CHAPTER 12--H.F.No. 2253

An act relating to workers' compensation; adopting recommendations of the Workers' Compensation Advisory Council; amending Minnesota Statutes 2020, sections 176.101, subdivision 1; 176.136, by adding a subdivision; 176.1362, subdivisions 1, 6; 176.1363, subdivisions 1, 2, 3; 176.194, subdivisions 3, 4; 176.223, as amended; 176.351, by adding a subdivision; Laws 2020, chapter 72, section 1.

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

Section 1. Minnesota Statutes 2020, 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, 2013, and each October 1 thereafter, the maximum weekly compensation payable is 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. Beginning on October 1, 2021, and each October 1 thereafter, the minimum weekly compensation shall be 20 percent of the maximum weekly compensation payable or the 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.

EFFECTIVE DATE. This section is effective for dates of injury on or after October 1, 2021.

Sec. 2. Minnesota Statutes 2020, section 176.136, is amended by adding a subdivision to read:

Subd. 2a. **Penalties, costs, and expenses for improper collection or attempts to collect payment for medical services from an employee.** (a) The commissioner may assess penalties, costs, and expenses against a health care provider who collects or attempts to collect payment from an employee in violation of subdivision 2; section 176.135, subdivision 7; or 176.83, subdivision 5, paragraph (c), as provided in this subdivision. For purposes of paragraphs (b) and (c):

(1) A violation occurs only if the health care provider or the provider's representative was informed that the treatment or service was for a claimed workers' compensation injury or that the bill should be submitted to a workers' compensation insurer.

(2) Once the health care provider has been provided the information described in clause (1), a violation occurs each time the health care provider, or any person acting on the provider's behalf or direction, collects or attempts to collect payment from the employee for charges on a bill for medical treatment or services. An attempt to collect payment from an employee includes:

(i) each contact made in person or by United States mail, telephone, text, e-mail, or any other type of contact seeking payment;

(ii) engaging a collection agency or other third party to collect from the employee;

(iii) filing a claim in conciliation court;

(iv) attaching the employee's tax refund; or

(v) submitting a report to a credit agency.

(b) The penalty assessed against a health care provider for each violation shall be $1,000, payable to the assigned risk safety account, except that:

(1) the penalty shall be $2,000, payable to the assigned risk safety account, for each violation if the employee paid the health care provider as a result of the violation, or for the violations described in paragraph (a), clause (2), items (ii) to (v); and

(2) the commissioner shall not assess a penalty under this paragraph unless the commissioner has documentation that the health care provider or the health care provider's representative has been provided with written notice that the attempted collection or collection from an employee is prohibited by workers' compensation law and that penalties may be assessed for a violation of the law. The notice required by this clause may be provided by any agency or person, including an employee, self-insured employer, insurer, third-party administrator, or attorney. The written notice required by this clause must only be provided once and once provided, the commissioner may assess penalties under this paragraph for a health care provider's or the health care provider's representative's improper collection or attempts to collect payment for medical services from any employee without provision of written notice required by this paragraph. Written notice provided before the effective date of this subdivision satisfies the notice requirement. The commissioner shall post on the department's website a model notice. The model notice is presumed to provide sufficient

notice for purposes of this clause when provided to a health care provider's billing office by any agency or person.

(c) In addition to any penalty assessed under paragraph (b), the commissioner has the authority to order the health care provider to pay the employee the following amounts as reasonable reimbursement of costs and expenses incurred by the employee as a result of one or more violations, as provided in clauses (1) and (2), and to take all reasonable action to restore the employee's credit rating if it has been damaged as a result of the violation:

(1) the health care provider must reimburse the employee all amounts that the employee paid to the health care provider as a result of a violation, with interest, as specified in section 176.221, subdivision 7; and

(2) for violations described in paragraph (a), clause (2), items (ii) to (v), the health care provider must reimburse the employee a minimum lump-sum payment of $500 for which no supporting documentation is required to be provided, in addition to costs or expenses documented by the employee over that amount.

Nonexclusive examples of costs and expenses incurred as a result of a violation include attorney fees, lost wages, filing fees, court costs, courier fees, photocopying or facsimile charges, telephone and postage charges, computer or research costs, witness fees, records, and travel expenses. Costs and expenses incurred by the employee as a result of a violation are payable whether or not the health care provider has been provided with the notice described in paragraph (b), clause (2).

EFFECTIVE DATE. This section is effective for violations on or after August 1, 2021.

Sec. 3. Minnesota Statutes 2020, section 176.1362, subdivision 1, is amended to read:

Subdivision 1. **Payment based on Medicare MS-DRG system.** (a) Except as provided in subdivisions 2 and 3, the maximum reimbursement for inpatient hospital services, articles, and supplies is 200 percent of the amount calculated for each hospital under the federal Inpatient Prospective Payment System developed for Medicare, using the inpatient Medicare PC-Pricer program or the inpatient PPS Web Pricer for the applicable MS-DRG as provided in this subdivision. All adjustments included in the PC-Pricer program or the inpatient PPS Web Pricer are included in the amount calculated, including but not limited to any outlier payments.

(b) Payment under this section is effective for services, articles, and supplies provided to patients discharged from the hospital on or after January 1, 2016. Payment for services, articles, and supplies provided to patients discharged on January 1, 2016, through December 31, 2016, must be based on the Medicare PC-Pricer program in effect on January 1, 2016.

(c) For patients discharged on or after May 31, 2017, payment for inpatient services, articles, and supplies must be calculated according to the PC-Pricer program identified on Medicare's website as FY 2016.1, updated on January 19, 2016.

(d) For patients discharged on or after October 1, 2017, payment for inpatient services, articles, and supplies must be calculated according to the PC-Pricer program or the inpatient PPS Web Pricer posted on the Department of Labor and Industry's website as follows:

(1) No later than October 1, 2017, and October 1 of each subsequent year until October 1, 2021, the commissioner must post on the department's website the version of the PC-Pricer program that is most recently available on Medicare's website as of the preceding July 1. If no PC-Pricer program is available on

the Medicare website on any July 1, the PC-Pricer program most recently posted on the department's website remains in effect.

~~(2)~~ The commissioner must publish notice of the applicable PC-Pricer program in the State Register no later than October 1 of each year.

(2) Beginning on October 1, 2021, payment for inpatient services, articles, and supplies must be calculated using the inpatient PPS Web Pricer available on Medicare's website using the applicable dates of inpatient hospitalization. The department must publish the link to the inpatient PPS Web Pricer on its website.

(e) The MS-DRG grouper software or program that corresponds to or is included with the applicable version of the PC-Pricer program or inpatient PPS Web Pricer must be used to determine payment under this subdivision.

(f) Hospitals must bill workers' compensation insurers using the same codes, formats, and details that are required for billing for hospital inpatient services by the Medicare program. The bill must be submitted to the insurer within the time period required by section 62Q.75, subdivision 3. For purposes of this section, "insurer" includes both workers' compensation insurers and self-insured employers.

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

Sec. 4. Minnesota Statutes 2020, section 176.1362, subdivision 6, is amended to read:

Subd. 6. **Postpayment audits; records; interest.** (a) The insurer may conduct a postpayment audit if both of the following requirements are met:

(1) the insurer paid the hospital's bill within 30 days according to the PC-Pricer program or inpatient PPS Web Pricer amount described in subdivision 1; and

(2) the amount paid according to the PC-Pricer program or inpatient PPS Web Pricer in subdivision 1 included an outlier payment.

(b) If an audit is permitted under paragraph (a), the insurer must request any additional records needed to conduct the audit within six months after payment. The records requested may include an itemized statement of charges. Within 30 days of the insurer's request, the hospital must provide the additional documentation requested. An insurer must not request additional information from a hospital more than three times per audit.

(c) An insurer must pay the hospital interest at an annual rate of four percent if it is determined that the insurer is liable for additional hospital charges following a postpayment audit. A 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 audit. Interest is payable by the insurer from the date payment was due under this section or section 176.135. Interest is payable by the hospital from the date the overpayment was made.

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

Sec. 5. Minnesota Statutes 2020, section 176.1363, subdivision 1, is amended to read:

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) "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.

(d) "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.

(e) "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.

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

(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.

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

Sec. 6. Minnesota Statutes 2020, section 176.1363, subdivision 2, is amended to read:

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

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

(2) the Medicare ASCPS payment on the total bill, 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.

(iii) When more than one covered surgical procedure is included on a bill, payment shall be: (A) 100 percent of the applicable ASCPS payment amount under paragraph (a), clause (2), for the procedure with the highest ASC payment rate; and (B) 50 percent of the applicable ASC payment amount under paragraph (a), clause (2), for all other covered surgical procedures. However, the total payment must still not exceed the ASC's usual and customary charge for all services, supplies, and implantable devices provided. This item only applies when more than one procedure on a bill is identified as subject to multiple procedure discounting on Addendum AA.

(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 website as of July 1, 2018, and the corresponding rules and Medicare claims processing manual described in subdivision 1, paragraph (c).

(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 website 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 website 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 include 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.

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

Sec. 7. Minnesota Statutes 2020, section 176.1363, subdivision 3, is amended to read:

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; or (2) the payment indicator provides it is contractor priced~~; or (3) a payment rate is not otherwise provided~~.

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

Sec. 8. Minnesota Statutes 2020, section 176.194, subdivision 3, is amended to read:

Subd. 3. **Prohibited conduct.** The following conduct is prohibited:

(1) failing to reply, within 30 calendar days after receipt, to all written communication about a claim from a claimant that requests a response;

(2) failing, within 45 calendar days after receipt of a written request, to commence benefits or to advise the claimant of the acceptance or denial of the claim by the insurer;

(3) failing to pay or deny medical bills within 45 days after the receipt of all information requested from medical providersthat is necessary to make a payment determination;

(4) filing a denial of liability for workers' compensation benefits without conducting an investigation;

(5) failing to regularly pay weekly benefits in a timely manner as prescribed by rules adopted by the commissioner once weekly benefits have begun. Failure to regularly pay weekly benefits means failure to pay an employee on more than three occasions in any 12-month period within three business days of when payment was due;

(6) failing to respond to the department within 30 calendar days after receipt of a written inquiry from the department about ~~a claim~~ a matter related to benefits. Responses must be substantive and address the question;

(7) failing to pay pursuant to an order of the department, compensation judge, court of appeals, or the supreme court, within 45 days from the filing of the order unless the order is under appeal;

(8) advising a claimant not to obtain the services of an attorney or representing that payment will be delayed if an attorney is retained by the claimant; ~~or~~

(9) altering information on a document to be filed with the department without the notice and consent of any person who previously signed the document and who would be adversely affected by the alteration~~.~~;

(10) providing fraudulent written information to the department or an employee pertaining to a workers' compensation matter; or

(11) failing to pay a claim, or otherwise correct behavior on a claim, for which a penalty assessed has been paid or has become a final order.

EFFECTIVE DATE. This section is effective for prohibited conduct occurring on or after July 1, 2021.

Sec. 9. Minnesota Statutes 2020, section 176.194, subdivision 4, is amended to read:

Subd. 4. **Penalties.** The penalties for violations of subdivision 3, clauses (1) ~~through~~ to (6) ~~and (9)~~, are as follows:

1st through 5th violation of each paragraph	written warning
6th through 10th violation of each paragraph	$3,000 per violation in excess of five
11 or more violations of each paragraph	$6,000 per violation in excess of ten

For violations of subdivision 3, clauses (7) ~~and (8)~~ to (11), the penalties are:

1st through 5th violation of each paragraph	$3,000 per violation
6 or more violations of each paragraph	$6,000 per violation in excess of five

The penalties under this section may be imposed in addition to other penalties under this chapter that might apply for the same violation. The penalties under this section are assessed by the commissioner and are payable to the commissioner for deposit in the assigned risk safety account. A party may object to the penalty and request a formal hearing under section 176.85. If an entity has more than 30 violations within any 12-month period, in addition to the monetary penalties provided, the commissioner may refer the matter to the commissioner of commerce with recommendation for suspension or revocation of the entity's (a) license to write workers' compensation insurance; (b) license to administer claims on behalf of a self-insured, the assigned risk plan, or the Minnesota Insurance Guaranty Association; (c) authority to self-insure; or (d) license to adjust claims. The commissioner of commerce shall follow the procedures specified in section 176.195.

EFFECTIVE DATE. This section is effective for violations on or after July 1, 2021.

Sec. 10. Minnesota Statutes 2020, section 176.223, as amended by Laws 2020, Seventh Special session chapter 1, article 2, section 12, is amended to read:

176.223 PROMPT FIRST ACTION REPORT.

(a) For purposes of this section:

(1) "insurer" means a workers' compensation insurer licensed in Minnesota and a self-insured employer approved to self-insure by the commissioner of commerce;

(2) "prompt first action" means that an insurer commenced payment of wage loss benefits, or filed a denial of liability for an injury or for wage loss benefits, within the time frames required by section 176.221, subdivision 1; and

(3) "wage loss benefits" means temporary total disability, temporary partial disability, and permanent total disability benefits, as described in section 176.101.

(b) No later than March 15 of each year, beginning on March 15, 2022, the department shall publish a report providing data for each insurer on the total number of the insurer's claims, and the number and percentage of the insurer's claims with prompt first action. The report must be based on data that the insurer reported to the commissioner in the previous calendar year, except that the commissioner may exclude incomplete or unreliable data. ~~Each report shall contain the required information for each of the last four years the report has been compiled so that a total of five years is included. The department shall make the report available to employers and shall provide a copy to each insurer listed in the report for the current year.~~ The five most recent reports must be published on the department's website.

(c) On or before January 15 ~~of each year~~, 2022, and on or before each January 15 thereafter, the department must provide each insurer listed in the report with notice of the data on that insurer that the department plans to include in the report. By February 15, 2022, and by each February 15 thereafter, the insurer must ~~notify the department in writing of inaccurate data reported to the commissioner and of any corrections to the data that should be reflected in the March 15 report. Effective the day following final enactment, the insurer must~~ electronically file ~~the~~ corrected data with the commissioner in CAMPUS in order for it to be reflected in the March 15 report.

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

Sec. 11. Minnesota Statutes 2020, section 176.351, is amended by adding a subdivision to read:

Subd. 2b. **Subpoenas not permitted of department employees who provide assistance.** The commissioner and any employee of the department shall not be subject to a subpoena for purposes of providing expert testimony or describing the nature of assistance or advice provided under this chapter. This prohibition does not apply to: testimony of a department employee in a workers' compensation enforcement proceeding brought by the commissioner; a dispute in which the commissioner or the special compensation fund is a party; or a qualified rehabilitation consultant, qualified rehabilitation consultant intern, or job placement coordinator employed in the department's vocational rehabilitation unit established under section 176.104, who has provided rehabilitation, job placement, or job development services under a rehabilitation plan for an employee with a workers' compensation claim.

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

Sec. 12. Laws 2020, chapter 72, section 1, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective for employees who contract COVID-19 on or after the day following final enactment. Paragraph (f) sunsets ~~on May 1, 2021~~ at 11:59 p.m. on December 31, 2021. Employees with dates of injury that occur on or after January 1, 2022, are not entitled to the presumption in section 176.011, subdivision 15, paragraph (f), but are not precluded from claiming an occupational disease as provided in other paragraphs of section 176.011, subdivision 15, or from claiming a personal injury under section 176.011, subdivision 16.

EFFECTIVE DATE. This section is effective the day following final enactment. If Laws 2020, chapter 72, section 1, subdivision 15, paragraph (f), has expired on the effective date of this section, then paragraph (f) is revived and reenacted retroactive to May 1, 2021.

Presented to the governor April 23, 2021

Signed by the governor April 26, 2021, 1:32 p.m.