPTER 70–S.F.No. 1234

An act relating to workers' compensation; making various policy and housekeeping changes; adopting advisory council recommendations; requiring a report; amending Minnesota Statutes 2012, sections 176.011, subdivisions 15, 16; 176.081, subdivisions 1, 7; 176.101, subdivision 1; 176.102, subdivisions 3a, 5, 10; 176.106, subdivisions 1, 3; 176.129, subdivision 13; 176.136, subdivision 1b; 176.138; 176.183, subdivision 4; 176.245; 176.521; 176.645; 176.83, subdivision 5.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

WORKERS' COMPENSATION DEPARTMENT PROPOSALS

Section 1. Minnesota Statutes 2012, section 176.102, subdivision 3a, is amended to read:

Subd. 3a. **Disciplinary actions.** The panel has authority to discipline qualified rehabilitation consultants and vendors and may impose a penalty of up to $3,000 per violation, payable to the commissioner for deposit in the assigned risk safety account, and may suspend or revoke certification. Complaints against registered qualified rehabilitation consultants and vendors shall be made to the commissioner who ~~shall~~ may investigate ~~all~~ complaints. If the investigation indicates a violation of this chapter or rules adopted under this chapter, the commissioner may initiate a contested case proceeding under the provisions of chapter 14. In these cases, the rehabilitation review panel shall make the final decision following receipt of the report of an administrative law judge. The decision of the panel is appealable to the Workers' Compensation Court of Appeals in the manner provided by section 176.421. The panel shall continuously study rehabilitation services and delivery, develop and recommend rehabilitation rules to the commissioner, and assist the commissioner in accomplishing public education.

The commissioner may appoint alternates for one-year terms to serve as a member when a member is unavailable. The number of alternates shall not exceed one labor member, one employer or insurer member, and one member representing a licensed or registered health care provider, chiropractic, or rehabilitation.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 2. Minnesota Statutes 2012, section 176.106, subdivision 1, is amended to read:

Subdivision 1. **Scope.** All determinations by the commissioner or compensation judge pursuant to section 176.102, 176.103, 176.135, or 176.136 shall be in accordance with the procedures contained in this section. For medical disputes under sections 176.135 and 176.136, the commissioner shall have jurisdiction to hold an administrative conference and issue decisions and orders under this section if the amount in dispute at the time the medical request is filed is $7,500 or less. The $7,500 limit does not apply if the medical issue to be determined is whether a charge for a service, article, or supply is excessive under section 176.136, subdivision 1, 1a, 1b, or 1c, and corresponding Minnesota Rules.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to medical disputes filed on or after that date.

Sec. 3. Minnesota Statutes 2012, section 176.129, subdivision 13, is amended to read:

Subd. 13. **Employer reports.** (a) All employers and insurers shall make reports to the commissioner as required for the proper administration of this section and Minnesota Statutes 1990, section 176.131, and Minnesota Statutes 1994, section 176.132. Employers and insurers may not be reimbursed from the special compensation fund for any periods unless the employer or insurer is up to date with all past due and currently due assessments, penalties, and reports to the special compensation fund under this section. The commissioner may allow an offset of the reimbursements due an employer or insurer pursuant to Minnesota Statutes 1990, section 176.131, and Minnesota Statutes 1994, section 176.132, against the assessment due under the section or against any other debt owed to the special compensation fund by the employer or insurer.

(b) Except as provided in paragraph (c), the special compensation fund shall not reimburse an insolvent insurer for subsequent injury or supplementary benefits after a declaration of bankruptcy or order of liquidation or insolvency is issued for the insurer, even if the benefits were paid before the declaration or order. This does not limit the claim distribution or set-off authority of a court, trustee, or liquidator under federal bankruptcy law or under chapter 60B or a similar law in another jurisdiction. For purposes of this paragraph, subsequent injury benefits are the benefits paid pursuant to Minnesota Statutes 1990, section 176.131, and supplementary benefits are the benefits paid pursuant to Minnesota Statutes 1994, section 176.132.

(c) The special compensation fund shall reimburse an insolvent insurer for subsequent injury or supplemental benefits after a declaration of bankruptcy or order of liquidation or insolvency to an insolvent insurer who has filed for reimbursement from the special compensation fund before June 1, 2013. This includes reimbursement for any past, pending, or future claims that may arise out of the insolvent insurer's coverage.

EFFECTIVE DATE. This section is effective the day following final enactment and applies to claims for reimbursement filed with the special compensation fund on or after that date.

Sec. 4. Minnesota Statutes 2012, section 176.138, is amended to read:

176.138 MEDICAL DATA; ACCESS.

(a) Notwithstanding any other state laws related to the privacy of medical data or any private agreements to the contrary, the release in writing, by telephone discussion, or otherwise of medical data related to a current claim for compensation under this chapter to the employee, employer, or insurer who are parties to the claim, or to the Department of Labor and Industry, shall not require prior approval of any party to the claim. This section does not preclude the release of medical data under section 175.10 or 176.231, subdivision 9. Requests for pertinent data shall be made, and the date of discussions with medical providers about medical data shall be confirmed, in writing to the person or organization that collected or currently possesses the data. Written medical data that exists at the time the request is made shall be provided by the collector or possessor within seven working days of receiving the request. Nonwritten medical data may be provided, but is not required to be provided, by the collector or possessor. In all cases of a request for the data or discussion with a medical provider about the data, except when it is the employee who is making the request, the employee shall be sent written notification of the request by the party requesting the data at the same time the request is made or a written confirmation of the discussion. This data shall be treated as private data by the party who requests or receives the data and the party receiving the data shall provide the employee or the employee's attorney with a copy of all data requested by the requester.

(b) Medical data which is not directly related to a current injury or disability shall not be released without prior authorization of the employee.

(c) The commissioner may impose a penalty of up to $600 payable to the commissioner for deposit in the assigned risk safety account against a party who does not timely release data as required in this section. A party who does not treat this data as private pursuant to this section is guilty of a misdemeanor. This paragraph applies only to written medical data which exists at the time the request is made.

(d) Workers' compensation insurers and self-insured employers may, for the sole purpose of identifying duplicate billings submitted to more than one insurer, disclose to health insurers, including all insurers writing insurance described in section 60A.06, subdivision 1, clause (5)(a), nonprofit health service plan corporations subject to chapter 62C, health maintenance organizations subject to chapter 62D, and joint self-insurance employee health plans subject to chapter 62H, computerized information about dates, coded items, and charges for medical treatment of employees and other medical billing information submitted to them by an employee, employer, health care provider, or other insurer in connection with a current claim for compensation under this chapter, without prior approval of any party to the claim. The data may not be used by the health insurer for any other purpose whatsoever and must be destroyed after verification that there has been no duplicative billing. Any person who is the subject of the data which is used in a manner not allowed by this paragraph has a cause of action for actual damages and punitive damages for a minimum of $5,000.

(e) Medical data collected, stored, used, or disseminated by or filed with the commissioner in connection with a claim for workers' compensation benefits governed by this chapter does not constitute genetic information for the purposes of section 13.386.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 5. Minnesota Statutes 2012, section 176.183, subdivision 4, is amended to read:

Subd. 4. **Notice by commissioner; rights of parties.** (a) If the commissioner authorizes the special compensation fund to commence payment without the issuance of a temporary order, the commissioner shall serve by ~~certified~~ first class mail notice upon the employer and other interested parties of the intention to commence payment. This notice shall be served at least ten calendar days before commencing payment and shall be mailed to the last known address of the ~~parties~~ employer. The notice shall include a statement that failure of the employer to respond within ten calendar days of the date of service will be deemed acceptance by the employer of the proposed action by the ~~commissioner~~ special compensation fund and will be deemed a waiver of defenses the employer has to ~~a subrogation or indemnity action by the commissioner~~ the special compensation fund's action to recover amounts specified under subdivision 2. At any time prior to final determination of liability, the employer may appear as a party and present defenses the employer has, whether or not an appearance by the employer has previously been made in the matter. The ~~commissioner~~ special compensation fund has a cause of action against the employer to recover ~~compensation paid by the special fund under this section~~ amounts specified under subdivision 2.

(b) The commissioner shall notify the employer by first class mail if the special compensation fund intends to enter into a settlement agreement with the employee for the payment of benefits under this section. This notice shall be sent by first class mail to the last known address of the employer at least 15 calendar days before executing the settlement agreement, and shall include:

(1) a copy of the proposed settlement agreement;

(2) a statement that within 15 calendar days the employer must notify the special compensation fund in writing of its objection to the proposed settlement; and

(3) a statement that if the special compensation fund does not receive the employer's written objection within 15 calendar days, the employer must be deemed to have waived all defenses to the special compensation fund's claim for amounts specified under subdivision 2.

(c) If a settlement agreement is approved by the commissioner or compensation judge after the commissioner has provided notice to the employer under paragraph (b), and if the employer did not provide timely written notification to the special compensation fund of the employer's objection, then the employer must be deemed to have waived all defenses to the special compensation fund's claim for amounts specified under subdivision 2.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 6. Minnesota Statutes 2012, section 176.245, is amended to read:

176.245 RECEIPTS FOR PAYMENT OF COMPENSATION, FILING.

An employer shall promptly file with the division receipts for payment of compensation as may be required by the rules of the division.

The commissioner of the Department of Labor and Industry shall periodically check its records to determine whether these receipts have been promptly filed, and if not, shall require the employer to do so. The commissioner may determine~~, using statistical methodology similar to Six Sigma,~~ the most efficient manner of reviewing or auditing the records filed under this chapter, including using sampling methodology, to determine compliance with this chapter.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 7. Minnesota Statutes 2012, section 176.521, is amended to read:

176.521 SETTLEMENT OF CLAIMS.

Subdivision 1. **Validity.** (a) An agreement between an employee or an employee's dependent and the employer or insurer to settle any claim~~, which is not upon appeal before the court of appeals,~~ for compensation under this chapter is valid where it has been executed in writing and signed by the parties and intervenors in the matter, and, where one or more of the parties is not represented by an attorney, the commissioner or a compensation judge has approved the settlement and made an award thereon. If the matter is upon appeal before the ~~Court of Appeals or~~ district court, the ~~court of appeals or~~ district court is the approving body. An agreement to settle any claim is not valid if a guardian or conservator is required under section 176.092 and an employee or dependent has no guardian or conservator.

(b) If the matter is on appeal before the workers' compensation court of appeals, the proposed settlement shall be submitted for approval to a compensation judge at the Office of Administrative Hearings. Before the settlement is submitted to the compensation judge, the parties shall notify the workers' compensation court of appeals and request that it suspend further action on the appeal pending review of the settlement by the compensation judge. Within 14 days after the compensation judge's final approval or disapproval of the settlement, the parties shall notify the workers' compensation court of appeals of the compensation judge's action and shall request that the appeal be dismissed or reactivated.

Subd. 2. **Approval.** Settlements shall be approved only if the terms conform with this chapter.

The commissioner, a compensation judge, ~~the court of appeals,~~ and the district court shall exercise discretion in approving or disapproving a proposed settlement.

The parties to the agreement of settlement have the burden of proving that the settlement is reasonable, fair, and in conformity with this chapter. A settlement agreement where both the employee or the employee's

dependent and the employer or insurer are represented by an attorney shall be conclusively presumed to be reasonable, fair, and in conformity with this chapter except when the settlement purports to be a full, final, and complete settlement of an employee's right to medical compensation under this chapter or rehabilitation under section 176.102. A settlement which purports to do so must be approved by the commissioner~~,~~ or a compensation judge~~, or court of appeals~~.

The conclusive presumption in this subdivision is not available in cases involving an employee or dependent with a guardian or conservator.

The conclusive presumption in this subdivision applies to a settlement agreement entered into on or after January 15, 1982, whether the injury to which the settlement applies occurred prior to or on or after January 15, 1982.

Subd. 2a. **Settlements not subject to approval.** When a settled case is not subject to approval, upon receipt of the stipulation for settlement, the commissioner~~,~~ or a compensation judge~~, or the court of appeals~~ shall immediately sign the award and file it with the commissioner. Payment pursuant to the award shall be made within 14 days after it is filed with the commissioner. The commissioner may correct mathematical or clerical errors at any time.

Subd. 3. **Setting aside award upon settlement.** Notwithstanding the provisions of subdivision 1, 2, or 2a, or any provision in the agreement of settlement to the contrary, upon the filing of a petition by any party to the settlement, the workers' compensation court of appeals may set aside an award made upon a settlement, pursuant to this chapter. In appropriate cases, the workers' compensation court of appeals may refer the matter to the chief administrative law judge for assignment to a compensation judge for hearing.

EFFECTIVE DATE. This section is effective for settlement agreements submitted for approval on or after July 1, 2013.

ARTICLE 2

WORKERS' COMPENSATION ADVISORY COUNCIL RECOMMENDATIONS

Section 1. Minnesota Statutes 2012, section 176.011, subdivision 15, is amended to read:

Subd. 15. **Occupational disease.** (a) "Occupational disease" means a mental impairment as defined in paragraph (d) or physical disease arising out of and in the course of employment peculiar to the occupation in which the employee is engaged and due to causes in excess of the hazards ordinary of employment and shall include undulant fever. Physical stimulus resulting in mental injury and mental stimulus resulting in physical injury shall remain compensable. Mental impairment is not considered a disease if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer. Ordinary diseases of life to which the general public is equally exposed outside of employment are not compensable, except where the diseases follow as an incident of an occupational disease, or where the exposure peculiar to the occupation makes the disease an occupational disease hazard. A disease arises out of the employment only if there be a direct causal connection between the conditions under which the work is performed and if the occupational disease follows as a natural incident of the work as a result of the exposure occasioned by the nature of the employment. An employer is not liable for compensation for any occupational disease which cannot be traced to the employment as a direct and proximate cause and is not recognized as a hazard characteristic of and peculiar to the trade, occupation, process, or employment or which results from a hazard to which the worker would have been equally exposed outside of the employment.

(b) If immediately preceding the date of disablement or death, an employee was employed on active duty with an organized fire or police department of any municipality, as a member of the Minnesota State

Patrol, conservation officer service, state crime bureau, as a forest officer by the Department of Natural Resources, state correctional officer, or sheriff or full-time deputy sheriff of any county, and the disease is that of myocarditis, coronary sclerosis, pneumonia or its sequel, and at the time of employment such employee was given a thorough physical examination by a licensed doctor of medicine, and a written report thereof has been made and filed with such organized fire or police department, with the Minnesota State Patrol, conservation officer service, state crime bureau, Department of Natural Resources, Department of Corrections, or sheriff's department of any county, which examination and report negatived any evidence of myocarditis, coronary sclerosis, pneumonia or its sequel, the disease is presumptively an occupational disease and shall be presumed to have been due to the nature of employment. If immediately preceding the date of disablement or death, any individual who by nature of their position provides emergency medical care, or an employee who was employed as a licensed police officer under section 626.84, subdivision 1; firefighter; paramedic; state correctional officer; emergency medical technician; or licensed nurse providing emergency medical care; and who contracts an infectious or communicable disease to which the employee was exposed in the course of employment outside of a hospital, then the disease is presumptively an occupational disease and shall be presumed to have been due to the nature of employment and the presumption may be rebutted by substantial factors brought by the employer or insurer. Any substantial factors which shall be used to rebut this presumption and which are known to the employer or insurer at the time of the denial of liability shall be communicated to the employee on the denial of liability.

(c) A firefighter on active duty with an organized fire department who is unable to perform duties in the department by reason of a disabling cancer of a type caused by exposure to heat, radiation, or a known or suspected carcinogen, as defined by the International Agency for Research on Cancer, and the carcinogen is reasonably linked to the disabling cancer, is presumed to have an occupational disease under paragraph (a). If a firefighter who enters the service after August 1, 1988, is examined by a physician prior to being hired and the examination discloses the existence of a cancer of a type described in this paragraph, the firefighter is not entitled to the presumption unless a subsequent medical determination is made that the firefighter no longer has the cancer.

(d) For the purposes of this chapter, "mental impairment" means a diagnosis of post-traumatic stress disorder by a licensed psychiatrist or psychologist. For the purpose of this chapter, "post-traumatic stress disorder" means the condition as described in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association.

Sec. 2. Minnesota Statutes 2012, section 176.011, subdivision 16, is amended to read:

Subd. 16. **Personal injury.** "Personal injury" means any mental impairment as defined in subdivision 15, paragraph (d), or physical injury arising out of and in the course of employment and includes personal injury caused by occupational disease; but does not cover an employee except while engaged in, on, or about the premises where the employee's services require the employee's presence as a part of that service at the time of the injury and during the hours of that service. Where the employer regularly furnished transportation to employees to and from the place of employment, those employees are subject to this chapter while being so transported. Physical stimulus resulting in mental injury and mental stimulus resulting in physical injury shall remain compensable. Mental impairment is not considered a personal injury if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer. Personal injury does not include an injury caused by the act of a third person or fellow employee intended to injure the employee because of personal reasons, and not directed against the employee as an employee, or because of the employment. An injury or disease resulting from a vaccine in response to a declaration by the Secretary of the United States Department of Health and Human Services under the Public Health Service Act to address an actual or potential health risk related to the employee's employment is an injury or disease arising out of and in the course of employment.

Sec. 3. Minnesota Statutes 2012, section 176.081, subdivision 1, is amended to read:

Subdivision 1. **Limitation of fees.** (a) A fee for legal services of ~~25~~ 20 percent of the first ~~$4,000 of compensation awarded to the employee and 20 percent of the next $60,000~~ $130,000 of compensation awarded to the employee is the maximum permissible fee and does not require approval by the commissioner, compensation judge, or any other party. All fees, including fees for obtaining medical or rehabilitation benefits, must be calculated according to the formula under this subdivision, except as otherwise provided in clause (1) or (2).

(1) The contingent attorney fee for recovery of monetary benefits according to the formula in this section is presumed to be adequate to cover recovery of medical and rehabilitation benefit or services concurrently in dispute. Attorney fees for recovery of medical or rehabilitation benefits or services shall be assessed against the employer or insurer only if the attorney establishes that the contingent fee is inadequate to reasonably compensate the attorney for representing the employee in the medical or rehabilitation dispute. In cases where the contingent fee is inadequate the employer or insurer is liable for attorney fees based on the formula in this subdivision or in clause (2).

For the purposes of applying the formula where the employer or insurer is liable for attorney fees, the amount of compensation awarded for obtaining disputed medical and rehabilitation benefits under sections 176.102, 176.135, and 176.136 shall be the dollar value of the medical or rehabilitation benefit awarded, where ascertainable.

(2) The maximum attorney fee for obtaining a change of doctor or qualified rehabilitation consultant, or any other disputed medical or rehabilitation benefit for which a dollar value is not reasonably ascertainable, is the amount charged in hourly fees for the representation or $500, whichever is less, to be paid by the employer or insurer.

(3) The fees for obtaining disputed medical or rehabilitation benefits are included in the ~~$13,000~~ $26,000 limit in paragraph (b). An attorney must concurrently file all outstanding disputed issues. An attorney is not entitled to attorney fees for representation in any issue which could reasonably have been addressed during the pendency of other issues for the same injury.

(b) All fees for legal services related to the same injury are cumulative and may not exceed ~~$13,000~~ $26,000. If multiple injuries are the subject of a dispute, the commissioner, compensation judge, or court of appeals shall specify the attorney fee attributable to each injury.

(c) If the employer or the insurer or the defendant is given written notice of claims for legal services or disbursements, the claim shall be a lien against the amount paid or payable as compensation. Subject to the foregoing maximum amount for attorney fees, up to ~~25~~ 20 percent of the first ~~$4,000~~ $130,000 of periodic compensation awarded to the employee ~~and 20 percent of the next $60,000 of periodic compensation awarded to the employee~~ may be withheld from the periodic payments for attorney fees or disbursements if the payor of the funds clearly indicates on the check or draft issued to the employee for payment the purpose of the withholding, the name of the attorney, the amount withheld, and the gross amount of the compensation payment before withholding. In no case shall fees be calculated on the basis of any undisputed portion of compensation awards. Allowable fees under this chapter shall be based solely upon genuinely disputed claims or portions of claims, including disputes related to the payment of rehabilitation benefits or to other aspects of a rehabilitation plan. The existence of a dispute is dependent upon a disagreement after the employer or insurer has had adequate time and information to take a position on liability. Neither the holding of a hearing nor the filing of an application for a hearing alone may determine the existence of a dispute. Except where the employee is represented by an attorney in other litigation pending at the department or at the Office of Administrative Hearings, a fee may not be charged after June 1, 1996, for services with respect to a medical or rehabilitation issue arising under section 176.102, 176.135, or 176.136

performed before the employee has consulted with the department and the department certifies that there is a dispute and that it has tried to resolve the dispute.

(d) An attorney who is claiming legal fees for representing an employee in a workers' compensation matter shall file a statement of attorney fees with the commissioner, compensation judge before whom the matter was heard, or Workers' Compensation Court of Appeals on cases before the court. A copy of the signed retainer agreement shall also be filed. The employee and insurer shall receive a copy of the statement. The statement shall be on a form prescribed by the commissioner and shall report the number of hours spent on the case.

(e) Employers and insurers may not pay attorney fees or wages for legal services of more than ~~$13,000~~ $26,000 per case.

(f) An attorney must file a statement of attorney fees within 12 months of the date the attorney has submitted the written notice specified in paragraph (c). If the attorney has not filed a statement of attorney fees within the 12 months, the attorney must send a renewed notice of lien to the insurer. If 12 months have elapsed since the last notice of lien has been received by the insurer and no statement of attorney fees has been filed, the insurer must release the withheld money to the employee, except that before releasing the money to the employee, the insurer must give the attorney 30 days' written notice of the pending release. The insurer must not release the money if the attorney files a statement of attorney fees within the 30 days.

Sec. 4. Minnesota Statutes 2012, section 176.081, subdivision 7, is amended to read:

Subd. 7. **Award; additional amount.** If the employer or insurer files a denial of liability, notice of discontinuance, or fails to make payment of compensation or medical expenses within the statutory period after notice of injury or occupational disease, or otherwise unsuccessfully resists the payment of compensation or medical expenses, or unsuccessfully disputes the payment of rehabilitation benefits or other aspects of a rehabilitation plan, and the injured person has employed an attorney at law, who successfully procures payment on behalf of the employee or who enables the resolution of a dispute with respect to a rehabilitation plan, the compensation judge, commissioner, or the Workers' Compensation Court of Appeals upon appeal, upon application, shall award to the employee against the insurer or self-insured employer or uninsured employer, in addition to the compensation benefits paid or awarded to the employee, an amount equal to 30 percent of that portion of the attorney's fee which has been awarded pursuant to this section that is in excess of $250. This subdivision shall apply only to contingent fees payable from the employee's compensation benefits, and not to other fees paid by the employer and insurer, including but not limited to those fees payable for resolution of a medical dispute or rehabilitation dispute, or pursuant to section 176.191.

Sec. 5. Minnesota Statutes 2012, section 176.101, subdivision 1, is amended to read:

Subdivision 1. **Temporary total disability.** (a) For injury producing temporary total disability, the compensation is 66-2/3 percent of the weekly wage at the time of injury.

(b)(1) Commencing on October 1, ~~2008~~ 2013, and each October 1 thereafter, the maximum weekly compensation payable is ~~$850 per week~~ 102 percent of the statewide average weekly wage for the period ending December 31 of the preceding year.

(2) The Workers' Compensation Advisory Council may consider adjustment increases and make recommendations to the legislature.

(c) The minimum weekly compensation payable is $130 per week or the injured employee's actual weekly wage, whichever is less.

(d) Temporary total compensation shall be paid during the period of disability subject to the cessation and recommencement conditions in paragraphs (e) to (l).

(e) Temporary total disability compensation shall cease when the employee returns to work. Except as otherwise provided in section 176.102, subdivision 11, temporary total disability compensation may only be recommenced following cessation under this paragraph, paragraph (h), or paragraph (j) prior to payment of 130 weeks of temporary total disability compensation and only as follows:

(1) if temporary total disability compensation ceased because the employee returned to work, it may be recommenced if the employee is laid off or terminated for reasons other than misconduct if the layoff or termination occurs prior to 90 days after the employee has reached maximum medical improvement. Recommenced temporary total disability compensation under this clause ceases when any of the cessation events in paragraphs (e) to (l) occurs; or

(2) if temporary total disability compensation ceased because the employee returned to work or ceased under paragraph (h) or (j), it may be recommenced if the employee is medically unable to continue at a job due to the injury. Where the employee is medically unable to continue working due to the injury, temporary total disability compensation may continue until any of the cessation events in paragraphs (e) to (l) occurs following recommencement. If an employee who has not yet received temporary total disability compensation becomes medically unable to continue working due to the injury after reaching maximum medical improvement, temporary total disability compensation shall commence and shall continue until any of the events in paragraphs (e) to (l) occurs following commencement. For purposes of commencement or recommencement under this clause only, a new period of maximum medical improvement under paragraph (j) begins when the employee becomes medically unable to continue working due to the injury. Temporary total disability compensation may not be recommenced under this clause and a new period of maximum medical improvement does not begin if the employee is not actively employed when the employee becomes medically unable to work. All periods of initial and recommenced temporary total disability compensation are included in the 130-week limitation specified in paragraph (k).

(f) Temporary total disability compensation shall cease if the employee withdraws from the labor market. Temporary total disability compensation may be recommenced following cessation under this paragraph only if the employee reenters the labor market prior to 90 days after the employee reached maximum medical improvement and prior to payment of 130 weeks of temporary total disability compensation. Once recommenced, temporary total disability ceases when any of the cessation events in paragraphs (e) to (l) occurs.

(g) Temporary total disability compensation shall cease if the total disability ends and the employee fails to diligently search for appropriate work within the employee's physical restrictions. Temporary total disability compensation may be recommenced following cessation under this paragraph only if the employee begins diligently searching for appropriate work within the employee's physical restrictions prior to 90 days after maximum medical improvement and prior to payment of 130 weeks of temporary total disability compensation. Once recommenced, temporary total disability compensation ceases when any of the cessation events in paragraphs (e) to (l) occurs.

(h) Temporary total disability compensation shall cease if the employee has been released to work without any physical restrictions caused by the work injury.

(i) Temporary total disability compensation shall cease if the employee refuses an offer of work that is consistent with a plan of rehabilitation filed with the commissioner which meets the requirements of section 176.102, subdivision 4, or, if no plan has been filed, the employee refuses an offer of gainful employment that the employee can do in the employee's physical condition. Once temporary total disability compensation has ceased under this paragraph, it may not be recommenced.

(j) Temporary total disability compensation shall cease 90 days after the employee has reached maximum medical improvement, except as provided in section 176.102, subdivision 11, paragraph (b). For purposes of this subdivision, the 90-day period after maximum medical improvement commences on the

earlier of: (1) the date that the employee receives a written medical report indicating that the employee has reached maximum medical improvement; or (2) the date that the employer or insurer serves the report on the employee and the employee's attorney, if any. Once temporary total disability compensation has ceased under this paragraph, it may not be recommenced except if the employee returns to work and is subsequently medically unable to continue working as provided in paragraph (e), clause (2).

(k) Temporary total disability compensation shall cease entirely when 130 weeks of temporary total disability compensation have been paid, except as provided in section 176.102, subdivision 11, paragraph (b). Notwithstanding anything in this section to the contrary, initial and recommenced temporary total disability compensation combined shall not be paid for more than 130 weeks, regardless of the number of weeks that have elapsed since the injury, except that if the employee is in a retraining plan approved under section 176.102, subdivision 11, the 130-week limitation shall not apply during the retraining, but is subject to the limitation before the plan begins and after the plan ends.

(l) Paragraphs (e) to (k) do not limit other grounds under law to suspend or discontinue temporary total disability compensation provided under this chapter.

(m) Once an employee has been paid 52 weeks of temporary total compensation, the employer or insurer must notify the employee in writing of the 130-week limitation on payment of temporary total compensation. A copy of this notice must also be filed with the department.

Sec. 6. Minnesota Statutes 2012, section 176.102, subdivision 5, is amended to read:

Subd. 5. **On-the-job training; job development limitation.** (a) On-the-job training is to be given consideration in developing a rehabilitation plan especially where it would produce an economic status similar to that enjoyed prior to disability.

(b) For purposes of this subdivision, job development means systematic contact with prospective employers resulting in opportunities for interviews and employment that might not otherwise have existed, and includes identification of job leads and arranging for job interviews. Job development facilitates a prospective employer's consideration of a qualified employee for employment. Job development services provided by a qualified rehabilitation consultant firm or a registered rehabilitation vendor must not exceed 20 hours per month or 26 consecutive or intermittent weeks. When 13 consecutive or intermittent weeks of job development services have been provided, the qualified rehabilitation consultant must consult with the parties and either file a plan amendment reflecting an agreement by the parties to extend job development services for up to an additional 13 consecutive or intermittent weeks, or file a request for a rehabilitation conference under section 176.106. The commissioner or compensation judge may issue an order modifying the rehabilitation plan or make other determinations about the employee's rehabilitation, but must not order more than 26 total consecutive or intermittent weeks of job development services.

Sec. 7. Minnesota Statutes 2012, section 176.102, subdivision 10, is amended to read:

Subd. 10. **Rehabilitation; consultants and vendors.** (a) The commissioner shall approve rehabilitation consultants who may propose and implement plans if they satisfy rules adopted by the commissioner for rehabilitation consultants. A consultant may be an individual or public or private entity, and except for rehabilitation services, Department of Employment and Economic Development, a consultant may not be a vendor or the agent of a vendor of rehabilitation services. The commissioner shall also approve rehabilitation vendors if they satisfy rules adopted by the commissioner.

(b) An individual qualified rehabilitation consultant registered by the commissioner must not provide any medical, rehabilitation, or disability case management services related to an injury that is compensable under this chapter when these services are part of the same claim, unless the case management services are part of an approved rehabilitation plan.

Sec. 8. Minnesota Statutes 2012, section 176.106, subdivision 3, is amended to read:

Subd. 3. **Conference.** The matter shall be scheduled for an administrative conference within 60 days after receipt of the request for a conference, except that an administrative conference on a rehabilitation issue under section 176.102 must be held within 21 days, unless the issue involves only fees for rehabilitation services that have already been provided or there is good cause for holding the conference later than 21 days. If there is a rehabilitation plan in effect, the qualified rehabilitation consultant must continue to provide reasonable services under the plan until the date the conference was initially scheduled to be held. Notice of the conference shall be served on all parties no later than 14 days prior to the conference, unless the commissioner or compensation judge determines that a conference shall not be held. The commissioner or compensation judge may order an administrative conference before the commissioner's designee whether or not a request for conference is filed.

The commissioner or compensation judge may refuse to hold an administrative conference and refer the matter for a settlement or pretrial conference or may certify the matter to the Office of Administrative Hearings for a full hearing before a compensation judge.

Sec. 9. Minnesota Statutes 2012, section 176.136, subdivision 1b, is amended to read:

Subd. 1b. **Limitation of liability.** (a) The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a small hospital shall be the hospital's usual and customary charge, unless the charge is determined by the commissioner or a compensation judge to be unreasonably excessive. A "small hospital," for purposes of this paragraph, is a hospital which has 100 or fewer licensed beds.

(b) The liability of the employer for the treatment, articles, and supplies that are not limited by subdivision 1a or 1c or paragraph (a) shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower. On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph. A prevailing charge established under Minnesota Rules, part 5221.0500, subpart 2, must be based on no more than two years of billing data immediately preceding the date of the service.

(c) The limitation of liability for charges provided by paragraph (b) does not apply to a nursing home that participates in the medical assistance program and whose rates are established by the commissioner of human services.

(d) An employer's liability for treatment, articles, and supplies provided under this chapter by a health care provider located outside of Minnesota is limited to the payment that the health care provider would receive if the treatment, article, or supply were paid under the workers' compensation law of the jurisdiction in which the treatment was provided.

Sec. 10. Minnesota Statutes 2012, section 176.645, is amended to read:

176.645 ADJUSTMENT OF BENEFITS.

Subdivision 1. **Amount.** For injuries occurring after October 1, 1975, for which benefits are payable under section 176.101, subdivisions 1, 2 and 4, and section 176.111, subdivision 5, the total benefits due the employee or any dependents shall be adjusted in accordance with this section. On October 1, 1981, and thereafter on the anniversary of the date of the employee's injury the total benefits due shall be adjusted by multiplying the total benefits due prior to each adjustment by a fraction, the denominator of which is the statewide average weekly wage for December 31, of the year two years previous to the adjustment and

the numerator of which is the statewide average weekly wage for December 31, of the year previous to the adjustment. For injuries occurring after October 1, 1975, all adjustments provided for in this section shall be included in computing any benefit due under this section. Any limitations of amounts due for daily or weekly compensation under this chapter shall not apply to adjustments made under this section. No adjustment increase made on or after October 1, 1977, but prior to October 1, 1992, under this section shall exceed six percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be six percent. No adjustment increase made on or after October 1, 1992, under this section shall exceed four percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be four percent. For injuries occurring on and after October 1, 1995, no adjustment increase made on or after October 1, 1995, shall exceed two percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be two percent. For injuries occurring on and after October 1, 2013, no adjustment increase shall exceed three percent a year. If the adjustment under the formula of this section would exceed three percent, the increase shall be three percent. No adjustment under this section shall be less than zero percent. The Workers' Compensation Advisory Council may consider adjustment or other further increases and make recommendations to the legislature.

Subd. 2. **Time of first adjustment.** For injuries occurring on or after October 1, 1981, the initial adjustment made pursuant to subdivision 1 is deferred until the first anniversary of the date of the injury. For injuries occurring on or after October 1, 1992, the initial adjustment under subdivision 1 is deferred until the second anniversary of the date of the injury. The adjustment made at that time shall be that of the last year only. For injuries occurring on or after October 1, 1995, the initial adjustment under subdivision 1 is deferred until the fourth anniversary of the date of injury. The adjustment at that time shall be that of the last year only. For injuries occurring on or after October 1, 2013, the initial adjustment under subdivision 1 is deferred until the third anniversary of the date of injury. The adjustment made at that time shall be that of the last year only.

Sec. 11. Minnesota Statutes 2012, section 176.83, subdivision 5, is amended to read:

Subd. 5. **Treatment standards for medical services.** (a) In consultation with the Medical Services Review Board or the rehabilitation review panel, the commissioner shall adopt rules establishing standards and procedures for health care provider treatment. The rules shall apply uniformly to all providers including those providing managed care under section 176.1351. The rules shall be used to determine whether a provider of health care services and rehabilitation services, including a provider of medical, chiropractic, podiatric, surgical, hospital, or other services, is performing procedures or providing services at a level or with a frequency that is excessive, unnecessary, or inappropriate under section 176.135, subdivision 1, based upon accepted medical standards for quality health care and accepted rehabilitation standards.

(b) The rules shall include, but are not limited to, the following:

(1) criteria for diagnosis and treatment of the most common work-related injuries including, but not limited to, low back injuries and upper extremity repetitive trauma injuries;

(2) criteria for surgical procedures including, but not limited to, diagnosis, prior conservative treatment, supporting diagnostic imaging and testing, and anticipated outcome criteria;

(3) criteria for use of appliances, adaptive equipment, and use of health clubs or other exercise facilities;

(4) criteria for diagnostic imaging procedures;

(5) criteria for inpatient hospitalization; ~~and~~

(6) criteria for treatment of chronic pain; and

(7) criteria for the long-term use of opioids or other scheduled medications to alleviate intractable pain and improve function, including the use of written contracts between the injured worker and the health care provider who prescribes the medication.

(c) If it is determined by the payer that the level, frequency, or cost of a procedure or service of a provider is excessive, unnecessary, or inappropriate according to the standards established by the rules, the provider shall not be paid for the procedure, service, or cost by an insurer, self-insurer, or group self-insurer, and the provider shall not be reimbursed or attempt to collect reimbursement for the procedure, service, or cost from any other source, including the employee, another insurer, the special compensation fund, or any government program unless the commissioner or compensation judge determines at a hearing or administrative conference that the level, frequency, or cost was not excessive under the rules in which case the insurer, self-insurer, or group self-insurer shall make the payment deemed reasonable.

(d) A rehabilitation provider who is determined by the rehabilitation review panel board, after hearing, to be consistently performing procedures or providing services at an excessive level or cost may be prohibited from receiving any further reimbursement for procedures or services provided under this chapter. A prohibition imposed on a provider under this subdivision may be grounds for revocation or suspension of the provider's license or certificate of registration to provide health care or rehabilitation service in Minnesota by the appropriate licensing or certifying body. The commissioner and Medical Services Review Board shall review excessive, inappropriate, or unnecessary health care provider treatment under section 176.103.

Sec. 12. **PATIENT ADVOCATE PILOT PROGRAM.**

The commissioner of labor and industry shall implement a two-year patient advocate program for employees with back injuries who are considering back fusion surgery. The purpose of the program is to ensure that injured workers understand their treatment options and receive treatment for their work injuries according to accepted medical standards. The services provided by the patient advocate shall be paid for from the special compensation fund.

Sec. 13. **REIMBURSEMENT COST STUDY.**

The commissioner of labor and industry shall study the effectiveness and costs of potential reforms and barriers within the workers' compensation carrier and health care provider reimbursement system, including, but not limited to, carrier administrative costs, prompt payment, uniform claim components, and the effect on provider reimbursements and injured worker co-payments of implementing the subjects studied. The commissioner shall consult with interested stakeholders including health care providers, workers' compensation insurance carriers, and representatives of business and labor to provide relevant data promptly to the department to complete the study. The commissioner shall report findings and recommendations to the Workers' Compensation Advisory Council by December 31, 2013.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 14. **EFFECTIVE DATE.**

(a) Sections 1 to 6 and 10 are effective for employees with dates of injury occurring on or after October 1, 2013.

(b) Sections 7, 8, and 12 are effective on October 1, 2013.

(c) Section 9 is effective on October 1, 2013, and shall be used to establish prevailing charges on or after that date.

(d) Section 11 is effective October 1, 2013, and applies to employees with all dates of injury who receive treatment after the rules are adopted.

Presented to the governor May 13, 2013

Signed by the governor May 16, 2013, 5:40 p.m.