CHAPTER 176

WORKERS' COMPENSATION

176.011 DEFINITIONS.

[For text of subds 1 to 8, see M.S.2004]

Subd. 9. **Employee.** "Employee" means any person who performs services for another for hire including the following:

(1) an alien;

(2) a minor;

(3) a sheriff, deputy sheriff, constable, marshal, police officer, firefighter, county highway engineer, and peace officer while engaged in the enforcement of peace or in the pursuit or capture of a person charged with or suspected of crime;

(4) a person requested or commanded to aid an officer in arresting or retaking a person who has escaped from lawful custody, or in executing legal process, in which cases, for purposes of calculating compensation under this chapter, the daily wage of the person shall be the prevailing wage for similar services performed by paid employees;

(5) a county assessor;

(6) an elected or appointed official of the state, or of a county, city, town, school district, or governmental subdivision in the state. An officer of a political subdivision elected or appointed for a regular term of office, or to complete the unexpired portion of a regular term, shall be included only after the governing body of the political subdivision has adopted an ordinance or resolution to that effect;

(7) an executive officer of a corporation, except those executive officers excluded by section 176.041;

(8) a voluntary uncompensated worker, other than an inmate, rendering services in state institutions under the commissioners of human services and corrections similar to those of officers and employees of the institutions, and whose services have been accepted or contracted for by the commissioner of human services or corrections as authorized by law. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services in institutions where the services are performed by paid employees;

(9) a voluntary uncompensated worker engaged in emergency management as defined in section 12.03, subdivision 4, who is:

(i) registered with the state or any political subdivision of it, according to the procedures set forth in the state or political subdivision emergency operations plan; and

(ii) acting under the direction and control of, and within the scope of duties approved by, the state or political subdivision.

The daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed by paid employees;

(10) a voluntary uncompensated worker participating in a program established by a local social services agency. For purposes of this clause, "local social services agency" means any agency established under section 393.01. In the event of injury or death of the worker, the wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid in the county at the time of the injury or death for similar services performed by paid employees working a normal day and week;

(11) a voluntary uncompensated worker accepted by the commissioner of natural resources who is rendering services as a volunteer pursuant to section 84.089. The daily wage of the worker for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(12) a voluntary uncompensated worker in the building and construction industry who renders services for joint labor-management nonprofit community service projects. The daily wage of the worker for the purpose of calculating compensation under this chapter shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(13) a member of the military forces, as defined in section 190.05, while in state active service, as defined in section 190.05, subdivision 5a. The daily wage of the member for the purpose of calculating compensation under this chapter shall be based on the member's usual earnings in civil life. If there is no evidence of previous occupation or earning, the trier of fact shall consider the member's earnings as a member of the military forces;

(14) a voluntary uncompensated worker, accepted by the director of the Minnesota Historical Society, rendering services as a volunteer, pursuant to chapter 138. The daily wage of the worker, for the purposes of calculating compensation under this chapter, shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(15) a voluntary uncompensated worker, other than a student, who renders services at the Minnesota State Academy for the Deaf or the Minnesota State Academy for the Blind, and whose services have been accepted or contracted for by the commissioner of education, as authorized by law. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed in institutions by paid employees;

(16) a voluntary uncompensated worker, other than a resident of the veterans home, who renders services at a Minnesota veterans home, and whose services have been accepted or contracted for by the commissioner of veterans affairs, as authorized by law. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed in institutions by paid employees;

(17) a worker who renders in-home attendant care services to a physically handicapped person, and who is paid directly by the commissioner of human services for these services, shall be an employee of the state within the meaning of this subdivision, but for no other purpose;

(18) students enrolled in and regularly attending the Medical School of the University of Minnesota in the graduate school program or the postgraduate program. The students shall not be considered employees for any other purpose. In the event of the student's injury or death, the weekly wage of the student for the purpose of calculating compensation under this chapter, shall be the annualized educational stipend awarded to the student, divided by 52 weeks. The institution in which the student is enrolled shall be considered the "employer" for the limited purpose of determining responsibility for paying benefits under this chapter;

(19) a faculty member of the University of Minnesota employed for an academic year is also an employee for the period between that academic year and the succeeding academic year if:

(a) the member has a contract or reasonable assurance of a contract from the University of Minnesota for the succeeding academic year; and

(b) the personal injury for which compensation is sought arises out of and in the course of activities related to the faculty member's employment by the University of Minnesota;

(20) a worker who performs volunteer ambulance driver or attendant services is an employee of the political subdivision, nonprofit hospital, nonprofit corporation, or other entity for which the worker performs the services. The daily wage of the worker for the purpose of calculating compensation under this chapter shall be the usual wage paid at the time of injury or death for similar services performed by paid employees;

(21) a voluntary uncompensated worker, accepted by the commissioner of administration, rendering services as a volunteer at the Department of Administration. In the event of injury or death of the worker, the daily wage of the worker, for the purpose of calculating compensation under this chapter, shall be the usual wage paid at the time of the injury or death for similar services performed in institutions by paid employees;

(22) a voluntary uncompensated worker rendering service directly to the Pollution Control Agency. The daily wage of the worker for the purpose of calculating compensation payable under this chapter is the usual going wage paid at the time of injury or death for similar services if the services are performed by paid employees;

(23) a voluntary uncompensated worker while volunteering services as a first responder or as a member of a law enforcement assistance organization while acting under the supervision and authority of a political subdivision. The daily wage of the worker for the purpose of calculating compensation payable under this chapter is the usual going wage paid at the time of injury or death for similar services if the services are performed by paid employees; and

(24) a voluntary uncompensated member of the civil air patrol rendering service on the request and under the authority of the state or any of its political subdivisions. The daily wage of the member for the purposes of calculating compensation payable under this chapter is the usual going wage paid at the time of injury or death for similar services if the services are performed by paid employees.

If it is difficult to determine the daily wage as provided in this subdivision, the trier of fact may determine the wage upon which the compensation is payable.

[For text of subds 9a to 27, see M.S.2004]

History: *2005 c 90 s 1*

176.041 EXCLUDED EMPLOYMENTS; APPLICATION, EXCEPTIONS, ELECTION OF COVERAGE.

[For text of subds 1 to 5a, see M.S.2004]

Subd. 5b. **North Dakota employers.** Notwithstanding the provisions of subdivision 4, workers' compensation benefits for an employee hired in North Dakota by a North Dakota employer, arising out of that employee's temporary work in Minnesota, shall not be payable under this chapter. North Dakota workers' compensation law provides the exclusive remedy available to the injured worker. For purposes of this subdivision, temporary work means work in Minnesota for a period of time not to exceed 15 consecutive calendar days or a maximum of 240 total hours worked by that employee in a calendar year.

[For text of subd 6, see M.S.2004]

History: *2005 c 90 s 2*

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 rehabilitation 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.

(f) An attorney must file a statement of attorney fees within 12 months of the date the attorney has submitted the written notice specified in paragraph (c). If the attorney has not filed a statement of attorney fees within the 12 months, the attorney must send a renewed notice of lien to the insurer. If 12 months have elapsed since the last notice of lien has been received by the insurer and no statement of attorney fees has been filed, the insurer must release the withheld money to the employee, except that before releasing the money to the employee, the insurer must give the attorney 30 days' written notice of the pending release. The insurer must not release the money if the attorney files a statement of attorney fees within the 30 days.

[For text of subds 3 to 12, see M.S.2004]

History: *2005 c 90 s 3*

176.092 GUARDIAN; CONSERVATOR.

[For text of subd 1, see M.S.2004]

Subd. 1a. **Parent as guardian.** A parent is presumed to be the guardian of the minor employee for purposes of this section. Where the parents of the minor employee are divorced, either parent with legal custody may be considered the guardian for purposes of this section. Notwithstanding subdivision 1, where the employee receives or is eligible for a lump sum payment of permanent total disability benefits, supplementary benefits, or permanent partial disability benefits totaling more than $3,000 or if the employee receives or is offered a settlement that exceeds five times the statewide average weekly wage, the compensation judge shall review such cases to determine whether benefits should be paid in a lump sum or through an annuity.

[For text of subds 2 to 4, see M.S.2004]

History: *2005 c 90 s 4*

176.102 REHABILITATION.

[For text of subds 1 to 3, see M.S.2004]

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 commissioner for deposit in the assigned risk safety account, 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 14, see M.S.2004]

History: *2005 c 90 s 5*

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. For medical disputes under sections 176.135 and 176.136, the commissioner or the commissioner's designee shall have jurisdiction to hold an administrative conference and issue decisions and orders under this section if the amount in dispute at the time the medical request is filed is $7,500 or less.

[For text of subds 2 to 9, see M.S.2004]

History: *2005 c 90 s 6*

176.129 CREATION OF SPECIAL COMPENSATION FUND.

[For text of subds 1 and 1a, see M.S.2004]

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

(b) "Paid indemnity losses" means gross benefits paid for temporary total disability, economic recovery compensation, permanent partial disability, temporary partial disability, impairment compensation, permanent total disability, retraining compensation paid to the employee as provided by section 176.102, subdivision 11, or dependency benefits, exclusive of medical and supplementary benefits. In the case of policy deductibles, paid indemnity losses includes all benefits paid, including the amount below deductible limits.

(c) "Standard workers' compensation premium" means the data service organization's designated statistical reporting pure premium after excluding retrospective rating plan adjustments, other individual risk rating plan adjustments such as schedule rating, premium credits for small and large deductible coverage, and other deviations from the data service organization's designated statistical reporting pure premiums and experience rating plan modification factors but prior to the application of premium discounts, policyholder dividends, other premium adjustments, and expense constants.

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

February 1 of the following calendar year. Each insurer must pay the full amount due as stated in the commissioner's notification, regardless of the amount the insurer actually collects from the premium surcharge.

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

(c) The portion of the total assessment allocated to self-insured employers that shall be paid by each self-insured employer must be based upon paid indemnity losses made by that self-insured employer during the preceding calendar year. The portion of the total assessment allocated to insured employers that is paid by each insurer must be based on standard workers' compensation premium earned in the state by that insurer during the preceding calendar year. An employer who has ceased to be self-insured shall continue to be liable for assessments based on paid indemnity losses arising out of injuries occurring during periods when the employer was self-insured, unless the self-insured employer has purchased a replacement policy covering those losses. An insurer who assumes a self-insured employer's obligation under a replacement policy shall separately report and pay assessments based on indemnity losses paid by the insurer under the replacement policy. The replacement policy may provide for reimbursement of the assessment to the insurer by the self-insured employer.

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

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

[For text of subds 6 to 12, see M.S.2004]

Subd. 13. **Employer reports.** All employers and insurers shall make reports to the commissioner as required for the proper administration of this section and Minnesota Statutes 1990, section 176.131, and Minnesota Statutes 1994, section 176.132. Employers and insurers may not be reimbursed from the special compensation fund for any periods unless the employer or insurer is up to date with all past due and currently due assessments, penalties, and reports to the special compensation fund under this section. The commissioner may allow an offset of the reimbursements due an employer or insurer pursuant to Minnesota Statutes 1990, section 176.131, and Minnesota Statutes 1994, section 176.132, against the assessment due under the section.

History: *2005 c 90 s 7-9*

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.

(g) An employer may designate a pharmacy or network of pharmacies that employees must use to obtain outpatient prescription and nonprescription medications. An employee is not required to obtain outpatient medications at a designated pharmacy unless the pharmacy is located within 15 miles of the employee's place of residence.

(h) Notwithstanding any fees established by rule adopted under section 176.136, an employer may contract for the cost of medication provided to employees.

[For text of subds 1a to 6, see M.S.2004]

Subd. 7. **Medical bills and records.** Health care providers shall submit to the insurer an itemized statement of charges on a billing form prescribed by the commissioner. A paper billing form is not required if the health care provider and insurer agree to electronic submission under section 62J.535. Health care providers shall also submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury. Health care providers may charge for copies of any records or reports that are in existence and directly relate to the items for which payment is sought under this chapter. The commissioner shall adopt a schedule of reasonable charges by rule.

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

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

History: *2005 c 90 s 10,11*

176.1351 MANAGED CARE.

[For text of subds 1 to 4, see M.S.2004]

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 commissioner for deposit in the assigned risk safety account in an amount up to $25,000 for each violation or incidence of noncompliance. The commissioner may adopt 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.2004]

History: *2005 c 90 s 12*

176.136 MEDICAL FEE REVIEW.

[For text of subd 1, see M.S.2004]

Subd. 1a. **Relative value fee schedule.** (a) The liability of an employer for services included in the medical fee schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee, whichever is lower. The medical fee schedule effective on October 1, 1991, remains 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 must contain reasonable classifications including, but not limited to, classifications that differentiate among health care provider disciplines. The conversion factors for the original relative value fee schedule must reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in effect. The reduction need not be applied equally to all treatment or services, but must represent a gross 15 percent reduction.

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

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

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

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

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

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

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

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

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

(g) After permanent rules have been adopted to implement this section, the conversion factors must be adjusted annually on October 1 by no more than the percentage change computed under section 176.645, but without the annual cap provided by that section. 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 is in lieu of the requirements of chapter 14. The commissioner shall follow the requirements of section 14.386, paragraph (a). The annual adjustments to the conversion factors and the medical fee schedules adopted under this section, including all previous fee schedules, are not subject to expiration under section 14.386, paragraph (b).

[For text of subds 1b to 3, see M.S.2004]

History: *1Sp2005 c 1 art 4 s 40*

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 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 chapter 79A, or a group of private employers who purchase workers' compensation insurance as a group, 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.

[For text of subds 2 to 5, see M.S.2004]

Subd. 6. [Repealed, 2005 c 90 s 20]

[For text of subd 7, see M.S.2004]

History: *2005 c 90 s 13*

176.185 POLICY OF INSURANCE.

Subdivision 1. **Notice of coverage; notice to insured before policy cancellation, termination or nonrenewal.** Within ten days after the issuance or renewal of a policy of insurance covering the liability to pay compensation under this chapter written by an insurer licensed to insure such liability in this state, the insurer shall file notice of coverage with the commissioner under rules and on forms prescribed by the commissioner. No policy shall be canceled by the insurer within the policy period nor terminated upon its expiration date until a notice in writing is delivered or mailed to the insured that meets all of the requirements in paragraphs (a) to (c).

(a) The notice must specify the date the policy will be terminated if the premium is not paid, declare that the insurer intends to cancel the policy by the specified date, or does not intend to renew the policy upon the expiration date.

(b) The notice must include the following statement, which must be placed on or sent with the premium invoice or other document sent by the insurer to notify the insured of the intended cancellation or termination: "You must maintain workers' compensation insurance, or obtain permission to self-insure for workers' compensation from the Minnesota Department of Commerce. The failure to maintain workers' compensation coverage is a violation of section 176.181, and could result in criminal prosecution and civil penalties of up to $1,000 per week per uninsured employee." This statement must be in at least 12-point font, bold-faced type, and be set out in a separate paragraph.

(c) The notice must be mailed or delivered to the insured at least 60 days before the actual date the policy is due to expire or be terminated or canceled. This 60-day advance notice to the insured applies to cancellation, termination, or nonrenewal of all workers' compensation policies for any reason, notwithstanding any contrary time frame for notice to the policyholder in section 60A.36 or 60A.37.

Subd. 1a. **Notice to commissioner of cancellation or termination; effective date.** (a) Within ten calendar days after the specified cancellation or termination date, the insurer must send to the insured and file with the commissioner a written notice of cancellation or termination in the manner prescribed by the commissioner. Upon the commissioner's request, the insurer shall provide documentation of the dates the notices required by this subdivision and subdivision 1 were sent to the insured. The effective dates of cancellation or termination specified in paragraphs (b) to (e) apply notwithstanding any contrary time frames in section 60A.36 or 60A.37.

(b) If within the ten calendar days after the specified cancellation or termination date the notice of cancellation or termination is both sent to the insured and received by the commissioner, the cancellation or termination shall be effective on the date specified on the notice of cancellation or termination, except as otherwise provided in paragraph (d).

(c) If within the ten calendar days after the specified cancellation or termination date the notice of cancellation or termination is not sent to the insured and received by the commissioner, the cancellation or termination shall not be effective until the notice has been sent to the insured and received by the commissioner, except as otherwise provided in paragraph (d) or (e).

(d) If the notice required by subdivision 1 is not sent to the insured or does not meet all of the requirements of subdivision 1, the cancellation or termination shall not be effective until 60 days after the notice of cancellation or termination has been sent

to the insured and received by the commissioner, except as otherwise provided in paragraph (e).

(e) Paragraphs (c) and (d) do not extend the effective date of cancellation or termination if, on or before the cancellation or termination date determined under paragraph (c) or (d), the employer obtains other insurance coverage or an order exempting the employer from carrying insurance as provided in section 176.181.

Subd. 1b. **Continued or replacement coverage.** If, after receiving a notice of cancellation or termination of a policy under subdivision 1a, the commissioner does not receive a notice of continued or replacement coverage, the commissioner shall notify the insured that the insured must obtain coverage from some other licensed carrier and that, if unable to do so, the insured shall request the commissioner of commerce to require the issuance of a policy as provided in section 79.251, subdivision 4. Upon a cancellation or termination of a policy by the insurer, the employer is entitled to be assigned a policy in accordance with sections 79.251 and 79.252.

Subd. 1c. **Cancellation by employer.** Notice of cancellation or termination by the insured shall be served upon the insurer by written statement mailed or delivered to the insurer. Upon receipt of the notice, the insurer shall notify the commissioner of the cancellation or termination and the commissioner shall ask the employer for the reasons for the cancellation or termination and notify the employer of the duty under this chapter to insure the employer's employees.

[For text of subds 2 to 6, see M.S.2004]

Subd. 7. **Notice, effect.** Where an employer has properly insured the payment of compensation to an employee, the employee, or the employee's dependent, shall proceed directly against the insurer. In such case but subject to subdivision 8a, the employer is released from further liability in this respect.

Subd. 8a. **Insolvent insurer.** (a) If an insurer is or becomes insolvent as defined in section 60C.03, subdivision 8, the insured employer is liable, as of May 23, 2003, for payment of the compensable workers' compensation claims that were covered under the employer's policy with the insolvent insurer, to the extent that the Insurance Guaranty Association has determined that the claims are not covered claims under chapter 60C. This paragraph does not in any way limit the Insurance Guaranty Association's right of recovery from an employer under section 60C.11, subdivision 7, for workers' compensation claims that are covered claims under chapter 60C.

The Insurance Guaranty Association shall notify the employer and the commissioners of the Departments of Commerce and Labor and Industry of the association's determination and of the employer's liability under this subdivision. The association's failure to notify the employer or the commissioners shall not relieve the employer of its liability and obligations under this subdivision.

(b) An employer who is liable for payment of claims under paragraph (a) shall have all of the rights, responsibilities, and obligations of a self-insured employer under this chapter for those claims only, but without the need for an order from the commissioner of commerce. The employer shall not be self-insured for purposes of the workers' compensation self-insurers' security fund under chapter 79A for those claims. The employer shall not be required to pay assessments to the workers' compensation self-insurers' security fund, and the security fund shall not be liable for the claims under section 79A.10. Notwithstanding any contrary provision of chapter 60C, the Insurance Guaranty Association shall pay the claims as covered claims under chapter 60C if the employer fails to pay the claims as required under this chapter and the commissioner of commerce determines that:

(1) the employer is the subject of a voluntary or involuntary petition under the United States Bankruptcy Code, title 11;

(2) a court of competent jurisdiction has declared the employer to be bankrupt or insolvent; or

(3) the employer is insolvent.

(c) If the employer contracts with an entity or person to administer the claims under paragraph (a), the entity or person must be a licensed workers' compensation

insurer or a licensed third-party administrator under section 60A.23, subdivision 8. The commissioner of commerce may require the employer to contract with a licensed third-party administrator when the commissioner determines it is necessary to ensure proper payment of compensation under this chapter.

(d) For all claims that an employer is liable for under paragraph (a) and pays on or after May 26, 2005, and for all deductible amounts an employer pays on or after May 26, 2005, under an employer's policy with an insurer that became insolvent before May 23, 2003:

(1) the employer shall file reports and pay assessments to the special compensation fund, according to the requirements of section 176.129 that apply to self-insured employers, based on paid indemnity losses for the claims and deductible amounts it paid; and

(2) the employer may request supplementary benefit and second injury reimbursement from the special compensation fund for the claims and deductible amounts it paid, subject to section 176.129, subdivision 13. Reimbursement from the special compensation fund is limited to claims that are eligible for supplementary benefit and second injury reimbursement under Minnesota Statutes 1990, section 176.131, and Minnesota Statutes 1994, section 176.132.

(e) For all claims for which an employer is liable under paragraph (a) and paid between the date of the insurer's insolvency and May 26, 2005, and for all deductible amounts an employer paid between the date of the insurer's insolvency and May 26, 2005, under an employer's policy with an insurer that became insolvent before May 23, 2003, the employer may request supplementary benefit and second injury reimbursement from the special compensation fund, subject to section 176.129, subdivision 13, if:

(1) the employer files reports and pays all past assessments based on paid indemnity losses, for all claims and deductible amounts it paid from the date of the insolvency of the insurer to May 26, 2005, at the rate that was in effect for self-insured employers under section 176.129 during the applicable assessment reporting period;

(2) the employer has a pending request for reimbursement of the claims and deductible amounts it paid from the special compensation fund as of May 26, 2005, or files a request for reimbursement within one year after May 26, 2005; and

(3) the claims are eligible for supplementary benefit and second injury reimbursement under Minnesota Statutes 1990, section 176.131, and Minnesota Statutes 1994, section 176.132.

(f) An employer who is liable for claims under paragraph (a) shall be eligible for reimbursement from the Workers' Compensation Reinsurance Association under chapter 79 for those claims to the extent they exceed the applicable retention limit selected by the insolvent insurer and if the employer has complied with the requirements for reimbursement established by the Workers' Compensation Reinsurance Association for its self-insured members. The employer is not responsible for payment of premiums to the reinsurance association to the extent the premiums have been paid by the insolvent insurer.

(g) The expenses of the employer in handling the claims paid under paragraph (a) are accorded the same priority as the liquidator's expenses. The employer must be recognized as a claimant in the liquidation of an insolvent insurer for amounts paid by the employer under this subdivision, and must receive dividends and other distributions at the priority set forth in chapter 60B. The receiver, liquidator, or statutory successor of an insolvent insurer is bound by settlements of claims made by the employer under this subdivision. The court having jurisdiction shall grant the claims priority equal to that which the claimant would have been entitled against the assets of the insolvent insurer in the absence of this subdivision.

(h) The Workers' Compensation Reinsurance Association and the special compensation fund, as a condition of directly reimbursing an employer eligible for reimbursement, may require the employer to hold it harmless from any claims by a liquidator, receiver, or statutory successor to the insolvent insurer that the Workers' Compensation Reinsurance Association or special compensation fund improperly indemnified or

reimbursed the employer. In no event shall the Workers' Compensation Reinsurance Association or the special compensation fund be required to reimburse any amounts for any claim more than once.

[For text of subds 9 and 10, see M.S.2004]

History: *2005 c 90 s 14-16*

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

[For text of subds 1 and 1a, see M.S.2004]

Subd. 3. **Insurer payment.** If a dispute exists as to whether an employee's injury is compensable under this chapter and the employee is otherwise covered by an insurer or entity pursuant to chapters 62A, 62C, 62D, 62E, 62R, and 62T, that insurer or entity shall pay any medical costs incurred by the employee for the injury up to the limits of the applicable coverage and shall make any disability payments otherwise payable by that insurer or entity in the absence of or in addition to workers' compensation liability. If the injury is subsequently determined to be compensable pursuant to this chapter, the workers' compensation insurer shall be ordered to reimburse the insurer or entity that made the payments for all payments made under this subdivision by the insurer or entity, including interest at a rate of 12 percent a year. If a payment pursuant to this subdivision exceeds the reasonable value as permitted by sections 176.135 and 176.136, the provider shall reimburse the workers' compensation insurer for all the excess as provided by rules promulgated by the commissioner.

[For text of subds 4 to 8, see M.S.2004]

History: *2005 c 132 s 36*

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

[For text of subds 1 to 4, see M.S.2004]

Subd. 5. **Forms for reports.** The commissioner shall prescribe forms for use in making the reports required by this section. Forms for reports required by this section shall be as prescribed by the commissioner and shall be the only forms used by an employer, insurer, self-insurer, group self-insurer, and all health care providers.

[For text of subds 6 to 12, see M.S.2004]

History: *2005 c 90 s 17*

176.238 NOTICE OF DISCONTINUANCE OF COMPENSATION.

[For text of subds 1 to 9, see M.S.2004]

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 commissioner for deposit in the assigned risk safety account.

[For text of subd 11, see M.S.2004]

History: *2005 c 90 s 18*

176.391 INVESTIGATIONS.

[For text of subd 1, see M.S.2004]

Subd. 2. **Appointment of physicians, surgeons, and other experts.** The compensation judge assigned to a matter, or the commissioner, may appoint one or more neutral physicians or surgeons to examine the injury of the employee and report thereon except as provided otherwise pursuant to section 176.1361. Where necessary to determine the facts, the services of other experts may also be employed.

[For text of subds 3 and 4, see M.S.2004]

History: *2005 c 90 s 19*