SENATE
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S.F. No. 1603

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DATE	D-PG	OFFICIAL STATUS
04/15/2013	1837	Introduction and first reading Referred to Jobs, Agriculture and Rural Development
05/01/2013	3156a	Comm report: To pass as amended Joint rule 2.03, referred to Rules and Administration Withdrawn Joint rule 3.02, returned to Jobs, Agriculture and Rural Development See SF1234, Art. 2

A bill for an act

relating to workers' compensation; adopting recommendations of the Workers' Compensation Advisory Council; amending Minnesota Statutes 2012, sections 176.011, subdivisions 15, 16; 176.081, subdivisions 1, 7; 176.101, subdivision 1; 176.102, subdivisions 5, 10; 176.106, subdivision 3; 176.136, subdivision 1b; 176.191, subdivision 3; 176.645; 176.83, subdivision 5.

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

Section 1. Minnesota Statutes 2012, section 176.011, subdivision 15, is amended to read:

Subd. 15. **Occupational disease.** (a) "Occupational disease" means a mental impairment as defined in paragraph (d) or physical disease arising out of and in the course of employment peculiar to the occupation in which the employee is engaged and due to causes in excess of the hazards ordinary of employment and shall include undulant fever. Physical stimulus resulting in mental injury and mental stimulus resulting in physical injury shall remain compensable. Mental impairment is not considered a disease if it results from a disciplinary action work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer. Ordinary diseases of life to which the general public is equally exposed outside of employment are not compensable, except where the diseases follow as an incident of an occupational disease, or where the exposure peculiar to the occupation makes the disease an occupational disease hazard. A disease arises out of the employment only if there be a direct causal connection between the conditions under which the work is performed and if the occupational disease follows as a natural incident of the work as a result of the exposure occasioned by the nature of the employment. An employer is not liable for compensation for any occupational disease which cannot be traced to the employment as a direct and proximate cause and is not recognized as a hazard characteristic of and peculiar

to the trade, occupation, process, or employment or which results from a hazard to which the worker would have been equally exposed outside of the employment.

(b) If immediately preceding the date of disablement or death, an employee was employed on active duty with an organized fire or police department of any municipality, as a member of the Minnesota State Patrol, conservation officer service, state crime bureau, as a forest officer by the Department of Natural Resources, state correctional officer, or sheriff or full-time deputy sheriff of any county, and the disease is that of myocarditis, coronary sclerosis, pneumonia or its sequel, and at the time of employment such employee was given a thorough physical examination by a licensed doctor of medicine, and a written report thereof has been made and filed with such organized fire or police department, with the Minnesota State Patrol, conservation officer service, state crime bureau, Department of Natural Resources, Department of Corrections, or sheriff's department of any county, which examination and report negatived any evidence of myocarditis, coronary sclerosis, pneumonia or its sequel, the disease is presumptively an occupational disease and shall be presumed to have been due to the nature of employment. If immediately preceding the date of disablement or death, any individual who by nature of their position provides emergency medical care, or an employee who was employed as a licensed police officer under section 626.84, subdivision 1; firefighter; paramedic; state correctional officer; emergency medical technician; or licensed nurse providing emergency medical care; and who contracts an infectious or communicable disease to which the employee was exposed in the course of employment outside of a hospital, then the disease is presumptively an occupational disease and shall be presumed to have been due to the nature of employment and the presumption may be rebutted by substantial factors brought by the employer or insurer. Any substantial factors which shall be used to rebut this presumption and which are known to the employer or insurer at the time of the denial of liability shall be communicated to the employee on the denial of liability.

(c) A firefighter on active duty with an organized fire department who is unable to perform duties in the department by reason of a disabling cancer of a type caused by exposure to heat, radiation, or a known or suspected carcinogen, as defined by the International Agency for Research on Cancer, and the carcinogen is reasonably linked to the disabling cancer, is presumed to have an occupational disease under paragraph (a). If a firefighter who enters the service after August 1, 1988, is examined by a physician prior to being hired and the examination discloses the existence of a cancer of a type described in this paragraph, the firefighter is not entitled to the presumption unless a subsequent medical determination is made that the firefighter no longer has the cancer.

(d) For the purposes of this chapter, "mental impairment" means a diagnosis of post-traumatic stress disorder by a licensed physician or psychologist. For the purpose of this chapter, "post-traumatic stress disorder" means the condition as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Sec. 2. Minnesota Statutes 2012, section 176.011, subdivision 16, is amended to read:

Subd. 16. **Personal injury.** "Personal injury" means any mental impairment as defined in subdivision 15, paragraph (d), or physical 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. Physical stimulus resulting in mental injury and mental stimulus resulting in physical injury shall remain compensable. Mental impairment is not considered a personal injury if it results from a disciplinary action work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer. 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 personal reasons, and not directed against the employee as an employee, or because of the employment. An injury or disease resulting from a vaccine in response to a declaration by the Secretary of the United States Department of Health and Human Services under the Public Health Service Act to address an actual or potential health risk related to the employee's employment is an injury or disease arising out of and in the course of employment.

Sec. 3. Minnesota Statutes 2012, section 176.081, subdivision 1, is amended to read:

Subdivision 1. **Limitation of fees.** (a) A fee for legal services of ~~25~~ 20 percent of the first ~~$4,000 of compensation awarded to the employee and 20 percent of the next $60,000~~ $130,000 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~~ $26,000 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~~ $26,000. 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.

Sec. 4. Minnesota Statutes 2012, section 176.081, subdivision 7, is amended to read:

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 disputes 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. This subdivision shall apply only to contingent fees payable from the employee's compensation benefits, and not to other fees paid by the employer and insurer, including but not limited to those fees payable for resolution of a medical dispute or rehabilitation dispute, or pursuant to section 176.191.

Sec. 5. Minnesota Statutes 2012, section 176.101, subdivision 1, is amended to read:

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

(b)(1) Commencing on October 1, ~~2008~~ 2013, and each October 1 thereafter, the maximum weekly compensation payable is ~~$850 per week~~ 102 percent of the statewide average weekly wage for the period ending December 31 of the preceding year.

(2) The Workers' Compensation Advisory Council may consider adjustment increases and make recommendations to the legislature.

(c) The minimum weekly compensation payable is $130 per week or the injured employee's actual weekly wage, whichever is less.

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

(e) Temporary total disability compensation shall cease when the employee returns to work. Except as otherwise provided in section 176.102, subdivision 11, temporary total disability compensation may only be recommenced following cessation under this paragraph, paragraph (h), or paragraph (j) prior to payment of 130 weeks of temporary total disability compensation and only as follows:

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

(2) if temporary total disability compensation ceased because the employee returned to work or ceased under paragraph (h) or (j), it may be recommenced if the employee is

medically unable to continue at a job due to the injury. Where the employee is medically unable to continue working due to the injury, temporary total disability compensation may continue until any of the cessation events in paragraphs (e) to (l) occurs following recommencement. If an employee who has not yet received temporary total disability compensation becomes medically unable to continue working due to the injury after reaching maximum medical improvement, temporary total disability compensation shall commence and shall continue until any of the events in paragraphs (e) to (l) occurs following commencement. For purposes of commencement or recommencement under this clause only, a new period of maximum medical improvement under paragraph (j) begins when the employee becomes medically unable to continue working due to the injury. Temporary total disability compensation may not be recommenced under this clause and a new period of maximum medical improvement does not begin if the employee is not actively employed when the employee becomes medically unable to work. All periods of initial and recommenced temporary total disability compensation are included in the 130-week limitation specified in paragraph (k).

(f) Temporary total disability compensation shall cease if the employee withdraws from the labor market. Temporary total disability compensation may be recommenced following cessation under this paragraph only if the employee reenters the labor market prior to 90 days after the employee reached maximum medical improvement and prior to payment of 130 weeks of temporary total disability compensation. Once recommenced, temporary total disability ceases when any of the cessation events in paragraphs (e) to (l) occurs.

(g) Temporary total disability compensation shall cease if the total disability ends and the employee fails to diligently search for appropriate work within the employee's physical restrictions. Temporary total disability compensation may be recommenced following cessation under this paragraph only if the employee begins diligently searching for appropriate work within the employee's physical restrictions prior to 90 days after maximum medical improvement and prior to payment of 130 weeks of temporary total disability compensation. Once recommenced, temporary total disability compensation ceases when any of the cessation events in paragraphs (e) to (l) occurs.

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

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

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

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

(k) Temporary total disability compensation shall cease entirely when 130 weeks of temporary total disability compensation have been paid, except as provided in section 176.102, subdivision 11, paragraph (b). Notwithstanding anything in this section to the contrary, initial and recommenced temporary total disability compensation combined shall not be paid for more than 130 weeks, regardless of the number of weeks that have elapsed since the injury, except that if the employee is in a retraining plan approved under section 176.102, subdivision 11, the 130-week limitation shall not apply during the retraining, but is subject to the limitation before the plan begins and after the plan ends.

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

(m) Once an employee has been paid 52 weeks of temporary total compensation, the employer or insurer must notify the employee in writing of the 130-week limitation on payment of temporary total compensation. A copy of this notice must also be filed with the department.

Sec. 6. Minnesota Statutes 2012, section 176.102, subdivision 5, is amended to read:

Subd. 5. **On-the-job training; job placement and job development limitation.** (a) On-the-job training is to be given consideration in developing a rehabilitation plan especially where it would produce an economic status similar to that enjoyed prior to disability.

(b) For purposes of this subdivision, job placement includes job development services as defined in rules adopted by the commissioner. Job placement services provided by a qualified rehabilitation consultant firm or a registered rehabilitation vendor must not exceed 20 hours per month or 24 consecutive or intermittent weeks. When 12

consecutive or intermittent weeks of job placement services have been provided, the qualified rehabilitation consultant must consult with the parties and either file a plan amendment reflecting an agreement by the parties to extend job placement services for up to an additional 12 consecutive or intermittent weeks, or file a request for a rehabilitation conference under section 176.106. The commissioner or compensation judge may issue an order modifying the rehabilitation plan or make other determinations about the employee's rehabilitation, but must not order more than 24 total consecutive or intermittent weeks of job placement services.

Sec. 7. Minnesota Statutes 2012, section 176.102, subdivision 10, is amended to read:

Subd. 10. **Rehabilitation; consultants and vendors.** (a) The commissioner shall approve rehabilitation consultants who may propose and implement plans if they satisfy rules adopted by the commissioner for rehabilitation consultants. A consultant may be an individual or public or private entity, and except for rehabilitation services, Department of Employment and Economic Development, a consultant may not be a vendor or the agent of a vendor of rehabilitation services. The commissioner shall also approve rehabilitation vendors if they satisfy rules adopted by the commissioner.

(b) An individual qualified rehabilitation consultant registered by the commissioner must not provide any medical, rehabilitation, or disability case management services related to an injury that is compensable under this chapter unless the case management services are part of an approved rehabilitation plan.

Sec. 8. Minnesota Statutes 2012, section 176.106, subdivision 3, is amended to read:

Subd. 3. **Conference.** The matter shall be scheduled for an administrative conference within 60 days after receipt of the request for a conference, except that an administrative conference on a rehabilitation issue under section 176.102 must be held within 21 days, unless the issue involves only fees for rehabilitation services that have already been provided or there is good cause for holding the conference later than 21 days. If there is a rehabilitation plan in effect, the qualified rehabilitation consultant must continue to provide reasonable services under the plan until the date the conference was initially scheduled to be held. Notice of the conference shall be served on all parties no later than 14 days prior to the conference, unless the commissioner or compensation judge determines that a conference shall not be held. The commissioner or compensation judge may order an administrative conference before the commissioner's designee whether or not a request for conference is filed.

The commissioner or compensation judge 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.

Sec. 9. Minnesota Statutes 2012, section 176.136, subdivision 1b, is amended to read:

Subd. 1b. **Limitation of liability.** (a) The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a 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. A prevailing charge established under Minnesota Rules, part 5221.0500, subpart 2, must be based on no more than two years of billing data immediately preceding the date of the service.

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

(d) An employer's liability for treatment, articles, and supplies provided under this chapter by a health care provider located outside of Minnesota is limited to the payment that the health care provider would receive if the treatment, article, or supply were paid under the workers' compensation law of the jurisdiction in which the treatment was provided.

Sec. 10. Minnesota Statutes 2012, section 176.191, subdivision 3, is amended to read:

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 the health care provider accepts payment for the services from the insurer or entity under chapter 62A, 62C, 62D, 62E, 62R, or 62T, the payment shall be deemed payment in full and the employer is not liable for additional payment under this chapter for the services. 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.

Sec. 11. Minnesota Statutes 2012, section 176.645, is amended to read:

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 previous 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. For injuries occurring on

and after October 1, 2013, no adjustment increase shall exceed three percent a year. If the adjustment under the formula of this section would exceed three percent, the increase shall be three percent. No adjustment under this section shall be less than zero 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. For injuries occurring on or after October 1, 2013, the initial adjustment under subdivision 1 is deferred until the third anniversary of the date of injury. The adjustment made at that time shall be that of the last year only.

Sec. 12. Minnesota Statutes 2012, section 176.83, subdivision 5, is amended to read:

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

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

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

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

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

(4) criteria for diagnostic imaging procedures;

(5) criteria for inpatient hospitalization; ~~and~~

(6) criteria for treatment of chronic pain; and

(7) criteria for the long-term use of opioids or other scheduled medications to alleviate intractable pain and improve function, including the use of written contracts between the injured worker and the health care provider who prescribes the medication.

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

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

Sec. 13. **PATIENT ADVOCATE PILOT PROGRAM.**

The commissioner of labor and industry shall implement a two-year patient advocate program for employees with back injuries who are considering back fusion surgery. The purpose of the program is to ensure that injured workers understand their treatment options and receive treatment for their work injuries according to accepted medical standards. The services provided by the patient advocate shall be paid for from the special compensation fund.