CHAPTER 182--H.F.No. 2658

An act relating to workers' compensation; adopting the recommendations of the Workers' Compensation Advisory Council;amending Minnesota Statutes 2012, sections 176.129, subdivisions 2a, 7; 176.135, subdivision 7; 176.136, subdivision 1a; 176.231, subdivision 2; 176.305, subdivision 1a; Minnesota Statutes 2013 Supplement, section 176.011, subdivision 15; repealing Minnesota Statutes 2012, sections 175.006, subdivision 1; 175.08; 175.14; 175.26; 176.1311; 176.136, subdivision 3; 176.2615; 176.641.

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

Section 1. Minnesota Statutes 2013 Supplement, 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 occu-

pational 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 purposes 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. For purposes of section 79.34, subdivision 2, one or more compensable mental impairment claims arising out of a single event or occurrence shall constitute a single loss occurrence.

EFFECTIVE DATE. This section is effective for employees with dates of injury on or after October 1, 2013.

Sec. 2. Minnesota Statutes 2012, section 176.129, subdivision 2a, is amended to read:

Subd. 2a. **Payments to fund.** (a) On or before April 1 of each year, all self-insured employers shall report paid indemnity losses and insurers shall report paid indemnity losses and standard workers' compensation premium in the form and manner prescribed by the commissioner. On June 1 of each year, the commissioner shall determine the total amount needed to pay all estimated liabilities, including administrative expenses, of the special compensation fund for the following fiscal year. The commissioner shall assess this amount against self-insured employers and insurers. The total amount of the assessment must be allocated between self-insured employers and insured employers based on paid indemnity losses for the preceding calendar year, as provided by paragraph (b). The method of assessing self-insured employers must be based on paid indemnity losses, as provided by paragraph (c). The method of assessing insured employers is based on standard workers' compensation premium, as provided by paragraph (c). Each insurer shall collect the assessment through a policyholder surcharge as provided by paragraph (d). On or before June 30 of each year, the commissioner shall provide notification to each self-insured employer and insurer of amounts due. Each self-insured employer and each insurer shall pay at least one-half of the amount due to the commissioner for deposit into the special compensation fund on or before August 1 of the same calendar year. The remaining balance is due on February 1 of the following calendar year. Each insurer must pay the full amount due as stated in the commissioner's notification, regardless of the amount the insurer actually collects from the ~~premium~~ policyholder surcharge.

(b) The portion of the total assessment that is allocated to self-insured employers is the proportion that paid indemnity losses made by all self-insured employers bore to the total paid indemnity losses made by all self-insured employers and insured employers during the preceding calendar year. The portion of the total assessment that is allocated to insured employers is the proportion that paid indemnity losses made on

behalf of all insured employers bore to the total paid indemnity losses made by all self-insured employers and insured employers during the preceding calendar year.

(c) The portion of the total assessment allocated to self-insured employers that shall be paid by each self-insured employer must be based upon paid indemnity losses made by that self-insured employer during the preceding calendar year. The portion of the total assessment allocated to insured employers that is paid by each insurer must be based on standard workers' compensation premium earned in the state by that insurer during the ~~preceding~~ current calendar year. If the current calendar year earned standard workers' compensation premium is not available, the commissioner shall estimate the portion of the total assessment allocated to insured employers that is paid by each insurer using the earned standard workers' compensation premium from the preceding calendar year. The commissioner shall then perform a reconciliation and final determination of the portion of the total assessment to be paid by each insurer when the earned standard workers' compensation premium for the current calendar year is calculable, but the final determination must not be made after December 1 of the following calendar year. An employer who has ceased to be self-insured shall continue to be liable for assessments based on paid indemnity losses arising out of injuries occurring during periods when the employer was self-insured, unless the self-insured employer has purchased a replacement policy covering those losses. An insurer who assumes a self-insured employer's obligation under a replacement policy shall separately report and pay assessments based on indemnity losses paid by the insurer under the replacement policy. The replacement policy may provide for reimbursement of the assessment to the insurer by the self-insured employer.

(d) Insurers shall collect the assessments from their insured employers through a surcharge based on standard workers' compensation premium for each employer. Assessments when collected do not constitute an element of loss for the purpose of establishing rates for workers' compensation insurance but for the purpose of collection are treated as separate costs imposed on insured employers. The ~~premium~~ policyholder surcharge is included in the definition of gross premium as defined in section 297I.01 only for premium tax purposes. An insurer may cancel a policy for nonpayment of the ~~premium~~ policyholder surcharge. The ~~premium~~ policyholder surcharge is excluded from the definition of premium for all other purposes, except as otherwise provided in this paragraph.

(e) For purposes of this section, the workers' compensation assigned risk plan established under section 79.252, shall report and pay assessments on standard workers' compensation premium in the same manner as an insurer.

EFFECTIVE DATE. This section is effective for assessments due under Minnesota Statutes, section 176.129, subdivision 2a, paragraph (a), on August 1, 2013, and February 1, 2014, and for the first reconciliation and final determination under Minnesota Statutes, section 176.129, subdivision 2a, paragraph (c), due on or before December 1, 2014.

Sec. 3. Minnesota Statutes 2012, section 176.129, subdivision 7, is amended to read:

Subd. 7. **Refunds.** In case deposit is or has been made pursuant to subdivision 2a by mistake or inadvertence, or under circumstances that justice requires a refund, the commissioner of management and budget is authorized to refund the deposit under order of the commissioner, a compensation judge, the Workers' Compensation Court of Appeals, or a district court. Claims for refunds must be submitted to the commissioner within three years of the ~~assessment due~~ date of reconciliation and final determination under

subdivision 2a. There is appropriated to the commissioner from the fund an amount sufficient to make the refund and payment.

EFFECTIVE DATE. This section is effective for assessments due under Minnesota Statutes, section 176.129, subdivision 2a, paragraph (a), on August 1, 2013, and February 1, 2014, and for the first reconciliation and final determination under Minnesota Statutes, section 176.129, subdivision 2a, paragraph (c), due on or before December 1, 2014.

Sec. 4. Minnesota Statutes 2012, section 176.135, subdivision 7, is amended to read:

Subd. 7. **Medical bills and records.** (a) Health care providers shall submit to the insurer an itemized statement of charges in the standard electronic transaction format when required by section 62J.536 or, if there is no prescribed standard electronic transaction format, on a billing form prescribed by the commissioner. Health care providers shall also submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury. Health care providers may charge for copies of any records or reports that are in existence and directly relate to the items for which payment is sought under this chapter. The commissioner shall adopt a schedule of reasonable charges by rule.

A health care provider shall not collect, attempt to collect, refer a bill for collection, or commence an action for collection against the employee, employer, or any other party until the information required by this section has been furnished.

A United States government facility rendering health care services to veterans is not subject to the uniform billing form requirements of this subdivision.

(b) For medical services provided under this section, the codes from the International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System (ICD-10), must be used to report medical diagnoses and hospital inpatient procedures when required by the United States Department of Health and Human Services for federal programs. The commissioner must replace the codes from the International Classification of Diseases, Ninth Edition, Clinical Modification/Procedure Coding System (ICD-9), with equivalent ICD-10 codes wherever the ICD-9 codes appear in rules adopted under this chapter. The commissioner must use the General Equivalence Mappings established by the Centers for Medicare and Medicaid Services to replace the ICD-9 diagnostic codes with ICD-10 codes in the rules.

(c) The commissioner shall amend rules adopted under this chapter as necessary to implement the ICD-10 coding system in paragraph (b). The amendments shall be adopted by giving notice in the State Register according to the procedures in section 14.386, paragraph (a). The amended rules are not subject to expiration under section 14.386, paragraph (b).

Sec. 5. Minnesota Statutes 2012, section 176.136, subdivision 1a, is amended to read:

Subd. 1a. **Relative value fee schedule.** (a) The liability of an employer for services included in the medical fee schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee, whichever is lower. The commissioner shall adopt permanent rules regulating fees allowable for medical, chiropractic, podiatric, surgical, and other health care provider treatment or service, including those provided to hospital outpatients, by implementing a relative value fee schedule. The commissioner may adopt by reference, according to the procedures in paragraph ~~(h)~~ (d), clause (2), the relative value fee schedule tables adopted for the federal Medicare program. The relative value fee schedule must contain reasonable classifications including, but not limited to, classifications that

differentiate among health care provider disciplines. The conversion factors for the original relative value fee schedule must reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in effect. The reduction need not be applied equally to all treatment or services, but must represent a gross 15 percent reduction.

(b) Effective October 1, 2005, the commissioner shall remove all scaling factors from the relative value units and establish four separate conversion factors ~~according to paragraphs (c) and (d)~~ for each of the following parts of Minnesota Rules:

(1) medical/surgical services in Minnesota Rules, part 5221.4030, as defined in part 5221.0700, subpart 3, item C, subitem (2);

(2) pathology and laboratory services in Minnesota Rules, part 5221.4040, as defined in part 5221.0700, subpart 3, item C, subitem (3);

(3) physical medicine and rehabilitation services in Minnesota Rules, part 5221.4050, as defined in part 5221.0700, subpart 3, item C, subitem (4); and

(4) chiropractic services in Minnesota Rules, part 5221.4060, as defined in part 5221.0700, subpart 3, item C, subitem (5).

~~(c) The four conversion factors established under paragraph (b) shall be calculated so that there is no change in each maximum fee for each service under the current fee schedule, except as provided in paragraphs (d) and (e).~~

~~(d) By October 1, 2006, the conversion factor for chiropractic services described in paragraph (b), clause (4), shall be increased to equal 72 percent of the conversion factor for medical/surgical services described in paragraph (b), clause (1). Beginning October 1, 2005, the increase in chiropractic conversion factor shall be phased in over two years by approximately equal percentage point increases.~~

~~(e) When adjusting the conversion factors in accordance with paragraph (g) on October 1, 2005, and October 1, 2006, the commissioner may adjust by no less than zero, all of the conversion factors as necessary to offset any overall increase in payments under the fee schedule resulting from the increase in the chiropractic conversion factor.~~

~~(f) The commissioner shall give notice of the relative value units and conversion factors established under paragraphs (b), (c), and (d) according to the procedures in section 14.386, paragraph (a). The relative value units and conversion factors established under paragraphs (b), (c), and (d) are not subject to expiration under section 14.386, paragraph (b).~~

~~(g)~~ (c) The conversion factors shall be adjusted as follows:

(1) After permanent rules have been adopted to implement this section, the conversion factors must be adjusted annually on October 1 by no more than the percentage change computed under section 176.645, but without the annual cap provided by that section.

(2) Each time the workers' compensation relative value fee schedule tables are updated under paragraph ~~(h)~~ (d), the commissioner shall adjust the conversion factors so that, for services in both fee schedules, there is no difference between the overall payment in each category of service listed in paragraph (b) under the new schedule and the overall payment for that category under the workers' compensation fee schedule most recently in effect. This adjustment must be made before making any additional adjustment under clause (1).

~~(h)~~ (d) The commissioner shall give notice of the adjusted conversion factors and updates to the relative value fee schedule as follows:

(1) The commissioner shall annually give notice in the State Register of the adjusted conversion factors and any amendments to rules to implement Medicare relative value tables incorporated by reference under this subdivision. The notices of the adjusted conversion factors and amended rules to implement the relative value tables are subject to the requirements of section 14.386, paragraph (a). The annual adjustments to the conversion factors and the medical fee schedules adopted under this section, including all previous fee schedules, are not subject to expiration under section 14.386, paragraph (b).

(2) The commissioner shall periodically, but at least once every three years, update the workers' compensation relative value tables by incorporating by reference the relative value tables in the national physician fee schedule relative value file established by the Centers for Medicare and Medicaid Services. The commissioner shall publish the notices of the incorporation by reference in the State Register at least 60 days before the tables are to become effective for purposes of payment under this section. Each notice of incorporation must state the date the incorporated tables will become effective and must include information on how the Medicare relative value tables may be obtained. The published notices of incorporation by reference and the incorporated tables are not rules subject to section 14.386 or other provisions of chapter 14, but have the force and effect of law as of the date specified in the notices.

Sec. 6. Minnesota Statutes 2012, section 176.231, subdivision 2, is amended to read:

Subd. 2. **Initial report, written report.** Where subdivision 1 requires an injury to be reported within 48 hours, the employer may make an initial report by telephone~~, telegraph,~~ or personal notice, and file a written report of the injury within seven days from its occurrence or within such time as the commissioner of labor and industry designates. All written reports of injuries required by subdivision 1 shall include the date of injury. The reports shall be on a form designed by the commissioner, with a clear copy suitable for imaging to the commissioner, one copy to the insurer, and one copy to the employee.

The employer must give the employee the "Minnesota Workers' Compensation System Employee Information Sheet" at the time the employee is given a copy of the first report of injury.

If an insurer or self-insurer repeatedly fails to pay benefits within three days of the due date, pursuant to section 176.221, the insurer or self-insurer shall be ordered by the commissioner to explain, in person, the failure to pay benefits due in a reasonable time. If prompt payments are not thereafter made, the commissioner shall refer the insurer or self-insurer to the commissioner of commerce for action pursuant to section 176.225, subdivision 4.

Sec. 7. Minnesota Statutes 2012, section 176.305, subdivision 1a, is amended to read:

Subd. 1a. **Settlement and pretrial conferences; summary decision.** The chief administrative law judge shall promptly assign the petition to a compensation judge under section 176.307, and shall schedule a settlement conference before a compensation judge, to be held no later than 180 days after a claim petition was filed, or 45 days after a petition to discontinue, objection to discontinuance, or request for formal hearing was filed.

All parties must appear at the settlement conference, either personally or by representative, must be prepared to discuss settlement of all issues, and must be prepared to discuss or present the information required by the joint rules of the division and the office. If a representative appears on behalf of a party,

the representative must have authority to fully settle the matter. The parties shall serve and file a pretrial statement no fewer than five days before the settlement conference.

If settlement is not reached, the chief administrative law judge shall schedule a hearing to be held within 90 days from the scheduled settlement conference. However, the hearing must be held earlier than 90 days from the scheduled settlement conference if this chapter requires an expedited hearing to be held at an earlier date. The hearing must be held before a compensation judge other than the compensation judge who conducted the settlement conference. The compensation judge assigned to hold the hearing may choose to conduct a pretrial conference to clarify the issues and evidence that will be presented at the hearing.

Cancellations and continuations of proceedings are disfavored but may be granted upon the showing of good cause under section 176.341, subdivision 4.

The compensation judge conducting the settlement conference may require the parties to present copies of all documentary evidence not previously filed and a summary of the evidence they will present at a formal hearing. If appropriate, a written summary decision shall be issued within ten days after the conference stating the issues and a determination of each issue. If a party fails to appear at the conference, all issues may be determined contrary to the absent party's interest, provided the party in attendance presents a prima facie case.

The summary decision is final unless a written request for a formal hearing is served on all parties and filed with the commissioner within 30 days after the date of service and filing of the summary decision. Within ten days after receipt of the request, the commissioner shall certify the matter to the office for a de novo hearing. ~~In proceedings under section 176.2615, the summary decision is final and not subject to appeal or de novo proceedings.~~

Sec. 8. **REPEALER.**

Minnesota Statutes 2012, sections 175.006, subdivision 1; 175.08; 175.14; 175.26; 176.1311; 176.136, subdivision 3; 176.2615; and 176.641, are repealed.

Presented to the governor April 29, 2014

Signed by the governor April 30, 2014, 9:52 a.m.