A bill for an act

relating to workers' compensation; adopting recommendations of the Workers' Compensation Advisory Council; amending Minnesota Statutes 2006, sections 176.101, subdivision 1; 176.102, subdivision 11; 176.136, subdivisions 1a, 1b; 176.275, subdivision 1; repealing Minnesota Statutes 2006, section 176.669.

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

Section 1. Minnesota Statutes 2006, 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, ~~2000~~ 2007, the maximum weekly compensation payable is ~~$750~~ $850 per week.

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

(c) The minimum weekly compensation payable is $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 ~~104~~ 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 ~~104-week~~ 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 ~~104~~ 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 ~~104~~ 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 ~~104~~ 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 ~~104~~ 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 ~~104 week~~ 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 ~~104-week~~ 130-week limitation on payment of temporary total compensation. A copy of this notice must also be filed with the department.

Sec. 2. Minnesota Statutes 2006, section 176.102, subdivision 11, is amended to read:

Subd. 11. **Retraining; compensation.** (a) Retraining is limited to 156 weeks. An employee who has been approved for retraining may petition the commissioner

or compensation judge for additional compensation not to exceed 25 percent of the compensation otherwise payable. If the commissioner or compensation judge determines that this additional compensation is warranted due to unusual or unique circumstances of the employee's retraining plan, the commissioner may award additional compensation in an amount not to exceed the employee's request. This additional compensation shall cease at any time the commissioner or compensation judge determines the special circumstances are no longer present.

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

(c) Any request for retraining shall be filed with the commissioner before ~~156~~ 208 weeks of any combination of temporary total or temporary partial compensation have been paid. Retraining shall not be available after ~~156~~ 208 weeks of any combination of temporary total or temporary partial compensation benefits have been paid unless the request for the retraining has been filed with the commissioner prior to the time the ~~156~~ 208 weeks of compensation have been paid.

(d) The employer or insurer must notify the employee in writing of the ~~156-week~~ 208-week limitation for filing a request for retraining with the commissioner. This notice must be given before 80 weeks of temporary total disability or temporary partial disability compensation have been paid, regardless of the number of weeks that have elapsed since the date of injury. If the notice is not given before the 80 weeks, the period of time within which to file a request for retraining is extended by the number of days the notice is late, but in no event may a request be filed later than 225 weeks after any combination of temporary total disability or temporary partial disability compensation have been paid. The commissioner may assess a penalty of $25 per day that the notice is late, up to a maximum penalty of $2,000, against an employer or insurer for failure to provide the notice. The penalty is payable to the commissioner for deposit in the assigned risk safety account.

Sec. 3. Minnesota Statutes 2006, section 176.136, subdivision 1a, is amended to read:

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, according to the procedures in paragraph (h), clause (2), the relative value fee schedule tables 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) The conversion factors shall be adjusted as follows:

(1) 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.

(2) Each time the workers' compensation relative value fee schedule tables are updated under paragraph (h), the commissioner shall adjust the conversion factors so that, for services in both fee schedules, there is no difference between the overall payment in each category of service listed in paragraph (b) under the new schedule and the overall payment for that category under the workers' compensation fee schedule most recently in effect. This adjustment shall be made before making any additional adjustment under clause (1).

(h) The commissioner shall give notice of the adjusted conversion factors and updates to the relative value fee schedule as follows:

(1) 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~~ and any amendments to rules to implement Medicare relative value tables incorporated by reference under this subdivision. 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~~ and amended rules to implement the relative value tables are subject to 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).

(2) The commissioner may periodically update the workers' compensation relative value tables by incorporating by reference the relative value tables in the national physician fee schedule relative value file established by the Centers for Medicare and Medicaid Services. The commissioner shall publish the notices of the incorporation by reference in the State Register at least 60 days before the tables are to become effective for purposes of payment under this section. Each notice of incorporation must state the date the incorporated tables will become effective and must include information on how the Medicare relative value tables may be obtained. The published notices of incorporation by reference and the incorporated tables are not rules subject to section 14.386 or other provision of chapter 14, but have the force and effect of law as of the date specified in the notices.

Sec. 4. Minnesota Statutes 2006, 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 located outside the 11-county metropolitan area 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) Except as provided in paragraph (c), the liability of the employer for the treatment, articles, and supplies provided by a hospital located within the 11-county metropolitan area, regardless of the number of licensed beds, shall be as follows:

(1) For outpatient treatment, articles, and supplies, the employer's liability is limited to the maximum fee in the fee schedule adopted under subdivision 1a or rules adopted under this section.

(2) For outpatient treatment, articles, and supplies that are not limited by clause (1), and for all inpatient treatment, articles, and supplies that are not limited by a rule adopted under this section, the employer's liability is limited to the hospital's usual and customary charge multiplied by the "adjusted aggregate payment-to-charge ratio."

(i) The "aggregate payment-to-charge ratio" shall be determined on the basis of the most recently available payment-to-charge data collected by the Department of Health as of June 30 of each year. For purposes of this clause, the aggregate payment-to-charge ratio equals the aggregate payments made for nonpublic program patients from commercial insurers, nonprofit health plans, and private managed care to hospitals whose inpatient

facilities are located in the 11-county metropolitan area, divided by the aggregate charges submitted by those hospitals to commercial insurers, nonprofit health plans, and private managed care.

(ii) The "adjusted aggregate payment-to-charge ratio" is the aggregate payment-to-charge ratio plus 15 percentage points (0.15) as a workers' compensation premium.

(iii) For example, if a hospital's usual and customary charge is $10,000, and the aggregate payment-to-charge ratio is 0.570, the adjusted aggregate payment-to-charge ratio is 0.720 (0.570 plus 0.15). The maximum payment to the hospital would be $7,200 ($10,000 multiplied by 0.720).

(iv) The commissioner shall annually publish in the State Register, no later than October 1, notice of the adjusted aggregate payment-to-charge ratio as determined under this paragraph. The published notice and ratio are not rules subject to section 14.386 or other provision of chapter 14, but have the force and effect of law as of each October 1 for purposes of payment under this paragraph.

(c) The liability of the employer for surgical implants provided to an employee while an inpatient or outpatient at a clinic, hospital, or other facility in the 11-county metropolitan area is limited to the invoice cost of the implant to the entity that bills the employer directly for the implant, plus the following:

(1) an additional 50 percent if the invoice cost is less than or equal to $500;

(2) an additional 30 percent if the invoice cost is from $500.01 to $1,000; or

(3) an additional 25 percent if the invoice cost is $1,000.01 or greater.

This reimbursement shall be paid to the billing clinic, hospital, other facility, or third-party vendor.

~~(b)~~ (d) The liability of the employer for the treatment, articles, and supplies that are not limited by paragraph (a), (b), or (c), is as follows:

(1) For outpatient treatment, articles, and supplies provided by a hospital with more than 100 licensed beds that is located outside the 11-county metropolitan area, the employer's liability is limited to the maximum fee in the fee schedule adopted under subdivision 1a or a rule adopted under this section, if applicable. If the treatment, articles, and supplies are not limited by the fee schedule or rule, the employer's liability is as provided in clause (2).

(2) For all treatment, articles, and supplies that are not limited by the fee schedule adopted under subdivision 1a ~~or 1c or paragraph (a)~~, or a rule adopted under this section, including all inpatient treatment, articles, and supplies provided by a hospital with more than 100 licensed beds that is located outside the 11-county metropolitan area, the

employer's liability 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~~ limitations specified in this ~~paragraph~~ section.

(f) For purposes of this subdivision, the 11-county metropolitan area consists of Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright Counties. A hospital's location is determined by the county in which its inpatient facility is located.

(g) This section also governs the employer's liability for treatment, articles, and supplies provided under this chapter by out-of-state providers.

~~(c)~~ (h) The limitation of liability for charges provided by ~~paragraph (b)~~ this subdivision 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.

Sec. 5. Minnesota Statutes 2006, section 176.275, subdivision 1, is amended to read:

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

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

Sec. 6. **REPEALER.**

Minnesota Statutes 2006, section 176.669, is repealed.

Sec. 7. **EFFECTIVE DATE.**

Sections 1 and 2 are effective for injuries occurring on or after October 1, 2007. Section 3 is effective the day following final enactment. Section 4 is effective for treatment, articles, and supplies provided on or after October 1, 2007.