CHAPTER 185--H.F.No. 3873

An act relating to workers' compensation; adopting recommendations of the Workers' Compensation Advisory Council; modifying workers' compensation provisions; modifying hospital outpatient fee schedules; modifying billing, payment, and dispute resolution; defining ambulatory surgical center payments; modifying covered benefits; amending Minnesota Statutes 2016, sections 175A.05; 176.011, subdivision 15; 176.101, subdivisions 2, 2a, 4; 176.102, subdivision 11; 176.136, subdivision 1b; 176.231, subdivision 9; 176.83, subdivision 5; Minnesota Statutes 2017 Supplement, section 15A.083, subdivision 7; Laws 2017, chapter 94, article 1, section 6; proposing coding for new law in Minnesota Statutes, chapter 176.

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

ARTICLE 1

WORKERS' COMPENSATION GENERAL

Section 1. Minnesota Statutes 2017 Supplement, section 15A.083, subdivision 7, is amended to read:

Subd. 7. **Workers' Compensation Court of Appeals and compensation judges.** Salaries of judges of the Workers' Compensation Court of Appeals are ~~98.52~~ 105 percent of the salary for ~~district court~~ workers' compensation judges of the Office of Administrative Hearings. The salary of the chief judge of the Workers' Compensation Court of Appeals is ~~98.52~~ 107 percent of the salary for ~~a chief district court judge~~ workers' compensation judges of the Office of Administrative Hearings. Salaries of compensation judges are 98.52 percent of the salary of district court judges.

EFFECTIVE DATE. This section is effective June 1, 2018.

Sec. 2. Minnesota Statutes 2016, section 175A.05, is amended to read:

175A.05 QUORUM.

Subdivision 1. **Judges' quorum.** A majority of the judges of the Workers' Compensation Court of Appeals shall constitute a quorum for the exercise of the powers conferred and the duties imposed on the Workers' Compensation Court of Appeals except that all appeals shall be heard by no more than a panel of three of the five judges unless the case appealed is determined to be of exceptional importance by the chief judge prior to assignment of the case to a panel, or by a three-fifths vote of the judges prior to assignment of the case to a panel or after the case has been considered by the panel but prior to the service and filing of the decision.

Subd. 2. **Vacancy.** A vacancy shall not impair the ability of the remaining judges of the Workers' Compensation Court of Appeals to exercise all the powers and perform all of the duties of the Workers' Compensation Court of Appeals.

Subd. 3. **Retired judges.** Where the number of Workers' Compensation Court of Appeals judges available to hear a case is insufficient to constitute a quorum, the chief judge of the Workers' Compensation Court of Appeals may, with the retired judge's consent, assign a judge who is retired from the Workers' Compensation Court of Appeals or the Office of Administrative Hearings to hear any case properly assigned to a judge of the Workers' Compensation Court of Appeals. The retired judge assigned to the case may act on it with the full powers of the judge of the Workers' Compensation Court of Appeals. A retired judge performing this service shall receive pay and expenses in the amount and manner provided by law for judges serving on the court, less the amount of retirement pay the judge is receiving under chapter 352 or 490.

EFFECTIVE DATE. This section is effective June 1, 2018.

Sec. 3. Minnesota Statutes 2016, section 176.231, subdivision 9, is amended to read:

Subd. 9. **Uses ~~which~~ that may be made of reports.** (a) Reports filed with the commissioner under this section may be used in hearings held under this chapter, and for the purpose of state investigations and for statistics. These reports are available to the Department of Revenue for use in enforcing Minnesota income tax and property tax refund laws, and the information shall be protected as provided in chapter 270B.

(b) The division or Office of Administrative Hearings or Workers' Compensation Court of Appeals may permit the examination of its file by the employer, insurer, employee, or dependent of a deceased employee or any person who furnishes ~~written~~ signed authorization to do so from the employer, insurer, employee, or dependent of a deceased employee. Reports filed under this section and other information the commissioner has regarding injuries or deaths shall be made available to the Workers' Compensation Reinsurance Association for use by the association in carrying out its responsibilities under chapter 79.

(c) The division may provide the worker identification number assigned under section 176.275, subdivision 1, without a signed authorization required under paragraph (b) to an:

(1) attorney who represents one of the persons described in paragraph (b);

(2) attorney who represents an intervenor or potential intervenor under section 176.361;

(3) intervenor; or

(4) employee's assigned qualified rehabilitation consultant under section 176.102.

EFFECTIVE DATE. This section is effective June 1, 2018.

Sec. 4. **[176.2611] COORDINATION OF THE OFFICE OF ADMINISTRATIVE HEARINGS' CASE MANAGEMENT SYSTEM AND THE WORKERS' COMPENSATION IMAGING SYSTEM.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the definitions in this subdivision apply unless otherwise specified.

(b) "Commissioner" means the commissioner of labor and industry.

(c) "Department" means the Department of Labor and Industry.

(d) "Document" includes all data, whether in electronic or paper format, that is filed with or issued by the office or department related to a claim-specific dispute resolution proceeding under this section.

(e) "Office" means the Office of Administrative Hearings.

Subd. 2. **Applicability.** This section governs filing requirements pending completion of the workers' compensation modernization program and access to documents and data in the office's case management system, the workers' compensation Informix imaging system, and the system that will be developed as a result of the workers' compensation modernization program. This section prevails over any conflicting provision in this chapter, Laws 1998, chapter 366, or corresponding rules.

Subd. 3. **Documents that must be filed with the office.** Except as provided in subdivision 4 and section 176.421, all documents that require action by the office under this chapter must be filed, electronically or in paper format, with the office as required by the chief administrative law judge. Filing a document that initiates or is filed in preparation for a proceeding at the office satisfies any requirement under this chapter that the document must be filed with the commissioner.

Subd. 4. **Documents that must be filed with the commissioner.** (a) The following documents must be filed directly with the commissioner in the format and manner prescribed by the commissioner:

(1) all requests for an administrative conference under section 176.106, regardless of the amount in dispute;

(2) a motion to intervene in an administrative conference that is pending at the department;

(3) any other document related to an administrative conference that is pending at the department;

(4) an objection to a penalty assessed by the commissioner or the department;

(5) requests for medical and rehabilitation dispute certification under section 176.081, subdivision 1, paragraph (c), including related documents; and

(6) except as provided in this subdivision or subdivision 3, any other document required to be filed with the commissioner.

(b) The filing requirement in paragraph (a), clause (1), makes no changes to the jurisdictional provisions in section 176.106. A claim petition that contains only medical or rehabilitation issues, unless primary liability is disputed, is considered to be a request for an administrative conference and must be filed with the commissioner.

(c) The commissioner must refer a timely, unresolved objection to a penalty under paragraph (a), clause (4), to the office within 60 calendar days.

Subd. 5. **Form revision and access to documents and data.** (a) The commissioner must revise dispute resolution forms, in consultation with the chief administrative law judge, to reflect the filing requirements in this section.

(b) For purposes of this subdivision, "complete, read-only electronic access" means the ability to view all data and document contents, including scheduling information, related to workers' compensation disputes, except for the following:

(1) a confidential mediation statement, including any documents submitted with the statement for the mediator's review;

(2) work product of a compensation judge, mediator, or commissioner that is not issued. Examples of work product include personal notes of hearings or conferences and draft decisions;

(3) the department's Vocational Rehabilitation Unit's case management system data;

(4) the special compensation fund's case management system data; and

(5) audit trail information.

(c) The office must be provided with continued, complete, read-only electronic access to the workers' compensation Informix imaging system.

(d) The department must be provided with read-only electronic access to the office's case management system, including the ability to view all data, including scheduling information, but excluding access into filed documents.

(e) The office must send the department all documents that are accepted for filing or issued by the office. The office must send the documents to the department, electronically or by courier, within two business days of when the documents are accepted for filing or issued by the office.

(f) The department must place documents that the office sends to the department in the appropriate imaged file for the employee.

(g) The department must send the office copies of the following documents, electronically or by courier, within two business days of when the documents are filed with or issued by the department:

(1) notices of discontinuance;

(2) decisions issued by the department; and

(3) mediated agreements.

(h) Upon integration of the office's case management system and the department's system resulting from the workers' compensation modernization program, each agency will be provided with complete, read-only electronic access to the other agency's system.

(i) Each agency's responsible authority pursuant to section 13.02, subdivision 16, is responsible for its own employees' use and dissemination of the data and documents in the workers' compensation Informix imaging system, the office's case management system, and the system developed as a result of the workers' compensation modernization program.

Subd. 6. **Data privacy.** (a) All documents filed with or issued by the department or the office under this chapter are private data on individuals and nonpublic data pursuant to chapter 13, except that the documents are available to the following:

(1) the office;

(2) the department;

(3) the employer;

(4) the insurer;

(5) the employee;

(6) the dependent of a deceased employee;

(7) an intervenor in the dispute;

(8) the attorney to a party in the dispute;

(9) a person who furnishes written authorization from the employer, insurer, employee, or dependent of a deceased employee; and

(10) a person, agency, or other entity allowed access to the documents under this chapter or other law.

(b) The office and department may post notice of scheduled proceedings on the agencies' Web sites and at their principal places of business in any manner that protects the employee's identifying information.

Subd. 7. **Workers' Compensation Court of Appeals.** The Workers' Compensation Court of Appeals has authority to amend its rules of procedure to reflect electronic filing with the office under this section for purposes of section 176.421, subdivision 5, and to allow electronic filing with the court under section 176.285. The court may amend its rules using the procedure in section 14.389.

EFFECTIVE DATE. This section is effective June 1, 2018.

Sec. 5. Laws 2017, chapter 94, article 1, section 6, is amended to read:

Sec. 6. **WORKERS' COMPENSATION COURT OF APPEALS**	**$**	**1,913,000**	**$**	~~**1,913,000**~~ **1,946,000**

This appropriation is from the workers' compensation fund.

ARTICLE 2

HOSPITAL OUTPATIENT FEE SCHEDULE

Section 1. **[176.1364] WORKERS' COMPENSATION HOSPITAL OUTPATIENT FEE SCHEDULE.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Addendum A" means the addendum entitled "OPPS APCs for CY 2018," or its successor, developed by the Centers for Medicare and Medicaid Services (Medicare) for use in the Medicare Hospital Outpatient Prospective Payment System (OPPS) system under Code of Federal Regulations, title 42, part 419, as may be amended from time to time.

(c) "Addendum B" means the addendum entitled "OPPS Payment by HCPCS Codes for CY 2018," or its successor, developed by the Centers for Medicare and Medicaid Services (Medicare) for use in the Medicare Hospital Outpatient Prospective Payment System (OPPS) system under Code of Federal Regulations, title 42, part 419, as may be amended from time to time.

(d) "HCPCS code" means a numeric or alphanumeric code included in the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System. A HCPCS code is used to identify a specific medical service.

(e) "Hospital" means a facility that is licensed by the Department of Health under section 144.50.

(f) "HOFS" means the workers' compensation hospital outpatient fee schedule established under subdivision 3.

(g) "Insurer" includes workers' compensation insurers and self-insured employers.

(h) "Services" includes articles, supplies, procedures, and implantable devices provided by the hospital with the service. Services are identified by a code described in subdivision 3.

Subd. 2. **Applicability.** (a) This section only applies to payment of charges for hospital outpatient services if the charges include a service listed in the workers' compensation hospital outpatient fee schedule established by the commissioner under subdivision 3. If the charges do not include a service listed in the HOFS, payment shall be:

(1) the liability for each service that is included in the workers' compensation relative value fee schedule as provided in section 176.136, subdivision 1a, and corresponding rules adopted by the commissioner to implement the relative value fee schedule; or

(2) the liability as provided in section 176.136, subdivision 1b, paragraphs (b) and (c), for each service that is not included in the workers' compensation relative value fee schedule.

(b) This section does not apply to outpatient services provided at a hospital that is certified by Medicare as a critical access hospital. Outpatient services provided by these hospitals shall be paid as provided in section 176.136, subdivision 1b, paragraph (a).

Subd. 3. **Hospital outpatient fee schedule (HOFS).** (a) Effective for hospital outpatient services on or after October 1, 2018, the commissioner shall establish a workers' compensation hospital outpatient fee schedule (HOFS) to establish the payment for hospital bills with charges for services with a J1 or J2 status indicator as listed in the status indicator (SI) column of Addendum B and the comprehensive observation services Ambulatory Payment Classification (APC) 8011 with a J2 status indicator in Addendum A. The

commissioner shall publish a link to the HOFS in the State Register before October 1, 2018, and shall maintain the current HOFS on the department's Web site.

(b) The amount listed for each of the procedures in the HOFS as described in paragraph (a) shall be the relative weight for the procedure multiplied by a HOFS conversion factor that results in the same overall payment for hospital outpatient services under this section as the actual payments made in the most recent 12-month period available before the effective date of this section. The commissioner must establish separate conversion factors to achieve the same overall payment for noncritical access hospitals of 100 or fewer licensed beds and hospitals with more than 100 licensed beds. The commissioner shall establish the two conversion factors according to the requirements in clauses (1) to (4) in consultation with insurer and hospital representatives.

(1) The commissioner shall obtain a suitable sample of de-identified data for Minnesota workers' compensation outpatient cases at Minnesota hospitals for the most recently available 12-month period. The commissioner may obtain de-identified data from any reliable source, including Minnesota hospitals and insurers, or their representatives. Any data provided to the commissioner by a hospital, insurer, or their representative under this subdivision is nonpublic data under section 13.02, subdivision 9.

(2) The sample must be divided into a data set for hospitals over 100 licensed beds, and 100 or fewer licensed beds, excluding critical access hospitals.

(3) For each data set the commissioner shall:

(i) calculate the total amount of the actual payments made in the most recent 12-month period available before the effective date of this section, adjusted for inflation to July 2018; and

(ii) apply all of the payment provisions in this section to each claim including, as applicable, payment under the relative value fee schedule or 85 percent of the hospital's usual and customary charge under section 176.136, subdivisions 1a and 1b, to determine the total payment amount using the Medicare conversion factor in effect for the OPPS in effect on July 1, 2018.

(4) The commissioner shall calculate the Minnesota conversion factor to equal the Medicare conversion factor multiplied by the ratio of total payments under clause (3), item (i), divided by the total payments under clause (3), item (ii).

(c) For purposes of this section:

(1) the relative weight is the amount in the "relative weight" column in Addendum B and Addendum A for comprehensive observation services.

(2) references to J1, J2, and H status indicators; Addenda A and B; APC 8011; and HCPCS code G0378 includes any successor status indicators, addenda, APC, or HCPCS code established by the Centers for Medicare and Medicaid Services.

(d) On October 1 of each year, the commissioner shall adjust the HOFS conversion factors based on the market basket index for inpatient hospital services calculated by Medicare and published on its Web site. The adjustment on each October 1 shall be a percentage equal to the value of that index averaged over the four quarters of the most recent calendar year divided by the value of that index over the four quarters of the prior calendar year.

(e) No later than October 1, 2021, and at least once every three years thereafter, the commissioner shall update the HOFS established under this subdivision by incorporating services with a J1 or J2 status indicator, and the corresponding relative weights, listed in the Addenda A and B most recently available on Medicare's Web site as of the preceding July 1. If Addenda A and B are not available on Medicare's Web site on the preceding July 1, the HOFS most recently published on the department's Web site remains in effect.

(1) Each time the HOFS is updated under this paragraph, the commissioner shall adjust the conversion factors so that there is no difference between the overall payment under the new HOFS and the overall payment under the HOFS most recently in effect, for services in both HOFSs.

(2) The conversion factor adjustments under this paragraph shall be made separately for each hospital category in paragraph (b).

(3) The conversion factor adjustments under this paragraph must be made before making any additional adjustment under paragraph (d).

(f) The commissioner shall give notice in the State Register of the adjusted conversion factor in paragraph (d) no later than October 1 annually. The commissioner shall give notice in the State Register of an updated HOFS under paragraph (e) no later than October 1 of the year in which the HOFS becomes effective. The notice must include a link to the HOFS published on the department's Web site. The notices, the updated fee schedules, and the adjusted conversion factors are not rules subject to chapter 14, but have the force and effect of law as of the effective date published in the State Register.

Subd. 4. **Payment under the hospital outpatient fee schedule.** (a) Services in the HOFS, and other hospital outpatient services provided with or as part of service in the HOFS, are paid according to paragraphs (b) and (c).

(b) If a hospital bill includes a charge for one or more services with a J1 status indicator, payment shall be as provided in this paragraph.

(1) If the bill includes a charge for only one service with only a J1 status indicator, payment shall be the amount listed in the HOFS for that service, regardless of the amount charged by the hospital.

(2) If the bill includes charges for more than one service with a J1 status indicator, the service with the highest listed fee in the HOFS shall be paid at 100 percent of the listed fee. Each additional service listed in the hospital outpatient fee shall be paid at 50 percent of the listed fee. Payment under this clause shall be based on the applicable percentage of the listed fee, regardless of the amount charged by the hospital.

(3) If the bill includes an additional charge for a service that does not have a J1 status indicator listed in the HOFS, no separate payment is made for the additional service. Payment for the additional service, including any service with a J2 status indicator, is packaged into and is not paid separately from the payment amount listed in the HOFS for the service with the J1 status indicator. Implantable devices are paid separately only as provided in subdivision 5.

(4) The insurer must not deny payment for any additional service packaged into payment for a service listed in the HOFS on the basis that the additional service was not reasonably required or causally related to an admitted work injury.

(c) If a hospital bill includes one or more charges for services with a J2 status indicator, and does not include any charges for services with a J1 status indicator, payment shall be as provided in this paragraph.

(1) Except for services packaged into an observation service as provided in clause (4), payment for each service with a J2 status indicator shall be the amount listed in the HOFS, regardless of the amount charged by the hospital.

(2) If a service without a HCPCS code is billed with a service with a J2 status indicator, payment is packaged into the payment for the J2 service.

(3) Payment for drugs with a HCPCS code is separate from payment for the service with the J2 code as provided in this clause.

(i) If the drug is delivered by injection or infusion, payment for the drug is packaged into payment for the injection or infusion service.

(ii) If the drug is not delivered by injection or infusion, payment for the drug is paid at the Medicare Average Sales Price (ASP) of the drug on the day the drug is dispensed. No later than October 1, 2018, and October 1 of each subsequent year, the commissioner must publish on the department's Web site a link to the ASP most recently available as of the preceding July 1. If no ASP is available, the most recently posted ASP linked on the department's Web site remains in effect.

(4) If a bill includes eight or more units of service with the HCPCS code G0378 (observation services, per hour), and there is a physician's or dentist's order for observation, payment shall be the amount listed in the HOFS for the comprehensive observation services Ambulatory Payment Classification 8011, regardless of the amount charged by the hospital. All other services billed by the hospital, including other services with a J2 status indicator, are packaged into the payment amount and are not paid separately from the payment amount listed in the fee schedule for HCPCS code G0378.

(5) For any other service on the same bill as the service with a J2 status indicator, payment shall be as provided in subdivision 2, paragraph (a).

Subd. 5. **Implantable devices.** The maximum fee for any service in the HOFS includes payment for all implantable devices, even if the Medicare OPPS would otherwise allow separate payment for the implantable device. However, separate payment in the amount of 85 percent of the hospital's usual and customary charge for an implantable device is allowed if the implantable device:

(1) has an H status indicator in Addendum B;

(2) is properly charged on a bill with a service with a J1 status indicator in the HOFS; and

(3) is properly billed with another HCPCS code, if required by Medicare's OPPS system.

The commissioner shall update the HOFS each October 1 to include any HCPCS codes that are payable under this section according to the Addendum B most recently available on the preceding July 1.

Subd. 6. **Study.** (a) The commissioner shall conduct a study analyzing the percentage of claims with a service in the HOFS that were paid timely and the percentage of claims paid accurately. The commissioner must report the results of the study and recommendations to the Workers' Compensation Advisory Council and chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over workers' compensation by January 15, 2021.

(b) Based on the results of the study, the WCAC shall consider whether there is a minimum 80 percent compliance in timeliness and accuracy of payments, and additional statutory amendments, including but not limited to:

(1) a maximum ten percent reduction in payments under the HOFS; and

(2) an increase in indemnity benefits to injured workers.

Subd. 7. **Rulemaking.** The commissioner may adopt or amend rules, using the authority in section 14.386, paragraph (a), to implement this section. The rules are not subject to expiration under section 14.386, paragraph (b).

EFFECTIVE DATE. This section is effective for hospital outpatient services provided on or after October 1, 2018.

ARTICLE 3

OUTPATIENT BILLING, PAYMENT, AND DISPUTE RESOLUTION

Section 1. Minnesota Statutes 2016, 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 Critical Access Hospital certified by the Centers for Medicare and Medicaid Services~~, or while an outpatient at a hospital with 100 or fewer licensed beds,~~ 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.

(b) The liability of the employer for the treatment, articles, and supplies that are not limited by paragraph (a), subdivision 1a~~,~~ or 1c, ~~or~~ section 176.1362, 176.1363, or 176.1364, 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, except as provided in paragraph (e). 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.

(e) The limitation of the employer's liability based on 85 percent of prevailing charge does not apply to charges by an ambulatory surgical center as defined in section 176.1363, subdivision 1, paragraph (b), or a hospital as defined in section 176.1364, subdivision 1, paragraph (e).

(f) For purposes of this chapter, "inpatient" means a patient that has been admitted to a hospital by an order from a physician or dentist. If there is no inpatient admission order, the patient is deemed an outpatient. The hospital must provide documentation of an inpatient order upon the request of the employer.

EFFECTIVE DATE. This section is effective for treatment, articles, and supplies provided on or after October 1, 2018.

Sec. 2. **[176.1365] OUTPATIENT BILLING, PAYMENT, AND DISPUTE RESOLUTION.**

Subdivision 1. **Scope.** This section applies to billing, payment, and dispute resolution for services provided by an ambulatory surgical center (ASC) under section 176.1363 and hospital outpatient services under section 176.1364. For purposes of this section, "insurer" includes self-insured employer and "services" is as defined in section 176.1364.

Subd. 2. **Outpatient billing, coding, and prior notification.** (a) Ambulatory surgical centers and hospitals must bill workers' compensation insurers for services governed by sections 176.1363 and 176.1364 using the same codes, formats, and details that are required for billing the Medicare program, including coding consistent with the American Medical Association Current Procedural Terminology coding system and Medicare's Ambulatory Surgical Center Payment System, Outpatient Prospective Payment System, Outpatient Code Editor, Healthcare Current Procedural Terminology Coding System, and the National Correct Coding Initiative Policy Manual for Medicare Services and associated Web page and tables.

(b) All charges for ASC or hospital outpatient fee schedule services governed by sections 176.1363 and 176.1364 must be submitted to the insurer on the appropriate electronic transaction required by section 176.135, subdivisions 7 and 7a. ASCs must submit charges on the electronic 837P form. ASCs must not

separately bill for the services and items included in the ASC facility fee under Code of Federal Regulations, title 42, section 416.164(a). Minnesota Rules, part 5221.4033, subpart 1a, does not apply to ASCs under this section, but does apply to hospital outpatient facility fees to the extent they are not covered by the hospital outpatient fee schedule under section 176.1364.

(c) Hospitals, ASCs, and insurers must comply with the prior notification and approval or authorization requirements specified in Minnesota Rules, part 5221.6050, subpart 9. Prior notification may be provided by either the hospital, ASC, or the surgeon. For purposes of prior notification under Minnesota Rules, part 5221.6050, subpart 9, "inpatient" has the meaning as provided under section 176.136, subdivision 1b, paragraph (d).

(d) ASC or hospital bills must be submitted to insurers as required by section 176.135, subdivisions 7 and 7a, and within the time period required by section 62Q.75, subdivision 3. Insurers must respond to the initial bill as provided in section 176.135, subdivisions 6 and 7a. Copies of any records or reports relating to the items for which payment is sought are separately payable as provided in section 176.135, subdivision 7, paragraph (a).

Subd. 3. **ASC or hospital request for reconsideration; insurer response; time frames.** (a) Following receipt of the insurer's explanation of review (EOR) or explanation of benefits (EOB), the ASC or hospital may request reconsideration of a payment denial or reduction. The ASC or hospital must submit its request for reconsideration in writing to the insurer within one year of the date of the EOR or EOB.

(b) The insurer must issue a written response to the ASC or hospital's request for reconsideration within 30 days, as provided in section 176.135, subdivision 6. The written response must address the issues raised by the request for reconsideration and not simply reiterate the information on the EOR or EOB.

Subd. 4. **Insurer request for reimbursement of overpayment; time frame.** If the payer determines it has overpaid an ASC or hospital's charges based on workers' compensation statutes and rules, the payer must submit its request for reimbursement in writing to the ASC or hospital within one year of the date of the payment.

Subd. 5. **Medical requests for administrative conference; time frame to file.** (a) An ASC, hospital, or insurer must notify the provider or payer, as applicable, of its intent to file a medical request for an administrative conference under section 176.106 at least 20 days before filing one with the department. The insurer, or the ASC or hospital if permitted by section 176.136, subdivision 2, must file the medical request for an administrative conference no later than the latest of:

(1) one year after the date of the initial EOR or EOB if the ASC or hospital does not request a reconsideration of a payment denial or reduction under subdivision 3;

(2) one year after the date of the insurer's response to the ASC or hospital's request for reconsideration under subdivision 3; or

(3) one year after the insurer's request for reimbursement of an overpayment from an ASC or hospital under subdivision 4.

(b) Paragraph (a) does not prohibit an employee from filing a medical request for assistance or claim petition for the payment denied or reduced by the insurer. However, the ASC or hospital may not bill the employee for the denied or reduced payment when prohibited by this chapter.

Subd. 6. **Interest.** (a) An insurer must pay the ASC or hospital interest at an annual rate of four percent if it is determined that the insurer is liable for additional ASC or hospital charges following a denial of payment. Interest is payable by the insurer on the additional amount owed from the date payment was due.

(b) An ASC or hospital must pay the insurer interest at an annual rate of four percent if it is determined that the hospital owes the insurer reimbursement following the insurer's request for reimbursement of an

overpayment. Interest is payable by the ASC or hospital on the amount of the overpayment from the date the overpayment was made.

EFFECTIVE DATE. This section is effective for services provided on or after October 1, 2018.

ARTICLE 4

AMBULATORY SURGICAL CENTERS

Section 1. **[176.1363] AMBULATORY SURGICAL CENTER PAYMENT.**

Subdivision 1. **Definitions.** (a) For the purpose of this section, the terms defined in this subdivision have the meanings given them.

(b) "Ambulatory surgical center" or "ASC" means a facility that is: (1) certified as an ASC by the Centers for Medicare and Medicaid Services; or (2) licensed by the Department of Health as a freestanding outpatient surgical center and not owned by a hospital.

(c) "Conversion factor" means the Medicare ambulatory surgical center payment system (ASCPS) conversion factor used for ASCs that meet the Medicare quality reporting requirements, whether or not the ASC submitting the bill has met the quality reporting requirements.

(d) "Covered surgical procedures and ancillary services" means the procedures listed in ASCPS, addendum AA, and the ancillary services integral to covered surgical procedures listed in ASCPS, addendum BB.

(e) "Insurer" includes workers' compensation insurers and self-insured employers.

(f) "Ambulatory surgical center payment system" or "ASCPS" means the system developed by the Centers for Medicare and Medicaid Services for payment of surgical services provided by federally certified ASCs as specified in:

(1) Code of Federal Regulations, title 42, part 416, including without limitation the geographic adjustment for the ASC and the multiple surgical procedure reduction rule;

(2) annual revisions to Code of Federal Regulations, title 42, part 416, as published in the Federal Register;

(3) the corresponding addendum AA (final ASC covered surgical procedures), addendum BB (final covered ancillary services integral to covered surgical procedures), addendum DD1 (final ASC payment indicators), and any successor or replacement addenda; and

(4) the Medicare claims processing manual.

(g) "Medicare ASCPS payment" means the Medicare ASCPS payment used for ASCs that meet the Medicare quality reporting requirements, whether or not the ASC submitting the bill has met the Medicare quality reporting requirements.

Subd. 2. **Payment for covered surgical procedures and ancillary services based on Medicare ASCPS.** (a) Except as provided in subdivisions 3 and 4, the payment to the ASC for covered surgical procedures and ancillary services shall be the lesser of:

(1) the ASC's usual and customary charge for all services, supplies, and implantable devices provided; or

(2) the Medicare ASCPS payment, times a multiplier of 320 percent.

(i) The amount payable under this clause includes payment for all implantable devices, even if the Medicare ASCPS would otherwise allow separate payment for the implantable device.

(ii) The 320 percent described in this clause must be adjusted if, on July 1, 2019, or any subsequent July 1, the conversion factor is less than 98 percent of the conversion factor in effect on the previous July 1. When this occurs, the multiplier must be 320 percent times 98 percent divided by the percentage that the current Medicare conversion factor bears to the Medicare conversion factor in effect on the prior July 1. In subsequent years, the multiplier is 320 percent, unless the Medicare ASCPS conversion factor declines by more than two percent.

(b) Payment under this section is effective for covered surgical procedures and ancillary services provided by an ASC on or after October 1, 2018, through September 30, 2019, and shall be based on the addenda AA, BB, and DD1 most recently available on the Centers for Medicare and Medicaid Services Web site as of July 1, 2018, and the corresponding rules and Medicare claims processing manual described in subdivision 1, paragraph (f).

(1) Payment for covered surgical procedures and ancillary services provided by an ASC on or after each subsequent October 1 shall be based on the addenda AA, BB, and DD1 most recently available on the Centers for Medicare and Medicaid Services Web site as of the preceding July 1 and the corresponding rules and Medicare claims processing manual.

(2) If the Centers for Medicare and Medicaid Services has not updated addendum AA, BB, or DD1 on its Web site since the commissioner's previous notice under paragraph (c), the addenda identified in the notice published by the commissioner in paragraph (c) and the corresponding rules and Medicare claims processing manual shall remain in effect.

(3) Addenda AA, BB, and DD1 under this subdivision includes successor or replacement addenda.

(c) The commissioner shall annually give notice in the State Register of any adjustment to the multiplier under paragraph (a), clause (2), and of the applicable addenda in paragraph (b) no later than October 1. The notice must identify and include a link to the applicable addenda. The notices and any adjustment to the multiplier are not rules subject to chapter 14, but have the force and effect of law as of the effective date published in the State Register.

Subd. 3. **Payment for compensable surgical services not covered under ASCPS.** (a) If a surgical procedure provided by an ASC is compensable under this chapter but is not listed in addendum AA or BB of the Medicare ASCPS, payment must be 75 percent of the ASC's usual and customary charge for the procedure with the highest charge. Payment for each subsequent surgical procedure not listed in addendum AA or BB must be paid at 50 percent of the ASC's usual and customary charge.

(b) Payment must be 75 percent of the ASC's usual and customary charge for a surgical procedure or ancillary service if the procedure or service is listed in Medicare ASCPS addendum AA or BB and: (1) the payment indicator provides it is paid at a reasonable cost; (2) the payment indicator provides it is contractor priced; or (3) a payment rate is not otherwise provided.

Subd. 4. **Study.** The commissioner shall conduct a study analyzing the impact of the reforms, including timeliness and accuracy of payment under this section, and recommend further changes if needed. The commissioner must report the results of the study to the Workers' Compensation Advisory Council and the chairs and ranking minority members of the legislative committees with jurisdiction over workers' compensation by January 15, 2021.

Subd. 5. **Rulemaking.** The commissioner may adopt or amend rules using the authority in section 14.386, paragraph (a), to implement this section and the Medicare ASCPS for workers' compensation. The rules are not subject to expiration under section 14.386, paragraph (b).

EFFECTIVE DATE. This section is effective for procedures and services provided by an ASC on or after October 1, 2018, except subdivision 5 is effective the day following final enactment.

ARTICLE 5

WORKERS' COMPENSATION BENEFITS

Section 1. Minnesota Statutes 2016, 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 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.

(e) If, preceding the date of disablement or death, an employee who was employed on active duty as: a licensed police officer; a firefighter; a paramedic; an emergency medical technician; a licensed nurse employed to provide emergency medical services outside of a medical facility; a public safety dispatcher; an officer employed by the state or a political subdivision at a corrections, detention, or secure treatment facility; a sheriff or full-time deputy sheriff of any county; or a member of the Minnesota State Patrol is diagnosed with a mental impairment as defined in paragraph (d), and had not been diagnosed with the mental impairment previously, then the mental impairment is presumptively an occupational disease and shall be presumed to have been due to the nature of employment. This presumption may be rebutted by substantial factors brought by the employer or insurer. Any substantial factors that are used to rebut this presumption and that 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. The mental impairment is not considered an occupational 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.

EFFECTIVE DATE. This section is effective for employees with dates of injury on or after January 1, 2019.

Sec. 2. Minnesota Statutes 2016, section 176.101, subdivision 2, is amended to read:

Subd. 2. **Temporary partial disability.** (a) In all cases of temporary partial disability the compensation shall be 66-2/3 percent of the difference between the weekly wage of the employee at the time of injury and the wage the employee is able to earn in the employee's partially disabled condition. This compensation shall be paid during the period of disability except as provided in this section, payment to be made at the intervals when the wage was payable, as nearly as may be, and subject to the maximum rate for temporary total compensation.

(b) Temporary partial compensation may be paid only while the employee is employed, earning less than the employee's weekly wage at the time of the injury, and the reduced wage the employee is able to earn in the employee's partially disabled condition is due to the injury. Except as provided in section 176.102, subdivision 11, paragraphs (b) and (c), temporary partial compensation may not be paid for more than ~~225~~ 275 weeks, or after 450 weeks after the date of injury, whichever occurs first.

(c) Temporary partial compensation must be reduced to the extent that the wage the employee is able to earn in the employee's partially disabled condition plus the temporary partial disability payment otherwise payable under this subdivision exceeds 500 percent of the statewide average weekly wage.

Sec. 3. Minnesota Statutes 2016, section 176.101, subdivision 2a, is amended to read:

Subd. 2a. **Permanent partial disability.** (a) Compensation for permanent partial disability is as provided in this subdivision. Permanent partial disability must be rated as a percentage of the whole body in accordance with rules adopted by the commissioner under section 176.105. The percentage determined pursuant to the rules must be multiplied by the corresponding amount in the following table:

Impairment Rating (percent)	Amount

less than 5.5	$	~~75,000~~ 78,800
5.5 to less than 10.5		~~80,000~~ 84,000
10.5 to less than 15.5		~~85,000~~ 89,300
15.5 to less than 20.5		~~90,000~~ 94,500
20.5 to less than 25.5		~~95,000~~ 99,800
25.5 to less than 30.5		~~100,000~~ 105,000
30.5 to less than 35.5		~~110,000~~ 115,500
35.5 to less than 40.5		~~120,000~~ 126,000
40.5 to less than 45.5		~~130,000~~ 136,500
45.5 to less than 50.5		~~140,000~~ 147,000
50.5 to less than 55.5		~~165,000~~ 173,300
55.5 to less than 60.5		~~190,000~~ 199,500
60.5 to less than 65.5		~~215,000~~ 225,800
65.5 to less than 70.5		~~240,000~~ 252,000
70.5 to less than 75.5		~~265,000~~ 278,300
75.5 to less than 80.5		~~315,000~~ 330,800
80.5 to less than 85.5		~~365,000~~ 383,300
85.5 to less than 90.5		~~415,000~~ 435,800
90.5 to less than 95.5		~~465,000~~ 488,300
95.5 up to and including 100		~~515,000~~ 540,800

An employee may not receive compensation for more than a 100 percent disability of the whole body, even if the employee sustains disability to two or more body parts.

(b) Permanent partial disability is payable upon cessation of temporary total disability under subdivision 1. If the employee requests payment in a lump sum, then the compensation must be paid within 30 days. This lump-sum payment may be discounted to the present value calculated up to a maximum five percent basis. If the employee does not choose to receive the compensation in a lump sum, then the compensation is payable in installments at the same intervals and in the same amount as the employee's temporary total disability rate on the date of injury. Permanent partial disability is not payable while temporary total compensation is being paid.

Sec. 4. Minnesota Statutes 2016, section 176.101, subdivision 4, is amended to read:

Subd. 4. **Permanent total disability.** For permanent total disability, as defined in subdivision 5, the compensation shall be 66-2/3 percent of the daily wage at the time of the injury, subject to a maximum weekly compensation equal to the maximum weekly compensation for a temporary total disability and a minimum weekly compensation equal to 65 percent of the statewide average weekly wage. This compensation shall be paid during the permanent total disability of the injured employee but after a total of $25,000 of weekly compensation has been paid, the amount of the weekly compensation benefits being paid by the employer shall be reduced by the amount of any disability benefits being paid by any government disability benefit program if the disability benefits are occasioned by the same injury or injuries which give rise to payments under this subdivision. This reduction shall also apply to any old age and survivor insurance benefits. Payments shall be made at the intervals when the wage was payable, as nearly as may be. In case an employee who is permanently and totally disabled becomes an inmate of a public institution, no compensation shall be payable during the period of confinement in the institution, unless there is wholly dependent on the employee for support some person named in section 176.111, subdivision 1, 2 or 3, in which case the compensation provided for in section 176.111, during the period of confinement, shall be paid for the benefit of the dependent person during dependency. The dependency of this person shall be determined as though the employee were deceased. Permanent total disability shall cease at age ~~67 because the employee is presumed retired from the labor market~~ 72, except that if an employee is injured after age 67, permanent total disability benefits shall cease after five years of those benefits have been paid. ~~This presumption is rebuttable by the employee. The subjective statement the employee is not retired is not sufficient in itself to rebut the presumptive evidence of retirement but may be considered along with other evidence.~~

Sec. 5. Minnesota Statutes 2016, section 176.102, subdivision 11, is amended to read:

Subd. 11. **Retraining; compensation.** (a) Retraining is limited to 156 weeks. An employee who has been approved for retraining may petition the commissioner or compensation judge for additional compensation not to exceed 25 percent of the compensation otherwise payable. If the commissioner or compensation judge determines that this additional compensation is warranted due to unusual or unique circumstances of the employee's retraining plan, the commissioner may award additional compensation in an amount not to exceed the employee's request. This additional compensation shall cease at any time the commissioner or compensation judge determines the special circumstances are no longer present.

(b) If the employee is not employed during a retraining plan that has been specifically approved under this section, temporary total compensation is payable for up to 90 days after the end of the retraining plan; except that, payment during the 90-day period is subject to cessation in accordance with section 176.101. If the employee is employed during the retraining plan but earning less than at the time of injury, temporary partial compensation is payable at the rate of 66-2/3 percent of the difference between the employee's weekly wage at the time of injury and the weekly wage the employee is able to earn in the employee's partially disabled condition, subject to the maximum rate for temporary total compensation. Temporary partial

compensation is not subject to the ~~225-week~~ 275-week or 450-week limitations provided by section 176.101, subdivision 2, during the retraining plan, but is subject to those limitations before and after the plan.

(c) Any request for retraining shall be filed with the commissioner before 208 weeks of any combination of temporary total or temporary partial compensation have been paid. Retraining shall not be available after 208 weeks of any combination of temporary total or temporary partial compensation benefits have been paid unless the request for the retraining has been filed with the commissioner prior to the time the 208 weeks of compensation have been paid.

(d) The employer or insurer must notify the employee in writing of the 208-week limitation for filing a request for retraining with the commissioner. This notice must be given before 80 weeks of temporary total disability or temporary partial disability compensation have been paid, regardless of the number of weeks that have elapsed since the date of injury. If the notice is not given before the 80 weeks, the period of time within which to file a request for retraining is extended by the number of days the notice is late, but in no event may a request be filed later than 225 weeks after any combination of temporary total disability or temporary partial disability compensation have been paid. The commissioner may assess a penalty of $25 per day that the notice is late, up to a maximum penalty of $2,000, against an employer or insurer for failure to provide the notice. The penalty is payable to the commissioner for deposit in the assigned risk safety account.

Sec. 6. Minnesota Statutes 2016, 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;

(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~~.~~; and

(8) criteria for treatment of post-traumatic stress disorder. In developing such treatment criteria, the commissioner and the Medical Services Review Board shall consider the guidance set forth in the American Psychological Association's most recently adopted Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults. The commissioner shall adopt such rules using the expedited rulemaking process in section 14.389, including subdivision 5, to commence promptly upon final enactment

of the legislation enacting this clause. Such rules shall apply to employees with all dates of injury who receive treatment after the commissioner adopts the rules. In consultation with the Medical Services Review Board, the commissioner shall review and update the rules governing criteria for treatment of post-traumatic stress disorder each time the American Psychological Association adopts a significant change to their Clinical Practice Guideline for the Treatment of PTSD in Adults, using the expedited rulemaking process in section 14.389, including subdivision 5.

(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.

EFFECTIVE DATE. This section is effective June 1, 2018.

Sec. 7. **EFFECTIVE DATE.**

Unless otherwise specified, this article is effective for employees with dates of injury on or after October 1, 2018.

Presented to the governor May 18, 2018