CHAPTER 176

WORKERS' COMPENSATION

176.011 DEFINITIONS.

[For text of subds 1 to 7, see M.S.1994]

Subd. 7a. (1) **Compensation judge.** "Compensation judge" means a workers' compensation judge at the office of administrative hearings.

(2) **Calendar judge.** "Calendar judge" means a workers' compensation judge at the office of administrative hearings.

(3) **Settlement judge.** "Settlement judge" means a compensation judge at the department of labor and industry. Settlement judges may conduct settlement conferences, issue summary decisions, approve settlements and issue awards thereon, determine petitions for attorney fees and costs, and make other determinations, decisions, orders, and awards as may be delegated to them by the commissioner. Settlement judges must be learned in the law.

[For text of subds 8 to 15, see M.S.1994]

Subd. 16. **Personal injury.** "Personal injury" means injury arising out of and in the course of employment and includes personal injury caused by occupational disease; but does not cover an employee except while engaged in, on, or about the premises where the employee's services require the employee's presence as a part of that service at the time of the injury and during the hours of that service. Where the employer regularly furnished transportation to employees to and from the place of employment, those employees are subject to this chapter while being so transported. Personal injury does not include an injury caused by the act of a third person or fellow employee intended to injure the employee because of per-

sonal reasons, and not directed against the employee as an employee, or because of the employment.

[For text of subds 17 to 24, see M.S.1994]

Subd. 25. **Maximum medical improvement.** "Maximum medical improvement" means the date after which no further significant recovery from or significant lasting improvement to a personal injury can reasonably be anticipated, based upon reasonable medical probability, irrespective and regardless of subjective complaints of pain. Except where an employee is medically unable to continue working under section 176.101, subdivision 1, paragraph (e), clause (2), once the date of maximum medical improvement has been determined, no further determinations of other dates of maximum medical improvement for that personal injury is permitted. The determination that an employee has reached maximum medical improvement shall not be rendered ineffective by the worsening of the employee's medical condition and recovery therefrom.

Subd. 26. [Repealed, 1995 c 231 art 1 s 36; art 2 s 110]

[For text of subd 27, see M.S.1994]

History: *1995 c 224 s 69; 1995 c 231 art 1 s 13; art 2 s 44*

176.021 APPLICATION TO EMPLOYERS AND EMPLOYEES.

[For text of subds 1 to 2, see M.S.1994]

Subd. 3. **Compensation, commencement of payment.** All employers shall commence payment of compensation at the time and in the manner prescribed by this chapter without the necessity of any agreement or any order of the division. Except for medical, burial, and other nonperiodic benefits, payments shall be made as nearly as possible at the intervals when the wage was payable, provided, however, that payments for permanent partial disability shall be governed by section 176.101. If doubt exists as to the eventual permanent partial disability, payment shall be then made when due for the minimum permanent partial disability ascertainable, and further payment shall be made upon any later ascertainment of greater permanent partial disability. Prior to or at the time of commencement of the payment of permanent partial compensation, the employee and employer shall be furnished with a copy of the medical report upon which the payment is based and all other medical reports which the insurer has that indicate a permanent partial disability rating, together with a statement by the insurer as to whether the tendered payment is for minimum permanent partial disability or final and eventual disability. After receipt of all reports available to the insurer that indicate a permanent partial disability rating, the employee shall make available or permit the insurer to obtain any medical report that the employee has or has knowledge of that contains a permanent partial disability rating which the insurer does not already have. Permanent partial compensation pursuant to section 176.101 is payable in addition to but not concurrently with compensation for temporary total disability but is payable pursuant to section 176.101. Impairment compensation is payable concurrently and in addition to compensation for permanent total disability pursuant to section 176.101. Permanent partial compensation pursuant to section 176.101 shall be withheld pending completion of payment for temporary total disability, and no credit shall be taken for payment of permanent partial compensation against liability for temporary total or future permanent total disability. Liability on the part of an employer or the insurer for disability of a temporary total, temporary partial, and permanent total nature shall be considered as a continuing product and part of the employee's inability to earn or reduction in earning capacity due to injury or occupational disease and compensation is payable accordingly, subject to section 176.101. Permanent partial compensation is payable for functional loss of use or impairment of function, permanent in nature, and payment therefore shall be separate, distinct, and in addition to payment for any other compensation, subject to section 176.101. The right to receive temporary total, temporary partial, or permanent total disability payments vests in the injured employee or the employee's dependents under this chapter or, if none, in the employee's legal heirs at the time the disability can be ascertained and the right is not abrogated by the employee's death prior to the making of the payment.

The right to receive permanent partial compensation vests in an injured employee at the time the disability can be ascertained provided that the employee lives for at least 30 days beyond the date of the injury. Upon the death of an employee who is receiving economic recovery compensation or impairment compensation, further compensation is payable pursuant to section 176.101. Impairment compensation is payable under this paragraph if vesting has occurred, the employee dies prior to reaching maximum medical improvement, and the requirements and conditions under section 176.101, subdivision 3e, are not met.

Disability ratings for permanent partial disability shall be based on objective medical evidence.

Subd. 3a. **Permanent partial benefits, payment.** Payments for permanent partial disability as provided in section 176.101, subdivision 2a, shall be made in the following manner:

(a) If the employee returns to work, payment shall be made at the same intervals as temporary total payments were made;

(b) If temporary total payments have ceased, but the employee has not returned to work, payment shall be made at the same intervals as temporary total payments were made;

(c) If temporary total disability payments cease because the employee is receiving payments for permanent total disability or because the employee is retiring or has retired from the work force, then payment shall be made at the same intervals as temporary total payments were made;

(d) If the employee completes a rehabilitation plan pursuant to section 176.102, but the employer does not furnish the employee with work the employee can do in a permanently partially disabled condition, and the employee is unable to procure such work with another employer, then payment shall be made at the same intervals as temporary total payments were made.

[For text of subds 3b to 9, see M.S.1994]

History: *1995 c 231 art 1 s 14,15*

176.061 THIRD PARTY LIABILITY.

[For text of subds 1 to 9, see M.S.1994]

Subd. 10. **Indemnity.** Notwithstanding the provisions of chapter 65B or any other law to the contrary, an employer has a right of indemnity for any compensation paid or payable pursuant to this chapter, including temporary total compensation, temporary partial compensation, permanent partial compensation, medical compensation, rehabilitation, death, and permanent total compensation.

History: *1995 c 231 art 1 s 16*

176.081 LEGAL SERVICES OR DISBURSEMENTS; LIEN; REVIEW.

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

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

For the purposes of applying the formula where the employer or insurer is liable for attorney fees, the amount of compensation awarded for obtaining disputed medical and rehabi-

litation benefits under sections 176.102, 176.135, and 176.136 shall be the dollar value of the medical or rehabilitation benefit awarded, where ascertainable.

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

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

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

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

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

(e) Employers and insurers may not pay attorney fees or wages for legal services of more than $13,000 per case unless the additional fees or wages are approved under subdivision 2.

(f) Each insurer and self-insured employer shall file annual statements with the commissioner detailing the total amount of legal fees and other legal costs incurred by the insurer or employer during the year. The statement shall include the amount paid for outside and in-house counsel, deposition and other witness fees, and all other costs relating to litigation.

Subd. 2. [Repealed, 1995 c 231 art 2 s 110]

[For text of subd 3, see M.S.1994]

Subd. 5. [Repealed, 1995 c 231 art 2 s 110]

[For text of subd 6, see M.S.1994]

Subd. 7. **Award; additional amount.** If the employer or insurer files a denial of liability, notice of discontinuance, or fails to make payment of compensation or medical expenses within the statutory period after notice of injury or occupational disease, or otherwise unsuccessfully resists the payment of compensation or medical expenses, or unsuccessfully dis-

putes the payment of rehabilitation benefits or other aspects of a rehabilitation plan, and the injured person has employed an attorney at law, who successfully procures payment on behalf of the employee or who enables the resolution of a dispute with respect to a rehabilitation plan, the compensation judge, commissioner, or the workers' compensation court of appeals upon appeal, upon application, shall award to the employee against the insurer or self–insured employer or uninsured employer, in addition to the compensation benefits paid or awarded to the employee, an amount equal to 30 percent of that portion of the attorney's fee which has been awarded pursuant to this section that is in excess of $250.

Subd. 7a. **Settlement offer.** At any time prior to one day before a matter is to be heard, a party litigating a claim made pursuant to this chapter may serve upon the adverse party a reasonable offer of settlement of the claim, with provision for costs and disbursements then accrued. If before the hearing the adverse party serves written notice that the offer is accepted, either party may then file the offer and notice of acceptance, together with the proof of service thereof, and thereupon judgment shall be entered.

If an offer by an employer or insurer is not accepted by the employee, it shall be deemed withdrawn and evidence thereof is not admissible, except in a proceeding to determine attorney's fees.

If an offer by an employee is not accepted by the employer or insurer, it shall be deemed withdrawn and evidence thereof is not admissible, except in a proceeding to determine attorney's fees.

The fact that an offer is made but not accepted does not preclude a subsequent offer.

Subd. 8. [Repealed, 1995 c 231 art 2 s 110]

Subd. 9. **Retainer agreement.** An attorney who is hired by an employee to provide legal services with respect to a claim for compensation made pursuant to this chapter shall prepare a retainer agreement in which the provisions of this section are specifically set out and provide a copy of this agreement to the employee. The retainer agreement shall provide a space for the signature of the employee. A signed agreement shall raise a conclusive presumption that the employee has read and understands the statutory fee provisions. No fee shall be awarded pursuant to this section in the absence of a signed retainer agreement.

The retainer agreement shall contain a notice to the employee regarding the maximum fee allowed under this section in ten–point type, which shall read:

Notice of Maximum Fee

The maximum fee allowed by law for legal services is 25 percent of the first $4,000 of compensation awarded to the employee and 20 percent of the next $60,000 of compensation awarded to the employee subject to a cumulative maximum fee of $13,000 for fees related to the same injury.

The employee shall take notice that the employee is under no legal or moral obligation to pay any fee for legal services in excess of the foregoing maximum fee.

[For text of subds 10 and 11, see M.S.1994]

Subd. 12. **Sanctions; failure to prepare, appear, or participate.** If a party or party's attorney fails to appear at any conference or hearing scheduled under this chapter, is substantially unprepared to participate in the conference or hearing, or fails to participate in good faith, the commissioner or compensation judge, upon motion or upon its own initiative, shall require the party or the party's attorney or both to pay the reasonable expenses including attorney fees, incurred by the other party due to the failure to appear, prepare, or participate. Attorney fees or other expenses may not be awarded if the commissioner or compensation judge finds that the noncompliance was substantially justified or that other circumstances would make the sanction unjust. The department of labor and industry, and the office of administrative hearings may by rule establish additional sanctions for failure of a party or the party's attorney to appear, prepare for, or participate in a conference or hearing.

History: *1995 c 231 art 2 s 45–49*

176.101 COMPENSATION SCHEDULE.

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

(b) (1) Commencing on October 1, 1995, the maximum weekly compensation payable is $615 per week.

(2) The workers' compensation advisory council may consider adjustment increases and make recommendations to the legislature.

(c) The minimum weekly compensation payable is $104 per week or the injured employee's actual weekly wage, whichever is less.

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

(e) Temporary total disability compensation shall cease when the employee returns to work. Except as otherwise provided in section 176.102, subdivision 11, temporary total disability compensation may only be recommenced following cessation under this paragraph, paragraph (h), or paragraph (j) prior to payment of 104 weeks of temporary total disability compensation and only as follows:

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

(2) if temporary total disability compensation ceased because the employee returned to work or ceased under paragraph (h) or (j), it may be recommenced if the employee is medically unable to continue at a job due to the injury. Where the employee is medically unable to continue working due to the injury, temporary total disability compensation may continue until any of the cessation events in paragraphs (e) to (l) occurs following recommencement. If an employee who has not yet received temporary total disability compensation becomes medically unable to continue working due to the injury after reaching maximum medical improvement, temporary total disability compensation shall commence and shall continue until any of the events in paragraphs (e) to (l) occurs following commencement. For purposes of commencement or recommencement under this clause only, a new period of maximum medical improvement under paragraph (j) begins when the employee becomes medically unable to continue working due to the injury. Temporary total disability compensation may not be recommenced under this clause and a new period of maximum medical improvement does not begin if the employee is not actively employed when the employee becomes medically unable to work. All periods of initial and recommenced temporary total disability compensation are included in the 104–week limitation specified in paragraph (k).

(f) Temporary total disability compensation shall cease if the employee withdraws from the labor market. Temporary total disability compensation may be recommenced following cessation under this paragraph only if the employee reenters the labor market prior to 90 days after the employee reached maximum medical improvement and prior to payment of 104 weeks of temporary total disability compensation. Once recommenced, temporary total disability ceases when any of the cessation events in paragraphs (e) to (l) occurs.

(g) Temporary total disability compensation shall cease if the total disability ends and the employee fails to diligently search for appropriate work within the employee's physical restrictions. Temporary total disability compensation may be recommenced following cessation under this paragraph only if the employee begins diligently searching for appropriate work within the employee's physical restrictions prior to 90 days after maximum medical improvement and prior to payment of 104 weeks of temporary total disability compensation. Once recommenced, temporary total disability compensation ceases when any of the cessation events in paragraphs (e) to (l) occurs.

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

(i) Temporary total disability compensation shall cease if the employee refuses an offer of work that is consistent with a plan of rehabilitation filed with the commissioner which meets the requirements of section 176.102, subdivision 4, or, if no plan has been filed, the employee refuses an offer of gainful employment that the employee can do in the employee's

physical condition. Once temporary total disability compensation has ceased under this paragraph, it may not be recommenced.

(j) Temporary total disability compensation shall cease 90 days after the employee has reached maximum medical improvement, except as provided in section 176.102, subdivision 11, paragraph (b). For purposes of this subdivision, the 90–day period after maximum medical improvement commences on the earlier of: (1) the date that the employee receives a written medical report indicating that the employee has reached maximum medical improvement; or (2) the date that the employer or insurer serves the report on the employee and the employee's attorney, if any. Once temporary total disability compensation has ceased under this paragraph, it may not be recommenced except if the employee returns to work and is subsequently medically unable to continue working as provided in paragraph (e), clause (2).

(k) Temporary total disability compensation shall cease entirely when 104 weeks of temporary total disability compensation have been paid, except as provided in section 176.102, subdivision 11, paragraph (b). Notwithstanding anything in this section to the contrary, initial and recommenced temporary total disability compensation combined shall not be paid for more than 104 weeks, regardless of the number of weeks that have elapsed since the injury, except that if the employee is in a retraining plan approved under section 176.102, subdivision 11, the 104 week limitation shall not apply during the retraining, but is subject to the limitation before the plan begins and after the plan ends.

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

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

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

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

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

Impairment rating (percent)	Amount
0–25	$ 75,000
26–30	80,000
31–35	85,000
36–40	90,000
41–45	95,000
46–50	100,000
51–55	120,000
56–60	140,000
61–65	160,000
66–70	180,000
71–75	200,000
76–80	240,000

81–85	280,000
86–90	320,000
91–95	360,000
96–100	400,000

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

(b) Permanent partial disability is payable upon cessation of temporary total disability under subdivision 1. The compensation is payable in installments at the same intervals and in the same amount as the employee's temporary total disability rate on the date of injury. Permanent partial disability is not payable while temporary total compensation is being paid.

Subd. 3a. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3b. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3c. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3d. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3e. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3f. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3g. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3h. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3i. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3j. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3k. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3l. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3m. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3n. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3o. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3p. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3q. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3r. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3s. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3t. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3u. [Repealed, 1995 c 231 art 1 s 36]

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

[For text of subd 4a, see M.S.1994]

Subd. 5. **Definition.** For purposes of subdivision 4, "permanent total disability" means only:

(1) the total and permanent loss of the sight of both eyes, the loss of both arms at the shoulder, the loss of both legs so close to the hips that no effective artificial members can be used, complete and permanent paralysis, total and permanent loss of mental faculties; or

(2) any other injury which totally and permanently incapacitates the employee from working at an occupation which brings the employee an income, provided that the employee must also meet the criteria of one of the following clauses:

(a) the employee has at least a 17 percent permanent partial disability rating of the whole body;

(b) the employee has a permanent partial disability rating of the whole body of at least 15 percent and the employee is at least 50 years old at the time of injury; or

(c) the employee has a permanent partial disability rating of the whole body of at least 13 percent and the employee is at least 55 years old at the time of the injury, and has not completed grade 12 or obtained a GED certificate.

For purposes of this clause, "totally and permanently incapacitated" means that the employee's physical disability in combination with any one of clause (a), (b), or (c) causes the employee to be unable to secure anything more than sporadic employment resulting in an insubstantial income. Other factors not specified in clause (a), (b), or (c), including the employee's age, education, training and experience, may only be considered in determining whether an employee is totally and permanently incapacitated after the employee meets the threshold criteria of clause (a), (b), or (c). The employee's age, level of physical disability, or education may not be considered to the extent the factor is inconsistent with the disability, age, and education factors specified in clause (a), (b), or (c).

Subd. 6. **Minors; apprentices.** (a) If any employee entitled to the benefits of this chapter is an apprentice of any age and sustains a personal injury arising out of and in the course of employment resulting in permanent total or a compensable permanent partial disability, for the purpose of computing the compensation to which the employee is entitled for the injury, the compensation rate for temporary total, temporary partial, or permanent total disability shall be the maximum rate for temporary total disability under subdivision 1.

(b) If any employee entitled to the benefits of this chapter is a minor and sustains a personal injury arising out of and in the course of employment resulting in permanent total disability, for the purpose of computing the compensation to which the employee is entitled for the injury, the compensation rate for a permanent total disability shall be the maximum rate for temporary total disability under subdivision 1.

Subd. 8. **Cessation of benefits.** Temporary total disability payments shall cease at retirement. "Retirement" means that a preponderance of the evidence supports a conclusion that an employee has retired. The subjective statement of an employee that the employee is not retired is not sufficient in itself to rebut objective evidence of retirement but may be considered along with other evidence.

For injuries occurring after January 1, 1984, an employee who receives social security old age and survivors insurance retirement benefits under the Social Security Act, Public Law Number 98–21, as amended, is presumed retired from the labor market. This presumption is rebuttable by a preponderance of the evidence.

History: *1995 c 231 art 1 s 17–23*

176.102 REHABILITATION.

[For text of subds 1 to 3, see M.S.1994]

Subd. 3a. **Disciplinary actions.** The panel has authority to discipline qualified rehabilitation consultants and vendors and may impose a penalty of up to $3,000 per violation, payable to the special compensation fund, and may suspend or revoke certification. Complaints against registered qualified rehabilitation consultants and vendors shall be made to the commissioner who shall investigate all complaints. If the investigation indicates a violation of

this chapter or rules adopted under this chapter, the commissioner may initiate a contested case proceeding under the provisions of chapter 14. In these cases, the rehabilitation review panel shall make the final decision following receipt of the report of an administrative law judge. The decision of the panel is appealable to the workers' compensation court of appeals in the manner provided by section 176.421. The panel shall continuously study rehabilitation services and delivery, develop and recommend rehabilitation rules to the commissioner, and assist the commissioner in accomplishing public education.

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

[For text of subds 3b to 10, see M.S.1994]

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

(b) If the employee is not employed during a retraining plan that has been specifically approved under this section, temporary total compensation is payable for up to 90 days after the end of the retraining plan; except that, payment during the 90–day period is subject to cessation in accordance with section 176.101. If the employee is employed during the retraining plan but earning less than at the time of injury, temporary partial compensation is payable at the rate of 66–2/3 percent of the difference between the employee's weekly wage at the time of injury and the weekly wage the employee is able to earn in the employee's partially disabled condition, subject to the maximum rate for temporary total compensation. Temporary partial compensation is not subject to the 225–week or 450–week limitations provided by section 176.101, subdivision 2, during the retraining plan, but is subject to those limitations before and after the plan.

(c) Any request for retraining shall be filed with the commissioner before 104 weeks of any combination of temporary total or temporary partial compensation have been paid. Retraining shall not be available after 104 weeks of any combination of temporary total or temporary partial compensation benefits have been paid unless the request for the retraining has been filed with the commissioner prior to the time the 104 weeks of compensation have been paid.

(d) The employer or insurer must notify the employee in writing of the 104 week limitation for filing a request for retraining with the commissioner. This notice must be given before 80 weeks of temporary total disability or temporary partial disability compensation have been paid, regardless of the number of weeks that have elapsed since the date of injury. If the notice is not given before the 80 weeks, the period of time within which to file a request for retraining is extended by the number of days the notice is late, but in no event may a request be filed later than 225 weeks after any combination of temporary total disability or temporary partial disability compensation have been paid. The commissioner may assess a penalty of $25 per day that the notice is late, up to a maximum penalty of $2,000, against an employer or insurer for failure to provide the notice. The penalty is payable to the assigned risk safety account.

[For text of subds 11a to 14, see M.S.1994]

History: *1995 c 231 art 2 s 50,51*

176.103 MEDICAL HEALTH CARE REVIEW.

[For text of subd 1, see M.S.1994]

Subd. 2. **Scope.** The commissioner shall monitor the medical and surgical treatment provided to injured employees, the services of other health care providers and shall also monitor hospital utilization as it relates to the treatment of injured employees. This monitoring shall include determinations concerning the appropriateness of the service, whether the treatment is necessary and effective, the proper cost of services, the quality of the treatment, the right of providers to receive payment under this chapter for services rendered or the right to receive payment under this chapter for future services. Insurers and self–insurers must assist the commissioner in this monitoring by reporting to the commissioner cases of suspected excessive, inappropriate, or unnecessary treatment. The commissioner in consultation with the medical services review board shall adopt rules defining standards of treatment including inappropriate, unnecessary, or excessive treatment and the sanctions to be imposed for inappropriate, unnecessary, or excessive treatment. The sanctions imposed may include, without limitation, a warning, a restriction on providing treatment, requiring preauthorization by the board for a plan of treatment, and suspension from receiving compensation for the provision of treatment under chapter 176. The commissioner's authority under this section also includes the authority to make determinations regarding any other activity involving the questions of utilization of medical services, and any other determination the commissioner deems necessary for the proper administration of this section, but does not include the authority to make the initial determination of primary liability, except as provided by section 176.305.

Subd. 2a. [Repealed, 1995 c 231 art 2 s 110]

Subd. 3. **Medical services review board; selection; powers.** (a) There is created a medical services review board composed of the commissioner or the commissioner's designee as an ex officio member, two persons representing chiropractic, one person representing hospital administrators, one physical therapist, and six physicians representing different specialties which the commissioner determines are the most frequently utilized by injured employees. The board shall also have one person representing employees, one person representing employers or insurers, and one person representing the general public. The members shall be appointed by the commissioner and shall be governed by section 15.0575. Terms of the board's members may be renewed. The board may appoint from its members whatever subcommittees it deems appropriate.

The commissioner may appoint alternates for one–year terms to serve as a member when a member is unavailable. The number of alternates shall not exceed one chiropractor, one physical therapist, one hospital administrator, three physicians, one employee representative, one employer or insurer representative, and one representative of the general public.

The board shall review clinical results for adequacy and recommend to the commissioner scales for disabilities and apportionment.

The board shall review and recommend to the commissioner rates for individual clinical procedures and aggregate costs. The board shall assist the commissioner in accomplishing public education.

In evaluating the clinical consequences of the services provided to an employee by a clinical health care provider, the board shall consider the following factors in the priority listed:

(1) the clinical effectiveness of the treatment;

(2) the clinical cost of the treatment; and

(3) the length of time of treatment.

The board shall advise the commissioner on the adoption of rules regarding all aspects of medical care and services provided to injured employees.

(b) The medical services review board may upon petition from the commissioner and after hearing, issue a warning, a penalty of $200 per violation, a restriction on providing treatment that requires preauthorization by the board, commissioner, or compensation judge for a plan of treatment, disqualify, or suspend a provider from receiving payment for services rendered under this chapter if a provider has violated any part of this chapter or rule adopted under this chapter, or where there has been a pattern of, or an egregious case of, inappropriate, unnecessary, or excessive treatment by a provider. The hearings are initiated by the commissioner under the contested case procedures of chapter 14. The board shall make the final decision following receipt of the recommendation of the administrative law judge. The

board's decision is appealable to the workers' compensation court of appeals in the manner provided by section 176.421.

(c) The board may adopt rules of procedure. The rules may be joint rules with the rehabilitation review panel.

History: *1995 c 231 art 2 s 52,53*

176.104 REHABILITATION PRIOR TO DETERMINATION OF LIABILITY.

Subdivision 1. **Dispute.** If there exists a dispute regarding medical causation or whether an injury arose out of and in the course and scope of employment and an employee is otherwise eligible for rehabilitation services under section 176.102 prior to determination of liability, the employee shall be referred by the commissioner to the department's vocational rehabilitation unit which shall provide rehabilitation consultation if appropriate. The services provided by the department's vocational rehabilitation unit and the scope and term of the rehabilitation are governed by section 176.102 and rules adopted pursuant to that section. Rehabilitation costs and services under this subdivision shall be monitored by the commissioner.

[For text of subds 2 to 4, see M.S.1994]

History: *1995 c 231 art 2 s 54*

176.105 COMMISSIONER TO ESTABLISH DISABILITY SCHEDULES.

[For text of subds 1 to 3, see M.S.1994]

Subd. 4. **Legislative intent; rules; loss of more than one body part.** For the purpose of establishing a disability schedule, the legislature declares its intent that the commissioner establish a disability schedule which shall be determined by sound actuarial evaluation and shall be based on the benefit level which exists on January 1, 1983.

The commissioner shall by rulemaking adopt procedures setting forth rules for the evaluation and rating of functional disability and the schedule for permanent partial disability and to determine the percentage of loss of function of a part of the body based on the body as a whole, including internal organs, described in section 176.101, subdivision 3, and any other body part not listed in section 176.101, subdivision 3, which the commissioner deems appropriate.

The rules shall promote objectivity and consistency in the evaluation of permanent functional impairment due to personal injury and in the assignment of a numerical rating to the functional impairment.

Prior to adoption of rules the commissioner shall conduct an analysis of the current permanent partial disability schedule for the purpose of determining the number and distribution of permanent partial disabilities and the average compensation for various permanent partial disabilities. The commissioner shall consider setting the compensation under the proposed schedule for the most serious conditions higher in comparison to the current schedule and shall consider decreasing awards for minor conditions in comparison to the current schedule.

The commissioner may consider, among other factors, and shall not be limited to the following factors in developing rules for the evaluation and rating of functional disability and the schedule for permanent partial disability benefits:

(1) the workability and simplicity of the procedures with respect to the evaluation of functional disability;

(2) the consistency of the procedures with accepted medical standards;

(3) rules, guidelines, and schedules that exist in other states that are related to the evaluation of permanent partial disability or to a schedule of benefits for functional disability provided that the commissioner is not bound by the degree of disability in these sources but shall adjust the relative degree of disability to conform to the expressed intent of this section;

(4) rules, guidelines, and schedules that have been developed by associations of health care providers or organizations provided that the commissioner is not bound by the degree of

disability in these sources but shall adjust the relative degree of disability to conform to the expressed intent of this section;

(5) the effect the rules may have on reducing litigation;

(6) the treatment of preexisting disabilities with respect to the evaluation of permanent functional disability provided that any preexisting disabilities must be objectively determined by medical evidence; and

(7) symptomatology and loss of function and use of the injured member.

The factors in paragraphs (1) to (7) shall not be used in any individual or specific workers' compensation claim under this chapter but shall be used only in the adoption of rules pursuant to this section.

Nothing listed in paragraphs (1) to (7) shall be used to dispute or challenge a disability rating given to a part of the body so long as the whole schedule conforms with the expressed intent of this section.

If an employee suffers a permanent functional disability of more than one body part due to a personal injury incurred in a single occurrence, the percent of the whole body which is permanently partially disabled shall be determined by the following formula so as to ensure that the percentage for all functional disability combined does not exceed the total for the whole body:

$$A + B (1 - A)$$

where: A is the greater percentage whole body loss of the first body part; and B is the lesser percentage whole body loss otherwise payable for the second body part. A + B (1–A) is equivalent to A + B – AB.

For permanent partial disabilities to three body parts due to a single occurrence or as the result of an occupational disease, the above formula shall be applied, providing that A equals the result obtained from application of the formula to the first two body parts and B equals the percentage for the third body part. For permanent partial disability to four or more body parts incurred as described above, A equals the result obtained from the prior application of the formula, and B equals the percentage for the fourth body part or more in arithmetic progressions.

History: *1995 c 231 art 1 s 24*

176.106 ADMINISTRATIVE CONFERENCE.

Subdivision 1. **Scope.** All determinations by the commissioner or the commissioner's designee pursuant to section 176.102, 176.103, 176.135, or 176.136 shall be in accordance with the procedures contained in this section.

Subd. 2. **Request for conference.** Any party may request an administrative conference by filing a request on a form prescribed by the commissioner.

Subd. 3. **Conference.** The matter shall be scheduled for an administrative conference within 60 days after receipt of the request for a conference. Notice of the conference shall be served on all parties no later than 14 days prior to the conference, unless the commissioner determines that a conference shall not be held. The commissioner may order an administrative conference before the commissioner's designee whether or not a request for conference is filed.

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

Subd. 4. **Appearances.** All parties shall appear either personally, by telephone, by representative, or by written submission. The commissioner's designee shall determine the issues in dispute based upon the information available at the conference.

Subd. 5. **Decision.** A written decision shall be issued by the commissioner's designee determining all issues considered at the conference or if a conference was not held, based on the written submissions. Disputed issues of fact shall be determined by a preponderance of the evidence. The decision must be issued within 30 days after the close of the conference or if no conference was held, within 60 days after receipt of the request for conference. The decision must include a statement indicating the right to request a de novo hearing before a compensation judge and how to initiate the request.

Subd. 6. **Penalty.** At a conference, if the insurer does not provide a specific reason for nonpayment of the items in dispute, the commissioner's designee may assess a penalty of $300 payable to the assigned risk safety account, unless it is determined that the reason for the lack of specificity was the failure of the insurer, upon timely request, to receive information necessary to remedy the lack of specificity. This penalty is in addition to any penalty that may be applicable for nonpayment.

Subd. 7. **Request for hearing.** Any party aggrieved by the decision of the commissioner's designee may request a formal hearing by filing the request with the commissioner and serving the request on all parties no later than 30 days after the decision; provided, however, that the commissioner shall review a decision of the commissioner's designee regarding a claim for a medical benefit of $1,500 or less and the commissioner's decision shall be final. Requests on other issues shall be referred to the office of administrative hearings for a de novo hearing before a compensation judge. Except where the only issues to be determined pursuant to this section involve liability for past treatment or services that will not affect entitlement to ongoing or future proposed treatment or services under section 176.102 or 176.135, the commissioner shall refer a timely request to the office of administrative hearings within five working days after filing of the request and the hearing at the office of administrative hearings must be held on the first date that all parties are available but not later than 60 days after the office of administrative hearings receives the matter. Following the hearing, the compensation judge must issue the decision within 30 days. The decision of the compensation judge is appealable pursuant to section 176.421.

Subd. 8. **Denial of primary liability.** The commissioner does not have authority to make determinations relating to medical or rehabilitation benefits when there is a genuine dispute over whether the injury initially arose out of and in the course of employment, except as provided by section 176.305.

Subd. 9. **Subsequent causation issues.** If initial liability for an injury has been admitted or established and an issue subsequently arises regarding causation between the employee's condition and the work injury, the commissioner may make the subsequent causation determination subject to de novo hearing by a compensation judge with a right to review by the court of appeals, as provided in this chapter.

History: *1995 c 231 art 2 s 55*

176.107 TELECONFERENCES.

The division, department, office, or the court of appeals may, at its discretion, conduct mediation sessions, administrative conferences, settlement conferences, or hearings as provided in this chapter in person, by telephone, or by visual or audio teleconferencing methods.

History: *1995 c 231 art 2 s 56*

176.108 LIGHT–DUTY WORK POOLS.

Employers may form light–duty work pools for the purpose of encouraging the return to work of injured employees. The commissioner may adopt emergency and permanent rules necessary to implement this section.

History: *1995 c 231 art 2 s 57*

176.129 CREATION OF THE SPECIAL COMPENSATION FUND.

[For text of subds 1 to 8, see M.S.1994]

Subd. 9. **Powers of fund.** In addition to powers granted to the special compensation fund by this chapter the fund may do the following:

(a) sue and be sued in its own name;

(b) intervene in or commence an action under this chapter or any other law, including, but not limited to, intervention or action as a subrogee to the division's right in a third–party action, any proceeding under this chapter in which liability of the special compensation fund is an issue, or any proceeding which may result in other liability of the fund or to protect the legal right of the fund;

(c) enter into settlements including but not limited to structured, annuity purchase agreements with appropriate parties under this chapter. Notwithstanding any other provision of this chapter, any settlement may provide that the fund partially or totally denies liability for payment of benefits, and no determination of employer insurance status and liability under section 176.183, subdivision 2, shall be required for approval of the stipulation for a settlement;

(d) contract with another party to administer the special compensation fund;

(e) take any other action which an insurer is permitted by law to take in operating within this chapter; and

(f) conduct a financial audit of indemnity claim payments and assessments reported to the fund. This may be contracted by the fund to a private auditing firm.

Subd. 10. **Penalty.** Sums paid to the commissioner pursuant to this section shall be in the manner prescribed by the commissioner. The commissioner may impose a penalty payable to the assigned risk safety account of up to 15 percent of the amount due under this section but not less than $1,000 in the event payment is not made in the manner prescribed.

[For text of subds 11 to 13, see M.S.1994]

History: *1995 c 231 art 2 s 58,59*

176.130 TARGETED INDUSTRY FUND; LOGGERS.

[For text of subds 1 to 8, see M.S.1994]

Subd. 9. **False reports.** Any person or entity that, for the purpose of evading payment of the assessment or avoiding the reimbursement, or any part of it, makes a false report under this section shall pay to the assigned risk safety account, in addition to the assessment, a penalty of 75 percent of the amount of the assessment. A person who knowingly makes or signs a false report, or who knowingly submits other false information, is guilty of a misdemeanor.

[For text of subds 10 and 11, see M.S.1994]

History: *1995 c 231 art 2 s 60*

176.132 [Repealed, 1995 c 231 art 1 s 35; art 2 s 110]

176.133 [Repealed, 1995 c 231 art 2 s 110]

176.135 TREATMENT; APPLIANCES; SUPPLIES.

Subdivision 1. **Medical, psychological, chiropractic, podiatric, surgical, hospital.** (a) The employer shall furnish any medical, psychological, chiropractic, podiatric, surgical and hospital treatment, including nursing, medicines, medical, chiropractic, podiatric, and surgical supplies, crutches and apparatus, including artificial members, or, at the option of the employee, if the employer has not filed notice as hereinafter provided, Christian Science treatment in lieu of medical treatment, chiropractic medicine and medical supplies, as may reasonably be required at the time of the injury and any time thereafter to cure and relieve from the effects of the injury. This treatment shall include treatments necessary to physical rehabilitation.

(b) The employer shall pay for the reasonable value of nursing services provided by a member of the employee's family in cases of permanent total disability.

(c) Exposure to rabies is an injury and an employer shall furnish preventative treatment to employees exposed to rabies.

(d) The employer shall furnish replacement or repair for artificial members, glasses, or spectacles, artificial eyes, podiatric orthotics, dental bridge work, dentures or artificial teeth, hearing aids, canes, crutches, or wheel chairs damaged by reason of an injury arising out of and in the course of the employment. For the purpose of this paragraph, "injury" includes damage wholly or in part to an artificial member. In case of the employer's inability or refusal seasonably to provide the items required to be provided under this paragraph, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing the

same, including costs of copies of any medical records or medical reports that are in existence, obtained from health care providers, and that directly relate to the items for which payment is sought under this chapter, limited to the charges allowed by subdivision 7, and attorney fees incurred by the employee.

(e) Both the commissioner and the compensation judges have authority to make determinations under this section in accordance with sections 176.106 and 176.305.

(f) An employer may require that the treatment and supplies required to be provided by an employer by this section be received in whole or in part from a managed care plan certified under section 176.1351 except as otherwise provided by that section.

[For text of subds 1a to 7, see M.S.1994]

History: *1995 c 231 art 2 s 61*

176.1351 MANAGED CARE.

Subdivision 1. **Application.** Any person or entity, other than a workers' compensation insurer or an employer for its own employees, may make written application to the commissioner to have a plan certified that provides management of quality treatment to injured workers for injuries and diseases compensable under this chapter. Specifically, and without limitation, an entity licensed under chapter 62C or 62D or a preferred provider organization that is subject to chapter 72A is eligible for certification under this section. Each application for certification shall be accompanied by a reasonable fee prescribed by the commissioner which shall be deposited in the special compensation fund. A plan may be certified to provide services in a limited geographic area. A certificate is valid for the period the commissioner prescribes unless revoked or suspended. Application for certification shall be made in the form and manner and shall set forth information regarding the proposed plan for providing services as the commissioner may prescribe. The information shall include, but not be limited to:

(1) a list of the names of all health care providers who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for those providers to practice in this state; and

(2) a description of the places and manner of providing services under the plan.

[For text of subds 2 to 4, see M.S.1994]

Subd. 5. **Revocation, suspension, and refusal to certify; penalties and enforcement.** (a) The commissioner shall refuse to certify or shall revoke or suspend the certification of a managed care plan if the commissioner finds that the plan for providing medical or health care services fails to meet the requirements of this section, or service under the plan is not being provided in accordance with the terms of a certified plan.

(b) In lieu of or in addition to suspension or revocation under paragraph (a), the commissioner may, for any noncompliance with the managed care plan as certified or any violation of a statute or rule applicable to a managed care plan, assess an administrative penalty payable to the special compensation fund in an amount up to $25,000 for each violation or incidence of noncompliance. The commissioner may adopt emergency or permanent rules necessary to implement this subdivision. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

(1) the number of workers affected or potentially affected by the violation or noncompliance;

(2) the effect or potential effect of the violation or noncompliance on workers' health, access to health services, or workers' compensation benefits;

(3) the effect or potential effect of the violation or noncompliance on workers' understanding of their rights and obligations under the workers' compensation law and rules;

(4) whether the violation or noncompliance is an isolated incident or part of a pattern of violations; and

(5) the potential or actual economic benefits derived by the managed care plan or a participating provider by virtue of the violation or noncompliance.

The commissioner shall give written notice to the managed care plan of the penalty assessment and the reasons for the penalty. The managed care plan has 30 days from the date the penalty notice is issued within which to file a written request for an administrative hearing and review of the commissioner's determination pursuant to section 176.85, subdivision 1.

(c) If the commissioner, for any reason, has cause to believe that a managed care plan has or may violate a statute or rule or a provision of the managed care plan as certified, the commissioner may, before commencing action under paragraph (a) or (b), call a conference with the managed care plan and other persons who may be involved in the suspected violation or noncompliance for the purpose of ascertaining the facts relating to the suspected violation or noncompliance and arriving at an adequate and effective means of correcting or preventing the violation or noncompliance. The commissioner may enter into stipulated consent agreements with the managed care plan for corrective or preventive action or the amount of the penalty to be paid. Proceedings under this paragraph shall not be governed by any formal procedural requirements, and may be conducted in a manner the commissioner deems appropriate under the circumstances.

(d) The commissioner may issue an order directing a managed care plan or a representative of a managed care plan to cease and desist from engaging in any act or practice that is not in compliance with the managed care plan as certified, or that it is in violation of an applicable statute or rule. Within 30 days of service of the order, the managed care plan may request review of the cease and desist order by an administrative law judge pursuant to chapter 14. The decision of the administrative law judge shall include findings of fact, conclusions of law and appropriate orders, which shall be the final decision of the commissioner. In the event of noncompliance with a cease and desist order, the commissioner may institute a proceeding in district court to obtain injunctive or other appropriate relief.

(e) A managed care plan, participating health care provider, or an employer or insurer that receives services from the managed care plan, shall cooperate fully with an investigation by the commissioner. For purposes of this section, cooperation includes, but is not limited to, attending a conference called by the commissioner under paragraph (c), responding fully and promptly to any questions relating to the subject of the investigation, and providing copies of records, reports, logs, data, and other information requested by the commissioner to assist in the investigation.

(f) Any person acting on behalf of a managed care plan who knowingly submits false information in any report required to be filed by a managed care plan is guilty of a misdemeanor.

[For text of subd 6, see M.S.1994]

History: *1995 c 231 art 2 s 62,63*

176.136 MEDICAL FEE REVIEW.

[For text of subd 1, see M.S.1994]

Subd. 1a. **Relative value fee schedule.** The liability of an employer for services included in the medical fee schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee, whichever is lower. The medical fee schedule effective on October 1, 1991, shall remain in effect until the commissioner adopts a new schedule by permanent rule. The commissioner shall adopt permanent rules regulating fees allowable for medical, chiropractic, podiatric, surgical, and other health care provider treatment or service, including those provided to hospital outpatients, by implementing a relative value fee schedule to be effective on October 1, 1993. The commissioner may adopt by reference the relative value fee schedule adopted for the federal Medicare program or a relative value fee schedule adopted by other federal or state agencies. The relative value fee schedule shall contain reasonable classifications including, but not limited to, classifications that differentiate among health care provider disciplines. The conversion factors for the original relative value fee schedule must reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in effect. The reduction need not be applied equally to all treatment or services, but must represent a gross 15 percent reduction.

After permanent rules have been adopted to implement this section, the conversion factors must be adjusted annually on October 1 by no more than the percentage change com-

puted under section 176.645, but without the annual cap provided by that section. The commissioner shall annually give notice in the State Register of the adjusted conversion factors and may also give annual notice of any additions, deletions, or changes to the relative value units or service codes adopted by the federal Medicare program. The relative value units may be statistically adjusted in the same manner as for the original workers' compensation relative value fee schedule. The notices of the adjusted conversion factors and additions, deletions, or changes to the relative value units and service codes shall be in lieu of the requirements of chapter 14.

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

(b) The liability of the employer for the treatment, articles, and supplies that are not limited by subdivision 1a or 1c or paragraph (a) shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower. On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph.

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

[For text of subd 1c, see M.S.1994]

Subd. 2. **Excessive fees.** If the employer or insurer determines that the charge for a health service or medical service is excessive, no payment in excess of the reasonable charge for that service shall be made under this chapter nor may the provider collect or attempt to collect from the injured employee or any other insurer or government amounts in excess of the amount payable under this chapter unless the commissioner, compensation judge, or court of appeals determines otherwise. In such a case, the health care provider may initiate an action under this chapter for recovery of the amounts deemed excessive by the employer or insurer.

A charge for a health service or medical service is excessive if it:

(1) exceeds the maximum permissible charge pursuant to subdivision 1, 1a, 1b, or 1c;

(2) is for a service provided at a level, duration, or frequency that is excessive, based upon accepted medical standards for quality health care and accepted rehabilitation standards;

(3) is for a service that is outside the scope of practice of the particular provider or is not generally recognized within the particular profession of the provider as of therapeutic value for the specific injury or condition treated; or

(4) is otherwise deemed excessive or inappropriate pursuant to rules adopted pursuant to this chapter.

[For text of subd 3, see M.S.1994]

History: *1995 c 231 art 2 s 64–66*

176.138 MEDICAL DATA; ACCESS.

(a) Notwithstanding any other state laws related to the privacy of medical data or any private agreements to the contrary, the release in writing, by telephone discussion, or otherwise of medical data related to a current claim for compensation under this chapter to the employee, employer, or insurer who are parties to the claim, or to the department of labor and industry, shall not require prior approval of any party to the claim. This section does not preclude the release of medical data under section 175.10 or 176.231, subdivision 9. Requests for pertinent data shall be made, and the date of discussions with medical providers about

medical data shall be confirmed, in writing to the person or organization that collected or currently possesses the data. Written medical data that exists at the time the request is made shall be provided by the collector or possessor within seven working days of receiving the request. Nonwritten medical data may be provided, but is not required to be provided, by the collector or possessor. In all cases of a request for the data or discussion with a medical provider about the data, except when it is the employee who is making the request, the employee shall be sent written notification of the request by the party requesting the data at the same time the request is made or a written confirmation of the discussion. This data shall be treated as private data by the party who requests or receives the data and the party receiving the data shall provide the employee or the employee's attorney with a copy of all data requested by the requester.

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

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

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

History: *1995 c 231 art 2 s 67*

176.139 NOTICE OF RIGHTS POSTED.

[For text of subd 1, see M.S.1994]

Subd. 2. **Failure to post; penalty.** The commissioner may assess a penalty of $500 against the employer payable to the assigned risk safety account if, after notice from the commissioner, the employer violates the posting requirement of this section.

History: *1995 c 231 art 2 s 68*

176.171 PAYMENT TO TRUSTEE.

At any time after the amount of any award or commutation is finally determined, a sum equal to the present value of all future installments of the compensation, calculated on a five percent basis, where death or the nature of the injury renders the amount of future payments certain, may be paid by the employer to any bank, mutual savings bank, savings association, or trust company in this state approved and designated by the commissioner of the department of labor and industry, compensation judge, or workers' compensation court of appeals in cases upon appeal. Such sum, together with all interest thereon, shall be held in trust for the employee or for the dependents of the employee, who shall have no further recourse against the employer. The employer's payment of this sum evidenced by a receipt of the trustee filed with the commissioner of the department of labor and industry, operates as a satisfaction of the compensation liability as to the employer. The trustee shall make payments from the fund in the same amounts and at the same time as are required of the employer until the fund and interest is exhausted, except when otherwise ordered by the commissioner of the department

of labor and industry. In the appointment of trustee the preference shall be given to the choice of the injured employee or the choice of the dependents of the deceased employee.

History: *1995 c 202 art 1 s 25*

176.178 FRAUD.

Subdivision 1. **Intent.** Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3.

Subd. 2. **Forms.** The text of subdivision 1 shall be placed on all forms prescribed by the commissioner for claims or responses to claims for workers' compensation benefits under this chapter. The absence of the text does not constitute a defense against prosecution under subdivision 1.

History: *1995 c 231 art 1 s 25*

176.179 RECOVERY OF OVERPAYMENTS.

Notwithstanding section 176.521, subdivision 3, or any other provision of this chapter to the contrary, except as provided in this section, no lump sum or weekly payment, or settlement, which is voluntarily paid to an injured employee or the survivors of a deceased employee in apparent or seeming accordance with the provisions of this chapter by an employer or insurer, or is paid pursuant to an order of the workers' compensation division, a compensation judge, or court of appeals relative to a claim by an injured employee or the employee's survivors, and received in good faith by the employee or the employee's survivors shall be refunded to the paying employer or insurer in the event that it is subsequently determined that the payment was made under a mistake in fact or law by the employer or insurer. When the payments have been made to a person who is entitled to receive further payments of compensation for the same injury, the mistaken compensation may be taken as a partial credit against future periodic benefits. The credit applied against further payments of temporary total disability, temporary partial disability, permanent partial disability, permanent total disability, retraining benefits, death benefits, or weekly payments of economic recovery or impairment compensation shall not exceed 20 percent of the amount that would otherwise be payable.

A credit may not be applied against medical expenses due or payable.

Where the commissioner or compensation judge determines that the mistaken compensation was not received in good faith, the commissioner or compensation judge may order reimbursement of the compensation. For purposes of this section, a payment is not received in good faith if it is obtained through fraud, or if the employee knew that the compensation was paid under mistake of fact or law, and the employee has not refunded the mistaken compensation.

History: *1995 c 231 art 1 s 26*

176.181 INSURANCE.

[For text of subd 1, see M.S.1994]

Subd. 2. **Compulsory insurance; self–insurers.** (1) Every employer, except the state and its municipal subdivisions, liable under this chapter to pay compensation shall insure payment of compensation with some insurance carrier authorized to insure workers' compensation liability in this state, or obtain a written order from the commissioner of commerce exempting the employer from insuring liability for compensation and permitting self–insurance of the liability. The terms, conditions and requirements governing self–insurance shall be established by the commissioner pursuant to chapter 14. The commissioner of commerce shall also adopt, pursuant to clause (2)(c), rules permitting two or more employers, whether or not they are in the same industry, to enter into agreements to pool their liabilities under this chapter for the purpose of qualifying as group self–insurers. With the approval of the commissioner of commerce, any employer may exclude medical, chiropractic and hospital bene-

fits as required by this chapter. An employer conducting distinct operations at different locations may either insure or self–insure the other portion of operations as a distinct and separate risk. An employer desiring to be exempted from insuring liability for compensation shall make application to the commissioner of commerce, showing financial ability to pay the compensation, whereupon by written order the commissioner of commerce, on deeming it proper, may make an exemption. An employer may establish financial ability to pay compensation by providing financial statements of the employer to the commissioner of commerce. Upon ten days' written notice the commissioner of commerce may revoke the order granting an exemption, in which event the employer shall immediately insure the liability. As a condition for the granting of an exemption the commissioner of commerce may require the employer to furnish security the commissioner of commerce considers sufficient to insure payment of all claims under this chapter, consistent with subdivision 2b. If the required security is in the form of currency or negotiable bonds, the commissioner of commerce shall deposit it with the state treasurer. In the event of any default upon the part of a self–insurer to abide by any final order or decision of the commissioner of labor and industry directing and awarding payment of compensation and benefits to any employee or the dependents of any deceased employee, then upon at least ten days notice to the self–insurer, the commissioner of commerce may by written order to the state treasurer require the treasurer to sell the pledged and assigned securities or a part thereof necessary to pay the full amount of any such claim or award with interest thereon. This authority to sell may be exercised from time to time to satisfy any order or award of the commissioner of labor and industry or any judgment obtained thereon. When securities are sold the money obtained shall be deposited in the state treasury to the credit of the commissioner of commerce and awards made against any such self–insurer by the commissioner of commerce shall be paid to the persons entitled thereto by the state treasurer upon warrants prepared by the commissioner of commerce and approved by the commissioner of finance out of the proceeds of the sale of securities. Where the security is in the form of a surety bond or personal guaranty the commissioner of commerce, at any time, upon at least ten days notice and opportunity to be heard, may require the surety to pay the amount of the award, the payments to be enforced in like manner as the award may be enforced.

(2)(a) No association, corporation, partnership, sole proprietorship, trust or other business entity shall provide services in the design, establishment or administration of a group self–insurance plan under rules adopted pursuant to this subdivision unless it is licensed, or exempt from licensure, pursuant to section 60A.23, subdivision 8, to do so by the commissioner of commerce. An applicant for a license shall state in writing the type of activities it seeks authorization to engage in and the type of services it seeks authorization to provide. The license shall be granted only when the commissioner of commerce is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. The commissioner of commerce may issue a license subject to restrictions or limitations, including restrictions or limitations on the type of services which may be supplied or the activities which may be engaged in. The license is for a two–year period.

(b) To assure that group self–insurance plans are financially solvent, administered in a fair and capable fashion, and able to process claims and pay benefits in a prompt, fair and equitable manner, entities licensed to engage in such business are subject to supervision and examination by the commissioner of commerce.

(c) To carry out the purposes of this subdivision, the commissioner of commerce may promulgate administrative rules pursuant to sections 14.001 to 14.69. These rules may:

(i) establish reporting requirements for administrators of group self–insurance plans;

(ii) establish standards and guidelines consistent with subdivision 2b to assure the adequacy of the financing and administration of group self–insurance plans;

(iii) establish bonding requirements or other provisions assuring the financial integrity of entities administering group self–insurance plans;

(iv) establish standards, including but not limited to minimum terms of membership in self–insurance plans, as necessary to provide stability for those plans;

(v) establish standards or guidelines governing the formation, operation, administration, and dissolution of self–insurance plans; and

(vi) establish other reasonable requirements to further the purposes of this subdivision.

[For text of subds 2a to 6, see M.S.1994]

Subd. 7. **Penalty.** Any entity that is self–insured pursuant to subdivision 2, and that knowingly violates any provision of subdivision 2 or any rule adopted pursuant thereto is subject to a civil penalty of not more than $10,000 for each offense.

Subd. 8. **Data sharing.** (a) The departments of labor and industry, economic security, human services, agriculture, transportation, and revenue are authorized to share information regarding the employment status of individuals, including but not limited to payroll and withholding and income tax information, and may use that information for purposes consistent with this section and regarding the employment or employer status of individuals, partnerships, limited liability companies, corporations, or employers, including, but not limited to, general contractors, intermediate contractors, and subcontractors. The commissioner shall request data in writing and the responding department shall respond to the request by producing the requested data within 30 days.

(b) The commissioner is authorized to inspect and to order the production of all payroll and other business records and documents of any alleged employer in order to determine the employment status of persons and compliance with this section. If any person or employer refuses to comply with such an order, the commissioner may apply to the district court of the county where the person or employer is located for an order compelling production of the documents.

History: *1995 c 231 art 2 s 69,70; 1995 c 233 art 2 s 56; 1995 c 258 s 62*

176.1812 COLLECTIVE BARGAINING AGREEMENTS.

Subdivision 1. **Requirements.** Upon appropriate filing, the commissioner, compensation judge, workers' compensation court of appeals, and courts shall recognize as valid and binding a provision in a collective bargaining agreement between a qualified employer or qualified groups of employers engaged in construction, construction maintenance, and related activities and the certified and exclusive representative of its employees to establish certain obligations and procedures relating to workers' compensation. For purposes of this section, "qualified employer" means any self–insured employer, any employer, through itself or any affiliate as defined in section 60D.15, subdivision 2, who is responsible for the first $100,000 or more of any claim, or a private employer developing or projecting an annual workers' compensation premium, in Minnesota, of $250,000 or more. For purposes of this section, a "qualified group of employers" means a group of private employers engaged in workers' compensation group self–insurance complying with section 79A.03, subdivision 6, which develops or projects annual workers' compensation insurance premiums of $2,000,000 or more. This agreement must be limited to, but need not include, all of the following:

(a) an alternative dispute resolution system to supplement, modify, or replace the procedural or dispute resolution provisions of this chapter. The system may include mediation, arbitration, or other dispute resolution proceedings, the results of which may be final and binding upon the parties. A system of arbitration shall provide that the decision of the arbiter is subject to review either by the workers' compensation court of appeals in the same manner as an award or order of a compensation judge or, in lieu of review by the workers' compensation court of appeals, by the office of administrative hearings, by the district court, by the Minnesota court of appeals, or by the supreme court in the same manner as the workers' compensation court of appeals and may provide that any arbiter's award disapproved by a court be referred back to the arbiter for reconsideration and possible modification;

(b) an agreed list of providers of medical treatment that may be the exclusive source of all medical and related treatment provided under this chapter which need not be certified under section 176.1351;

(c) the use of a limited list of impartial physicians to conduct independent medical examinations;

(d) the creation of a light duty, modified job, or return to work program;

(e) the use of a limited list of individuals and companies for the establishment of vocational rehabilitation or retraining programs which list is not subject to the requirements of section 176.102;

(f) the establishment of safety committees and safety procedures; or

(g) the adoption of a 24–hour health care coverage plan if a 24–hour plan pilot project is authorized by law, according to the terms and conditions authorized by that law.

Subd. 2. **Filing and review.** A copy of the agreement and the approximate number of employees who will be covered under it must be filed with the commissioner. Within 21 days of receipt of an agreement, the commissioner shall review the agreement for compliance with this section and the benefit provisions of this chapter and notify the parties of any additional information required or any recommended modification that would bring the agreement into compliance. Upon receipt of any requested information or modification, the commissioner must notify the parties within 21 days whether the agreement is in compliance with this section and the benefit provisions of this chapter.

In order for any agreement to remain in effect, it must provide for a timely and accurate method of reporting to the commissioner necessary information regarding service cost and utilization to enable the commissioner to annually report to the legislature. The information provided to the commissioner must include aggregate data on the:

(i) person hours and payroll covered by agreements filed;

(ii) number of claims filed;

(iii) average cost per claim;

(iv) number of litigated claims, including the number of claims submitted to arbitration, the workers' compensation court of appeals, the office of administrative hearings, the district court, the Minnesota court of appeals or the supreme court;

(v) number of contested claims resolved prior to arbitration;

(vi) projected incurred costs and actual costs of claims;

(vii) employer's safety history;

(viii) number of workers participating in vocational rehabilitation; and

(ix) number of workers participating in light–duty programs.

Subd. 3. **Refusal to recognize.** A person aggrieved by the commissioner's decision concerning an agreement may request in writing, within 30 days of the date the notice is issued, the initiation of a contested case proceeding under chapter 14. The request to initiate a contested case must be received by the department by the 30th day after the commissioner's decision. An appeal from the commissioner's final decision and order may be taken to the workers' compensation court of appeals pursuant to sections 176.421 and 176.442.

Subd. 4. **Void agreements.** Nothing in this section shall allow any agreement that diminishes an employee's entitlement to benefits as otherwise set forth in this chapter. For the purposes of this section, the procedural rights and dispute resolution agreements under subdivision 1, clauses (a) to (g), are not agreements which diminish an employee's entitlement to benefits. Any agreement that diminishes an employee's entitlement to benefits as set forth in this chapter is null and void.

Subd. 5. **Notice to insurance carrier.** If the employer is insured under this chapter, the collective bargaining agreement provision shall not be recognized by the commissioner, compensation judge, workers' compensation court of appeals, and other courts unless the employer has given notice to the employer's insurance carrier, in the manner provided in the insurance contract, of intent to enter into an agreement with its employees as provided in this section.

Subd. 6. **Pilot program.** The commissioner shall establish a pilot program ending December 31, 2001, in which up to ten private and up to ten public employers shall be authorized to enter into valid agreements under this section with their employees. The agreements shall be recognized and enforced as provided by this section. Employers shall participate in the pilot program through collectively bargained agreements with the certified and exclusive representatives of their employees and without regard to the dollar insurance premium limitations in subdivision 1.

Subd. 7. **Rules.** The commissioner may adopt emergency or permanent rules necessary to implement this section.

History: *1995 c 231 art 2 s 71*

176.182 BUSINESS LICENSES OR PERMITS; COVERAGE REQUIRED.

Every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of section 176.181, subdivision 2, by providing the name of the insurance company, the policy number, and dates of coverage or the permit to self–insure. The commissioner shall assess a penalty to the employer of $2,000 payable to the assigned risk safety account, if the information is not reported or is falsely reported.

Neither the state nor any governmental subdivision of the state shall enter into any contract for the doing of any public work before receiving from all other contracting parties acceptable evidence of compliance with the workers' compensation insurance coverage requirement of section 176.181, subdivision 2.

This section shall not be construed to create any liability on the part of the state or any governmental subdivision to pay workers' compensation benefits or to indemnify the special compensation fund, an employer, or insurer who pays workers' compensation benefits.

History: *1995 c 231 art 2 s 72*

176.183 UNINSURED AND SELF–INSURED EMPLOYERS; BENEFITS TO EMPLOYEES AND DEPENDENTS; LIABILITY OF EMPLOYER.

Subdivision 1. When any employee sustains an injury arising out of and in the course of employment while in the employ of an employer, other than the state or its political subdivisions, not insured or self–insured as provided for in this chapter, the employee or the employee's dependents shall nevertheless receive benefits as provided for in this chapter from the special compensation fund. As used in subdivision 1 or 2, "employer" includes any owners or officers of a corporation who direct and control the activities of employees. In any petition for benefits under this chapter, the naming of an employer corporation not insured or self–insured as provided for in this chapter, as a defendant, shall constitute without more the naming of the owners or officers as defendants, and service of notice of proceeding under this chapter on the corporation shall constitute service upon the owners or officers. An action to recover benefits paid shall be instituted unless the commissioner determines that no recovery is possible. There shall be no payment from the special compensation fund if there is liability for the injury under the provisions of section 176.215, by an insurer or self–insurer.

Subd. 2. After a hearing on a petition for benefits and prior to issuing an order against the special compensation fund to pay compensation benefits to an employee, a compensation judge shall first make findings regarding the insurance status of the employer and its liability. The special compensation fund shall not be found liable in the absence of a finding of liability against the employer. Where the liable employer is found after the hearing to be not insured or self–insured as provided for in this chapter, the compensation judge shall assess and order the employer to pay all compensation benefits to which the employee is entitled, the amount for actual and necessary disbursements expended by the special compensation fund, and a penalty in the amount of 65 percent of all compensation benefits ordered to be paid. The award issued against an employer after the hearing shall constitute a lien for government services pursuant to section 514.67 on all property of the employer and shall be subject to the provisions of the revenue recapture act in chapter 270A. The special compensation fund may enforce the terms of that award in the same manner as a district court judgment. The commissioner of labor and industry, in accordance with the terms of the order awarding compensation, shall pay compensation to the employee or the employee's dependent from the special compensation fund. The commissioner of labor and industry shall certify to the commissioner of finance and to the legislature annually the total amount of compensation paid from the special compensation fund under subdivision 1. The commissioner of finance shall upon proper certification reimburse the special compensation fund from the general fund appropriation provided for this purpose. The amount reimbursed shall be limited to the certified

amount paid under this section or the appropriation made for this purpose, whichever is the lesser amount. Compensation paid under this section which is not reimbursed by the general fund shall remain a liability of the special compensation fund and shall be financed by the percentage assessed under section 176.129.

[For text of subds 3 and 4, see M.S.1994]

History: *1995 c 231 art 2 s 73,74*

176.185 POLICY OF INSURANCE.

[For text of subds 1 to 5, see M.S.1994]

Subd. 5a. **Penalty for improper withholding.** An employer who violates subdivision 5 after notice from the commissioner is subject to a penalty of 400 percent of the amount withheld from or charged the employee. The penalty shall be imposed by the commissioner. Forty percent of this penalty is payable to the assigned risk safety account and 60 percent is payable to the employee.

[For text of subds 6 to 10, see M.S.1994]

History: *1995 c 231 art 2 s 75*

176.191 DISPUTE BETWEEN TWO OR MORE EMPLOYERS OR INSURERS REGARDING LIABILITY.

Subdivision 1. **Order; employer, insurer, or special compensation fund payment.** Where compensation benefits are payable under this chapter, and a dispute exists between two or more employers or two or more insurers or the special compensation fund as to which is liable for payment, the commissioner, compensation judge, or court of appeals upon appeal shall direct that one or more of the employers or insurers or the special compensation fund make payment of the benefits pending a determination of which has liability. The special compensation fund may be ordered to make payment only if it has been made a party to the claim because the petitioner has alleged that one or more of the employers is uninsured for workers' compensation under section 176.183. A temporary order may be issued under this subdivision whether or not the employers, insurers, or special compensation fund agree to pay under the order.

When liability has been determined, the party held liable for the benefits shall be ordered to reimburse any other party for payments which the latter has made, including interest at the rate of 12 percent a year. The claimant shall also be awarded a reasonable attorney fee, to be paid by the party held liable for the benefits.

An order directing payment of benefits pending a determination of liability may not be used as evidence before a compensation judge, the workers' compensation court of appeals, or court in which the dispute is pending.

Subd. 1a. **Equitable apportionment.** Equitable apportionment of liability for an injury under this chapter is not allowed except that apportionment among employers and insurers is allowed in a settlement agreement filed pursuant to section 176.521, and an employer or insurer may request equitable apportionment of liability for workers' compensation benefits among employer and insurers by arbitration pursuant to subdivision 5. For purposes of this subdivision, the term "equitable apportionment of liability" shall include all attempts to obtain contribution and/or reimbursement from other employers or insurers. To the same extent limited by this subdivision, contribution and reimbursement actions based on equitable apportionment are not allowed under this chapter. If the insurers choose to arbitrate apportionment, contribution, or reimbursement issues pursuant to subdivision 5, the arbitration proceeding is for the limited purpose of apportioning liability for workers' compensation benefits payable among employers and insurers. This subdivision applies without regard to whether one or more of the injuries results from cumulative trauma or a specific injury, but does not apply to an occupational disease. In the case of an occupational disease, section 176.66 applies. In the arbitration of equitable apportionment under subdivision 5, the parties and the arbitrator must be guided by general rules of arbitrator selection and presumptive

apportionment among employers and insurers that are developed and approved by the commissioner of the department of labor and industry. Apportionment against preexisting disability is allowed only for permanent partial disability as provided in section 176.101, subdivision 4a. Nothing in this subdivision shall be interpreted to repeal or in any way affect the law with respect to special compensation fund statutory liability or benefits.

Subd. 2. [Repealed, 1995 c 231 art 2 s 110]

[For text of subds 3 and 4, see M.S.1994]

Subd. 5. **Arbitration.** Where a dispute exists between an employer, insurer, the special compensation fund, or the workers' compensation reinsurance association, regarding apportionment of liability for benefits payable under this chapter, and the requesting party has expended over $10,000 in medical or 52 weeks worth of indemnity benefits and made the request within one year thereafter, a party may require submission of the dispute as to apportionment of liability among employers and insurers to binding arbitration. The decision of the arbitrator shall be conclusive on the issue of apportionment among employers and insurers. Consent of the employee is not required for submission of a dispute to arbitration pursuant to this section and the employee is not bound by the results of the arbitration. An arbitration award shall not be admissible in any other proceeding under this chapter. Notice of the proceeding shall be given to the employee.

The employee, or any person with material information to the facts to be arbitrated, shall attend the arbitration proceeding if any party to the proceeding deems it necessary. Nothing said by an employee in connection with any arbitration proceeding may be used against the employee in any other proceeding under this chapter. Reasonable expenses of meals, lost wages, and travel of the employee or witnesses in attending shall be reimbursed on a pro rata basis. Arbitration costs shall be paid by the parties, except the employee, on a pro rata basis.

[For text of subds 6 and 7, see M.S.1994]

Subd. 8. **Attorney fees.** No attorney's fees shall be awarded under either section 176.081 or 176.191 against any employer or insurer in connection with any arbitration proceeding unless the employee chooses to retain an attorney to represent the employee's interests during arbitration.

History: *1995 c 231 art 2 s 76–79*

176.192 BOMB DISPOSAL UNIT EMPLOYEES.

For purposes of this chapter, a member of a bomb disposal unit approved by the commissioner of public safety and employed by a municipality defined in section 466.01, is considered an employee of the department of public safety solely for the purposes of this chapter when disposing of or neutralizing bombs or other similar hazardous explosives, as defined in section 299C.063, for another municipality or otherwise outside the jurisdiction of the employer–municipality but within the state.

History: *1995 c 226 art 4 s 2*

176.194 PROHIBITED PRACTICES.

[For text of subds 1 to 3, see M.S.1994]

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

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

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

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

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

[For text of subd 5, see M.S.1994]

History: *1995 c 231 art 2 s 80*

176.215 SUBCONTRACTOR'S FAILURE TO COMPLY WITH CHAPTER.

[For text of subd 1, see M.S.1994]

Subd. 1a. **Enforcement of order.** If the compensation judge orders the general contractor, intermediate contractor, or subcontractor to pay compensation benefits, the award issued against the general contractor, intermediate contractor, or subcontractor constitutes a lien for government services under section 514.67 on all property of the general contractor, intermediate contractor, or subcontractor and is subject to the provisions of the revenue recapture act under chapter 270A. The special compensation fund may enforce the terms of the award in the same manner as a district court judgment.

[For text of subds 2 and 3, see M.S.1994]

History: *1995 c 231 art 2 s 81*

176.221 PAYMENT OF COMPENSATION AND TREATMENT CHARGES, COMMENCEMENT.

Subdivision 1. **Commencement of payment.** Within 14 days of notice to or knowledge by the employer of an injury compensable under this chapter the payment of temporary total compensation shall commence. Within 14 days of notice to or knowledge by an employer of a new period of temporary total disability which is caused by an old injury compensable under this chapter, the payment of temporary total compensation shall commence; provided that the employer or insurer may file for an extension with the commissioner within this 14–day period, in which case the compensation need not commence within the 14–day period but shall commence no later than 30 days from the date of the notice to or knowledge by the employer of the new period of disability. Commencement of payment by an employer or insurer does not waive any rights to any defense the employer has on any claim or incident either with respect to the compensability of the claim under this chapter or the amount of the compensation due. Where there are multiple employers, the first employer shall pay, unless it is shown that the injury has arisen out of employment with the second or subsequent employer. Liability for compensation under this chapter may be denied by the employer or insurer by giving the employee written notice of the denial of liability. If liability is denied for an injury which is required to be reported to the commissioner under section 176.231, subdivision 1, the denial of liability must be filed with the commissioner within 14 days after notice to or knowledge by the employer of an injury which is alleged to be compensable under this chapter. If the employer or insurer has commenced payment of compensation under this subdivi-

sion but determines within 60 days of notice to or knowledge by the employer of the injury that the disability is not a result of a personal injury, payment of compensation may be terminated upon the filing of a notice of denial of liability within 60 days of notice or knowledge. After the 60–day period, payment may be terminated only by the filing of a notice as provided under section 176.239. Upon the termination, payments made may be recovered by the employer if the commissioner or compensation judge finds that the employee's claim of work related disability was not made in good faith. A notice of denial of liability must state in detail the facts forming the basis for the denial and specific reasons explaining why the claimed injury or occupational disease was determined not to be within the scope and course of employment and shall include the name and telephone number of the person making this determination.

Subd. 3. **Penalty.** If the employer or insurer does not begin payment of compensation within the time limit prescribed under subdivision 1 or 8, the commissioner may assess a penalty, payable to the assigned risk safety account, which shall be a percentage of the amount of compensation to which the employee is entitled to receive up to the date compensation payment is made.

The amount of penalty shall be determined as follows:

Numbers of days late	Penalty
1 – 15	30 percent of compensation due, not to exceed $500,
16 – 30	55 percent of compensation due, not to exceed $1,500,
31 – 60	80 percent of compensation due, not to exceed $3,500,
61 or more	105 percent of compensation due, not to exceed $5,000.

The penalty under this section is in addition to any penalty otherwise provided by statute.

Subd. 3a. **Penalty.** In lieu of any other penalty under this section, the commissioner may assess a penalty of up to $2,000 payable to the assigned risk safety account for each instance in which an employer or insurer does not pay benefits or file a notice of denial of liability within the time limits prescribed under this section.

[For text of subd 6, see M.S.1994]

Subd. 6a. **Medical, rehabilitation, and permanent partial compensation.** The penalties provided by this section apply in cases where payment for treatment under section 176.135, rehabilitation expenses under section 176.102, subdivisions 9 and 11, or permanent partial compensation are not made in a timely manner as required by law or by rule adopted by the commissioner.

Subd. 7. **Interest.** Any payment of compensation, charges for treatment under section 176.135, rehabilitation expenses under section 176.102, subdivision 9, or penalties assessed under this chapter not made when due shall bear interest from the due date to the date the payment is made at the rate set by section 549.09, subdivision 1.

For the purposes of this subdivision, permanent partial disability payment is due 14 days after receipt of the first medical report which contains a disability rating if such payment is otherwise due under this chapter, and charges for treatment under section 176.135 are due 30 calendar days after receiving the bill and necessary medical data.

If the claim of the employee or dependent for compensation is contested in a proceeding before a compensation judge or the commissioner, the decision of the judge or commissioner shall provide for the payment of unpaid interest on all compensation awarded, including interest accruing both before and after the filing of the decision.

[For text of subds 8 and 9, see M.S.1994]

History: *1995 c 231 art 1 s 27; art 2 s 82–85*

176.223 PROMPT PAYMENT REPORT.

The department shall publish an annual report providing data on the promptness of all insurers and self–insurers in making first payments on a claim for injury. The report shall identify all insurers and self–insurers and state the percentage of first payments made within 14 days from the last date worked for each of the insurers and self–insurers. The report shall also list the total number of claims and the number of claims paid within the 14–day standard. Each report shall contain the required information for each of the last four years the report has been compiled so that a total of five years is included. The department shall make the report available to employers and shall provide a copy to each insurer and self–insurer listed in the report for the current year.

History: *1995 c 231 art 2 s 86*

176.225 ADDITIONAL AWARD AS PENALTY.

Subdivision 1. **Grounds.** Upon reasonable notice and hearing or opportunity to be heard, the commissioner, a compensation judge, or upon appeal, the court of appeals or the supreme court shall award compensation, in addition to the total amount of compensation award, of up to 30 percent of that total amount where an employer or insurer has:

(a) instituted a proceeding or interposed a defense which does not present a real controversy but which is frivolous or for the purpose of delay; or

(b) unreasonably or vexatiously delayed payment; or

(c) neglected or refused to pay compensation; or

(d) intentionally underpaid compensation; or

(e) frivolously denied a claim; or

(f) unreasonably or vexatiously discontinued compensation in violation of sections 176.238 and 176.239.

For the purpose of this section, "frivolously" means without a good faith investigation of the facts or on a basis that is clearly contrary to fact or law.

[For text of subds 2 to 4, see M.S.1994]

Subd. 5. **Penalty.** Where the employer is guilty of inexcusable delay in making payments, the payments which are found to be delayed shall be increased by 25 percent. Withholding amounts unquestionably due because the injured employee refuses to execute a release of the employee's right to claim further benefits will be regarded as inexcusable delay in the making of compensation payments. If any sum ordered by the department to be paid is not paid when due, and no appeal of the order is made, the sum shall bear interest at the rate of 12 percent per annum. Any penalties paid pursuant to this section shall not be considered as a loss or expense item for purposes of a petition for a rate increase made pursuant to chapter 79.

History: *1995 c 231 art 2 s 87,88*

176.231 REPORT OF DEATH OR INJURY TO COMMISSIONER OF THE DEPARTMENT OF LABOR AND INDUSTRY.

[For text of subds 1 to 9, see M.S.1994]

Subd. 10. **Failure to file required report, penalty.** If an employer, insurer, physician, chiropractor, or other health provider fails to file with the commissioner any report required by this section in the manner and within the time limitations prescribed, or otherwise fails to provide a report required by this section in the manner provided by this section, the commissioner may impose a penalty of up to $500 for each failure.

The imposition of a penalty may be appealed to a compensation judge within 30 days of notice of the penalty.

Penalties collected by the state under this subdivision shall be paid into the assigned risk safety account.

[For text of subd 11, see M.S.1994]

Subd. 12. **Reports; electronic monitoring.** Beginning July 1, 1995, the commissioner shall monitor electronically all reports of injury, all payments for reported injuries, and compliance with all reporting and payment timelines.

History: *1995 c 224 s 70; 1995 c 231 art 2 s 89*

176.232 [Repealed, 1995 c 231 art 2 s 110]

176.238 NOTICE OF DISCONTINUANCE OF COMPENSATION.

[For text of subds 1 to 5, see M.S.1994]

Subd. 6. **Expedited hearing before a compensation judge.** A hearing before a compensation judge shall be held within 60 calendar days after the office receives the file from the commissioner if:

(a) an objection to discontinuance has been filed under subdivision 4 within 60 calendar days after the notice of discontinuance was filed and where no administrative conference has been held;

(b) an objection to discontinuance has been filed under subdivision 4 within 60 calendar days after the commissioner's decision under this section has been issued;

(c) a petition to discontinue has been filed by the insurer in lieu of filing a notice of discontinuance; or

(d) a petition to discontinue has been filed within 60 calendar days after the commissioner's decision under this section has been issued.

If the petition or objection is filed later than the deadlines listed above, the expedited procedures in this section apply only where the employee is unemployed at the time of filing the objection and shows, to the satisfaction of the chief administrative judge, by sworn affidavit, that the failure to file the objection within the deadlines was due to some infirmity or incapacity of the employee or to circumstances beyond the employee's control. The hearing shall be limited to the issues raised by the notice or petition unless all parties agree to expanding the issues. If the issues are expanded, the time limits for hearing and issuance of a decision by the compensation judge under this subdivision shall not apply.

Once a hearing date has been set, a continuance of the hearing date will be granted only under the following circumstances:

(a) the employer has agreed, in writing, to a continuation of the payment of benefits pending the outcome of the hearing; or

(b) the employee has agreed, in a document signed by the employee, that benefits may be discontinued pending the outcome of the hearing.

Absent a clear showing of surprise at the hearing or the unexpected unavailability of a crucial witness, all evidence must be introduced at the hearing. If it is necessary to accept additional evidence or testimony after the scheduled hearing date, it must be submitted no later than 14 days following the hearing, unless the compensation judge, for good cause, determines otherwise.

The compensation judge shall issue a decision pursuant to this subdivision within 30 days following the close of the hearing record.

[For text of subds 7 to 9, see M.S.1994]

Subd. 10. **Fines; violation.** An employer who violates requirements set forth in this section or section 176.239 is subject to a fine of up to $1,000 for each violation payable to the special compensation fund.

[For text of subd 11, see M.S.1994]

History: *1995 c 231 art 2 s 90,91*

176.261 EMPLOYEE OF COMMISSIONER OF THE DEPARTMENT OF LABOR AND INDUSTRY MAY ACT FOR AND ADVISE A PARTY TO A PROCEEDING.

When requested by an employer or an employee or an employee's dependent, the commissioner of the department of labor and industry may designate one or more of the division

employees to advise that party of rights under this chapter, and as far as possible to assist in adjusting differences between the parties. The person so designated may appear in person in any proceedings under this chapter as the representative or adviser of the party. In such case, the party need not be represented by an attorney at law.

Prior to advising an employee or employer to seek assistance outside of the department, the department must refer employers and employees seeking advice or requesting assistance in resolving a dispute to an attorney or rehabilitation and medical specialist employed by the department, whichever is appropriate.

The department must make efforts to settle problems of employees and employers by contacting third parties, including attorneys, insurers, and health care providers, on behalf of employers and employees and using the department's persuasion to settle issues quickly and cooperatively. The obligation to make efforts to settle problems exists whether or not a formal claim has been filed with the department.

History: *1995 c 231 art 2 s 92*

176.2615 SMALL CLAIMS COURT.

[For text of subds 1 to 6, see M.S.1994]

Subd. 7. **Determination.** If the parties do not agree to a settlement, the settlement judge shall summarily hear and determine the issues and issue an order in accordance with section 176.305, subdivision 1a, except that there is no appeal or request for a formal de novo hearing from the order. Any determination by a settlement judge shall be res judicata in subsequent proceeding concerning issues determined under this section.

[For text of subd 8, see M.S.1994]

History: *1995 c 231 art 2 s 93*

176.275 FILING OF PAPERS; PROOF OF SERVICE.

Subdivision 1. **Filing.** If a document is required to be filed by this chapter or any rules adopted pursuant to authority granted by this chapter, the filing shall be completed by the receipt of the document at the division, department, office, or the court of appeals. The division, department, office, and the court of appeals shall accept any document which has been delivered to it for legal filing immediately upon its receipt, but may refuse to accept any form or document that lacks the name of the injured employee, employer, or insurer, the date of injury, or the injured employee's social security number. If the injured employee has fewer than three days of lost time from work, the party submitting the required document must attach to it, at the time of filing, a copy of the first report of injury.

A notice or other document required to be served or filed at either the department, the office, or the court of appeals which is inadvertently served or filed at the wrong one of these agencies shall be deemed to have been served or filed with the proper agency. The receiving agency shall note the date of receipt of a document and shall forward the documents to the proper agency no later than two working days following receipt.

[For text of subd 2, see M.S.1994]

History: *1995 c 231 art 2 s 94*

176.281 ORDERS, DECISIONS, AND AWARDS; FILING; SERVICE.

When the commissioner or compensation judge or office of administrative hearings or the workers' compensation court of appeals has rendered a final order, decision, or award, or amendment to an order, decision, or award, it shall be filed immediately with the commissioner. If the commissioner, compensation judge, office of administrative hearings, or workers' compensation court of appeals has rendered a final order, decision, or award, or amendment thereto, the commissioner or the office of administrative hearings or the workers' compensation court of appeals shall immediately serve a copy upon every party in interest, together with a notification of the date the order was filed.

On all orders, decisions, awards, and other documents, the commissioner or compensation judge or office of administrative hearings or the workers' compensation court of appeals may digitize the signatures of all officials, including judges, for the use of electronic data interchange and clerical automation. These signatures shall have the same legal authority of an original signature, provided that proper security is used to safeguard the use of the digitized signatures and each digitized signature has been certified by the division, department, office, or court of appeals before its use, in accordance with rules adopted by that agency or court.

History: *1995 c 231 art 2 s 95*

176.285 SERVICE OF PAPERS AND NOTICES.

Service of papers and notices shall be by mail or otherwise as the commissioner or the chief administrative law judge may by rule direct. Where service is by mail, service is effected at the time mailed if properly addressed and stamped. If it is so mailed, it is presumed the paper or notice reached the party to be served. However, a party may show by competent evidence that that party did not receive it or that it had been delayed in transit for an unusual or unreasonable period of time. In case of nonreceipt or delay, an allowance shall be made for the party's failure to assert a right within the prescribed time.

Where service to the division, department, office, or court of appeals is by electronic filing, digitized signatures may be used provided that the signature has been certified by the department no later than five business days after filing. The department or court may adopt rules for the certification of signatures.

When the electronic filing of a legal document with the department marks the beginning of a prescribed time for another party to assert a right, the prescribed time for another party to assert a right shall be lengthened by two calendar days when it can be shown that service to the other party was by mail.

The commissioner and the chief administrative law judge shall ensure that proof of service of all papers and notices served by their respective agencies is placed in the official file of the case.

History: *1995 c 231 art 2 s 96*

176.291 DISPUTES; PETITIONS; PROCEDURE.

Where there is a dispute as to a question of law or fact in connection with a claim for compensation, a party may serve on all other parties and file a petition with the commissioner stating the matter in dispute. The petition shall be on a form prescribed by the commissioner and shall be signed by the petitioner.

The petition shall also state and include, where applicable:

(1) names and residence or business address of parties;

(2) facts relating to the employment at the time of injury, including amount of wages received;

(3) extent and character of injury;

(4) notice to or knowledge by employer of injury;

(5) copies of written medical reports or other information in support of the claim;

(6) names and addresses of all known witnesses intended to be called in support of the claim;

(7) the desired location of any hearing and estimated time needed to present evidence at the hearing;

(8) any requests for a prehearing or settlement conference;

(9) a list of all known third parties, including the departments of human services and economic security, who may have paid any medical bills or other benefits to the employee for the injuries or disease alleged in the petition or for the time the employee was unable to work due to the injuries or disease, together with a listing of the amounts paid by each;

(10) the nature and extent of the claim; and

(11) a request for an expedited hearing which must include an attached affidavit of significant financial hardship which complies with the requirements of section 176.341, subdivision 6.

Incomplete petitions may be stricken from the calendar as provided by section 176.305, subdivision 4. Within 30 days of a request by a party, an employee who has filed a claim petition pursuant to section 176.271 or this section shall furnish a list of physicians and health care providers from whom the employee has received treatment for the same or a similar condition as well as authorizations to release relevant information, data, and records to the requester. The petition may be stricken from the calendar upon motion of a party for failure to timely provide the required list of health care providers or authorizations.

History: *1995 c 231 art 2 s 97*

176.305 PETITIONS FILED WITH THE WORKERS' COMPENSATION DIVISION.

[For text of subd 1, see M.S.1994]

Subd. 1a. **Settlement and pretrial conferences; summary decision.** The commissioner shall schedule a settlement conference, if appropriate, within 60 days after receiving the petition. All parties must appear at the conference, either personally or by representative, must be prepared to discuss settlement of all issues, and must be prepared to discuss or present the information required by the joint rules of the division and the office. If a representative appears on behalf of a party, the representative must have authority to fully settle the matter.

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

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

[For text of subds 2 to 4, see M.S.1994]

History: *1995 c 231 art 2 s 98*

176.445 SETTLEMENT JUDGES.

Notwithstanding section 176.011, subdivision 27, any provision in chapter 175 setting out general power of the commissioner, or any other law to the contrary:

(1) The chief settlement judge at the department is the administrator and supervisor of all dispute resolute functions and personnel, and reports directly to the commissioner.

(2) The commissioner may delegate authority only to settlement judges to make determinations under the procedure in sections 176.106, 176.238, and 176.239 and to approve settlements of claims under section 176.521. A settlement judge must preside at all workers' compensation settlement conferences conducted at the department.

History: *1995 c 224 s 71*

176.645 ADJUSTMENT OF BENEFITS.

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

vious to the adjustment. For injuries occurring after October 1, 1975, all adjustments provided for in this section shall be included in computing any benefit due under this section. Any limitations of amounts due for daily or weekly compensation under this chapter shall not apply to adjustments made under this section. No adjustment increase made on or after October 1, 1977, but prior to October 1, 1992, under this section shall exceed six percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be six percent. No adjustment increase made on or after October 1, 1992, under this section shall exceed four percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be four percent. For injuries occurring on and after October 1, 1995, no adjustment increase made on or after October 1, 1995, shall exceed two percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be two percent. The workers' compensation advisory council may consider adjustment or other further increases and make recommendations to the legislature.

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

History: *1995 c 231 art 1 s 28*

176.66 OCCUPATIONAL DISEASES; HOW REGARDED.

[For text of subds 1 and 10, see M.S.1994]

Subd. 11. **Amount of compensation.** The compensation for an occupational disease is 66–2/3 percent of the employee's weekly wage on the date of injury subject to a maximum compensation equal to the maximum compensation in effect on the date of last exposure.

History: *1995 c 231 art 1 s 29*

176.82 ACTION FOR CIVIL DAMAGES FOR OBSTRUCTING EMPLOYEE SEEKING BENEFITS.

Subdivision 1. **Retaliatory discharge.** Any person discharging or threatening to discharge an employee for seeking workers' compensation benefits or in any manner intentionally obstructing an employee seeking workers' compensation benefits is liable in a civil action for damages incurred by the employee including any diminution in workers' compensation benefits caused by a violation of this section including costs and reasonable attorney fees, and for punitive damages not to exceed three times the amount of any compensation benefit to which the employee is entitled. Damages awarded under this section shall not be offset by any workers' compensation benefits to which the employee is entitled.

Subd. 2. **Refusal to offer continued employment.** An employer who, without reasonable cause, refuses to offer continued employment to its employee when employment is available within the employee's physical limitations shall be liable in a civil action for one year's wages. The wages are payable from the date of the refusal to offer continued employment, and at the same time and at the same rate as the employee's preinjury wage, to continue during the period of the refusal up to a maximum of $15,000. These payments shall be in addition to any other payments provided by this chapter. In determining the availability of employment, the continuance in business of the employer shall be considered and written rules promulgated by the employer with respect to seniority or the provisions or any collective bargaining agreement shall govern. These payments shall not be covered by a contract of insurance. The employer shall be served directly and be a party to the claim. This subdivision shall not apply to employers who employ 15 or fewer full–time equivalent employees.

History: *1995 c 231 art 1 s 30*

176.83 RULES.

[For text of subds 1 to 4, see M.S.1994]

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

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

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

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

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

(4) criteria for diagnostic imaging procedures;

(5) criteria for inpatient hospitalization; and

(6) criteria for treatment of chronic pain.

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

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

[For text of subds 5a to 13, see M.S.1994]

Subd. 14. [Deleted, 1995 c 233 art 2 s 56]

[For text of subd 15, see M.S.1994]

History: *1995 c 231 art 2 s 99*

176.84 SPECIFICITY OF NOTICE OR STATEMENT.

[For text of subd 1, see M.S.1994]

Subd. 2. **Penalty.** The commissioner or compensation judge may impose a penalty of $500 for each violation of subdivision 1.

[For text of subd 3, see M.S.1994]

History: *1995 c 231 art 2 s 100*

176.86 [Repealed, 1995 c 231 art 1 s 36]

176.861 DISCLOSURE OF INFORMATION.

Subdivision 1. **Insurance information.** The commissioner may, in writing, require an insurance company to release to the commissioner any or all relevant information or evidence the commissioner deems important which the company may have in its possession relating to a workers' compensation claim including material relating to the investigation of the claim, statements of any person, and any other evidence relevant to the investigation. The writing from the commissioner requiring release of the information shall contain a statement that the commissioner has reason to believe a crime or civil fraud has been committed with respect to an insurance claim, payment, or application.

Subd. 2. **Information released to authorized persons.** If an insurance company has evidence that a claim may be fraudulent, the company shall, in writing, notify the commissioner and provide the commissioner with all relevant material related to the company's inquiry into the claim.

Subd. 3. **Good faith immunity.** An insurance company or its agent acting in its behalf and in good faith who releases oral or written information under subdivisions 1 and 2 is immune from civil or criminal liability that might otherwise be incurred or imposed.

Subd. 4. **Self–insurer; assigned risk plan.** For the purposes of this section "insurance company" includes a self–insurer and the assigned risk plan and their agents.

History: *1995 c 231 art 1 s 31*