CHAPTER 5220
DEPARTMENT OF LABOR AND INDUSTRY
COMPENSATION AND REHABILITATION

WORKERS' COMPENSATION REHABILITATION SERVICES

5220.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 5220.0100 to 5220.1910, the following terms have the meanings given them.

Subp. 1a. **Accredited.** "Accredited" institution in part 5220.1400 means that the institution is accredited by a recognized national accrediting body, and that,

where accreditation for those degrees listed in part 5220.1400, subpart 2 is available, the degree program is accredited by a recognized national accrediting body.

Subp. 1b. **Approved claims handler.** "Approved claims handler" means a claims handler who meets the requirements of part 5220.1910.

Subp. 2. **Commissioner.** "Commissioner" means commissioner of the Department of Labor and Industry.

Subp. 3. **Employer.** "Employer" means the employer of qualified employees and includes the insurer providing workers' compensation insurance required by Minnesota Statutes, chapter 176 to this employer.

Subp. 4. **Qualified employee.** "Qualified employee" means an employee who, because of the effects of a work-related injury or disease, whether or not combined with the effects of a prior injury or disability:

A. is permanently precluded or is likely to be precluded from engaging in the usual and customary occupation or position in which the individual was engaged at the time of injury; and

B. can reasonably be expected to benefit from rehabilitation services which could significantly reduce or eliminate the decrease in employability.

Subp. 5. **Qualified rehabilitation consultant.** "Qualified rehabilitation consultant" means a person who is professionally trained and experienced and who is approved by the commissioner to develop and monitor an appropriate plan for evaluation and provision of physical and vocational rehabilitation services for an employee entitled to rehabilitation benefits under Minnesota Statutes, section 176.102. A qualified rehabilitation consultant must be either affiliated as defined in subpart 6 or independent as defined in subpart 7.

Subp. 6. **Qualified rehabilitation consultant/affiliated.** "Qualified rehabilitation consultant/affiliated" means a consultant who is affiliated with an employer, insurer, or adjusting company; and who is approved by the commissioner to develop and monitor rehabilitation plans. A qualified rehabilitation consultant/affiliated as defined in this subpart is permitted to provide rehabilitation consultation only for the claims being handled by the entity with which the consultant is affiliated.

Subp. 7. **Qualified rehabilitation consultant/independent.** "Qualified rehabilitation consultant/independent" means a consultant neither affiliated with an employer, insurer, or adjusting company, nor with a facility or agency engaged in the provision of comprehensive rehabilitation services to qualified employees, and who is approved by the commissioner to develop and monitor rehabilitation plans.

Subp. 8. **Rehabilitation consultation.** "Rehabilitation consultation" means an evaluation by a qualified rehabilitation consultant of the likelihood that rehabilitation services will significantly reduce or eliminate the decrease in employability.

Subp. 8a. **Qualified rehabilitation consultant firm or firm.** "Qualified rehabilitation consultant firm" or "firm" means a public or private business, whether organized as a sole proprietorship, partnership, association, corporation, or other form, which is held out to the public as a business entity engaged in rehabilitation consultation. Only a qualified rehabilitation consultant independent shall be associated with or employed by a firm as defined in this subpart.

Subp. 9. **Rehabilitation plan.** "Rehabilitation plan" means a written document completed by a qualified rehabilitation consultant and which describes the manner and means by which it is proposed that a qualified employee may be returned to suitable, gainful employment through the use of rehabilitation service. The plan shall take into consideration the qualified employee's unique disabilities and assets.

Subp. 9a. **Rehabilitation provider.** "Rehabilitation provider" means the fol-

lowing four categories of rehabilitation professionals: qualified rehabilitation consultants; qualified rehabilitation consultant interns; qualified rehabilitation consultant firms; and registered rehabilitation vendors.

Subp. 10. **Rehabilitation service.** "Rehabilitation service" means service required to determine an employee's eligibility as a qualified employee, and service designed to return an individual to suitable, gainful employment by returning the individual to a job with the former employer or to a job related to the individual's former employment, or by placing the individual in a job in another work field, or by placing the individual in a job with higher economic status than would have occurred without the disability if it can be demonstrated that this is necessary to increase the likelihood of reemployment. The service may include, but is not limited to, medical evaluation, medically prescribed physical rehabilitation, work evaluation, counseling, job analysis, job modification, job placement, on-the-job training, or retraining.

Subp. 10a. **Rehabilitation Services or Rehabilitation and Medical Services.** "Rehabilitation Services" or "Rehabilitation and Medical Services" means the Rehabilitation and Medical Services Section in the Department of Labor and Industry.

Subp. 11. **Registered rehabilitation vendor.** "Registered rehabilitation vendor" means a public or private entity existing wholly or in part for the provision of rehabilitation services to the qualified employee and which has been registered to provide specific rehabilitation services in accord with a rehabilitation plan authorized by the commissioner. Vendors as defined in this subpart shall not employ or otherwise engage the services of qualified rehabilitation consultants.

Subp. 12. **Review panel.** "Review panel" means the panel created by Minnesota Statutes, section 176.102, subdivision 3.

Subp. 13. **Suitable gainful employment.** "Suitable gainful employment" means employment which is reasonably attainable and which offers an opportunity to restore the injured employee as soon as possible and as nearly as possible to employment which produces an economic status as close as possible to that which the employee would have enjoyed without disability. Consideration shall be given to the employee's former employment and the employee's qualifications, including, but not limited to, the employee's age, education, previous work history, interests, and skills.

Subp. 14. **Required rehabilitation report.** "Required rehabilitation report" means a report which must be submitted to rehabilitation services whenever a rehabilitation plan is initiated or proposed to be altered, suspended, or terminated.

Subp. 15. **Required progress record.** "Required progress record" means a record maintained by the qualified rehabilitation consultant which documents rehabilitation provider services and the employee's rehabilitation progress. The record shall include, among other things, case notes and all written reports (whether or not submitted to rehabilitation services) and correspondence received or prepared by the qualified rehabilitation consultant regarding an employee's rehabilitation.

Statutory Authority: *MS s 176.102 subds 2,10; 176.83 subd 2*

History: *8 SR 1777; 9 SR 1478*

5220.0200 [Repealed, 9 SR 1478]

5220.0210 WORK STATUS REPORT.

Subpart 1. **Time for filing.** The employer shall file with the commissioner a work status report, to which current medical reports are attached, in conformity with the following deadlines:

A. within 15 days of receipt of an employee's request for rehabilitation services;

B. within ten days of referral to a qualified rehabilitation consultant to develop and monitor an appropriate plan for evaluation and provision of physical and vocational rehabilitation services;

C. within five days after the employee has 30 days of lost work time due to a back injury or within five days after the employee has 60 days of lost work time due to a personal injury other than a back injury; or

D. within five days after an employer receives medical information prior to the times specified in items A to C that the employee will be unable to return to the job the employee held at the time of injury.

Subp. 2. **Contents.** The work status report shall either:

A. refer the employee to a qualified rehabilitation consultant for rehabilitation consultation; or

B. include a completed rehabilitation indicators form as prescribed by the commissioner which indicates that the employee has returned or will return to work in the near future or that rehabilitation consultation will not be useful in returning the employee to work.

Subp. 3. **Waiver of rehabilitation consultation.** A rehabilitation indicators form must be submitted where the employer requests a waiver of rehabilitation services on the work status report.

If the commissioner denies the request, notice of the denial shall be mailed to the employer within 15 days of the commissioner's receipt of the request. Within 15 days of the date of denial, the employer shall appoint a qualified rehabilitation consultant, or the commissioner shall appoint a qualified rehabilitation consultant to provide the consultation at the expense of the employer.

If the commissioner grants the request, no notice to the employer is required. The waiver, if granted, shall be effective for 60 days from the date of the commissioner's receipt of the request. If the employee does not return to work during this 60-day period, the employer shall at the expiration of the 60 days and every 60 days thereafter file another work status report as required by this part.

Statutory Authority: *MS s 176.83 subds 2,14*

History: *9 SR 1478*

5220.0300 INITIATION OF REHABILITATION SERVICE.

Subpart 1. **Employer's duty.** For the purpose of Minnesota Statutes, section 176.102, subdivision 4, the employer shall, in consultation with the employee, refer the employee to a qualified rehabilitation consultant, unless a rehabilitation indicators form is filed as required by part 5220.0210, subpart 2, item B. This shall be done within five days after an employer has medical information that an employee is unable to return to the job the employee held at the time of the injury, has 60 days of lost work time due to a personal injury other than a back injury, or 30 days of lost work time due to a back injury.

Subp. 2. **Employee's objection.** If the employer has made a selection of a qualified rehabilitation consultant, the employee may object to the employer's selection and shall make his or her own selection and notify the commissioner and the employer in writing. The employee has the final decision on which rehabilitation consultant is to be utilized. Upon receipt of the notice, the commissioner may schedule an administrative conference to discuss a requested change of qualified rehabilitation consultant.

Subp. 3. **Delay by employer.** When the commissioner receives information that the employee is qualified for rehabilitation benefits and the employer has not provided rehabilitation consultation within five days after receipt of similar information, the commissioner shall notify the employer that rehabilitation consultation shall be provided by the employer within 15 days of the notice or a qualified rehabilitation consultant shall be authorized by the commissioner to provide that consultation.

Statutory Authority: *MS s 176.83 subds 2,14*

History: *9 SR 1478*

5220.0400 REHABILITATION PLAN.

Subpart 1. **Submission of plan.** If the qualified rehabilitation consultant determines that rehabilitation would significantly reduce or eliminate the decrease in employability, the rehabilitation consultant shall develop and the employer shall submit a specific rehabilitation plan together with all related medical and vocational reports to the commissioner on forms prescribed for that purpose. The plan shall be signed by all interested parties. A labor market analysis is required in all plans which propose a change in the employee's occupation unless the requirement for such a plan is waived by the commissioner.

Subp. 2. **Approval or rejection of plan.** Within 30 days of submission of a properly documented plan, the commissioner shall approve or reject the plan. The commissioner may request additional information, confer with the parties, recommend modifications, and otherwise seek agreement concerning terms and conditions of the plan. If the vocational objective has not been determined, approval or rejection of the vocational objective may be deferred until 30 days following receipt by the commissioner of a plan progress report containing that objective and supporting rationale. Such a progress report shall be served on all interested parties and if no formal objection is received within ten days from the date of service, it shall be assumed that all parties are in agreement with the vocational objective and rationale.

If the commissioner does not approve or reject the plan within 30 days following its submission, a properly documented plan shall be deemed approved; provided, however, that the commissioner may extend the review period for an additional 30 days for good cause.

Implementation of the plan shall begin as soon as the qualified employee is capable of participating. Implementation may begin upon approval by the commissioner or on the date specified in the plan, whichever date is earlier. A plan shall be submitted to the commissioner before the implementation date. Commencement of a plan without objection from the commissioner shall not be deemed approval of the plan, nor shall it operate as a waiver or an estoppel of the commissioner's power over the plan.

Statutory Authority: *MS s 176.83 subds 2,14*

5220.0500 PLAN MODIFICATION.

Upon request of the employer, employee, or commissioner, the commissioner may suspend, terminate, or alter a rehabilitation plan for good cause, including, but not limited to:

A. a new or continuing physical limitation that significantly interferes with the implementation of the plan;

B. the employee's performance indicates that he or she is unlikely to complete the plan successfully;

C. the employee is not cooperating with the plan; or

D. the plan or its administration is substantially inadequate to achieve the rehabilitation plan objectives.

The commissioner may alter a plan on the request of an employee if the employee believes that the occupation for which he or she is being trained is not suited to him or her, provided that the employee's request shall be made within 90 days from the plan's implementation date and that no more than one change shall be permitted for this reason. Any decision of the commissioner regarding a change in a plan may be appealed to the review panel within 30 days of the filing of and service of the decision on the interested parties.

Statutory Authority: *MS s 176.83 subds 2,14*

History: *9 SR 1478*

5220.0600 COMPLETION OF PLAN.

The employer and qualified rehabilitation consultant shall report to the commissioner immediately upon the employee's completion of the rehabilitation plan, indicating the results and other pertinent information which the commissioner may require.

Statutory Authority: *MS s 176.83 subds 2,14*

5220.0700 CHANGE OF CONSULTANT OR VENDOR.

Any requests for change of a consultant or vendor shall be directed to the commissioner. The commissioner may schedule an administrative conference and may order a change of consultation or service if such is in the best interests of the parties. If the commissioner determines the consultant's work to be unsatisfactory or the consultant withdraws from the case, the commissioner shall make a referral to another consultant.

Statutory Authority: *MS s 176.83 subds 2,14*

5220.0800 DISPUTES.

Where questions exist concerning an employee's entitlement to rehabilitation services, or where a rehabilitation plan is not acceptable to the employee or to the employer, or in case of any other dispute involving rehabilitation, the commissioner, either on his own motion or upon request of the employer or employee, may schedule a conference to resolve the issues in dispute. The commissioner may require the parties to meet and confer informally prior to such a conference. The commissioner may order necessary and reasonable medical examinations and rehabilitation evaluations at the expense of the employer in preparation for such a conference. After allowing the parties an opportunity to be heard, the commissioner shall make a determination on the issues and serve copies on the parties. No determinations will be made with respect to rehabilitation entitlement until primary liability for the claim has been admitted or established.

Statutory Authority: *MS s 176.83 subds 2,14*

5220.0900 APPEAL TO REHABILITATION REVIEW PANEL.

Any person aggrieved by a decision of the commissioner may appeal the decision to the review panel within 30 days of the filing of and service of the decision on the interested parties. The appeal shall specify the grounds upon which the appeal is taken. The panel may approve or reject the commissioner's decision and may formulate its own rehabilitation plan.

Statutory Authority: *MS s 176.83 subds 2,14*

5220.1000 RETRAINING.

When the employee is entitled to additional compensation for retraining, or to after-tax compensation for on-the-job training, the compensation shall commence on the day the employee begins an approved retraining or on-the-job training program.

Statutory Authority: *MS s 176.83 subds 2,14*

History: *9 SR 1478*

5220.1100 LEGAL REPRESENTATION.

When an employee or employer is represented by an attorney in rehabilitation matters before the commissioner, the commissioner shall, at the earliest possible date, be notified in writing of the name, address, and telephone number of said representative. Any representative who has so advised the commissioner will be notified of any meetings, and will receive any reports.

Statutory Authority: *MS s 176.83 subds 2,14*

5220.1200 MANDATORY REHABILITATION SERVICES; SETTLEMENT AGREEMENTS.

Rehabilitation services pursuant to an approved rehabilitation plan are mandatory for qualified employees. A qualified employee's right to rehabilitation services shall not be subject to compromise and shall not be convertible into cash or other benefits by settlement and release agreement or otherwise. When a good faith dispute exists as to qualified employee status, however, the possible right to rehabilitation services may be converted into cash by settlement agreement. Any settlement agreement purporting to limit or compromise access to rehabilitation services must be approved by the commissioner. The value of rehabilitation services shall not be used in calculation of attorneys' fees. The legal fees shall be calculated in the same manner as in other types of cases.

Statutory Authority: *MS s 176.83 subds 2,14*

5220.1300 QUALIFIED REHABILITATION CONSULTANT AND REGISTERED REHABILITATION VENDOR.

Subpart 1. **Provision of services.** Rehabilitation services shall be provided each injured employee to the extent appropriate and which in the judgment of the commissioner will return the employee to suitable, gainful employment.

Subp. 2. **Delivery of services.** Policies and procedures as developed by the commissioner are the basic references for the delivery of rehabilitation services under the law. Adherence thereto shall be a criterion for continued registration as a qualified rehabilitation consultant or rehabilitation vendor.

Subp. 3. **Approval as a vendor or consultant.** An entity may be approved either to provide rehabilitation services as a vendor or to develop and monitor rehabilitation plans as a qualified rehabilitation consultant. These roles are distinct therefore a single entity shall not qualify for both functions. There shall be no ownership or financial relationships of any kind whatsoever between any vendor and consultant or between any vendor and firm. The rehabilitation vendor shall provide all physical rehabilitation and work evaluation and work adjustment services if they are included in a rehabilitation plan. Any number of vendors may provide services for a single rehabilitation plan.

With the written approval of the commissioner, an employer who would qualify as a vendor may hire a qualified rehabilitation consultant/affiliated to develop and monitor rehabilitation plans for their own employees. In such cases, the consultant shall certify that the employee has been advised of his or her right to object to the affiliated rehabilitation consultant. It is expected that the rehabilitation consultant/affiliated shall use outside vendor services if the employer cannot provide them.

Subp. 4. **Dispute over charges.** If a dispute arises with respect to charges for services performed by rehabilitation consultants or vendors, the commissioner shall make determinations as to the reasonable value of charges and the necessity for the services. All qualified rehabilitation consultants and registered rehabilitation vendors shall be bound by any such determination or shall seek recourse through the appellate procedure provided by Minnesota Statutes, chapter 176.

Subp. 5. **Reports.** The qualified rehabilitation consultant shall file all required reports with the commissioner and employer as they are received or created by the consultant. Reports shall also be furnished to the employee's attorney, if any, if he so requests.

The vendor shall make the required reports on a regular basis to the qualified rehabilitation consultant.

Subp. 6. **Following the plan.** The services provided by the registered rehabilitation vendor shall be in accordance with the rehabilitation plan developed for the qualified employee by the qualified rehabilitation consultant. All services provided shall be in accord with the approved plan and no deviation shall be

made from the plan without approval by the commissioner of an amendment to the plan. Time and cost estimates shall be adhered to.

Subp. 7. **Monitoring vendor performance.** Vendor performance shall be monitored by the qualified rehabilitation consultant.

Subp. 8. **Employee moves to other state.** Minnesota qualified employees who move to another state shall be serviced by that state's workers' compensation rehabilitation mechanism in coordination with a Minnesota qualified rehabilitation consultant.

Statutory Authority: *MS s 176.83 subds 2,14*

History: *9 SR 1478*

5220.1400 QUALIFYING ELIGIBILITY CRITERIA FOR REHABILITATION CONSULTANT.

Subpart 1. **Requirement.** The following eligibility criteria and procedures in subparts 2 to 5 shall be used by the commissioner in determining who is qualified for registration as a qualified rehabilitation consultant.

Subp. 2. **Educational background.** A qualified rehabilitation consultant/affiliated/independent shall possess the following credentials as applicable:

A. Holder of a masters or doctorate degree in vocational rehabilitation, counseling and guidance, counseling (including family counseling, community counseling, or other counseling degree with a similar designated specialization), psychology (including counseling psychology, educational psychology, or other psychology degree with a similar designated specialization), social work, occupational therapy, physical therapy, or nursing from an accredited institution, plus a current license as appropriate, plus one year of experience in vocational rehabilitation or physical rehabilitation. At least one year shall have been spent as a qualified rehabilitation consultant intern in rehabilitation of injured workers.

B. Holder of a baccalaureate degree in vocational rehabilitation, counseling and guidance, counseling (including family counseling, community counseling, or other counseling degree with a similar designated specialization), psychology (including counseling psychology, educational psychology, or other psychology degree with a similar designated specialization), social work, occupational therapy, physical therapy, or nursing, from an accredited institution, plus a current license as appropriate, plus two years of experience in vocational rehabilitation or physical rehabilitation. At least one year shall have been spent as a qualified rehabilitation consultant intern in rehabilitation of injured workers.

Subp. 3. **Rehabilitation consultant intern.** An individual who meets the minimum educational requirements but does not meet the minimum experience requirements may be registered as a consultant intern. When the intern is registered, the intern's employer shall provide the commissioner with the name of the qualified rehabilitation consultant under whose direct supervision the intern will work. The supervisor shall be considered to be directly responsible for the rehabilitation work on any case. The supervisor shall co-sign all work being done by the intern. So that all parties are aware of the intern's status, he shall be designated as an "intern." The intern may make application for "qualified" status when the minimum requirements in subpart 2, item A or B have been met.

Substantiated complaints about professional behavior or services, or failure to comply with laws, rules, or decisions and orders are grounds for denial of registration as a qualified rehabilitation consultant. The intern may appeal the denial as provided in part 5220.1500, subpart 2.

In cases where an intern has been supervised by a qualified rehabilitation consultant/affiliated who leaves the organization with which he has been affiliated and no other qualified rehabilitation consultant is available to supervise the intern, the intern may, with the approval of the commissioner, temporarily sign

all required documents in the capacity of a qualified rehabilitation consultant. Past performance and overall experience will be taken into consideration for this approval.

Subp. 4. **Experience criteria.** The burden of proof of experience shall be on the applicant. This shall include documentation of a history of employment in a position of physical rehabilitation or vocational rehabilitation. The experience requirements of subpart 2 for qualified rehabilitation consultants can be met only by full-time paid employment. School internship and volunteer activities are not acceptable as employment experience.

Supporting documents shall consist of signed statements by present and previous employers and insurers specifying the services, caseload, and amount of time spent in rehabilitation of work-related injuries and diseases.

Subp. 5. **General criteria.** All persons who are qualified rehabilitation consultants shall be exclusively self-employed or exclusively employed by a single organization that is approved for the employment of qualified rehabilitation consultants or an employer/insurer.

All persons who are qualified rehabilitation consultants shall be residents of Minnesota. An organization authorized for the employment of qualified rehabilitation consultants may request an exception for a consultant who lives contiguous to a Minnesota catchment area if the organization and any such consultant agrees, as a condition to approval, to appear at any hearing when requested, in the same manner as if they had been subpoenaed. Failure to do so shall result in automatic revocation of the individual consultant's approval.

A qualified rehabilitation consultant operating on the effective date of this amendment who is registered is deemed to meet the standards of this part. Registered qualified rehabilitation consultant interns operating on February 7, 1984, must meet the minimum requirements in effect on February 6, 1984, in order to make application for qualified rehabilitation consultant registration.

Statutory Authority: *MS s 176.102 subd 10*

History: *8 SR 1777; 9 SR 1478; 10 SR 17*

5220.1500 PROCEDURE FOR QUALIFYING AS REHABILITATION CONSULTANT.

Subpart 1. **Application.** An individual desiring to receive approval and registration as a qualified rehabilitation consultant shall submit to the commissioner, a complete application consisting of the following:

A. completed and signed application form which is notarized;

B. copy of current license or certification;

C. supporting experience documentation;

D. transcripts of all schools attended beyond high school;

E. list of pertinent continuing education by title, location, and date;

F. list of services and fees. This filing shall not constitute an approval or disapproval of the services or fees; and

G. the annual registration fee, which shall consist of $100 for qualified rehabilitation consultant firms and $50 for each qualified rehabilitation consultant or qualified rehabilitation consultant intern.

The commissioner shall issue a notice of acceptance or rejection to the applicant within 60 days of receipt of the completed application. Acceptance will be provisional until the completion of an introductory training session.

Subp. 2. **Appeal process.** The appeal process provides a mechanism for applicants to request reconsideration of a rejected application for registration, renewal, and reinstatement.

A written notice of appeal shall be filed with the commissioner within 30 days of mailing of notice of disapproval.

The decision shall be reviewed by the review panel. The applicant shall be advised of the date, time, and place of the review at least ten days prior to the hearing date, and is encouraged to be present.

Subp. 3. **Registration.** The commissioner shall assign a registration number to each qualified rehabilitation consultant. The registration number shall be on all reports submitted by the consultant.

To retain registration, the consultant must submit satisfactory evidence of approved continuing education pertinent to the workers' compensation rehabilitation field equivalent to 15 contact hours each year at the time registration is renewed.

Subp. 4. **Renewal.** Registration shall be renewed annually. If an interval of one year occurs without providing direct case service or without providing supervision to qualified rehabilitation consultants or qualified rehabilitation consultant interns who provide direct case service to workers' compensation recipients, the registration and approval is automatically suspended. A qualified rehabilitation consultant or intern may apply for reinstatement by providing verification to rehabilitation services of his attendance at the annual update sessions and fulfillment of continuing education requirements as provided by parts 5220.0100 to 5220.1900. The applicant must complete an introductory training session before approval is final. The suspension may be appealed to the rehabilitation review panel in accordance with subpart 5, item B.

Services and fee schedules shall be submitted to the commissioner whenever there is a change or no less than once each calendar year. This filing shall not constitute an approval or disapproval of the services or fees.

No later than 60 days prior to expiration of registration, the consultant shall request registration renewal on a form prescribed by the commissioner.

Subp. 5. **Revocation.** The commissioner may review the activities of registered qualified rehabilitation consultants and vendors to determine if they are in compliance with all rehabilitation services' rules.

A. When the commissioner becomes aware of an alleged violation concerning a qualified rehabilitation consultant or vendor he shall notify in writing the qualified rehabilitation consultant or vendor. The qualified rehabilitation consultant or vendor may then respond by letter or by requesting an administrative conference. If the qualified rehabilitation consultant or vendor does not request an administrative conference, the commissioner shall order that a conference occur unless the complaint is found to be frivolous or without merit. After the administrative conference, the commissioner shall determine if he should discipline the individual or firm based upon applicable rules and statutes and all evidence gathered by the conference. Regardless of the commissioner's decision, he shall issue an order setting forth the reasons for his actions. If discipline is decided on by the commissioner, it shall consist of one or more of the following:

(1) a written reprimand requesting the individual or firm to cease actions which resulted in the lack of compliance with rehabilitation services' rules;

(2) a full restitution of improperly charged fees and services by the individual or firm to the insurance carrier;

(3) an extension of intern status for up to six months beyond part 5220.1400 requirements for application;

(4) a restriction or prohibition on accepting new cases for up to six months.

If the commissioner imposes discipline twice in five years upon an individual or firm, the next alleged violation shall be referred to the rehabilitation review panel for review. An individual's discipline shall not be attributed to his employing firm unless the violation for which discipline is imposed also constitutes a violation by the firm and results in discipline to the firm.

B. An individual or firm may appeal the commissioner's disciplinary action to the rehabilitation review panel by requesting a hearing in writing to the director of rehabilitation services within 30 calendar days of the commissioner's determination.

C. Upon the commissioner's referral of a third alleged violation, the firm or individual shall be given written notice of the referral and grounds for the review.

D. The rehabilitation review panel shall follow the hearing procedures set forth in Minnesota Statutes, section 176.102, subdivision 3a. The panel shall take one or more of the following actions in reviewing rehabilitation providers alleged violations such as:

(1) absolving the individual or firm of any alleged rehabilitation rule violation;

(2) written reprimand;

(3) demotion of a qualified rehabilitation consultant to qualified rehabilitation consultant intern status;

(4) probation of a qualified rehabilitation consultant, qualified rehabilitation consultant intern, or vendor;

(5) revocation of qualified rehabilitation consultant, qualified rehabilitation consultant intern, or registered vendor status.

E. Procedures to appeal the determination of the review panel shall be as follows:

(1) The panel's written decision and order shall act as a final order for purposes of implementing discipline. The decision is appealable to the Workers' Compensation Court of Appeals and must be filed in accordance with its rules; and

(2) Unless otherwise ordered by the panel, an individual or firm whose registration has been revoked must wait at least one year from the effective date of revocation to reapply for a registered status.

Statutory Authority: *MS s 176.102 subds 2,10; 176.83, subd 2*

History: *8 SR 1777; 9 SR 1478*

5220.1600 PROCEDURE FOR APPROVAL AS A FIRM.

Subpart 1. **Criteria.** The firm shall be licensed to do business in Minnesota and shall maintain an administrative office within the state. The management staff shall consist of at least one member who meets the qualifications of a rehabilitation consultant. Eighty percent of the nonclerical staff shall be eligible, qualified rehabilitation consultants or consultant interns. Management shall provide ongoing continuing education opportunities in workers' compensation rehabilitation for approval by the commissioner and to meet the criteria for registration renewal of rehabilitation consultants. The firm shall not provide the services designated only as rehabilitation vendor services.

Subp. 2. **Application.** A private or public entity desiring to be approved as a firm shall submit to the commissioner a complete application consisting of the following:

A. a completed and signed application (notarized); and

B. any data or information attached to support application; and

C. documentation of intent to provide opportunities for continuing education to meet requirements for registration renewal of rehabilitation consultants; and

D. list of services and fees. This filing shall not constitute an approval or disapproval of the services or fees.

Subp. 3. **Appeal process.** The appeal process herein shall be conducted the same as that provided in part 5220.1500, subpart 2.

Subp. 4. **Renewal.** The renewal process herein shall be conducted the same as that provided in part 5220.1500, subpart 4.

Subp. 5. **Revocation.** The revocation process herein shall be conducted the same as that provided in part 5220.1500, subpart 5.

Statutory Authority: *MS s 176.83 subds 2,14*

History: *9 SR 1478*

5220.1700 PROCEDURE FOR APPROVAL AS REGISTERED REHABILITATION VENDOR.

Subpart 1. **Application.** A private or public entity desiring to be approved as a registered rehabilitation vendor shall submit to the commissioner a complete application consisting of all of the following:

A. A completed and signed application.

B. Any data or information attached to support an application.

C. A list of services and fees. This filing shall not constitute an approval or disapproval of the services or fees.

D. The annual registration fee of $100 for each registered vendor.

Subp. 2. **Appeal process.** The appeal process herein shall be conducted the same as that provided in part 5220.1500, subpart 2.

Subp. 3. **Renewal.** The renewal process herein shall be conducted the same as that provided in part 5220.1500, subpart 4.

Subp. 4. **Revocation.** The revocation process herein shall be conducted the same as that provided in part 5220.1500, subpart 5.

Statutory Authority: *MS s 176.102 subds 2,10; 176.83, subd 2*

History: *8 SR 1777*

5220.1800 STANDARDS OF PERFORMANCE.

The standards of conduct described in parts 5220.1801 to 5220.1805 establish minimum standards concerning the professional activities of qualified rehabilitation consultants and rehabilitation vendors in Minnesota. The performance evaluations by rehabilitation services of qualified rehabilitation consultants and vendors will be based upon these standards, as well as on the adherence to Minnesota Statutes, section 176.102 and rules adopted to administer it.

Statutory Authority: *MS s 176.102 subds 2,10; 176.83 subd 2*

History: *8 SR 1777*

5220.1801 PROFESSIONAL CONDUCT.

Subpart 1. **Services provided under the plan.** In accord with part 5220.0100, subpart 9, the qualified rehabilitation consultant or vendor shall provide rehabilitation services under a rehabilitation plan. The qualified rehabilitation consultant or vendor shall implement only those rehabilitation plans with which the employee, the employer/insurer, and the qualified rehabilitation consultant agree.

Subp. 2. **Assigned qualified rehabilitation consultant.** Only the assigned qualified rehabilitation consultant, or a qualified rehabilitation consultant designated by the assigned qualified rehabilitation consultant, shall be involved at any given time in the employee's rehabilitation effort, except as stated in subparts 4 and 5. The assigned qualified rehabilitation consultant must submit the rehabilitation plan to rehabilitation services and to the employer within 30 days of referral. The assigned qualified rehabilitation consultant must submit records or reports to the employer or employee as requested by the employer or employee. This subpart shall not apply to a qualified rehabilitation consultant acting on behalf of the reinsurance association in a monitoring or advisory capacity on a reinsurance claim file.

Subp. 3. **Approved change of consultant.** A qualified rehabilitation consultant

shall not provide services to any parties after there has been an approved change of qualified rehabilitation consultant except as provided in subparts 4 and 5.

Subp. 4. **Transfer of information.** A qualified rehabilitation consultant shall cooperate in transferring to a newly approved qualified rehabilitation consultant all data, reports, and relevant information within 15 days from the receipt of rehabilitation services letter approving the new qualified rehabilitation consultant.

Subp. 5. **Evaluation of employee.** If a hearing has been scheduled before a judge or a judicial body, a qualified rehabilitation consultant who is not the approved qualified rehabilitation consultant may perform an evaluation of the employee at the request of one of the parties. Rehabilitation services shall be notified in writing of the qualified rehabilitation consultant requested to do the evaluation. A copy of the evaluation report, if developed, shall be sent to rehabilitation services.

Subp. 6. **Consultant as witness.** A qualified rehabilitation consultant who has testified as an expert witness for any party in a judicial hearing may not function as the ongoing qualified rehabilitation consultant on the case unless agreed to by the employee.

Subp. 7. **Referrals.** A qualified rehabilitation consultant or vendor may make recommendations for referrals to appropriate resources.

Subp. 8. **Separate roles and functions.** The roles and functions of a claims agent and a qualified rehabilitation consultant or vendor are separate. A qualified rehabilitation consultant or vendor, or an agent of a rehabilitation provider, shall engage only in those activities designated in Minnesota Statutes, section 176.102, and its rules. Claims adjustment and claims investigation activities such as unilaterally providing for an adverse medical, vocational, or rehabilitation examination except as provided for in subpart 5, aiding insurers in determining monetary workers' compensation benefits, or determining the reasonableness of medical or rehabilitation service are prohibited for a rehabilitation provider. This subpart shall not prohibit a qualified rehabilitation consultant acting on behalf of the reinsurance association from consulting with the primary qualified rehabilitation consultant regarding the rehabilitation plan.

Statutory Authority: *MS s 176.102 subds 2,10; 176.83 subd 2*

History: *8 SR 1777; 9 SR 1478*

5220.1802 COMMUNICATIONS.

Subpart 1. **Legibility and content of reports.** All reports submitted by a qualified rehabilitation consultant or vendor shall be legible and show the employee's name, social security number, date of injury, street address, county, zip code of residence, and legal representative, if any.

Subp. 2. **Submission of reports.** All required rehabilitation reports shall be submitted in accordance with department forms as prescribed by the commissioner under Minnesota Statutes, section 176.83, clause (j).

Subp. 3. **Copies to employer.** The employer shall be provided with copies of all reporting forms.

Subp. 4. **Submission by vendor.** Vendors are to submit all reports directly to the qualified rehabilitation consultant.

Subp. 5. **Data privacy.** A qualified rehabilitation consultant or vendor must comply with all applicable data privacy acts.

Subp. 6. **Contact with physicians.** A qualified rehabilitation consultant or vendor shall not engage in communications with a physician concerning an employee without a release of information form from the employee.

Subp. 7. **Retirement.** A qualified rehabilitation consultant or vendor shall not make recommendations concerning an intent to or date of retirement but may

assist an employee in contacting resources concerning a choice of retirement or return to work.

Subp. 8. **Settlements.** A qualified rehabilitation consultant or vendor shall not recommend entering into settlement agreements.

Subp. 9. **Limited requests for information.** A qualified rehabilitation consultant or vendor shall request only that information and data which will assist the parties in developing and carrying out the rehabilitation plan.

Subp. 10. **Providing records.** The qualified rehabilitation consultant or vendor assigned to a case shall maintain all required progress records regarding a case and shall make these records available or provide copies to rehabilitation services upon request by the commissioner. This subpart shall not apply to the reinsurance association, unless the reinsurance association has assumed primary responsibility for the claim pursuant to Minnesota Statutes, section 79.35, clause (g).

Subp. 11. **Access to medical and rehabilitation reports.** A qualified rehabilitation consultant shall provide a vendor access to all appropriate medical and rehabilitation reports relating to a case.

Statutory Authority: *MS s 176.102 subds 2,10; 176.83 subd 2*

History: *8 SR 1777; 9 SR 1478*

5220.1803 RESPONSIBILITIES.

Subpart 1. **Instruction by consultant.** A qualified rehabilitation consultant is to instruct the employee of his rights and responsibilities by reviewing with him the purpose of rehabilitation services and the rights and responsibilities of the injured workers.

Subp. 2. **Knowledge of laws and rules.** A qualified rehabilitation consultant or vendor shall be knowledgeable and informed regarding portions of the workers' compensation law and rules that directly relate to the provision of rehabilitation services. If a qualified rehabilitation consultant or vendor communicates inaccurate information regarding workers' compensation not directly related to rehabilitation services, the rehabilitation provider is subject to discipline.

Subp. 3. **Clarification of issues.** A qualified rehabilitation consultant or vendor may contact rehabilitation services to clarify any rehabilitation issues or problems.

Subp. 4. **Disciplinary action.** A qualified rehabilitation consultant or vendor's registration is subject to disciplinary action up to and including revocation based on substantiated complaints about professional behavior, or services which show noncompliance with established laws, rules, decisions, or orders.

Statutory Authority: *MS s 176.102 subds 2,10; 176.83 subd 2*

History: *8 SR 1777*

5220.1804 CONTINUING EDUCATION AND COMPETENCIES.

Subpart 1. **Training sessions.** A qualified rehabilitation consultant or vendor shall attend at least one introductory training session provided by rehabilitation services within six months of being registered.

Subp. 2. **Update sessions.** Rehabilitation services annual update sessions are mandatory for all qualified rehabilitation consultants, qualified rehabilitation consultant interns, and all registered vendors.

Statutory Authority: *MS s 176.102 subds 2,10; 176.83 subd 2*

History: *8 SR 1777*

5220.1805 BUSINESS PRACTICES.

All registered qualified rehabilitation consultants, qualified rehabilitation consultant interns, and vendors shall abide by the following rules concerning a provider's business practices:

A. Rehabilitation providers shall adhere to all applicable federal, state, and local laws regulating business practices.

B. Rehabilitation providers shall not misrepresent themselves, their duties, or credentials. A rehabilitation provider must not promise or offer services or results he cannot deliver or has reason to believe he cannot provide. Competitive advertising must be factually accurate and must avoid exaggerating claims as to costs, results, and endorsements by other parties.

C. If a fellow rehabilitation provider violates parts 5220.0100 to 5220.1910, a rehabilitation provider having actual personal knowledge about the violation must direct the information to rehabilitation services.

D. A provider shall not solicit referrals directly or indirectly by offering money or gifts. De minimis gifts are not considered the offering of money or gifts. De minimis gifts are those that have a fair market value of less than $25.

E. A rehabilitation provider shall advise the referral source and payer of its fee structure in advance of rendering any services and shall also furnish upon request, detailed and accurate time records regarding any bills in question.

F. Any fee arrangement which prevents individual assessment and services for each employee shall subject the providers to discipline. Any fee arrangement which provides employees with standardized services whether or not the services are necessary shall also subject the rehabilitation providers to discipline.

G. A rehabilitation provider shall not incur profit, split fees, or have an ownership interest with another rehabilitation provider outside of his or her own firm.

H. Qualified rehabilitation consultants shall not incur profit, split fees, or have an ownership interest with health care providers. "Health care providers" means those defined in Minnesota Statutes, section 176.011, subdivision 24.

I. The prohibitions of items F, G, and H shall not be construed to prevent married couples or family members from engaging simultaneously in rehabilitation or health care.

Statutory Authority: *MS s 176.102 subds 2,10; 176.83 subd 2*

History: *8 SR 1777; 9 SR 1478*

5220.1900 REHABILITATION SERVICES AND FEES.

Subpart 1. **Fee monitoring.** Rehabilitation services has the responsibility and jurisdiction under Minnesota Statutes, section 176.102, subdivisions 2 and 9 to monitor and determine reasonable rehabilitation costs, the necessity of services provided, and to resolve any disputes that may arise between the parties according to part 5220.1300.

The employer/insurer has the primary responsibility for monitoring and paying the cost of necessary rehabilitation services provided. Either the employer/insurer or a rehabilitation provider may request rehabilitation services to make a determination of reasonable costs and necessity of services.

Rehabilitation services shall conduct periodic audits of costs, services, and compliance with reporting and recordkeeping requirements. The employer/insurer and the rehabilitation provider shall provide rehabilitation services with itemized services and costs upon request. Rehabilitation services must contact the parties to discuss costs and services deemed questionable by rehabilitation services or one of the parties. Rehabilitation services may order an administrative conference to discuss services and fee disputes, whether initiated by one of the parties or by rehabilitation services.

Subp. 2. **Reasonable and necessary services.** A qualified rehabilitation consultant or vendor shall bill for only those necessary and reasonable services which are rendered in accordance with rehabilitation services rules during completion

of a plan. Reasonable and necessary services and fees shall be determined by the commissioner. The commissioner's review must include all the following factors:

A. the employee's unique disabilities and assets in relation to the goals, objectives, and timetable of the rehabilitation plan;

B. the type of rehabilitation services provided and the actual amount of time and expense incurred in providing the service;

C. the rehabilitation providers' fee schedules on file with rehabilitation services and other fee schedules of providers on file with rehabilitation services;

D. an evaluation of whether services provided were unnecessary, duplicated other services, available at no charge to public, or were excessively sophisticated for the actual needs of the employee;

E. an evaluation of whether services rendered were expressly authorized by either the employer, insurer, or rehabilitation services;

F. an evaluation of whether Minnesota Statutes, chapter 176, and rehabilitation services' parts 5220.0100 to 5220.1910 have been followed by the provider.

No registered qualified rehabilitation consultant, qualified rehabilitation consultant intern, or registered vendor shall attempt to collect reimbursement for an unnecessary or unreasonable procedure, service, or cost from any other source, including the employee, another insurer, the special compensation fund, or any government program.

Subp. 3. **Reporting requirements.** The qualified rehabilitation consultant assigned to an employee must provide rehabilitation services with the following information regarding an employee's case for purposes of rehabilitation services' monitoring of services and overall record keeping requirements. This subpart shall not apply to the reinsurance association, unless the reinsurance association has assumed primary responsibility for the claim pursuant to Minnesota Statutes, section 79.35, clause (g).

The qualified rehabilitation consultant shall provide rehabilitation services with an initial evaluation narrative report concerning the employee which will include the following information in summary fashion: medical status, vocational history, educational history, social and economic status, transferable skills, employment barriers, and recommendations.

Thereafter, the qualified rehabilitation consultant shall provide additional narrative progress summaries, if requested by the commissioner, of up to one page.

The qualified rehabilitation consultant shall send, attached to the narrative progress summaries, completed copies of all vendor reports, medical, psychological, and vocational reports regarding an employee's case.

The requesting party shall pay for all costs incurred by a rehabilitation provider in creating a report not required or requested by rehabilitation services.

Subp. 4. **Estimated goal dates and costs.** When developing the rehabilitation plan and when submitting required rehabilitation reports, required progress records, or other documents, the qualified rehabilitation consultant must make a professional judgment regarding any projected goal date and estimated costs. This shall include projected goal date and estimated costs submitted by any vendor. When the date or cost has been exceeded, the qualified rehabilitation consultant and any rehabilitation vendor must submit to rehabilitation services an itemized billing and no more than a one page rationale regarding continued provision of rehabilitation services. The rehabilitation provider is to submit the rationale to the employer/insurer. If the parties are unable to agree about continued rehabilitation services, any party may request a review by rehabilitation services.

Subp. 5. **Invoices.** Invoices are to be attached to all plan completion forms.

Subp. 6. **Consent of employer/insurer; exceptions.** A qualified rehabilitation consultant or vendor shall obtain the express consent of the employer/insurer before providing the following services, however, the presence or the absence of express consent shall not preclude rehabilitation services from determining the reasonable value or necessity of these services:

A. when not directed to plan objectives, costs for physician visits, phone calls to physicians, accompanying employee to appointments or examinations;

B. follow-up activity with employers during job placement services to verify employee applications not arranged by qualified rehabilitation consultant or vendor;

C. phone calls to rehabilitation services regarding general procedures on questions or rehabilitation direction, not related to a specific rehabilitation plan;

D. unanswered attempted phone calls;

E. time spent for report writing not requested by a party beyond items indicated in the reporting guidelines of subpart 3;

F. qualified rehabilitation consultant billings during vendor activity periods beyond required reporting or specific problem solving activity;

G. time for attendance at an administrative conference by the supervisor of the qualified rehabilitation consultant who is providing services to the employee;

H. any services rendered prior to the acceptance of eligibility for rehabilitation by an insurer or determination or eligibility by rehabilitation services;

I. time spent reviewing the file and initial contact to establish rapport with interested parties by a qualified rehabilitation consultant or vendor when a case has been transferred from another qualified rehabilitation consultant or vendor within the same rehabilitation firm;

J. time spent by a supervisor, another qualified rehabilitation consultant, or support staff in addition to the qualified rehabilitation consultant of record except as provided for in part 5220.1801, subpart 2;

K. job placement activities beyond 90 days from the start of the job placement effort without a plan review;

L. wait time for a visit without a prearranged meeting or early arrival for a prearranged appointment;

M. time spent by a qualified rehabilitation consultant selected by the employee before approval of a qualified rehabilitation consultant change has been issued by rehabilitation services;

N. services that are not needed or repeat services already done;

O. charges beyond the hourly fee for testimony at a judicial hearing when the qualified rehabilitation consultant or vendor has provided rehabilitation service under the plan;

P. travel costs beyond those needed to develop or complete a plan; or

Q. any disputed services and fees in regard to rehabilitation provided.

Statutory Authority: *MS s 176.102 subds 2,10; 176.83 subd 2*

History: *8 SR 1777; 9 SR 1478*

5220.1910 APPROVED CLAIMS HANDLER.

Subpart 1. **Qualifications.** A person meeting all the requirements of this subpart is eligible for certification as an approved claims handler.

A. at least one year of experience handling Minnesota workers' compensation claims and making decisions on acceptance or denial of Minnesota workers' compensation claims; and

B. completion of a training session conducted by the commissioner; and

C. the person is not a rehabilitation provider as defined in part 5220.0100, subpart 9a.

Subp. 2. **Procedure for obtaining approval.** The employer, insurer, or adjusting company shall certify to the commissioner that the claims handler meets the requirements of this part. Approval is effective upon the commissioner's receipt of the certification. The approval remains in effect until the claims handler leaves the employ of the certifying entity, or the certification is withdrawn by the certifying entity. At the request of the commissioner, the certifying entity must consult with the commissioner regarding withdrawal of certification. The commissioner is authorized to withdraw approval if the claims handler does not meet the requirements of subpart 1.

Statutory Authority: *MS s 176.83 subds 2,14*

History: *9 SR 1478*

WORKERS' COMPENSATION RULES OF PRACTICE

5220.2500 [Repealed, 11 SR 1530]

5220.2510 SCOPE AND PURPOSE.

Parts 5220.2510 to 5220.2950 together with parts 5220.0100 to 5220.1910 govern all workers' compensation matters before the commissioner of the Department of Labor and Industry except matters which are governed by the joint rules of practice of the Workers' Compensation Division and the Office of Administrative Hearings in parts 1415.0100 to 1415.3600.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2520 DEFINITIONS.

Subpart 1. **Scope.** Terms used in parts 5220.2510 to 5220.2950, have the meanings given them in part 1415.0300 and this part.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Labor and Industry.

Subp. 3. **Days.** "Days" refers to calendar days unless otherwise indicated.

Subp. 4. **Department.** "Department" means the Department of Labor and Industry.

Subp. 5. **Division.** "Division" means the Workers' Compensation Division of the Department of Labor and Industry.

Subp. 6. **Health care provider.** "Health care provider" has the meaning given it in Minnesota Statutes, section 176.011, subdivision 24.

Subp. 7. **Insurer.** "Insurer" includes self-insured employers.

Subp. 8. **Office.** "Office" means the Office of Administrative Hearings.

Subp. 9. **Permanent total disability.** "Permanent total disability" means that after completion of medical and vocational assessment and any applicable rehabilitation, and after consideration of the employee's age, physical restrictions, transferable skills, and economic factors in the employee's employment community, the employee has not found and cannot be reasonably expected to find suitable gainful employment.

Subp. 10. **Section.** "Section" refers to the Rehabilitation and Medical Services Section of the Workers' Compensation Division of the Department of Labor and Industry.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2530 FIRST REPORT OF INJURY.

The first report of injury must be fully completed and submitted in duplicate to the division within the time limits established by Minnesota Statutes, section 176.231. It must be on a form prescribed by the commissioner, containing substantially the following:

A. information identifying the employee, employer, insurer, and any adjusting company;

B. claim numbers or codes;

C. information regarding all wages paid to the employee from any source;

D. information regarding employment status and the job held at the time of injury;

E. information regarding the circumstances of the injury, including the date, place, time, persons or objects involved, the date notice was received by the employer, and the name of the person who received notice;

F. a description of the claimed injury and how and where it occurred;

G. information regarding lost time from work;

H. information identifying the treating physician;

I. information identifying the employee's next of kin if the injury or disease has resulted in the death of the employee; and

J. verification by the employer or the employer's authorized representative and the date of submission to the insurer.

Failure to file the report in a timely manner may result in the assessment against the employer of the penalty set out in part 5220.2820 and against the insurer of the penalty set out in part 5220.2770.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2540 PAYMENT OF TEMPORARY TOTAL, TEMPORARY PARTIAL, OR PERMANENT TOTAL COMPENSATION.

Subpart 1. **Time of payment.** Payment of compensation must be commenced within 14 days of:

A. notice to or knowledge by the employer of an injury compensable under the act;

B. notice to or knowledge by the employer of a new period of lost time due to a previous work-related injury unless an extension is requested under Minnesota Statutes, section 176.221, subdivision 1; or

C. an order by the division, compensation judge, or workers' compensation court of appeals requiring payment of benefits which is not appealed.

Once temporary total or permanent total disability benefits have been commenced, they must continue to be paid on a regular basis. Payments are due on the date the employee would have received wages from the employer had the employee continued working.

The same time limits apply to payments of temporary partial disability benefits. If the current wage varies so that wage documentation for calculation of temporary partial disability benefits is necessary, payment is due ten days following the date the employee or employer sends wage verification to the insurer.

Subp. 2. **Place of payment.** With the exception of payments made subject to part 5220.2560 or other order of a compensation judge or the division, all payments of compensation must be made directly to the employee or dependent at the home address unless the employee or dependent, in writing, authorizes payment to be sent elsewhere. The employee or dependent may authorize payment to be sent to a bank, savings and loan association, or other financial institution by providing the employer or insurer with a written request for redirection of payment, the name and address of the institution, and the account number to which the payments should be credited. The insurer must comply with the request without a specific order from the division. The insurer must file a copy of the request with the division.

Subp. 3. **Notice to division.** The insurer must keep the division advised of all payments of compensation and amounts withheld and amounts paid for attorney fees by the filing of interim status reports 60 days after commencement of payment or an R-1 form, and thereafter each year on the anniversary date of the injury unless another time interval is specified by the division.

The insurer must also file with the division proof of payment which must indicate the amount of compensation paid and the date when the first payment was made, at each of the following times:

A. the insurer makes the first payment to the employee following the injury;

B. payments are reinstated after they have been previously discontinued by a notice of discontinuance or an order of the division under part 5220.2640, subpart 7;

C. monitoring period compensation is commenced under Minnesota Statutes, section 176.101, subdivision 3i; or

D. payments are commenced by order of the division, a compensation judge, the workers' compensation court of appeals, or the Minnesota Supreme Court.

Subp. 4. **Penalties.** If payment is not made within the time limits of subpart 1, and no denial of liability has been filed under part 5220.2570, subpart 1, or notice of appeal filed from an order of the division, compensation judge, workers' compensation court of appeals, or the Minnesota Supreme Court, the division may assess penalties under Minnesota Statutes, sections 176.221 and 176.225, and parts 5220.2770, 5220.2780, and 5220.2790. A penalty for failure to file a notice required under this part may be assessed under part 5220.2830.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2550 PAYMENT OF PERMANENT PARTIAL DISABILITY, INCLUDING IMPAIRMENT COMPENSATION AND ECONOMIC RECOVERY COMPENSATION.

Subpart 1. **Time of payment.** Permanent partial disability must be paid at the time specified in Minnesota Statutes, sections 176.021 and 176.101. When permanent partial disability compensation is being paid periodically following the payment of temporary total benefits or following or concurrent with the payment of temporary partial benefits, the payments must be continued without interruption at the same intervals that the temporary benefits were paid. When the employee reaches maximum medical improvement, the insurer must request an initial assessment of any permanent partial disability from the employee's physician.

A. When the extent of permanent partial disability is not disputed, upon receipt of a medical report containing a permanency rating, the employer or insurer must, within 30 days:

(1) make a lump sum payment or begin periodic payments to the employee; or

(2) inform the employee in writing of the disability rating and the time when the permanent partial disability payment will be payable under the statute.

B. When the extent of permanent partial disability is disputed, upon receipt of a medical report containing a permanency rating, the employer or insurer must, within 30 days:

(1) make a minimum lump sum payment or begin periodic payments based on no less than the lowest available medically documented rating; and

(2) notify the employee in writing that an adverse medical examination has been scheduled and the date, time, and place of the examination. The disability rating must be determined and any remaining permanent partial disability payments made or periodic payment begun, within 120 days of the insurer's receipt of the initial medical report containing a permanency rating; or

C. If permanent partial disability benefits are not currently payable, inform the employee in writing of the disability rating and the time when the permanent partial disability payment will be payable by statute.

Subp. 2. **Notice to division.**

A. For injuries before January 1, 1984, the employer or insurer must, when payment is made, file with the division and serve on the employee an itemized proof of payment indicating the amount of compensation paid and the date of payment together with a copy of the medical report upon which payment is based.

B. For injuries on or after January 1, 1984, when the insurer makes a lump sum payment of permanent partial disability benefits or begins periodic payment, the employer or insurer shall fully complete, serve on the employee, and file with the division a notice of permanent partial disability benefits which must be on a form prescribed by the commissioner, containing substantially the following information:

(1) information identifying the employee, employer, insurer, and any adjusting company;

(2) claim numbers or codes;

(3) the date of the injury;

(4) an explanation of the amount, type, and time of payment of permanent partial disability benefits, including the legal authority for the rating;

(5) monitoring period information;

(6) instructions to the employee;

(7) information regarding possible future permanent partial disability payments;

(8) information regarding previous permanent partial disability payments;

(9) copies of medical reports containing disability ratings;

(10) verification by the insurer, including the name and telephone number of the person making the decision to pay benefits; and

(11) the date the notice was served on the employee.

Subp. 3. **Place of payment.** Payment under this part is to be made as provided in part 5220.2540, subpart 2.

Subp. 4. **Penalties.** If benefits are not paid as required under subpart 1 or 2, the division may assess penalties under Minnesota Statutes, sections 176.221 and 176.225, and parts 5220.2750, 5220.2760, and 5220.2790. A penalty for failure to file a notice required by this subpart may be assessed under part 5220.2830.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2560 ATTACHMENT AND GARNISHMENT OF BENEFITS.

Workers' compensation benefits are not subject to attachment or garnishment, although they may be withheld under Minnesota Statutes, sections 518.54, subdivision 6 and 518.611, and paid for child support or spousal maintenance. If the other requirements of those statutes are met, the insurer shall file with the division a statement of the amount being withheld from the employee's benefits and paid to the county or obligee, a copy of the order for withholding of income, and verification of payments made.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2570 DENIALS OF LIABILITY.

Subpart 1. **Form.** When an employer or insurer denies liability for a work-related injury, it shall serve and file the documents prescribed by this part.

Subp. 2. **Denial of liability form.** A denial of primary liability under Minnesota Statutes, section 176.221, subdivision 1 (except a letter denial under subpart 4 or 5) must be fully completed and on a form prescribed by the commissioner, containing substantially the following:

A. information identifying the employee, employer, insurer, and any adjusting company;

B. the date of the claimed injury;

C. claim numbers or codes;

D. the signature, name, and telephone number of the person who made the determination;

E. a specific reason for the denial which must be in language easily readable and understandable to a person of average intelligence and education and clearly state the facts forming the basis for the denial. A denial which states only that the injury did not arise out of and in the course and scope of employment or that the injury was denied for lack of a medical report, for example, is not specific within the meaning of this item; and

F. instructions to the employee, including the availability of rehabilitation benefits, the statute of limitations for filing a workers' compensation claim, and the address and telephone numbers of division offices the employee may contact for information.

Subp. 3. **Notice of intention to discontinue benefits.** A denial of liability filed more than 30 days after notice to or knowledge by the employer of a work-related injury which is required to be reported to the commissioner under Minnesota Statutes, section 176.231, subdivision 1, and for which benefits have been paid must be made by a notice of intention to discontinue benefits under part 5220.2630 and must clearly indicate that its purpose is to deny liability for the entire claim.

Subp. 4. **Letter denial for new period of temporary total.** A denial of liability for temporary total disability benefits for a new period of lost time due to a previous work-related injury must be in writing and include:

A. information identifying the employee, employer, insurer, and any adjusting company;

B. the date of the claimed injury;

C. claim numbers or codes;

D. the signature, name, and telephone number of the person who made the decision; and

E. a specific reason for the denial in language easily readable and understandable to a person of average intelligence and education and clearly state the facts forming the basis for the denial.

Subp. 5. **Letter denial for other benefits.** A denial of liability for a portion of benefits or any other compensation where primary liability has been accepted, must be in writing and include:

A. information identifying the employee, employer, insurer, and any adjusting company;

B. the date of the claimed injury;

C. claim numbers or codes;

D. the signature, name, and telephone number of the person who made the decision; and

E. a specific reason for the denial in language easily readable and understandable to a person of average intelligence and education and clearly state the facts forming the basis for the denial.

Subp. 6. **Service.** The employer or insurer shall, as provided in part 5220.2890, serve on the employee the form or letter under subparts 1 to 5 with any relevant medical or other reports attached and a copy to the division.

Subp. 7. **Time for filing.** Denials of liability must be filed with the division within the following time limits:

A. Where appropriate, a denial under subpart 2 must be filed within 14 days of notice to or knowledge by the employer of an injury which is required to be reported to the commissioner under Minnesota Statutes, section 176.231, subdivision 1. Where appropriate, a denial under subpart 2 must be filed within 30 days after notice or knowledge where an extension has been requested in the event of a new period of temporary total or if payment has commenced. After the 30-day period, where appropriate, a denial must be filed under subpart 3.

B. A denial of liability under subpart 3 must be filed in accordance with part 5220.2630, subpart 4.

C. A denial of liability under subpart 4 must be filed within 14 days of notice or knowledge of a new period of lost time due to a previous work-related injury unless an extension is requested under Minnesota Statutes, section 176.221, subdivision 1.

Subp. 8. **Rejection of denials.** If a denial of liability does not provide specific reasons for the denial, the division may reject it within seven days of receipt and inform the denying party, in writing, of the right to submit a new denial. A copy of the rejection letter must be sent to the employee. An appropriately corrected denial that is filed within seven days of service of the division's rejection memo is considered filed as of the date of original filing.

Subp. 9. **Penalty.** Failure to pay or deny in a timely manner may result in the assessment of the penalties set out in parts 5220.2770 and 5220.2790.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2580 CLAIM FOR REFUND FROM EMPLOYEE OR DEPENDENT.

Subpart 1. **Request for refund.** All requests for refunds or reimbursements by an insurer for payments made under a mistake of fact or law, which were allegedly not received by an employee or dependent in good faith, must be made in writing to the employee with a copy immediately mailed to the attorney representing the employee or dependent, if any, and to the division.

Subp. 2. **Contents of request.** All requests must clearly indicate the basis for believing payments were not received in good faith, and set forth the following information:

A. amount of alleged overpayment;

B. what the original payment was made for;

C. the date on which the payment was made;

D. the mistake of fact or law which forms the basis for the claimed overpayment; and

E. a statement informing the employee that, if the employee has any questions regarding the legal obligations to repay any claims for overpayment alleged to have not been received in good faith, the employee should contact either a private attorney or the division.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2590 MEDICAL REPORTS.

Subpart 1. **All significant reports.** Within 30 days of receipt of the information, insurers shall file or cause to be filed with the division all significant medical reports concerning the nature or extent of any injury or disease arising under the act.

Subp. 2. **Physician's first report.** Promptly after the first treatment or evaluation of an employee who alleges to have incurred injury on the job, the physician shall fully complete a physician's first report form and submit it to the insurer if known, or the division if the insurer is not known. The physician's first report must be on the form prescribed by the commissioner, containing substantially the following:

A. information identifying the patient and employer, if known;

B. the state file number;

C. dates of treatment or examination;

D. the history, including the date of injury or disease as given by patient;

E. the findings, including test results;

F. a preliminary diagnosis and code number;

G. information regarding the relationship of the injury or disease to the employment activities and the ability of the employee to work, specifying any work restrictions and dates of disability;

H. information regarding the need for rehabilitation services;

I. predictions regarding possible permanent disability;

J. information regarding any related preexisting condition;

K. the need for further medical care;

L. information on hospitalizations and surgery, if any;

M. information identifying any physician to whom the patient was referred;

N. any additional remarks or information;

O. certification of the report; and

P. the physician's signature and identification information.

If a physician's first report is not submitted within ten days of a written request, the division may assess a penalty under Minnesota Statutes, section 176.231, subdivision 10 and part 5220.2830, subpart 1. Failure to release existing medical data may also result in assessment of a penalty under part 5220.2810.

Subp. 3. **Report of maximum medical improvement.** For injuries required to be reported to the commissioner occurring on or after January 1, 1984, upon the patient reaching maximum medical improvement, the physician shall promptly fully complete and submit to the insurer, if known, or to the division, if the insurer is not known, a report of maximum medical improvement on the form prescribed by the commissioner, containing substantially the following information:

A. information identifying the patient and employer, if known;

B. the state file number;

C. the date maximum medical improvement (date after which no further significant recovery from or lasting improvement to a personal injury can reasonably be anticipated) was reached;

D. the diagnostic conclusion and code number;

E. information regarding the permanent partial disability rating;

F. whether the patient will medically be able to resume former employment;

G. information regarding any preexisting conditions;

H. information regarding surgery;

I. information regarding further medical treatment;

J. any additional remarks or information;

K. the certification of the report; and

L. the physician's signature and identification information.

If an employee has reached maximum medical improvement but a report of maximum medical improvement form is not filed within ten days of a written request, the division may assess a penalty for the failure under Minnesota Statutes, section 176.231, subdivision 10, and part 5220.2830, subpart 1.

Subp. 4. **Charge for reports.** The information contained in the physician's first report as described in subpart 2 and the report of maximum medical improvement as described in subpart 3 is required by the state and when it is obtained for purposes of submission to the division file in the matter, no charge may be assessed against the state or a party for it.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2600 [Repealed, 11 SR 1530]

5220.2610 ADMINISTRATIVE CONFERENCES.

Subpart 1. **Scope.** This part governs administrative conferences conducted under Minnesota Statutes, sections 176.102, 176.103, 176.242, 176.2421, and 176.243, and applies to all medical, rehabilitation, discontinuance, and return to work conferences conducted by the division.

Subp. 2. **Notice.** The division must promptly notify the parties of the date, time, and place of the conference. The qualified rehabilitation consultant, if one is assigned, must be notified of a rehabilitation conference. The special compensation fund must be notified of all administrative conferences where the fund is reimbursing benefits to an insurer or self-insurer under Minnesota Statutes, section 176.131 or 176.132, or a claim has been made under the above referenced statutes against the fund for benefits by any of the parties, or the fund is paying benefits under Minnesota Statutes, section 176.191. The notice must explain the purpose of the conference. Telephone notice is sufficient for a discontinuance or return to work conference if timely service of notice by mail cannot be made.

Subp. 3. **Appearances.** All parties and the qualified rehabilitation consultant if the conference is conducted under section 176.102, must be given notice and the opportunity to attend administrative conferences or, at their option, to present documents on their behalf. Intervenors or a representative of the special compensation fund may attend the conference. A party may be represented by an attorney. The employee is required to attend an administrative conference under Minnesota Statutes, section 176.242, 176.2421, or 176.243 unless health reasons, distances, or other good cause prevents attendance. If absent because of distance, the employee must be available by telephone at the scheduled conference time.

Subp. 4. **Presiding official.** Conferences must be conducted by an impartial designee of the commissioner. The presiding official shall explain the purpose of the conference and the format to be followed. The presiding official may ask questions of the participants. Questioning of one party by other parties may be allowed at the discretion of the presiding official. The presiding official may halt questioning that is argumentative, harassing, intimidating, confusing, or designed to trick a participant.

Subp. 5. **Information considered.** The presiding official shall permit the parties to state their positions and to present reports or other documents or exhibits relevant to the issues involved. There is no provision in the statute for costs for testimony at a medical administrative conference. Reasonable opportunity to refute statements or other information submitted at the conference must

be allowed. Copies of documents submitted at the conference must be supplied to the other parties.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2620 MEDICAL CONFERENCES.

Subpart 1. **Definitions.** For purposes of this part, the following terms have the meanings given them.

"Medical issues" refers to all health care rendered under Minnesota Statutes, sections 176.135 and 176.136 and determinations under Minnesota Statutes, section 176.103, and includes:

A. the reasonableness of a fee for health care services;

B. the reasonableness and necessity of medications, health supplies, articles, and equipment;

C. the failure to pay a bill for health care services, treatment, equipment or supplies, or other health care under Minnesota Statutes, section 176.135, subdivision 1;

D. the reasonableness and necessity of treatment;

E. the need for a second opinion prior to surgery;

F. a request for change of physician;

G. the employee's cooperation with medical treatment;

H. the inability to secure a health care provider report;

I. the reasonableness and necessity of nursing services;

J. the appropriateness of a medical service;

K. the relationship of the health care to the work injury;

L. whether treatment for a medical condition is required as a result of a work-related injury;

M. the assessment of penalties for untimely response to medical billings; and

N. other problems related to medical treatment and supplies.

Subp. 2. **Medical claim, request.** An employee, insurer, or health care provider as defined by Minnesota Statutes, section 176.011, subdivision 24, may initiate a medical claim by filing an M-4 "request for assistance in resolving a workers' compensation medical issue" form or an M-10 "change of physician" form with the section and serve the other parties, including the employee, insurer, employer, and any health care provider directly involved in the dispute, specifying the medical issues in dispute and whether an administrative conference is requested. The requesting party must also specify the name and address of any third party who has paid or has been ordered to pay to reimburse medical or treatment expense, and the claim or policy number, if known. At the time the M-4 form is filed, the requesting party must mail a copy of the M-4 form to third parties who have paid benefits. A claim petition containing medical issues only or a referral of a medical issue from the office will be treated in the same manner as an M-4 form under this subpart.

Subp. 3. **Medical claims response.** If the employee or health care provider has filed an M-4 or M-10 form, the insurer must file an M-1 medical status report with the section and send copies to the other parties no later than 20 days after service of the M-4 or M-10 form. The insurer must respond on an M-10 form to an M-10 request to change physicians, file the response with the section, and send copies to the other parties no later than 20 days after service of the request to change physicians. Failure to file a form will be considered in the determination of penalties and interest.

Subp. 4. **Medical claim; application to intervene.** To intervene, the potential

intervenor must serve the parties and file with the section a written application to intervene promptly after service of the M-4 form on the applicant. The division shall issue to the applicant and the parties a written determination granting or denying permission to intervene in the case. The medical conference will not be held prior to five days following the intervention application period in Minnesota Statutes, section 176.361, unless the section has received from all potential intervenors either an application to intervene or notice that an application to intervene will not be filed.

Subp. 5. **Medical claim; denial of liability.** If an M-4 form has been mistakenly filed in a case in which initial issues of liability within the jurisdiction of the office exist, the matter will be certified to the office for hearing if the petitioner has standing to file a litigated claim. The date of filing of the form with the section is used by the office to determine when the hearing will be held. After initial issues over which the division does not have jurisdiction have been resolved, any remaining medical issues shall be scheduled for an administrative conference in accordance with this part.

Subp. 6. **Conciliation of medical issues.** The division may attempt to resolve medical issues through telephone contact with the parties, if appropriate. If no resolution is reached, the division will schedule an administrative conference in accordance with this part.

Subp. 7. **Medical claim; change of physician.** An injured employee seeking a change of physician shall contact the insurer and request the insurer's consent to the change. If the insurer consents to the change, the division need not authorize the change. If a party seeks a change of physician and the parties cannot agree to the change, the party requesting the change must file an M-10 form with the section under subpart 2 stating the reason for the request, the names of the present and proposed physicians, and whether an administrative conference is requested. The adverse party shall respond under subpart 2. The division may attempt to resolve the dispute through telephone contact with the parties, if appropriate. If no resolution is reached, the division must schedule an administrative conference in accordance with this part. If the adverse party defaults by failing to respond to the proposed change of physician within 20 days of the filing of the M-10 form, the change must be granted unless the change is clearly not in the best interest of the employee.

Subp. 8. **Medical and other issues on claim petition.**

A. If a claim petition contains medical as well as other issues and the employer or insurer admits primary liability, the case will be referred to a settlement judge under part 1415.1800. If the parties fail to reach a settlement, the settlement judge shall refer medical issues to the section for determination and refer the remaining issues to the office unless the complexity of the issues requires referral to the office before a medical determination can be made. In those complex cases, the case will be immediately referred to the office and the medical issues will not be determined until after the office issues a decision.

B. If a claim petition contains medical issues as well as other issues and the employer or insurer denies primary liability, the case will be referred to a settlement judge under part 1415.1800. If the settlement judge determines that a settlement conference is not appropriate or a settlement conference is held but a complete settlement is not reached, the case must be certified to the office.

A compensation judge may approve a stipulation for settlement of medical issues under part 1415.2000. If the medical issues are not resolved by agreement at the hearing, the matter must be immediately referred to the division to set for an administrative conference. An administrative conference in accordance with this part will be scheduled if conciliation is not attempted or is unsuccessful. If evidence was presented at the hearing related to medical issues under part 1415.2900, subpart 3, item F, which a party wishes considered at the conference, that party shall identify the portion of the hearing record to be considered. At the conference, the parties must submit the information they wish to be considered.

Subp. 9. **The medical decision.** A written decision must be issued and must include a statement indicating the right to appeal the decision to the board and how to initiate the appeal.

Subp. 10. **Continuances.** Continuances are disfavored but must be granted upon a showing of good cause. A party may request a continuance before the conference if the party has good cause for inability to appear at the conference. Good cause does not include:

A. unavailability of the insurer's representative because of engagement in another court or otherwise, unless all representatives practicing in the workers' compensation field are committed elsewhere, or unless all parties, including the employee personally, agree to a continuance and the continuance is requested at least ten business days before the conference; and

B. unavailability of the employee's representative because of engagement in another court or otherwise, unless the representative's associates practicing in the workers' compensation field are all committed elsewhere, or unless all parties, including the employee personally, agree to a continuance and the continuance is requested at least ten business days before the conference.

Requests for continuance made within five business days after service of the conference notice and at least ten business days before the conference will receive priority in rescheduling. Requests made within the ten days prior to the conference will generally not be granted.

If at the time of the conference the commissioner's designee determines that a person's rights will be affected by the proceeding and that a person has not been notified of the conference, the conference will be continued.

Subp. 11. **Appeal.** An appeal of the decision shall be as provided in part 5217.0030 (joint rules for the rehabilitation review panel and the medical services review board) or to a compensation judge if the issue is medical causation. The issues appealed will be the subject of a new hearing by the Rehabilitation Review Panel, Medical Services Review Board, or Compensation Judge.

Subp. 12. **Penalties.** Where payment of medical charges is not made in compliance with part 5221.0600, a penalty may be assessed under part 5220.2740.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2630 DISCONTINUANCE OF COMPENSATION.

Subpart 1. **Generally.** When an insurer proposes or intends to reduce, suspend, or discontinue an employee's benefits, it shall file one of the following documents described in this part.

Subp. 2. **Petition.**

A. The filing of a petition to discontinue compensation with the division commences a formal action to reduce, suspend, or discontinue compensation.

B. The petition must include substantially all the items listed in part 1415.1000, subpart 1, except that items H to J must list the benefits which the insurer wishes to discontinue. In addition, it must contain a clear and concise statement of the facts upon which the proposed discontinuance is based. Service and filing of the petition must be in accordance with part 1415.1000, subpart 2.

C. Following the filing of a petition to discontinue benefits, the insurer must continue paying compensation until the matter is resolved by agreement or until a judge orders otherwise.

D. The division shall refer the matter to the office under Minnesota Statutes, section 176.241.

Subp. 3. **Notice of discontinuance.**

A. The employer or insurer may discontinue the benefit indicated by the filing of a notice of discontinuance with the division and service of the notice on

the other parties at the time that the payment or return-to-work occurs when the discontinuance results from:

(1) a return to work;

(2) a lump sum payment of full permanent partial disability compensation;

(3) a final periodic payment of impairment compensation or economic recovery compensation;

(4) a final payment under an award, order, or stipulation; or

(5) for injuries occurring before August 1, 1975, where the employee is not permanently totally disabled, a final payment of temporary total disability or for injuries occurring before May 28, 1977, a final payment of temporary partial disability based on a statutory maximum number of weekly payments.

B. A notice of discontinuance must be fully completed and on the form prescribed by the commissioner, containing substantially the following:

(1) information identifying the employee, employer, insurer, and any adjusting company;

(2) the date of the injury or disease;

(3) claim numbers or codes;

(4) the type of benefits being reduced or discontinued;

(5) the effective date of the discontinuance;

(6) the reason for the discontinuance, stated in language easily readable and understandable to a person of average intelligence and education and in sufficient detail to inform the employee of the factual basis for the discontinuance;

(7) information regarding previous benefits paid and previous awards of benefits;

(8) information regarding attorney fees;

(9) information regarding permanent partial disability ratings received;

(10) the date the notice was served on the employee;

(11) verification and information identifying the person making the decision to discontinue benefits;

(12) instructions to the employee including who to contact for information regarding the discontinuance and how to request a formal hearing before a compensation judge;

(13) copies of relevant medical reports; and

(14) copies of any other relevant documents.

Supporting documents must be attached to all copies of the discontinuance notice served.

C. If the reason for the discontinuance is the employee's return to work and the employee has received temporary total or temporary partial compensation for 45 workdays prior to the return to work and no approved rehabilitation plan is in effect at the time the 14-day check under Minnesota Statutes, section 176.243, subdivision 1, is due, a 14-day check must be made and an administrative conference may be requested under part 5220.2650.

D. The employee may object to the discontinuance by filing an objection to discontinuance under Minnesota Statutes, section 176.241, with the division. This commences a formal action. The case will then be referred to the office and scheduled for hearing under part 1415.2100. The burden of establishing the basis for the discontinuance is on the party proposing the discontinuance.

Subp. 4. **Notice of intention to discontinue benefits.**

A. To discontinue temporary total, temporary partial, or permanent total benefits in situations not specified in subpart 3, the employer or insurer must

serve upon the employee and file with the division a notice of intention to discontinue benefits or a petition under subpart 2. The notice must be accompanied by a form prescribed by the commissioner with which to request an administrative conference on the proposed discontinuance which contains the employer's name, the date of the injury or disease, and the name, social security number, and address of the employee.

B. A notice of intention to discontinue benefits must be fully completed and on the form prescribed by the commissioner, containing substantially the following:

(1) information identifying the employee, employer, insurer, and any adjusting company;

(2) the date of the injury or disease;

(3) claim numbers or codes;

(4) the type of benefits being discontinued;

(5) the reason or reasons for the proposed discontinuance, stated in language which may easily be read and understood by a person of average intelligence and education, and in sufficient detail to inform the employee of the factual basis for the discontinuance;

(6) the effective date of the discontinuance;

(7) information regarding benefits previously paid;

(8) information regarding attorney fees;

(9) information regarding permanent partial disability ratings;

(10) the date the notice was served on the employee;

(11) verification and information identifying the person making the proposal to discontinue benefits;

(12) instructions to the employee;

(13) copies of relevant medical reports; and

(14) copies of any other relevant documents.

Supporting documents must be attached to all copies of the discontinuance notice served.

C. Continuation of benefits following a notice of intention to discontinue benefits is set out in part 5220.2640, subpart 3.

D. An employee may request a conference under part 5220.2640, subpart 2 following the filing of a notice of intention to discontinue benefits. If a notice of intention to discontinue benefits was required but was not filed, the commissioner may schedule a conference. At the conference the issue of jurisdiction shall be resolved prior to dealing with discontinuance issues. An insurer or employer may request a conference under part 5220.2640, subpart 2 at any time to discuss a proposed discontinuance of benefits.

E. Instead of requesting a conference under item D or after the conference determination, the employee may object to a proposed or allowed discontinuance by filing with the division an objection to discontinuance under Minnesota Statutes, section 176.241.

Subp. 5. **Notice by division of defect.** If a petition to discontinue compensation, a notice of discontinuance, or a notice of intention to discontinue benefits is filed without the information required by this part, the division may request that the employer or insurer file the required information within ten days of notice of the defect. The time for an employee to request an administrative conference ends ten days after the defect is corrected, served on the employee, and filed with the division.

Subp. 6. **Penalties.** Where compensation is discontinued, reduced, or suspended in violation of this part, a penalty may be assessed under parts 5220.2720 and 5220.2790.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2640 DISCONTINUANCE CONFERENCES.

Subpart 1. **Purpose.** The purpose of an administrative conference under Minnesota Statutes, section 176.242, is to determine whether reasonable grounds exist for a discontinuance of weekly benefits. The conference is an informal procedure to encourage discussion and clarify issues. If the parties do not reach an agreement on the issues, they will be resolved by a decision of the division. If all affected parties consent, rehabilitation and medical issues may also be discussed and clarified and decisions issued under Minnesota Statutes, sections 176.102 and 176.103.

Subp. 2. **Request.** The employee may request that the division schedule an administrative conference to discuss a proposed discontinuance of benefits. The employee's request for a conference must be personally delivered, mailed, or telephoned to the department no later than ten calendar days from the date a notice of intention to discontinue benefits was received by the division. The request is presumed mailed on the date indicated by the United States postmark. A request which does not include a legible United States postmark is presumed timely requested if received by the division no later than 13 days from the date a notice of intention to discontinue benefits was received by the division. Allowance will be made, if appropriate, for nonreceipt or delay under Minnesota Statutes, section 176.285.

If the insurer discontinues, reduces, or suspends benefits without filing a notice of intention to discontinue benefits in a situation in which a notice of intention to discontinue benefits was required under part 5220.2630, subpart 8 the employee may request an administrative conference at any time after the discontinuance or reduction but no later than ten days after a notice of intention to discontinue benefits is filed.

The employee's request should be on the form provided by the insurer which must include the employee's name, address, and social security number; the date of injury or disease; and the employer's name.

Subp. 3. **Continuation of benefits.**

A. If an employee requests an administrative conference within the time set out in this part, benefits must be paid through the date of the conference unless the employee has withdrawn the request for a conference or the commissioner determines that no conference is necessary subject to items B and C.

B. If an employee does not request an administrative conference or fails to appear at the conference without good cause and no continuance of the conference is allowed, benefits may terminate at the time stated in the notice of intention to discontinue benefits. The date for compensation to end must be no earlier than the day the notice of intention to discontinue benefits is served upon the employee and received by the division.

C. If an employee's request for a continuance under subpart 5 is granted and the employee is awarded ongoing benefits, benefits must be paid through the date of the conference and continuing. If the employee's request for a continuance is granted and the employee is not awarded benefits, benefits need not be paid during the period of continuance. If the employer or insurer requested the continuance, benefits must be paid during the period of continuance. If the employee and insurer's joint request for a continuance is granted, benefits must be paid during the period of continuance unless the employee agrees in writing to waive the interim payment and await a decision regarding payment under subpart 7 following the administrative conference.

Subp. 4. **Scheduling.** Subject to subpart 5, a discontinuance conference must be set within the time limits set by this subpart. Following a notice of intention

to discontinue benefits, the division shall schedule an administrative conference no later than ten calendar days after the division's receipt of a timely request for a conference. If no notice of intention to discontinue benefits was filed as required by part 5220.2630 and the employee requests a conference, the division shall schedule a conference no later than ten calendar days after the division's receipt of the employee's request if the conference request is received within 40 days from the date the employee's last benefit payment was received. If no notice of intention to discontinue benefits has been filed where an employer or insurer requests a conference, the division shall schedule an administrative conference to be held no later than 30 days after receipt of the request.

Subp. 5. **Continuances.** Continuances are disfavored but must be granted upon timely request and a showing of good cause. An employee or insurer may request a continuance if the party shows good cause for inability or failure to appear at the conference.

A. Good cause does not include:

(1) a party's lack of actual notice of the conference date and time when that party requested the conference and the notice was properly served on the party, or unless all parties, including the employee personally, agree to a continuance and the continuance is requested at least ten business days before the conference;

(2) unavailability of the insurer's representative because of engagement in another court or otherwise, unless all representatives practicing in the workers' compensation field are committed elsewhere, or unless all parties, including the employee personally, agree to a continuance and the continuance is requested at least ten business days before the conference; and

(3) unavailability of the employee's representative because of engagement in another court or otherwise, unless the representative's associates practicing in the workers' compensation field are all committed elsewhere, or unless all parties, including the employee personally, agree to a continuance and the continuance is requested at least ten business days before the conference.

B. An order continuing the conference must state the date and time of the rescheduled conference. It must be promptly mailed to the persons previously notified.

Subp. 6. **Standard and burden of proof.** The employer or insurer must prove by a preponderance of the information presented that reasonable grounds for a discontinuance exist.

Subp. 7. **The decision.** The decision must be based on information presented at the conference and information from the division file if the parties have been notified that file information will be reviewed and are given an opportunity to comment on those items considered. A written decision must be issued and must include notice of the right to have the matter heard by a compensation judge if a party is dissatisfied with the decision and the procedure for doing so and notice of the right to be represented by an attorney at a hearing before a compensation judge. The division shall mail a copy of the decision to the parties no later than five working days from the date of the conference. The decision is deemed notice of rights under Minnesota Statutes, section 176.241, to those parties served.

Subp. 8. **Petition to discontinue; objection to discontinuance.** Under Minnesota Statutes, section 176.241, if a discontinuance is denied, the employer or insurer may file a petition to discontinue or, if a discontinuance is allowed, the employee may file an objection to discontinuance. Where an objection or petition is filed the administrative decision is binding on the parties until a hearing on the objection or petition is held and a decision made by the compensation judge.

Subp. 9. **Penalties.** Penalties may be imposed for an improper discontinuance of compensation under Minnesota Statutes, section 176.242, subdivision 10, and part 5220.2720 and for unreasonable or inexcusable delay or other

grounds under Minnesota Statutes, section 176.225, subdivisions 1 and 5, and parts 5220.2760 and 5220.2790.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2650 RETURN TO WORK CONFERENCES.

Subpart 1. **Purpose.** The purpose of an administrative conference under Minnesota Statutes, section 176.2421 or 176.243, is to resolve disputed issues regarding payment of compensation following an employee's return to work. The conference is an informal procedure to encourage discussion, clarify issues, and reach agreement or obtain resolution by a decision of the division. If all affected parties consent, rehabilitation or medical issues may also be discussed, clarified, and a decision issued under Minnesota Statutes, sections 176.102 and 176.103.

Subp. 2. **Scope.** This part applies when an employee has received temporary total or temporary partial compensation for a total of at least 45 work days whether continuously or intermittently; and no rehabilitation plan in effect at the time the 14-day check is due has been approved under part 5220.0400, subpart 2. In addition, a return to work conference is also available when properly requested by the employee under subpart 4 and Minnesota Statutes, section 176.2421 because of an inability to work at least 14 work days upon the employee's return to work.

Subp. 3. **Notice regarding employment and wages.** Upon completion of a 14-day employment and wage confirmation but no later than ten days following the 14-day check under Minnesota Statutes, section 176.243, if the employee is not working or is earning a lower wage than at the time of injury, the insurer must file a notice regarding employment and wages. The notice must be accompanied by the form prescribed by the commissioner to request an administrative conference to object to the action taken, containing the items listed in subpart 4. The notice must be fully completed and on the form prescribed by the commissioner, containing substantially the following:

A. information identifying the employee, employer, insurer, and any adjusting company;

B. the date of injury or disease;

C. claim numbers or codes;

D. the date on which the employee was contacted;

E. information regarding employment status on the contact date;

F. information regarding the weekly wage on the contact date and at the time of the injury;

G. the action to be taken by the insurer regarding payment of compensation;

H. the date the notice was served on the employee;

I. verification and information identifying the person making the decision of the action to be taken;

J. instructions regarding the insurer's payment obligations; and

K. instructions to the employee.

Subp. 4. **Request.** The employee may request an administrative conference to discuss the action taken by the insurer upon the employee's return to work. The employee must request a conference no later than ten calendar days from the date the insurer's notice to the commissioner regarding employment status and wages was received by the division. Alternatively, the employee may request a conference no later than ten calendar days from the day the employee ceased working if the employee ceased working within the first 14 working days following the employee's return to work due to medical reasons associated with the injury. However, if a notice of discontinuance was not filed when the employee

returned to work, the employee may request an administrative conference under Minnesota Statutes, section 176.2421 within 40 days after the employee returned to work. Allowance will be made, if appropriate, for nonreceipt or delay under Minnesota Statutes, section 176.285. The employee's request for a conference must be personally delivered, mailed, or telephoned to the division within the ten-, 40-, or 64-day period described in this subpart. The request is presumed mailed on the date indicated by the United States postmark. A request which does not include a legible Unites States postmark is presumed timely requested if received by the division no later than three days following the ten-, 40-, or 64-day request period. The request must include the employee's name, address, and social security number; the date of injury or disease; the employer's name and address, and the insurer's claim number, if known. If a notice regarding employment and wages was required under subpart 3, but has not been filed, the employee may request a return to work conference within 64 days of the employee's return to work but if the notice is later filed no later than ten days after the notice is served and filed by the insurer.

Subp. 5. **Payment of benefits pending conference.** If the insurer has properly discontinued compensation under a notice of discontinuance before the employee ceases working, the insurer is not obligated to pay benefits pending a decision of the commissioner. If the insurer has voluntarily commenced payment upon the employee's cessation of work, compensation must continue to be paid until a proper notice of intention to discontinue benefits or notice of discontinuance of benefits under part 5220.2630 is filed, or until a decision of the commissioner is made subsequent to an administrative conference, whichever occurs first.

Subp. 6. **Scheduling.** If the request for conference is made under Minnesota Statutes, section 176.243, the division must schedule an administrative conference to be held no later than 14 calendar days after receipt of a timely request for a conference. If the request for conference is made under Minnesota Statutes, section 176.2421, the division must schedule an administrative conference no later than ten calendar days after receipt of a timely request for a conference.

Subp. 7. **The decision.** The decision must be based on information presented at the conference and information from the division file if the parties have been notified that file information will be reviewed and are given an opportunity to comment on those items considered. A written decision must be promptly issued and must include notice of the right to have the matter heard by a compensation judge if a party is dissatisfied with the decision, the procedure for doing so, and notice of the right to be represented by an attorney at a hearing before a compensation judge.

Subp. 8. **Penalty.** Where the appropriate notice regarding employment and wages is not given or compensation is discontinued in violation of this part, a penalty may be assessed under part 5220.2730. Penalties for an improper discontinuance or failure to pay following the decision issued under this part may be assessed under parts 5220.2720, 5220.2780, and 5220.2790.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2660 REHABILITATION CONFERENCES.

Subpart 1. **Governing rules.** Administrative conferences under Minnesota Statutes, section 176.102, are governed by parts 5220.0100 to 5220.1910, 5220.2610, and this part.

Subp. 2. **Scheduling.** A conference to determine a change of qualified rehabilitation consultant will be given priority status for scheduling purposes.

Subp. 3. **Continuances.** A party may request a continuance before the conference under part 5220.2620, subpart 10.

Subp. 4. **Decision.** A written decision must be issued and must include a

statement indicating the right to appeal the decision to obtain a new hearing before the Rehabilitation Review Panel and instructions regarding how to initiate the appeal.

Subp. 5. **Penalties.** A penalty for failure to provide rehabilitation services may be assessed under part 5220.2780.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2670 MEDIATION.

Subpart 1. **Evaluation for mediation.** Any party to a workers' compensation dispute may, at any stage of the proceedings, request evaluation of a disputed matter by the mediation unit to determine suitability of the dispute for further action by the unit. If the dispute is found to be suitable for resolution by the mediation process, the mediation unit will contact the parties to the dispute or their attorneys, if they are represented, to attempt conciliation or schedule a mediation session.

Subp. 2. **Conciliation.** Conciliation is the resolution of a dispute through informal means without conducting a full conference. If the dispute is appropriate for conciliation, the mediation unit may conciliate an agreement of the parties.

Subp. 3. **Agreement to mediate.** If conciliation does not occur or is not successful and all parties consent to participate in the mediation process, the unit will schedule a mediation session. The mediation unit will notify the parties of the date, time, and place for the session. An agreement to mediate must be executed by the parties prior to the commencement of mediation.

Subp. 4. **Mediation resolution.** If the mediation session results in a resolution of one or more of the disputed issues, the parties shall sign a written statement outlining the agreement. The mediation resolution need not contain all of the items listed in part 1415.2000, but must include a list of the issues under discussion and agreements reached by the parties. An intervenor is not required to sign the statement if it provides for reimbursement in full to the intervenor.

Subp. 5. **Mediation award.** A designee of the commissioner shall review the mediation resolution as provided by Minnesota Statutes, section 176.521, and shall issue a mediation award if the terms conform with the workers' compensation act. The award and the resolution must be served on the parties by mail within ten days of the conclusion of mediation unless the parties agree to allow a party to draft the mediation resolution. Both documents will be attached to and become part of the judgment roll of the division's file.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2680 SECOND INJURY LAW.

Subpart 1. **Registration application.** Application for registration of physically impaired employees must be on forms prescribed by the division and submitted in duplicate. The application must be typewritten.

Subp. 2. **Medical evidence.** Medical evidence of the physical impairment must be contained on the application or attached to the application. The evidence must show the date of the last examination, the nature of the impairment, the doctor's signature, the date of signature, and must be legible and suitable for microfilming.

Subp. 3. **Effect of acceptance.** The application for registration with satisfactory medical evidence when accepted by the division is prima facie evidence of the existence of the named "physical impairment" shown on the application, but is not determinative, and the burden of proof upon the issue of impairment, if contested at any time prior to a subsequent injury, is upon the party asserting its existence.

Subp. 4. **Acceptance or rejection, hearing.** Should the division deem the application unacceptable prior to the subsequent injury, the applicant may, within 60 days following the receipt of notice of rejection, petition the division in writing for a hearing upon the application. A copy of the petition must be served by the applicant upon the fund administrator, custodian of the special compensation fund, and upon the attorney general. Upon receipt of the petition, the division must set the matter for hearing, which must be conducted as provided by Minnesota Statutes, section 176.411, with right of appeal.

Subp. 5. **Notice of intention to claim reimbursement.** Notice of intention to claim reimbursement under Minnesota Statutes, section 176.131, subdivision 6, must be on forms prescribed by the division. In a claim under Minnesota Statutes, section 176.131, subdivision 1, forms must be filed within one year after the payment of sufficient weekly benefits or medical expenses to make claim against the special compensation fund. In a claim under Minnesota Statutes, section 176.131, subdivision 2, forms must be filed within one year from the first payment of weekly benefits or medical expense.

Subp. 6. **Claim for reimbursement.** Reimbursement will be made by an order of the division or workers' compensation court of appeals from the special compensation fund on a yearly basis upon application for reimbursement on forms prescribed by the division. The insurer must file the original and one copy with the division. The application must be verified, set out in detail expenditures made and expenditures for which reimbursement is claimed, and must be supported by medical reports, showing the nature and extent of disability and relationship to the injury and physical impairment for which reimbursement is claimed. The insurer must file the original and one copy of notice of intention to claim reimbursement and claim for reimbursement with the division.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2690 THIRD-PARTY RECOVERY.

Subpart 1. **Duty to inform division.** Any insurer, learning of a third-party recovery or settlement arising out of a personal injury for which the insurer is or may be liable, shall inform the division of the possible, pending, or completed third-party action, indicating:

A. name of the employee;

B. employee's social security number;

C. name of employer;

D. date of injury;

E. name and address of the attorney, if any, representing the employee in the third-party action; and

F. if the employee is not represented by an attorney in the third-party action or if the name of the attorney is not known, the name and address of the insurer for the third party, together with the name of their insured and any identifying file or claim numbers.

Subp. 2. **Subrogation information.** The parties shall furnish the division with the information necessary to issue its order determining the subrogation rights of the insurer, and any credit to which the insurer may be entitled against compensation liability. The division must serve the subrogation order on the parties.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2700 [Repealed, 11 SR 1530]

5220.2710 ASSESSMENT OF PENALTIES.

All penalties assessed by the commissioner or an authorized designee under Minnesota Statutes, chapter 176, shall be assessed within two years of the violation by service of a notice of assessment upon the party against whom the penalty is assessed which shall contain substantially the following:

A. a statement of the legal basis for the penalty assessment including a citation to the applicable statutes;

B. a clear and concise statement of the factual basis for the penalty assessment;

C. a statement of the right to object to the penalty assessment and the right to a hearing;

D. the procedure and time limits for making an objection and obtaining a hearing;

E. the amount of the penalty; and

F. the date payment is due if a timely objection is not filed.

The notice of assessment must be served upon the employee if it is payable to the employee, the employer, and the insurer.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2720 IMPROPER DISCONTINUANCES; PENALTY.

Subpart 1. **Basis.** A penalty assessment for improper discontinuance will be made by the division if appropriate where:

A. benefits were discontinued without the notice required under Minnesota Statutes, section 176.241 and part 5220.2630;

B. the discontinuance occurred despite an administrative determination denying a request to discontinue under Minnesota Statutes, section 176.242 and part 5220.2640;

C. the discontinuance occurred without notice despite a final decision of a compensation judge, the workers' compensation court of appeals, or the supreme court requiring payment of ongoing benefits;

D. an administrative conference was requested and the request was not withdrawn, the discontinuance occurred before the administrative conference was held, except where the employee requests a continued conference date and ongoing benefits are not awarded; or

E. when a notice of intention to discontinue benefits is required to be filed but the discontinuance is retroactive, taking effect prior to the date that the notice of intention to discontinue benefits is served and filed with the division or served on the employee.

Subp. 2. **Amount.** When the division makes a determination under subpart 1, notice will be given and fines assessed as follows:

A. (1) If an insurer has not had a penalty assessed in the two-year period before the assessment for violation of a particular item in subpart 1, the division will send a warning notice to the insurer that the division has determined the discontinuance is improper. The warning notice will direct the insurer to pay the improperly-discontinued benefits and serve and file any required notice of discontinuance within ten days of service of notice or a penalty will be assessed.

(2) If the improperly-discontinued benefits are not paid and any proper discontinuance filed within the ten days allowed, the division will send notice that a $100 penalty is imposed.

(3) If these actions are still not taken within 20 days after service of the warning notice, a penalty of an additional $200 will be imposed.

(4) In addition to the penalties assessed under subitems (2) and (3),

if these actions are not taken within 30 days after service of the warning notice, a penalty of an additional $200 will be imposed.

B. If an insurer has had a penalty assessed in the two-year period before the assessment for violation of an item in subpart 1 and again violates the same item:

(1) The division will send notice that a $100 penalty is imposed.

(2) If the improperly-discontinued benefits are not paid and any required notice of discontinuance served and filed within ten days after service of the first penalty assessment on that file, a penalty of an additional $200 will be imposed.

(3) If these actions are still not taken within 20 days after service of the first penalty assessment, a penalty of an additional $200 will be imposed.

C. If that insurer has been issued five or more penalties for violations under part 5220.2720 in a six-month period, a separate penalty of $500 for each additional violation within that six-month period will be assessed.

D. An additional penalty may be assessed under Minnesota Statutes, section 176.221, subdivision 3, of 100 percent of the amount of compensation to which the employee is entitled.

Subp. 3. **Payable to.** Penalties under this part are payable to the special compensation fund.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2730 IMPROPER FOLLOW-UP ON RETURN TO WORK; PENALTY.

Subpart 1. **Basis.** Under Minnesota Statutes, section 176.243, subdivision 11, a penalty may be assessed if the insurer has discontinued the employee's compensation due to return to work and has not:

A. contacted the employee 14 days after the employee's return to work to determine whether the employee is still working and ascertain the wages being paid; or

B. if the employee is not working or is working at a reduced income:

(1) notified the commissioner, in writing, of that fact and stated the actions that will be taken regarding payment of compensation; or

(2) served a copy of the notice, by certified mail, upon the employee.

Subp. 2. **Amount.** When the division makes a determination of violation under subpart 1, notice will be given and fines assessed as follows:

A. (1) If an insurer has not had a penalty assessed in the two-year period before the assessment for a violation under subpart 1, a warning letter will be sent by the division to the employer or insurer giving notice that the action or inaction by the insurer was improper. Suggested remedial steps will be listed and a time limit for action of ten days from the date of service of the notice. Warning of possible penalty assessments must be included in the letter;

(2) If, after ten days from the date of service of the warning letter, the improper action or inaction has not been corrected, a penalty of $100 will be assessed. Warning of possible further penalty if action to correct is not taken within ten days of the $100 assessment will be given;

(3) If, after 20 days from the date of service of the warning letter, the improper action or inaction has not been corrected, penalty of an additional $200 will be assessed;

(4) If, after 30 days from the date of service of the warning letter, the improper action or inaction has not been corrected, penalty of an additional $200 will be assessed;

(5) Continuing violation may result in a penalty of an additional $500.

B. (1) If an insurer has had a penalty assessed in the two-year period before the assessment for violation under subpart 1, the division will send notice that a penalty of $100 is assessed. Warning of possible further penalty if action to correct is not taken within ten days of the $100 assessment will be given;

(2) If, after ten days from the date of service of the assessment under subitem (1), the improper action or inaction has not been corrected, a penalty of an additional $200 will be assessed;

(3) If, after 20 days from the date of service of the assessment under subitem (1), the improper action or inaction has not been corrected, a fine of an additional $200 will be assessed;

(4) Continuing violation may result in a penalty assessment of an additional $500.

C. If the insurer has been issued penalties for five violations in the preceding six months, a separate penalty of $500 for each additional violation within the six-month period will be assessed.

D. An additional penalty may be assessed under Minnesota Statutes, section 176.221, subdivision 3, of 100 percent of the amount of compensation to which the employee is entitled.

Subp. 3. **Payable to.** Penalties paid under this part are payable to the special compensation fund.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2740 FAILURE TO MAKE TIMELY PAYMENT OF MEDICAL CHARGES; PENALTY.

Subpart 1. **Basis.** Under Minnesota Statutes, section 176.221, subdivision 6a, a penalty may be assessed where payment of medical charges is not made in a timely manner as provided in part 5221.0600.

Subp. 2. **Amount.** Under Minnesota Statutes, section 176.221, subdivision 3, a penalty of up to 100 percent of the amount owing shall be assessed unless the commissioner determines, pursuant to subpart 3, that either no penalty or a lesser amount should be assessed. Upon receipt of information that payment of a medical charge has not been made in a timely manner, the commissioner shall notify the payer of the complaint and provide warning that a penalty may be assessed. If notice is given on an M-4 or M-10 form, the commissioner need not provide additional notice or warning.

Alternatively, a penalty of up to $1,000 under Minnesota Statutes, section 176.221, subdivision 3a, for failure to make payment may be assessed.

Subp. 3. **Exceptions.** In considering an assessment for less than the maximum amount, the commissioner's designee shall take into consideration, if applicable, at least the following factors:

A. the amount of the bill;

B. the record of payments by this payer;

C. the timeliness and adequacy of information requests made;

D. the adequacy of the provider's initial submission;

E. the complexity of the medical issues; and

F. apportionment or other complicating legal factors.

Subp. 4. **Payable to.** Penalties assessed under this part are payable to the special compensation fund.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2750 FAILURE TO MAKE TIMELY PAYMENT OF ECONOMIC RECOVERY COMPENSATION OR IMPAIRMENT COMPENSATION; PENALTY.

Subpart 1. **Basis.** A penalty may be assessed where payment of economic recovery compensation or impairment compensation is not made in a timely manner as provided in Minnesota Statutes, section 176.101 and part 5220.2550.

Subp. 2. **Amount.** Under Minnesota Statutes, section 176.221, subdivisions 3 and 6a, a penalty of up to 100 percent of the amount owing may be assessed. Where payment is less than ten days late, a penalty of 25 percent may be assessed. Where payment is at least ten but less than 20 days late, a penalty of 50 percent may be assessed. Where payment is at least 20 but less than 30 days late, a penalty of 75 percent may be assessed. Payment 30 or more days late may result in the 100 percent penalty assessment.

Subp. 3. **Payable to.** The penalty is payable to the special compensation fund.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2760 ADDITIONAL AWARD AS PENALTY.

Subpart 1. **Basis.** Penalties under Minnesota Statutes, section 176.225, subdivision 1, in an amount up to 25 percent of the total amount of the compensation award may be assessed on the grounds listed in that section, including:

A. underpaying, delaying payment of, or refusing to pay within 14 days of the filing of an order by the division or a compensation judge the Workers' Compensation Court of Appeals or the Minnesota Supreme Court unless the order is appealed within the time limits for an appeal;

B. delay of payment, underpayment, or refusal to pay permanent partial disability benefits as provided in part 5220.2550; and

C. any other violation under Minnesota Statutes, section 176.225, subdivision 1, for which no other penalty is provided under the act.

This part does not affect the employee's independent right to seek penalties by filing a claim petition under Minnesota Statutes, section 176.271.

Subp. 2. **Amount.** A penalty assessed under this part will be for at least ten percent of the compensation owing.

Subp. 3. **Payable to.** Penalties assessed under this part are payable to the employee.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2770 FAILURE TO PAY OR DENY; PENALTY.

Subpart 1. **Basis.** Where payment is not made in a timely manner and no denial of primary liability is filed as provided by Minnesota Statutes, section 176.221, subdivision 1, the division may assess the penalties provided in Minnesota Statutes, section 176.221, subdivisions 3 and 3a.

Subp. 2. **Amount.** The commissioner's designee must use the following procedure to determine the amount of the penalty.

A. The commissioner's designee must complete a delayed payment worksheet containing information identifying the claim and setting forth the time period of late payment.

B. Calculation of the amount of the penalty will be in the following manner:

(1) the 14-day period is first calculated. The period will begin on the next day after either the first day of lost time or day of notice, whichever is latest;

(2) the number of days after the 14-day period until payment is made constitute the days late;

(3) the compensation due for the number of days late is calculated;

(4) amount:

(a) If payment is two or more weeks late the penalty is calculated at 100 percent of the compensation to which the employee is entitled at the time of payment or at the time of assessment if payment has not yet been made.

(b) If payment is less than two weeks late the penalty is calculated at 50 percent of the compensation to which the employee is entitled at the time of payment or at the time of assessement if payment has not yet been made.

C. Where an old injury recurs causing disability, an extension under Minnesota Statutes, section 176.221, subdivision 1, is filed, and payment is not made within 30 days, calculation of the amount owing under item B shall be made using a period of 30 days rather than 14 days.

D. Where no compensation has been paid but the insurer has failed to file a denial of liability within the statutory 14- or 30-day limit on a claim required to be reported to the division, a penalty of up to $1,000 for violations occurring after April 24, 1984, may be assessed under Minnesota Statutes, section 176.221, subdivision 3a.

In considering the amount of the assessment, the commissioner's designee shall take into consideration at least the following factors:

(1) the length of the delay;

(2) the amount of the claim;

(3) efforts made to comply;

(4) the past record of payment by this insurer; and

(5) the complexity of the issues involved.

Subp. 3. **Payable to.** This penalty is payable to the special compensation fund.

Subp. 4. **Repeated failure.** An insurer that has been penalized for failure to pay benefits or deny under Minnesota Statutes, section 176.221, on five or more percent of their claims required by statute to be filed within a given calendar year will be subject to the action set out in Minnesota Statutes, section 176.231, subdivision 2.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2780 FAILURE TO PAY UNDER ORDER OR PROVIDE REHABILITATION; PENALTY.

Subpart 1. **Basis.** Where payment of compensation is not made within 14 days following an order as required by Minnesota Statutes, section 176.221, subdivisions 6a and 8, the division may assess the penalties provided in Minnesota Statutes, section 176.221, subdivisions 3 and 3a. Where rehabilitation services are not provided as required by Minnesota Statutes, sections 176.102, 176.221, subdivision 6a, and part 5220.0300, the division may assess the penalty provided in Minnesota Statutes, section 176.221, subdivision 3a.

Subp. 2. **Amount.** The maximum penalty available under Minnesota Statutes, section 176.221, subdivision 3 or 3a, shall be assessed where there has been a failure to pay under an order which has not been appealed. Less than the maximum penalty available under Minnesota Statutes, section 176.221, subdivision 3, may be assessed where immediate assessment is necessary.

Subp. 3. **Payable to.** The penalty is payable to the special compensation fund.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2790 INEXCUSABLE DELAY IN MAKING PAYMENT, INCREASE IN PAYMENT.

Subpart 1. **Basis.**

A. When a claim has not been denied but payment is not made as provided by Minnesota Statutes, section 176.221, the failure is deemed inexcusable delay under Minnesota Statutes, section 176.225, subdivision 5.

B. Where other payment of temporary total, temporary partial, permanent total, or permanent partial disability benefits is not made within ten days of the date provided by statute or rule, the failure is deemed inexcusable.

Subp. 2. **Amount.** The amount of the increase in payment under Minnesota Statutes, section 176.225, subdivision 5, for a delay under subpart 1, item A, is calculated as ten percent of the amount in part 5220.2770, subpart 2, item B, subitem (4), unit (a).

The amount of the increase in payment assessed under subpart 1, item B, will be calculated at ten percent of the payment found to be delayed.

Subp. 3. **Payable to.** The amount of any penalty assessed under this part is payable to the employee.

Subp. 4. **Assessment.**

A. The procedure for assessment of a penalty under subpart 1, item A, must be made as provided in part 5220.2770 except that only ten percent of that amount shall be assessed as a penalty under this part.

B. The calculation of a penalty under subpart 1, item B, for late payment of temporary total, temporary partial, or permanent total disability benefits must be as follows:

(1) The due date specified in part 5220.2540 or 5220.2550 is determined.

(2) The number of days after the due date until payment is made constitute the days late.

(3) The compensation due for the number of days late is determined.

(4) The penalty is calculated at ten percent of the sum due at the time of the assessment or ten percent of the sum paid in an untimely manner.

C. The calculation of a penalty for late payment of permanent partial disability benefits, including economic recovery compensation and impairment compensation under subpart 1, item B, must be as follows:

(1) the due date specified in part 5220.2540 or 5220.2550 is determined;

(2) if payment of the sum due is not made within ten days of the due date, a penalty of ten percent of the sum due at the time of the assessment or ten percent of the sum paid in an untimely manner is assessed.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2800 [Repealed, 11 SR 1530]

5220.2810 FAILURE TO RELEASE MEDICAL DATA; PENALTY.

Subpart 1. **Application for penalty.** Any party or the division may request a penalty assessment against a collector or possessor for failure to release medical data in accordance with Minnesota Statutes, section 176.138. The application must be in writing, clearly state the factual basis upon which the penalty is requested, and be accompanied by copies of the written requests for medical data made by the applicant and any response received. The application also must be accompanied by a copy of the written notification to the employee of the request for medical data, unless the employee requested the medical data.

Subp. 2. **Assessment of penalty.** Upon receipt of an application for a penalty assessment, the division shall assess a penalty if it determines that the request meets the following requirements:

A. the medical data requested is related to a current claim for compensation, which means any claim for compensation under Minnesota Statutes, chapter 176, for which benefits are currently being paid or are being claimed by an employee, whether or not a claim petition has been filed;

B. the requested medical data is specifically identified and in existence at the time of the request;

C. the requested medical data is directly related to a current injury or disability for which compensation is claimed or being paid;

D. the applicant sent written notification of the request for medical data to the employee at the time the request was made;

E. if required by federal law, appropriate authorizations for release of information were furnished; and

F. the requested medical data was not provided within seven working days after receipt of the request by a party and receipt of appropriate authorizations, if required by federal law.

Subp. 3. **Amount.**

A. The division must send a warning letter before a monetary penalty is assessed. The warning letter must advise the collector or possessor against whom the penalty is sought of the obligation to provide medical data under Minnesota Statutes, section 176.138, and that a penalty will be assessed if it fails to provide the requested data within seven working days after the warning letter and to file written verification of the release of the data or a copy of the data with the division within that time.

B. If the requested data is not provided and written verification filed with the division within seven working days after receipt of the warning letter, a penalty of $50 shall be imposed. If that party or health care provider has had more than three penalties assessed or warning letters sent for violation of this part in the preceding 12 months, the penalty will be $200 as well as further penalties under items C and D.

C. If the requested data is not provided and written verification filed with the division within 30 days after the date of the warning letter, a penalty of $100 will be imposed.

D. If the requested data is not provided and written verification filed with the division within 60 days after the date of the warning letter, a penalty of $200 will be imposed.

Subp. 4. **Payable to.** The amount of any penalty assessed under this part is payable to the special compensation fund.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2820 FAILURE TO MAKE TIMELY REPORT OF INJURY; PENALTY.

Subpart 1. **Basis.** A penalty shall be assessed under Minnesota Statutes, section 176.231, subdivision 10, against the employer:

A. if a work-related death or serious injury occurs to an employee and the commissioner is not notified within 48 hours; or

B. if any other injury which must be reported to the division occurs and the first report of injury is received by the division more than 14 days after the first day of lost time due to the injury or 14 days after the date when notice was received by the employer, whichever is later.

Subp. 2. **Amount.** If the employer has violated subpart 1 and has had no similar violations in the 12-month period prior to the assessment, an advisory

letter informing the employer of the violation and the statutory requirement must be sent. If the employer has had one violation of subpart 1 in the past 12 months, a penalty of $50 must be assessed. If the employer has had two violations in the past 12 months, a penalty of $100 must be assessed. If the employer has had three violations in the past 12 months, a penalty of $150 must be assessed. If the employer has had four or more violations in the past 12 months, a penalty of $200 must be assessed.

Subp. 3. **Assessment.** The penalty must be assessed by letter informing the employer of the number of violations in the past 12 months on record and the amount of the penalty. The letter must contain instructions for payment.

Subp. 4. **Payable to.** The penalty is payable to the special compensation fund.

Subp. 5. **Nonpayment.** If payment of a penalty assessed under this part is not made within 30 days of its assessment, the matter must be referred for collection.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2830 OTHER FAILURE TO FILE REPORT IN MANNER OR WITHIN TIME LIMITS PROVIDED; PENALTY.

Subpart 1. **Basis.** The division may assess a penalty for failure to file a required report if:

A. a report other than the first report of injury required to be filed by Minnesota Statutes, section 176.231, is not filed in the manner or within the time limitations prescribed; or

B. a report on a form prescribed by the commissioner is requested by the commissioner but is not provided within 21 days of the commissioner's request.

Subp. 2. **Amount.** If, after a letter request from the commissioner or authorized designee, a report under this part is not received by the division within 21 days, a penalty of $50 must be assessed. A failure to file a report after a second request will result in a penalty assessment of $150. A subsequent failure will result in penalty assessments of $200.

Subp. 3. **Payable to.** The penalty is payable to the special compensation fund.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2840 FAILURE TO MAKE PAYMENT TO SPECIAL FUND; PENALTY.

For payments under Minnesota Statutes, section 176.129, the original payment notice will give warning that failure to pay by the due date without requesting an extension or showing good cause will result in a penalty.

Within 30 working days after the due date, the fund director must send notice of penalty by certified mail to those who have not responded to the original payment notice. Payment of the original amount due plus a fine of 15 percent of the amount due or $500, whichever is greater, must be made within 30 days of notice of penalty by the fund director or good cause must be shown, or a request for hearing must be filed with the division.

If the insurer penalized does not make payment within six months of the original payment notice, the fund director will refer the file to the department of commerce for consideration of license or permit revocation.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2850 FAILURE OF UNINSURED OR SELF-INSURED TO PAY; PENALTY.

The fund director will make referrals to the attorney general's office to seek reimbursement of benefits paid from the special fund under Minnesota Statutes, section 176.183, subdivision 1 or 1a. Punitive damages of up to 50 percent of all benefits and other expenditures on the claim may also be assessed in the court action initiated by the attorney general's office.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2860 FAILURE TO INSURE; PENALTY.

Penalties for failure to insure will be assessed by the commissioner as provided by Minnesota Statutes, section 176.181, subdivision 3. Referrals to the attorney general's office shall also be made as provided in that section.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2870 PENALTY OBJECTION AND HEARING.

A party to whom notice of assessment has been issued may object to the penalty assessment by filing a written objection with the division on the form prescribed by the commissioner. The objection must be served on the special compensation fund, the employee if the penalty is payable to the employee, the insurer and the employer. The objection must be filed and served within 30 days after the date the notice of assessment was served on that party by the division. The written objection must contain a detailed statement explaining the legal or factual basis for the objection and including any documentation supporting the objection. Upon receipt of a timely objection, unresolved issues shall be referred for a hearing to determine the amount and conditions of any penalty.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2880 EXAMINATION OF WORKERS' COMPENSATION FILES.

Subpart 1. **Division case.** Persons desiring to examine a file maintained by the division, shall present a written document authorizing their inspection of the file to designated personnel of the division. The authorization must be signed and dated within the preceding six months by a party to the claim who is either the employee, the employer, the insurer, the special compensation fund, a dependent in death cases, or a legal guardian in cases of mental or physical incapacity. The authorization must specify the person or party authorized to review the file. The authorization is placed in and becomes part of the file. Information from division files may not be released over the telephone without the written authorization required by this subpart.

Subp. 2. **Limitation on access.** This part shall not be construed to grant greater access to the files than that given by the Minnesota Government Data Practices Act or the Workers' Compensation Act.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2890 SERVICE.

Subpart 1. **Service by state.** The division must serve all notices, findings, orders, decisions, or awards upon the parties by first class mail at their addresses of record or by personal service.

If the division has received notice that a party is represented by an attorney or authorized agent, documents required to be served on the party must also be served on the attorney or agent.

Subp. 2. **Service by parties.** A party shall serve all documents and pleadings by first class mail or by personal service. Service of documents required to be served on a party must also be served on the party's attorney or authorized agent. If service is required, filed documents must be accompanied by an affidavit of mailing or proof of service.

Subp. 3. **Computation of time.** Computation of time for service is governed by Minnesota Statutes, section 645.15.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2900 [Repealed, 11 SR 1530]

5220.2910 EXHIBITS.

Subpart 1. **Request for removal.** A request for permission to remove an exhibit or document may be made by the party who submitted the item. A request for removal from the division file must be made to the supervisor of the records section of the division.

Subp. 2. **Return without consent or notice.** Upon the expiration of 120 days after a decision of the commissioner, if no further proceeding is commenced, exhibits or other documentary evidence may be returned to their source of origin without the consent of the parties or notice to them. A copy of the letter of transmittal of the exhibit or other documentary evidence must remain in the file as part of the record of the case.

Subp. 3. **Request for return.** Upon the request of the party which produced or introduced the exhibit or evidence at the conference, and upon expiration of 120 days after a decision, exhibits or other documentary evidence must be returned to their source of origin. A request for return of exhibits or other documentary evidence must be made in writing to the person specified in subpart 1 and include the title, identification number of the case, and the identity of the exhibits or other evidence requested. The name and telephone number of the person making the request must be included with the request.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2920 ATTORNEY FEES.

Subpart 1. **Applicable principles.** Attorney fees shall be awarded in accordance with Minnesota Statutes, section 176.081 and the following principles after resolution of a disputed benefit or service issue, whether the matter is settled or a decision is issued.

A. No fee will be awarded unless the attorney is successful in obtaining workers' compensation benefits or services for the employee.

B. If the attorney is successful in obtaining benefits or services, the attorney is entitled to a reasonable fee for the services rendered.

C. In general, each party shall be responsible for its own fees, except as provided by Minnesota Statutes, section 176.081, subdivisions 7, 7a, and 8, or 176.191.

D. Attorney fees shall not be awarded piecemeal where to do so would result in a double recovery. Where more than one type of benefit is resolved simultaneously, all benefits resolved shall be considered in determining fees.

E. Attorney fees for recovery of medical or rehabilitation benefits or services shall be assessed against the employer or insurer only to the extent that the fee computed under Minnesota Statutes, section 176.081, subdivision 1, in connection with all benefits currently in dispute which resolve simultaneously with such benefits is not sufficient to provide a reasonable fee to the attorney.

F. In determining what amount of fee is reasonable for services rendered

in connection with rehabilitation and medical services, the factors of Minnesota Statutes, section 176.081, subdivision 5, must be applied.

Subp. 2. **Withholding of attorney fees.** Upon receipt of the notice of representation, the employer and insurer may withhold attorney fees on genuinely disputed portions of claims under Minnesota Statutes, section 176.081. Attorney fees must be withheld on genuinely disputed portions of claims if the employee's attorney so requests.

Subp. 3. **Statement of fees, petition for disputed or excess attorney fees.** The following procedures must be followed in claiming fees.

A. If the claim for attorney fees does not exceed the fees allowed by Minnesota Statutes, section 176.081, subdivision 1, clause (a), the party claiming fees shall fully complete and file a statement of attorney fees on a form prescribed by the commissioner, including:

(1) information identifying the employee, employer, insurer, and any adjusting company;

(2) claim numbers or codes;

(3) the date of injury or disease;

(4) a list of benefits obtained which were genuinely in dispute and which would not have been recovered without the attorney's involvement, and the total dollar amount of benefits obtained;

(5) information concerning any retainer received from the employee;

(6) information concerning expense advancement;

(7) information regarding the withholding of attorney fees, if known;

(8) the specific dollar amount claimed for attorney fees;

(9) information regarding the attorney's license to practice law in the state;

(10) a statement of the statutory basis or other legal authority for attorney fees;

(11) a notice regarding how to object to the requested fees; and

(12) information identifying the employee's attorney.

The statement must be accompanied by the retainer agreement, if not previously filed, and proof of service on the employer or insurer, and employee.

B. If a party claims fees in excess of the amount listed in Minnesota Statutes, section 176.081, subdivision 1, clause (a) or an objection to the statement under item A is filed, or it is requested that fees be assessed against the employer or insurer for refusal to pay rehabilitation or medical benefits or provide services or the requested fees were incurred in connection with an administrative conference under Minnesota Statutes, section 176.242, 176.2421, 176.243, or 176.244, the party shall fully complete and file a petition for disputed or excess attorney fees on a form prescribed by the commissioner, including:

(1) information identifying the employee, employer, insurer, and any adjusting company;

(2) claim numbers or codes;

(3) date of the injury or disease;

(4) an exhibit showing specific legal services performed, the date performed, and the time spent;

(5) the number of hours spent in the employee's representation and the attorney's hourly fee;

(6) a statement of expertise and experience in workers' compensation matters;

(7) a brief description of the factual, medical, and legal issues in dispute;

(8) the nature of proof required in the case;

(9) a list of the benefits obtained which were genuinely in dispute and which would not have been recovered without the attorney's involvement, and the total dollar amount of benefits obtained;

(10) information concerning any retainer;

(11) the amount the employee advanced for expenses;

(12) the specific dollar amount claimed in fees;

(13) information regarding the withholding of attorney fees, if known;

(14) a list of the disbursements incurred and if the disbursement has been paid, by whom;

(15) information regarding the attorney's license to practice law in the state;

(16) a statement of the statutory basis or other legal authority for attorney fees;

(17) whether or not a hearing on attorney fees is requested; and

(18) information identifying the employee's attorney.

The petition must be accompanied by a copy of the retainer agreement, if not previously filed, and proof of service on the employer or insurer, and employee.

Subp. 4. **Fees, objection.** If a timely objection to the statement of attorney fees is filed, the compensation judge or settlement judge shall use Minnesota Statutes, section 176.081, subdivision 5.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2930 DEPENDENT'S BENEFITS.

Subpart 1. **Allocation of compensation by judge.**

A. A party may petition for an allocation of benefits under Minnesota Statutes, section 176.111, subdivision 10. The petition may contain a proposed allocation. The petition must be served on all parties and filed with the division within one year after the date of death or one year after the effective date of this rule, whichever is later. If a petition for allocation is not filed in a timely manner and the death occurred after June 30, 1981, the allocation will be as provided in subpart 2.

B. A party may object to a proposed allocation by serving on all parties and filing an objection with the division within 20 days after service of the petition. The objection must contain a clear and concise statement of the specific grounds for the objection and must be accompanied by any documentary evidence supporting the objection.

C. A settlement judge shall rule on the petition without a hearing. If a party objects to the judge's decision, the party may request a hearing by filing with the division a written request for hearing within 30 days after the decision was filed. Upon receipt of a timely request for hearing, the matter will be referred to the office for hearing.

Subp. 2. **Allocation of compensation in other cases.** In all cases where there has been no allocation of benefits by a judge under subpart 1, and the death occurs after June 30, 1981, compensation to which dependents are entitled under Minnesota Statutes, section 176.111, shall be allocated as follows:

A. If the deceased employee leaves a surviving spouse and one dependent child, 84 percent of the compensation due under Minnesota Statutes, section 176.111, shall be paid to the surviving spouse and the remaining 16 percent of the compensation shall be paid for the benefit of the dependent child.

B. If the deceased employee leaves a surviving spouse and two or more dependent children, 75 percent of the compensation due under Minnesota Statutes, section 176.111, shall be paid to the surviving spouse and the remaining 25 percent shall be paid for the benefit of the dependent children.

This allocation shall apply from the date of death until a court-determined allocation is made, if any.

Subp. 3. **Date of death governs.** An allocation of benefits under this part shall be based upon facts existing as of the date of death. Reallocations based on a change of circumstances of the dependents after the date of death, such as remarriage, termination of dependency status of one or more of the dependents, or any other reason, are not permitted.

Subp. 4. **Factors in allocating.** Factors which may justify a different allocation from that provided in subpart 2 include special circumstances which necessitate greater income to one or more of the dependents and the existence of other adequate means of support, other than workers' compensation benefits, for certain dependents but not for others.

Subp. 5. **Offset for government survivor benefits.** An offset for government survivor benefits is allowed under Minnesota Statutes, section 176.111, subdivision 21, only to the extent that the government survivor benefits, when combined with the weekly workers' compensation benefits, exceed the weekly wage of the deceased employee at the time of death or exceeds the dependents allocated portion of the weekly wage for deaths occurring prior to July 1, 1981. For purposes of this offset, the weekly wage must be increased by the adjustments provided by Minnesota Statutes, section 176.645.

A. Deaths prior to July 1, 1981. If there is a surviving spouse and one or more dependent children in a single household, the offset must be computed twice, once separately for the spouse and once separately for the children, the children being taken as a group. For purposes of this computation, the weekly wage, as adjusted pursuant to Minnesota Statutes, section 176.645, is allocated between the spouse and children in the same proportion as benefits are allocated pursuant to this rule. Mother's insurance benefits must be allocated to the children.

B. Deaths after June 30, 1981.

(1) Surviving spouse responsible for support of all dependents. If the support of all dependent children is the responsibility of the surviving spouse, the offset shall be computed only once, taking the spouse and dependent children together as one group. All government survivor benefits, including mother's insurance benefits, received by any member of the group shall be lumped together for purposes of computing the offset.

(2) Surviving spouse not responsible for support of all dependents. If support of one or more of the dependent children is not the responsibility of the surviving spouse, the offset shall be computed twice, once for the surviving spouse and the children dependent on the surviving spouse, all taken as a group, and once for the children whose support is not the responsibility of the surviving spouse. For purposes of the offset, the weekly wage, as adjusted under Minnesota Statutes, section 176.645, must be allocated between the spouse and children in the same proportion as benefits are allocated pursuant to this part. Mother's insurance benefits must be allocated to the group comprised of the dependent children for whose benefit the mother's insurance benefits are being paid.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2940 PEACE OFFICER DEATH BENEFITS.

Subpart 1. **Application for benefits.** The application for payment from the peace officers benefit fund of Minnesota Statutes, section 176B.02 shall be

submitted to the commissioner on a form prescribed by the commissioner. The form shall require at least the following:

A. The name, social security number, and job title of the peace officer.

B. A description of events preceding the death and the cause of death.

C. Identification of dependents and spouse, together with proof of relationship.

D. Whether a workers' compensation claim for death benefits has also been or will be made.

Subp. 2. **Investigation by commissioner.** Upon receipt of a completed application, the commissioner shall determine whether benefits are payable under Minnesota Statutes, chapter 176B. The commissioner shall make any inquiries or investigation necessary to the determination, and if necessary, shall require the filing of a first report of injury under Minnesota Statutes, chapter 176.

Subp. 3. **Denial of claim.** If the commissioner determines that benefits are not payable, or that there is insufficient information on which to make a determination, the commissioner shall deny the claim and inform the claimant.

Subp. 4. **Petition for payment.** Claimants who disagree with the denial and wish to pursue their claim shall file a petition for payment with the Department of Labor and Industry, following the procedures prescribed for the filing of claim petitions under Minnesota Statutes, chapter 176, and part 1415.1000. The petition shall name as respondent the administrator of the peace officers benefit fund and shall be served on the commissioner.

Subp. 5. **Subsequent procedures.** The petition will be treated as a claim petition under Minnesota Statutes, chapter 176, including referral to the office for hearing, if the case is not settled.

Subp. 6. **Consolidation with dependency benefit claim.** Upon order of a compensation judge, a claim under Minnesota Statutes, chapter 176B, must be consolidated with a claim for death benefits under Minnesota Statutes, chapter 176, if the factual issues are similar and consolidation would not unduly delay resolution of either claim. Consolidation shall not be construed as permitting application of the same legal standard to both claims.

Subp. 7. **Appeals.** A party aggrieved by an order of the compensation judge or the Workers' Compensation Court of Appeals may appeal pursuant to Minnesota Statutes, chapter 176, and rules applicable to cases under Minnesota Statutes, chapter 176.

Subp. 8. **Certification.** After investigation the commissioner may certify pursuant to Minnesota Statutes, section 176B.04. If a denied claim is appealed, after a final order that the benefit is due, the commissioner shall so certify.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.2950 SEVERABILITY.

If any provision of parts 5220.2510 to 5220.2940 is held to conflict with a governing statute, applicable provisions of the Administrative Procedure Act, or other relevant law; to exceed the statutory authority conferred; to lack a reasonable relationship to statutory purposes or to be unconstitutional, arbitrary, or unreasonable; or to be invalid or unenforceable for any other reason; the validity and enforceability of the remaining provisions of the rule shall in no manner be affected.

Statutory Authority: *MS s 175.17 cl (2); 176.83 subds 1,7,8,9,15*

History: *11 SR 1530*

5220.3000 [Repealed, 11 SR 1530]

5220.3100 [Repealed, 9 SR 333]
5220.3200 [Repealed, 11 SR 1530]
5220.3300 [Repealed, 9 SR 333]
5220.3400 [Repealed, 9 SR 333]
5220.3500 [Repealed, 9 SR 333]
5220.3600 [Repealed, 11 SR 1530]
5220.3700 [Repealed, 9 SR 333]
5220.3800 [Repealed, 9 SR 333]
5220.3900 [Repealed, 9 SR 333]
5220.4000 [Repealed, 9 SR 333]
5220.4100 [Repealed, 9 SR 333]
5220.4200 [Repealed, 9 SR 333]
5220.4300 [Repealed, 9 SR 333]
5220.4301 [Repealed, 9 SR 333]
5220.4302 [Repealed, 9 SR 333]
5220.4303 [Repealed, 9 SR 333]
5220.4304 [Repealed, 9 SR 333]
5220.4305 [Repealed, 9 SR 333]
5220.4800 [Repealed, 9 SR 333]
5220.4900 [Repealed, 9 SR 333]
5220.5000 [Repealed, 11 SR 1530]
5220.5100 [Repealed, 9 SR 333]
5220.5200 [Repealed, 9 SR 333]
5220.5300 [Repealed, 9 SR 333]
5220.5400 [Repealed, 9 SR 333]
5220.5500 [Repealed, 9 SR 333]
5220.5600 [Repealed, 9 SR 333]
5220.5700 [Repealed, 9 SR 333]
5220.6500 [Repealed, 9 SR 333]
5220.6600 [Repealed, 9 SR 333]
5220.6700 [Repealed, 9 SR 333]
5220.6800 [Repealed, 9 SR 333]
5220.6900 [Repealed, 9 SR 333]
5220.7000 [Repealed, 9 SR 333]
5220.7100 [Repealed, 9 SR 333]
5220.7200 [Repealed, 9 SR 333]