CHAPTER 5220
DEPARTMENT OF LABOR AND INDUSTRY
REHABILITATION AND COMPENSATION

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REHABILITATION; QUALIFIED REHABILITATION CONSULTANT OR REGISTERED REHABILITATION VENDOR REQUIREMENTS; RULES OF PRACTICE

5220.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 5220.0100 to 5220.1900, the following terms have the meanings given them.

Subp. 1a. [Repealed, 11 SR 2237]

Subp. 2. [Repealed, 17 SR 3361]

Subp. 3. **Assigned qualified rehabilitation consultant.** "Assigned qualified rehabilitation consultant" means the qualified rehabilitation consultant responsible for consulta-

tion, development, and implementation of the rehabilitation plan, whether the qualified rehabilitation consultant is:

A. selected by the insurer if the employee does not choose;

B. chosen by the employee if the employee exercises a choice provided by statute;

C. determined by a documented agreement of the parties or by the commissioner or a compensation judge in the event of a dispute; or

D. assigned by the commissioner under Minnesota Statutes, section 176.102, subdivision 4, paragraph (f).

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

Subp. 5. **Department.** "Department" means the Department of Labor and Industry.

Subp. 6. [Repealed, 16 SR 2520]

Subp. 7. [Repealed, 16 SR 2520]

Subp. 8. [Repealed, 16 SR 2520]

Subp. 9. **Employer.** "Employer" means the employer at the time of injury of the employee, unless the context clearly indicates otherwise.

Subp. 10. **Formal course of study.** "Formal course of study"means a program described by a published syllabus with established time parameters for completion which results in a diploma or other certification that is accepted as a credential of basic competence in a vocation.

Subp. 10a. [Repealed, 16 SR 2520]

Subp. 11. [Repealed, 16 SR 2520]

Subp. 12. **Identifying information.** "Identifying information" refers to the name, current mailing address, and current phone number of a person or entity. For employees, identifying information also includes the department file number and date of injury. For employers and insurers, identifying information also includes the name of the individual to contact about the claim. For rehabilitation providers, identifying information includes the rehabilitation provider registration number.

Subp. 12a. **Insurer.** "Insurer" includes self–insured employers.

Subp. 13. **Job analysis.** "Job analysis" means a systematic study that reports work activity as follows:

A. what the worker does in the job being analyzed in relation to data, people, and things;

B. what methods and techniques are employed by the worker;

C. what machines, tools, equipment, and work aids are used;

D. what materials, products, subject matter, or services result; and

E. what traits are required of the worker.

Depending upon the purpose for which the analysis is completed, a job analysis may describe a group of positions that are sufficiently alike to justify being covered by a single analysis or, if necessary, may describe a position that is the total work assignment of a single worker.

Subp. 14. [Repealed, 16 SR 2520]

Subp. 15. [Repealed, 16 SR 2520]

Subp. 16. **Job development.** "Job development" means systematic contact with prospective employers resulting in opportunities for interviews and employment that might not otherwise have existed. Job development facilitates a prospective employer's consideration of a qualified employee for employment.

Subp. 17. **Job modification.** "Job modification" means altering the work environment to accommodate physical or mental limitations by making changes in equipment, in the methods of completing tasks, or in job duties.

Subp. 18. **Job placement.** "Job placement" means activities that support a qualified employee's search for work, including the identification of job leads, arranging for job interviews, the preparation of a client to conduct an effective job search, and communication of

information about, but not limited to, the labor market, programs or laws offering employment incentives, and the qualified employee's physical limitations and capabilities as permitted by data privacy laws.

Subp. 19. **Job seeking skills training.** "Job seeking skills training" means the formal teaching of independent work search skills including, but not limited to, the completion of applications, preparation of resumes, effectiveness in job interviews, and techniques for obtaining job leads.

Subp. 20. **Medical management.** "Medical management" by a qualified rehabilitation consultant means rehabilitation services that assist communication of information among parties about the employee's medical condition and treatment, and rehabilitation services that coordinate the employee's medical treatment with the employee's vocational rehabilitation services. Medical management refers only to those rehabilitation services necessary to facilitate the employee's return to work.

Subp. 21. **On–the–job training.** "On–the–job training" means training while employed at a workplace where the employee receives instruction from an experienced worker and which is likely to result in employment with the on–the–job training employer upon its completion.

Subp. 22. **Qualified employee.** "Qualified employee" means an employee who, because of the effects of a work–related injury or disease, whether or not combined with the effects of a prior injury or disability:

A. is permanently precluded or is likely to be permanently precluded from engaging in the employee's usual and customary occupation or from engaging in the job the employee held at the time of injury;

B. cannot reasonably be expected to return to suitable gainful employment with the date–of–injury employer; and

C. can reasonably be expected to return to suitable gainful employment through the provision of rehabilitation services, considering the treating physician's opinion of the employee's work ability.

Subp. 23. **Qualified rehabilitation consultant.** "Qualified rehabilitation consultant" means a person who is professionally trained and experienced and who is registered by the commissioner to provide a rehabilitation consultation and to develop and implement an appropriate plan of rehabilitation services for an employee entitled to rehabilitation benefits under Minnesota Statutes, section 176.102.

Subp. 24. **Qualified rehabilitation consultant firm.** "Qualified rehabilitation consultant firm" means a public or private business, whether organized as a sole proprietorship, partnership, association, corporation, or other form, which is held out to the public as a business entity engaged in rehabilitation consultation and services.

Subp. 25. **Registered rehabilitation vendor.** "Registered rehabilitation vendor" means a public or private entity registered by the commissioner and existing wholly or in part for the provision of rehabilitation services in accord with an approved rehabilitation plan.

Subp. 26. **Rehabilitation consultation.** "Rehabilitation consultation" means a meeting of the employee and assigned qualified rehabilitation consultant to determine whether the employee is a qualified employee, as defined in subpart 22 to receive rehabilitation services, as defined in subpart 29, considering the treating physician's opinion of the employee's work ability.

Subp. 27. **Rehabilitation plan.** "Rehabilitation plan" means a written document completed by the assigned qualified rehabilitation consultant on a form prescribed by the commissioner describing a vocational goal and the specific services by which the qualified employee will be returned to suitable gainful employment.

Subp. 28. **Rehabilitation provider.** "Rehabilitation provider" means the following four categories of rehabilitation professionals:

A. qualified rehabilitation consultants;

B. qualified rehabilitation consultant interns;

C. qualified rehabilitation consultant firms; and

D. registered rehabilitation vendors.

Subp. 29. **Rehabilitation services.** "Rehabilitation services" means a program of vocational rehabilitation, including medical management, designed to return an individual to work consistent with Minnesota Statutes, section 176.102, subdivision 1, paragraph (b). The program begins with the first in–person visit of the employee by the assigned qualified rehabilitation consultant, including a visit for purposes of a rehabilitation consultation. The program consists of the sequential delivery and coordination of services by rehabilitation providers under an individualized rehabilitation plan. Specific services under this program may include, but are not limited to, vocational evaluation, counseling, job analysis, job modification, job development, job placement, labor market survey, vocational testing, transferable skills analysis, work adjustment, job seeking skills training, on–the–job training, and retraining.

Subp. 30. **Required progress record.** "Required progress record" means a record maintained by the rehabilitation provider that documents the rehabilitation provider's services and the employee's rehabilitation progress. The record shall include all case notes and written reports whether or not they are submitted to the commissioner and all correspondence received or prepared by the rehabilitation provider about an employee's rehabilitation.

Subp. 31. **Required rehabilitation report.** "Required rehabilitation report" means the rehabilitation consultation report, the plan progress report, and any other report that must be submitted to the commissioner whenever a rehabilitation plan is initiated, proposed to be amended, suspended or closed, or when a change of assigned qualified rehabilitation consultant occurs on a case.

Subp. 32. **Retraining plan.** "Retraining plan" means an individualized written plan describing the formal course of study through which the goal of the rehabilitation plan may be accomplished. Adult basic education or remedial programs may be a component of a retraining plan but do not constitute retraining in and of themselves.

Subp. 33. **Review panel.** "Review panel" means the rehabilitation review panel created by Minnesota Statutes, section 176.102, subdivision 3.

Subp. 34. **Suitable gainful employment.** "Suitable gainful employment" means employment which is reasonably attainable and which offers an opportunity to restore the injured employee as soon as possible and as nearly as possible to employment which produces an economic status as close as possible to that which the employee would have enjoyed without disability. Consideration shall be given to the employee's former employment and the employee's qualifications, including, but not limited to, the employee's age, education, previous work history, interests, and skills.

Subp. 35. **Transferable skills analysis.** "Transferable skills analysis" means identifying and comparing skills learned in previous vocational or avocational activities with those required by occupations which are within the qualified employee's physical and mental capabilities.

Subp. 36. **Vocational evaluation.** "Vocational evaluation" means the comprehensive assessment of vocational aptitudes and potential, using information about a qualified employee's past history, medical and psychological status, and information from appropriate vocational testing, which may use paper and pencil instruments, work samples, simulated work stations, or assessment in a real work environment.

Subp. 37. **Vocational rehabilitation.** "Vocational rehabilitation" means the sequential delivery and coordination of services by rehabilitation providers under a rehabilitation plan to achieve the goal of suitable gainful employment.

Subp. 38. **Vocational testing.** "Vocational testing" means the measurement of vocational interests, aptitudes, and ability using standardized, professionally accepted psychometric procedures.

Subp. 39. **Work adjustment.** "Work adjustment" means the use of real or simulated work activity under close supervision at a rehabilitation facility or other work setting to develop appropriate work behaviors, attitudes, or personal characteristics.

Subp. 40. **Work hardening.** "Work hardening" means a physical conditioning program in a clinical setting designed to develop strength and tolerance for work or a schedule of graduated resumption of employment consistent with the employee's physical condition.

Statutory Authority: *MS s 176.102; 176.83*

History: *8 SR 1777; 9 SR 1478; 16 SR 2520; 17 SR 3361*

5220.0105 INCORPORATION BY REFERENCE.

The following documents are incorporated by reference only to the extent specifically referenced in parts 5220.0100 to 5220.1900. The documents in items A and B are not subject to frequent change, although new editions may occasionally be published. The documents in item C are revised annually. All documents are available through the Minitex interlibrary loan system.

A. The Dictionary of Occupational Titles, fourth edition, revised 1991, United States Department of Labor, is available for purchase through the Superintendent of Documents, United States Government Printing Office, Washington, DC 20402.

B. The Guide to Job Analysis, March 1982, is published by and available for purchase through the Materials Development Center, Stout Vocational Rehabilitation Institute, University of Wisconsin–Stout, Menomonie, WI 54751.

C. The Commission on Accreditation of Rehabilitation Facilities (CARF) Directory of Accredited Organizations Serving People With Disabilities and its Standards Manual for Organizations Serving People With Disabilities, 1992, are available for purchase at 101 North Wilmot Road, Suite 500, Tucson, Arizona 85711.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.0110 REHABILITATION REQUEST; DISABILITY STATUS REPORT.

Subpart 1. [Repealed, 17 SR 3361]

Subp. 2. [Repealed, 17 SR 3361]

Subp. 3. [Repealed, 17 SR 3361]

Subp. 4. [Repealed, 17 SR 3361]

Subp. 5. **Rehabilitation consultation request.** The rehabilitation consultation may be requested by the employee, employer, or commissioner. A disability status report is used by the insurer to report rehabilitation consultation referral status.

Subp. 6. **Employee request for consultation.** The employee may request a rehabilitation consultation by giving written notice to the insurer requesting a rehabilitation consultation. Notification of the request shall be filed with the commissioner.

Subp. 7. **Disability status report.** The insurer shall file a disability status report to notify the commissioner of a referral for rehabilitation or to request a waiver of rehabilitation services.

A. When an employee has not returned to work following a workplace injury, the insurer shall complete a disability status report, file it with the commissioner, and serve a copy on the employee:

(1) within 14 calendar days after it becomes known that the disability will extend beyond 13 weeks from the date of injury;

(2) within 90 days of the date of injury; or

(3) within 14 calendar days after receiving a request for rehabilitation consultation, whichever is earlier.

Another disability status report shall be filed by the insurer 180 days after the injury if no party has requested a rehabilitation consultation and the employee has not returned to work. A disability status report is also required following each request for rehabilitation consultation.

B. The disability status report shall contain the following:

(1) identifying information on the employee, employer, and insurer;

(2) information about the duration of disability and the likelihood that the disability will extend beyond 13 weeks;

(3) the current work status of the employee;

(4) an indication of whether the employer will return the employee to work;

(5) information about accommodations or services being provided to the employee to assist in the return to the preinjury employer;

(6) an indication of whether a rehabilitation consultation is occurring or a request for a waiver of consultation is being made;

(7) if rehabilitation consultation is indicated, the name of the qualified rehabilitation consultant who will conduct the rehabilitation consultation; and

(8) a current treating physician's work ability report must be attached to the form.

C. The employee may object to the insurer's recommendation by filing a rehabilitation request for assistance with the commissioner.

Subp. 8. **Commissioner's authority.** If a disability status report is not filed according to this part, the commissioner may order a rehabilitation consultation by a qualified rehabilitation consultant at the insurer's expense, according to Minnesota Statutes, section 176.102, subdivision 4, paragraphs (b) and (f).

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.0120 WAIVER OF CONSULTATION AND REHABILITATION SERVICES.

Subpart 1. **Purpose.** A rehabilitation waiver is used to defer the initiation of rehabilitation services including the consultation.

Subp. 2. **Criteria.** A rehabilitation waiver is granted when the employer documents that the otherwise qualified employee will return to suitable gainful employment with the date–of–injury employer within 180 days after the injury. The waiver shall not be effective more than 180 days following the injury unless a renewal is granted under subpart 4.

Subp. 3. **Procedure and documentation.** A request for a rehabilitation waiver shall be documented on the disability status report form provided for in part 5220.0110, subpart 7.

Subp. 4. **Renewal of waiver.** If a waiver is in effect but the employee does not return to work within 180 days after the injury, the insurer may request a renewal of the waiver by filing another disability status report. A copy of the request for renewal shall be served on the employee who may object to the renewal by filing a rehabilitation request as provided in part 5220.0950. The renewal of a waiver will be granted only upon additional documentation that convinces the commissioner that a consultation is not necessary because the otherwise qualified employee's return to suitable gainful employment with the date–of–injury employer is imminent.

Subp. 5. **Commissioner's order.** If 180 days have passed since the date of injury and the employee has not returned to work, no rehabilitation consultation has taken place, and no waiver of rehabilitation services has been granted, the commissioner shall order a rehabilitation consultation at the insurer's expense under Minnesota Statutes, section 176.102, subdivision 4, paragraph (f), to be provided by the vocational rehabilitation unit of the department.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.0130 REHABILITATION CONSULTATION.

Subpart 1. **Purpose.** A rehabilitation consultation is used to determine whether an employee is a qualified employee for rehabilitation services. An employee must be a qualified employee as defined in part 5220.0100, subpart 22, before a rehabilitation plan is implemented.

Subp. 2. **Criteria.** If the employer requests a rehabilitation consultation or receives a request for a rehabilitation consultation from the commissioner, the insurer shall arrange for a rehabilitation consultation by a qualified rehabilitation consultant to take place within 15 calendar days of the receipt of the request.

If the insurer receives a request for a rehabilitation consultation from an employee and does not request a waiver of rehabilitation services, the insurer shall arrange for a rehabilita-

tion consultation by a qualified rehabilitation consultant to take place within 15 days of the receipt of the rehabilitation consultation request.

If the insurer requests a waiver of rehabilitation services, and no waiver of rehabilitation services is granted under part 5220.0120, the insurer shall arrange for a rehabilitation consultation by a qualified rehabilitation consultant to take place within 15 days of the notification that the waiver request has not been granted.

The rehabilitation consultation shall be held at a location not more than 50 miles from the employee's residence.

Subp. 3. **Consultation.** The procedure and documentation for a rehabilitation consultation are contained in items A to E.

A. Preconsultation actions. A copy of the first report of injury, the disability status report, and the accompanying current treating physician's work ability report shall be sent by the insurer to the assigned qualified rehabilitation consultant prior to the rehabilitation consultation.

B. Actions. During the first in–person meeting with the employee for purposes of conducting a rehabilitation consultation, the assigned qualified rehabilitation consultant shall:

(1) meet with the employee and, including those items in part 5220.1803, subparts 1 and 1a, explain the employee's rights and responsibilities regarding rehabilitation, including the employee's right to choose a qualified rehabilitation consultant; and

(2) gather information which will permit a determination of the employee's eligibility for rehabilitation.

C. Contents of report. The rehabilitation consultation shall be documented by the assigned qualified rehabilitation consultant on a rehabilitation consultation report form prescribed by the commissioner containing substantially the following:

(1) identifying information of the employee, employer, insurer, and qualified rehabilitation consultant;

(2) the rehabilitation consultation date;

(3) an indication of the likelihood that the employee will return to the preinjury employer or preinjury occupation; and

(4) an assessment of whether or not the employee is a qualified employee for rehabilitation services.

D. Time for filing. A rehabilitation consultation report shall be completed by the assigned qualified rehabilitation consultant in all cases. The assigned qualified rehabilitation consultant shall file the rehabilitation consultation report within seven days of the first in–person meeting with the employee and concurrently mail a copy to the employer, the employee, and the insurer.

E. Employee's objection. The employee may object to the qualified rehabilitation consultant's assessment by filing a rehabilitation request for assistance with the commissioner.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.0200 [Repealed, 9 SR 1478]

5220.0210 [Repealed, 16 SR 2520]

5220.0300 [Repealed, 16 SR 2520]

5220.0400 [Repealed, 16 SR 2520]

5220.0410 REHABILITATION PLAN.

Subpart 1. **Purpose.** The purpose of the rehabilitation plan is to communicate to all interested parties the vocational goal, the rehabilitation services, and the projected amounts of time and money that will be needed to achieve the vocational goal.

Authoritative references for describing a vocational history and a vocational goal in the plan and for analyzing jobs are the Dictionary of Occupational Titles and the Guide to Job Analysis. These documents are incorporated by reference in part 5220.0105.

Subp. 2. **Requirements.** If a rehabilitation consultation results in a determination that an employee is a qualified employee for rehabilitation services, the assigned qualified rehabilitation consultant shall, in consultation with the parties, develop, record, and file a rehabilitation plan on the form prescribed by the commissioner containing substantially the following:

A. information identifying the employee, employer, insurer, and assigned qualified rehabilitation consultant;

B. the employee's occupation at time of injury; the Dictionary of Occupational Titles, which is incorporated by reference in part 5220.0105, code for that occupation; and the vocational goal of the rehabilitation plan;

C. itemization of the rehabilitation services to be provided including any vendor names, anticipated service completion dates, estimated service costs, and projected total plan cost and plan completion date;

D. the dated signatures of the employee, insurer, and assigned qualified rehabilitation consultant if the parties are in agreement with the plan;

E. employee comments, if any; and

F. instructions to the parties that if they disagree with the plan they have 15 days from their receipt of the proposed plan to resolve the disagreement or object to the proposed plan, and that an objection must be filed with the commissioner.

Subp. 3. **Process.** Upon preparation of the proposed plan, and within 30 days of the first in–person contact between the assigned qualified rehabilitation consultant and the employee, the assigned qualified rehabilitation consultant shall provide to all parties a copy of the proposed rehabilitation plan.

Subp. 4. **Party's response.** Upon receipt of the proposed rehabilitation plan, each party must, within 15 days, either:

A. sign the plan signifying agreement and return it to the assigned qualified rehabilitation consultant; or

B. promptly notify the assigned qualified rehabilitation consultant of any objection to the plan and work with the assigned qualified rehabilitation consultant to resolve the objection by agreement.

However, if the objection is not resolved, the objecting party must file a rehabilitation request for assistance with the commissioner within 15 days of receipt of the proposed plan. These disputes will be resolved according to part 5220.0950.

If no rehabilitation request for assistance objecting to the plan is filed within 15 days of the party's receipt, the plan approval process will occur as provided in subpart 6.

Subp. 5. **Filing the plan.** The assigned qualified rehabilitation consultant shall file the rehabilitation plan with the commissioner within 45 days of the first in–person contact between the qualified rehabilitation consultant and the employee or within 15 days of circulation to the parties, whichever is earlier.

Subp. 6. **Plan approval.** A rehabilitation plan that all parties have signed is deemed approved by the commissioner upon filing.

If a party fails to sign the plan or fails to file a rehabilitation request for assistance objecting to the proposed plan within the 15 days specified in subpart 4, item B, it shall be presumed that the party is in substantial agreement with the plan's vocational objective and the services that are proposed. In this event the assigned qualified rehabilitation consultant shall file the plan with the commissioner along with evidence of the date the plan was sent to each party and, upon receipt, the plan will be deemed approved. A party's failure to sign a plan shall not constitute a waiver of any right to subsequently dispute the plan or to dispute payment of rehabilitation fees relative to the plan.

In reviewing rehabilitation plans pursuant to Minnesota Statutes, section 176.102, subdivision 6, the commissioner shall notify all interested parties of the nature of any additional information necessary for the review, any recommended modifications to the plan, and any decision approving, modifying, or rejecting a plan.

If the commissioner refers issues relating to a plan to a compensation judge or an administrative conference pursuant to Minnesota Statutes, section 176.106, all parties shall be notified of that action and of all applicable related procedures.

Commencement of a plan without objection from the commissioner shall not constitute a waiver or an estoppel of the commissioner's or compensation judge's authority over the plan.

Subp. 7. **Communication with treating doctor.** Upon filing the rehabilitation plan with the commissioner, the assigned qualified rehabilitation consultant shall, within the limitations of part 5220.1802, subpart 5, send a copy of the employee's rehabilitation plan to the employee's treating doctor.

Subp. 8. **Adherence to plan.** The services provided by rehabilitation providers shall be according to the approved rehabilitation plan.

Subp. 9. **Administration of plan.** All rehabilitation services shall be provided to an employee pursuant to Minnesota Statutes, section 176.102, as stated in the rehabilitation plan and any subsequent amendments, and shall be administered exclusively by a person or business entity registered and approved by the commissioner as a qualified rehabilitation consultant or a qualified rehabilitation consultant firm.

The assigned qualified rehabilitation consultant shall monitor registered rehabilitation vendor compliance with the rehabilitation plan.

Job development and job placement services shall be provided either by rehabilitation providers registered by the commissioner or by a facility accredited by the National Commission on Accreditation of Rehabilitation Facilities (CARF), Tucson, Arizona. The CARF Directory of Accredited Organizations Serving People with Disabilities and its Standards Manual for Organizations Serving People with Disabilities are incorporated by reference in part 5220.0105. The insurer may select the vendor of job development or job placement services.

Subp. 10. **Disputes.** In the case of a dispute about a rehabilitation plan or any rehabilitation services provided, any party may file a rehabilitation request for assistance according to Minnesota Statutes, chapter 176, or part 5220.0950.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.0450 PLAN PROGRESS REPORT.

Subpart 1. **Purpose.** The purpose of a plan progress report is to inform parties of the current status of the rehabilitation plan and provide a current estimate of plan cost and duration to completion.

Subp. 2. **Requirements.** Three months after the assigned qualified rehabilitation consultant has filed an approved rehabilitation plan with the commissioner, three months thereafter, and every six months thereafter, the assigned qualified rehabilitation consultant shall complete a plan progress report on the form prescribed by the commissioner that contains the following:

A. information identifying the employee, employer, insurer, and assigned qualified rehabilitation consultant;

B. the employee's current medical status and work status;

C. the costs to date for rehabilitation services by all rehabilitation providers and the estimated costs to plan completion;

D. the duration of the rehabilitation plan to date and the estimated duration to plan completion; and

E. the identification of barriers to successful completion of the rehabilitation plan and measures to be taken to overcome those barriers.

Subp. 3. **Filing.** The assigned qualified rehabilitation consultant shall file the six–month plan progress report with the commissioner, and provide copies to the employee, employer, and insurer within 15 days after six months have passed from the date of the filing of the rehabilitation plan. The three–month plan progress report shall be sent to the insurer only. Subsequent plan progress reports are to be filed with the commissioner within 15 days after every six month anniversary of the plan filing, with copies sent to the employee, employer, and insurer.

Subp. 4. **Commissioner's actions.** Based on the information contained in the current plan progress report and in other reports available to the commissioner, the commissioner

may decide to initiate further activities if the review indicates that the plan is inadequate to carry out the objectives of rehabilitation under Minnesota Statutes, section 176.102, subdivision 1, paragraph (b). These activities may include, but are not limited to the following:

A. requesting additional information from the assigned qualified rehabilitation consultant, the qualified rehabilitation consultant firm, and the registered rehabilitation vendor;

B. conducting an on–site inspection during normal business hours of the assigned qualified rehabilitation consultant's records for documentation of service provision according to the rehabilitation plan; and

C. other actions pursuant to Minnesota Statutes, section 176.102, subdivision 6, paragraph (b), and parts 5220.1800 to 5220.1806.

Statutory Authority: *MS s 176.102; 176.83*

History: *17 SR 3361*

5220.0500 [Repealed, 16 SR 2520]

5220.0510 PLAN AMENDMENT AND CLOSURE.

Subpart 1. **Reasons for amendment.** Whenever circumstances indicate that the rehabilitation plan objectives are not likely to be achieved, proposals for plan amendment may be considered by the parties. A rehabilitation plan may be amended for good cause, including but not limited to:

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

B. the employee is not participating effectively in the implementation of the plan;

C. a need to change the vocational goal of the rehabilitation plan;

D. the projected rehabilitation cost or duration, as stated in the rehabilitation plan, will be exceeded; or

E. the employee feels ill–suited for the type of work for which rehabilitation is being provided.

Subp. 2. **Procedure and responsibilities.** The assigned qualified rehabilitation consultant may recommend a plan amendment when reasons for amendment are present. Parties other than the assigned qualified rehabilitation consultant may propose amendments. It is the responsibility of the assigned qualified rehabilitation consultant to facilitate discussion of proposed amendments.

Subp. 2a. **Process.** Upon preparation of the proposed plan amendment the assigned qualified rehabilitation consultant shall provide a copy to all parties.

Subp. 2b. **Party's response.** Upon receipt of the proposed rehabilitation plan amendment, each party must, within 15 days, either:

A. sign the plan amendment signifying agreement and return it to the assigned qualified rehabilitation consultant; or

B. promptly notify the assigned qualified rehabilitation consultant of any objection to the plan amendment and work with the assigned qualified rehabilitation consultant to resolve the objection by agreement.

However, if the objection is not resolved, the objecting party must file a rehabilitation request for assistance with the commissioner within 15 days of receipt of the proposed amendment.These disputes will be resolved according to part 5220.0950.

If no rehabilitation request for assistance objecting to the plan amendment is filed within 15 days of the party's receipt, the approval process will occur as provided in subpart 2d.

Subp. 2c. **Filing.** The assigned qualified rehabilitation consultant shall file the rehabilitation plan amendment with the commissioner within 15 days of circulation to the parties.

Subp. 2d. **Approval.** A rehabilitation plan amendment that all parties have signed is deemed approved by the commissioner upon filing.

If a party fails to sign the plan amendment or fails to file a rehabilitation request for assistance objecting to the proposed plan within the 15 days specified in subpart 2b, it shall be presumed that the party is in substantial agreement with the plan amendment's vocational

objective and the services that are proposed. In this event the assigned qualified rehabilitation consultant shall file the plan amendment with the commissioner along with evidence of the date the plan amendment was sent to each party and, upon receipt, the plan amendment will be deemed approved. A party's failure to sign a plan amendment shall not constitute a waiver of any right to subsequently dispute it or to dispute payment of rehabilitation fees relative to it.

Subp. 3. **Requirements.** The rehabilitation plan amendment shall be filed on the form prescribed by the commissioner. The prescribed form shall contain substantially the following:

A. identifying information on the employee, employer, insurer, and assigned qualified rehabilitation consultant;

B. the proposed amendment;

C. a rationale for the amendment;

D. if the amendment adds rehabilitation services, an itemization of each additional rehabilitation service to be provided including any registered rehabilitation vendor names, dates of initiation and completion, and estimated costs of each service;

E. if the amendment will result in a change in the projected plan completion date, the new completion date;

F. if the amendment will result in a change in the projected plan cost, the new estimated cost;

G. employee comments, if any; and

H. the dated signatures of the employee, insurer, and assigned qualified rehabilitation consultant.

Subp. 4. **Amendment by commissioner.** If a plan is modified for good cause pursuant to Minnesota Statutes, section 176.102, subdivision 8, or as a result of an administrative conference pursuant to Minnesota Statutes, section 176.106, the commissioner shall notify all interested parties of the modification and the reasons for the modification.

Subp. 5. **Request for closure before plan completion.** At any time, the insurer or employee may request the closure of rehabilitation services by filing a rehabilitation request for assistance with the commissioner. The commissioner or a compensation judge may close rehabilitation services for good cause, including, but not limited to:

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

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

C. the employee is not participating effectively in the implementation of the plan; or

D. the employee is not likely to benefit from further rehabilitation services.

Subp. 6. **Commissioner's authority to initiate closure.** If the commissioner initiates the termination of rehabilitation services pursuant to Minnesota Statutes, section 176.102, subdivision 6, or through an administrative conference pursuant to Minnesota Statutes, section 176.106, all interested parties shall be provided written notice of the proposed decision and an opportunity to be heard either in person or through the submission of written information.

Subp. 7. **Closure report by assigned qualified rehabilitation consultant.** When an employee's rehabilitation plan is completed and closure of rehabilitation services is not disputed, the assigned qualified rehabilitation consultant shall file a report on a form prescribed by the commissioner. When the reason for the closure is a return to work, the qualified rehabilitation consultant shall not complete and file the closure report until the employee has continued working for at least 30 calendar days following the return to work. The form reporting plan closure must be sent to the employee and the insurer when filed with the commissioner. The form shall contain substantially the following:

A. identifying information on the employee, employer, insurer, and assigned qualified rehabilitation consultant;

B. the outcome of the rehabilitation plan;

C. the employee's employment status:

(1) if the employee is working, information identifying the employer with whom the employee returned to work, the job title and job code from the Dictionary of Occupational Titles described in part 5220.0105, the return to work date, the weekly wage upon return to work, and whether the employee has continued working for 30 calendar days; or

(2) if the employee is not working, information explaining why the plan should be closed or whether additional rehabilitation services would be of benefit;

D. a summary of the rehabilitation services provided and rehabilitation costs by all rehabilitation providers; and

E. the assigned qualified rehabilitation consultant's dated signature.

Subp. 8. **Disputes.** In the case of a dispute about a plan amendment or closure, any party may file a rehabilitation request for assistance according to Minnesota Statutes, chapter 176, and part 5220.0950.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.0600 [Repealed, 16 SR 2520]

5220.0700 [Repealed, 16 SR 2520]

5220.0710 EMPLOYEE CHOICE OF QUALIFIED REHABILITATION CONSULTANT; CHANGE OF QUALIFIED REHABILITATION CONSULTANT.

Subpart 1. **Employee right to choose.** Pursuant to Minnesota Statutes, section 176.102, subdivision 4, the qualified employee has a right to choose a qualified rehabilitation consultant as defined in part 5220.0100, subpart 23, once during the period commencing before a referral by the insurer or commissioner to a qualified rehabilitation consultant, or before a first in-person visit between a qualified rehabilitation consultant and the employee and continuing until 60 days after filing of the rehabilitation plan. If the employee chooses a qualified rehabilitation consultant under this part, the employee shall notify the insurer in writing of the name, address, and telephone number of the qualified rehabilitation consultant chosen.

Subp. 2. **Documentation.** When a change of qualified rehabilitation consultant occurs, the new assigned qualified rehabilitation consultant shall promptly inform the commissioner of the change in assigned qualified rehabilitation consultant by filing the prescribed form with the commissioner. The prescribed form shall contain identifying information on the employee, employer, insurer, the new assigned qualified rehabilitation consultant, and the former assigned qualified rehabilitation consultant.

Subp. 3. **Dispute resolution.** After exhaustion of the employee's choices in subpart 1, any party may propose a change of assigned qualified rehabilitation consultant. The parties may at any time agree to a change and select a new qualified rehabilitation consultant. If a dispute about change or selection arises, and the parties are not able to resolve that dispute, the dispute shall be resolved by a determination of the commissioner or a compensation judge as provided in Minnesota Statutes, chapter 176, and part 5220.0950. If the employee's choice has not been exhausted, the determination shall be made according to the employee's choice. If the employee's choice has been exhausted, the determination shall be made according to the best interest of the parties. The best interest of the parties shall be determined based on the goals of rehabilitation as provided in Minnesota Statutes, section 176.102, subdivision 1, paragraph (b). If the commissioner or compensation judge determines the qualified rehabilitation consultant's work to be unsatisfactory or the qualified rehabilitation consultant withdraws from the case, and the parties are unable to agree on the selection of a qualified rehabilitation consultant, the commissioner or compensation judge shall assign a new qualified rehabilitation consultant.

Subp. 4. **Employee residing or moving out of Minnesota.** Qualified employees who reside outside of Minnesota or who move out of Minnesota may receive services from a rehabilitation professional qualified under that jurisdiction's workers' compensation law to provide rehabilitation services. This subpart does not require the assignment of another rehabilitation professional if the services can be reasonably furnished by a rehabilitation provider registered in Minnesota. When services are provided outside of Minnesota by a rehabilita-

tion professional qualified in that jurisdiction, an assigned qualified rehabilitation consultant in Minnesota shall monitor the provision of services.

Subp. 5. **Change of consultant not an exercise of choice by employee.** A change of assigned qualified rehabilitation consultant necessitated by circumstances outside the control of the employee is not a choice by the employee and does not exhaust the employee's right to choice. Such circumstances include, but are not limited to, the assigned qualified rehabilitation consultant leaving practice or the extended illness of the assigned qualified rehabilitation consultant. Disputes about changes shall be resolved according to subpart 3.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.0750 RETRAINING.

Subpart 1. **Purpose.** The purpose of retraining is to return the employee to suitable gainful employment through a formal course of study. Retraining is to be given equal consideration with other rehabilitation services, and proposed for approval if other considered services are not likely to lead to suitable gainful employment.

Subp. 2. **Plan submission.** A proposed retraining plan shall be filed on a form prescribed by the commissioner and must contain substantially the following:

A. identifying information on the employee, employer, insurer, and assigned qualified rehabilitation consultant;

B. the retraining goal;

C. information about the formal course of study required by the retraining plan, including:

(1) the name of the school;

(2) titles of classes;

(3) the course's length in weeks, listing beginning and ending dates of attendance;

(4) an itemized cost of tuition, books, and other necessary school charges;

(5) mileage costs; and

(6) other required costs;

D. starting and completion dates;

E. preinjury job title and economic status, including, but not limited to preinjury wage;

F. a narrative rationale describing the reasons why retraining is proposed, including a summary comparative analysis of other rehabilitation alternatives and information documenting the likelihood that the proposed retraining plan will result in the employee's return to suitable gainful employment;

G. dated signatures of the employee, insurer, and assigned qualified rehabilitation consultant signifying an agreement to the retraining plan; and

H. an attached copy of the published course syllabus, physical requirements of the work for which the retraining will prepare the employee, medical documentation that the proposed training and field of work is within the employee's physical restrictions, reports of all vocational testing or evaluation, and a recent labor market survey of the field for which the training is proposed.

Subp. 3. **Amendment.** The commissioner or a compensation judge may amend a retraining plan at the request of an employee if the employee believes that the occupation the employee is being trained for is not suitable, and if the employee's request is made within 90 days from the commencement date of the retraining. No more than one change shall be permitted for this reason. Other amendments may be requested by the parties according to part 5220.0510.

Subp. 4. [Repealed, 17 SR 3361]

Subp. 5. **Retraining plan approval.** When the retraining plan is submitted to the commissioner, the commissioner shall review the proposed retraining plan within 30 days of its submission and notify the parties of plan approval or denial. The commissioner may also re-

quest additional information from the parties, confer with the parties, recommend modifications and otherwise seek agreement about the plan. The commissioner may make a determination or pursue resolution of questions regarding the plan consistent with part 5220.0950, subpart 3.

Subp. 6. **Disputes.** In the case of a dispute about a retraining plan, any party may file a rehabilitation request for assistance according to Minnesota Statutes, chapter 176 or part 5220.0950.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.0800 [Repealed, 16 SR 2520]

5220.0850 ON-THE-JOB TRAINING.

Subpart 1. **Objective of on-the-job training.** The primary objective of on-the-job training as defined in part 5220.0100, subpart 21, is suitable gainful employment with the on-the-job training employer that is likely to restore the employee as close as possible to preinjury economic status. A proposed on-the-job training plan may be rejected by the commissioner or compensation judge if the plan is unlikely to achieve this primary objective. However, documentation that the training will increase employability with other employers may be a basis for approval.

Subp. 2. **Plan submission.** A proposed on-the-job training plan shall be filed on a form prescribed by the commissioner and must contain the following:

A. identifying information on the employee, employer, insurer, and assigned qualified rehabilitation consultant;

B. information identifying the on-the-job training employer;

C. the title of the job for which the employee is being trained and its Dictionary of Occupational Titles code number;

D. a job analysis of the training position;

E. information documenting that the training position is within the employee's physical restrictions;

F. a description of the skills the employee will acquire as a result of the training;

G. training commencement and completion dates;

H. the intervals at which the progress of the on-the-job training plan will be assessed;

I. information indicating whether the on-the-job training employer will provide employment to the employee upon completion of the training;

J. the employee's wage during and after training;

K. supplies and tools required by the plan and their cost;

L. weekly workers' compensation benefits to be paid by the insurer during the training;

M. dated signatures of the employee, insurer, assigned qualified rehabilitation consultant, on-the-job training employer, and training instructor signifying agreement with the plan; and

N. a narrative rationale describing the reasons why on-the-job training is proposed, including information that demonstrates that the on-the-job training will result in the employee's return to a job that produces, as close as possible, the preinjury economic status.

Subp. 3. **Duration of plan.** A plan for on-the-job training that will last longer than six months may be justified by information that a plan that exceeds six months is needed to master required skills, or that training that exceeds six months will significantly increase the likelihood that the employee will recover preinjury economic status.

Subp. 4. **On-the-job training plan approval.** When an on-the-job training plan is submitted to the commissioner, the commissioner shall review the proposed plan within 30 days of its submission and notify the parties of plan approval or rejection. The plan approval process shall be subject to the procedures under part 5220.0410, subpart 6. The commissioner may make a determination or pursue resolution of questions regarding the plan consistent with part 5220.0950, subpart 3.

Subp. 5. **Disputes.** In the case of a dispute about an on–the–job training plan, any party may request resolution according to Minnesota Statutes, chapter 176 and part 5220.0950.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.0900 [Repealed, 16 SR 2520]

5220.0950 DISPUTES.

Subpart 1. **Request for assistance.** Where issues exist about an employee's entitlement to rehabilitation services, the appropriateness of a proposed plan, or any other dispute about rehabilitation, a party may request assistance to resolve the disputed issues by filing a form prescribed by the commissioner. The form with all its attachments must be served on all parties and be filed with the commissioner. The form must contain the following:

A. identifying information on the employee, employer, insurer, and assigned qualified rehabilitation consultant;

B. a statement of the rehabilitation issues to be resolved;

C. a statement of what the requester wants and supporting evidence and arguments;

D. a list showing that all parties were served and the date they were served;

E. the requester's name and signature; and

F. instructions for completion of the form.

Subp. 2. **Action by commissioner.** If the commissioner refers a dispute to a compensation judge or, based on the written submission of the parties, determines the dispute or schedules an administrative conference to determine the dispute, all parties shall be served with written notice of that action.

The commissioner may require the parties to meet and confer informally prior to a scheduled administrative conference if the facts and issues involved show that a meeting would facilitate resolution of the dispute.

When the commissioner or compensation judge makes a determination on the issues in dispute, copies shall be served on the parties. No determination will be made by the commissioner under Minnesota Statutes, section 176.106, with respect to rehabilitation entitlement if primary liability has been denied.

Subp. 3. **Commissioner's initiation of dispute resolution.** If the commissioner independently determines that issues exist regarding an employee's entitlement to rehabilitation or the appropriateness of a proposed plan, or otherwise initiates proceedings before a compensation judge or through an administrative conference, written notice of the issues in dispute shall be served upon the parties.

Subp. 4. **Formal hearing.** A party that disagrees with a decision of the commissioner under Minnesota Statutes, section 176.106, may request a formal hearing pursuant to part 5220.1010. The request for hearing will be referred to the Office of Administrative Hearings pursuant to Minnesota Statutes, section 176.106, subdivision 7.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520*

5220.1000 [Repealed, 16 SR 2520]

5220.1010 REQUEST FOR A FORMAL HEARING.

Any party who disagrees with a decision of the commissioner about rehabilitation under Minnesota Statutes, section 176.106 and part 5220.0950 may request a new, formal hearing by filing a form prescribed by the commissioner within 30 days of the service and filing of the commissioner's decision. The request must state what issues continue to be in dispute and must be received by the commissioner within 30 days of service and filing of the commissioner's decision. A copy of the request for hearing shall be served on all parties at the time of filing.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520*

5220.1100 LEGAL REPRESENTATION.

When an employee or insurer is represented by an attorney and if a notice of representation has not already been filed, the attorney shall notify the commissioner as provided in part 1415.0800. The attorney will receive notices as provided in part 1415.0700. The value of rehabilitation services shall not be used in the calculation of attorney's fees. The legal fees shall be calculated in the manner provided by law. An attorney who has so advised the commissioner will be notified of any proceedings, and will receive rehabilitation reports as provided by part 5220.1802, subpart 3.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.1200 REHABILITATION SERVICES, SETTLEMENT AGREEMENTS.

Rehabilitation services pursuant to an approved rehabilitation plan are mandatory for qualified employees. However, if a good faith dispute exists regarding entitlement to rehabilitation services, that dispute may be converted into cash by settlement agreement between the parties pursuant to Minnesota Statutes, section 176.521. Any settlement agreement purporting to compromise all rehabilitation services must be approved by the commissioner, a compensation judge, or the workers' compensation court of appeals.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520*

5220.1250 ROLES OF REGISTERED REHABILITATION PROVIDERS.

An entity may be approved to provide rehabilitation services either as a registered rehabilitation vendor or as a qualified rehabilitation consultant firm. An individual may be approved to provide rehabilitation services as a qualified rehabilitation consultant intern or, in cases of completion of internship and registration renewal, as a qualified rehabilitation consultant.

A qualified rehabilitation consultant and a qualified rehabilitation consultant intern are approved for the purpose of developing, administering, and implementing a rehabilitation plan, including the provision of rehabilitation services, in accordance with Minnesota Statutes, chapter 176 and the rules adopted to administer it.

A qualified rehabilitation consultant firm is approved for the purpose of employing qualified rehabilitation consultants, qualified rehabilitation consultant interns, and other professional staff as provided in part 5220.1600.

A registered rehabilitation vendor is approved for the purpose of providing the workers' compensation rehabilitation services of job development and job placement under an approved rehabilitation plan.

The roles of vendor and consultant are distinct and, therefore, a registered rehabilitation vendor or its employee may not be, or function as, a qualified rehabilitation consultant firm, a qualified rehabilitation consultant, or a qualified rehabilitation consultant intern. Nor may a qualified rehabilitation consultant firm, qualified rehabilitation consultant, or qualified rehabilitation consultant intern be or function as a registered rehabilitation vendor or as the agent of a vendor.

The distinction of roles between registered rehabilitation vendor and qualified rehabilitation consultant means the following: A registered rehabilitation vendor and its employees may provide job development and job placement services under an approved rehabilitation plan for any qualified employee; a qualified rehabilitation consultant firm and its employees may provide job development and job placement services only in cases for which a qualified rehabilitation consultant or qualified rehabilitation consultant intern employed by that firm is the assigned qualified rehabilitation consultant.

There shall be no ownership or financial relationships of any kind between any registered rehabilitation vendor and qualified rehabilitation consultant firm, qualified rehabilitation consultant, or qualified rehabilitation consultant intern.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.1300 [Repealed, 16 SR 2520]

5220.1400 QUALIFYING CRITERIA FOR REHABILITATION CONSULTANT.

Subpart 1. **Requirement.** To become registered as a qualified rehabilitation consultant, the certification, education, and internship requirements of subparts 2 to 5 must be met.

Subp. 2. **Certification and education.** A qualified rehabilitation consultant shall possess at least one of the following credentials:

A. a baccalaureate degree, together with certification by the Board of Rehabilitation Certification as a certified rehabilitation counselor or a certified insurance rehabilitation specialist;

B. a baccalaureate degree together with certification by the Association of Rehabilitation Nurses as a certified rehabilitation registered nurse; or

C. a baccalaureate degree together with certification by the American Occupational Therapy Certification Board as a registered occupational therapist. Certification by the American Occupational Therapy Certification Board shall have been held for five years prior to application.

Persons who were qualified rehabilitation consultants on June 15, 1987, must have obtained the certification described in item A or B by June 15, 1989. If a qualified rehabilitation consultant lacks two years or more of the experience required to meet the certifying body's minimum experience or internship requirement, the time for becoming certified shall equal the time remaining for completion of the certifying body's minimum experience or internship requirement. If a qualified rehabilitation consultant must also obtain a baccalaureate degree to meet the certifying body's minimum education requirements, the qualified rehabilitation consultant shall have an additional four years to become certified. If an examination is required for certification, the time allowed for certification under this part must include two scheduled examinations which the applicant is eligible to take.

Subp. 3. **Qualified rehabilitation consultant intern.** The purpose of internship is to provide a supportive, structured period of professional supervision and case review following registration. An individual who meets the requirements of subpart 2, item A, B, or C, may be registered as a qualified rehabilitation consultant intern. If an individual meets the requirements of subpart 2, item A or B, except for obtaining certification, that individual may be registered as a qualified rehabilitation consultant intern by documenting how the certification will be obtained within three years from the date of registration. A qualified rehabilitation consultant intern must complete an introductory training session sponsored by the department within six months of approval of registration. A qualified rehabilitation consultant intern shall not be a solo practitioner.

The failure to comply with the standards of performance and professional conduct contained in parts 5220.1800 and 5220.1801 or the violation of any of the provisions of Minnesota Statutes, chapter 176, parts 5220.0100 to 5220.1900, or orders issued under the statutes or rules constitute grounds for denial of registration as a qualified rehabilitation consultant or qualified rehabilitation consultant intern under Minnesota Statutes, section 176.102, subdivision 3, discipline under Minnesota Statutes, section 176.102, subdivision 3a, or delay of completion of internship. The intern may appeal the decision of the commissioner denying registration as provided in part 5220.1500, subpart 2.

In cases where an intern has been supervised by a qualified rehabilitation consultant who leaves the organization with which the intern has been employed and no other qualified rehabilitation consultant is available to supervise the intern, the intern may, with the prior written approval of the commissioner, sign all required documents in the capacity of a qualified rehabilitation consultant for a period of time deemed appropriate by the commissioner. Past performance and overall experience shall be taken into consideration for this approval.

Subp. 3a. **Commissioner's approval for supervised internship.** When the intern is registered, the intern's employer shall provide the commissioner with the name of the qualified rehabilitation consultant under whose direct supervision the intern will work, and shall submit a plan of supervision addressing the following items: the evaluation methods used; frequency of supervisory reviews and communication; procedures for dealing with administrative conferences or hearings and file reviews; procedures for review of the rules of practice; and procedures for review of progress toward obtaining certification, including the date

the intern will be eligible to take the certification examination. "Direct supervision" means that the supervisor is directly responsible for the rehabilitation work on any case, and for monitoring progress toward the certification required by subpart 2. The intern supervisor need not maintain an office at the same location as the intern. The supervisor shall cosign all written work being done by the intern. There shall be no billing by the supervisor for these supervisory duties. The supervisor shall attend all administrative conferences with the intern and shall arrange for training as required by the commissioner. The intern shall be designated as an "intern" on all documents bearing the name of the intern.

Subp. 4. **Completion of internship.** The burden of proof of experience shall be on the applicant. The intern must work at least one year full time as an intern in the rehabilitation of injured workers under Minnesota Statutes, section 176.102. Evidence of experience shall include documentation of a history of employment in a position of vocational rehabilitation. For purposes of this subpart, "full–time employment" is consistent with the employment experience requirement of the certifying body chosen by the qualified rehabilitation consultant intern. Where there is no definition of full–time employment by the certifying body chosen by the qualified rehabilitation consultant intern, full–time employment means a minimum of 37 hours per week during a 52–week period. Any part–time employment will be prorated based on this definition. The intern may make application for completion of internship when the minimum requirements in subparts 2 to 5 have been met.

The commissioner's action on the intern's application for completion of internship shall be based in part on the report of the qualified rehabilitation consultant intern supervisor about the competence of the intern to practice independently. The commissioner shall also consider information about the intern's professional competence including that obtained in the course of any investigation about professional conduct, and on any substantiated complaints regarding professional conduct. "Substantiated complaints" for purposes of denial of completion of internship means there has been a stipulation or order of discipline.

Subp. 5. **General criteria.** All persons who are qualified rehabilitation consultants shall be self–employed or employed by a single organization that is approved for the employment of qualified rehabilitation consultants as a qualified rehabilitation consultant firm or an employer or insurer. Qualified rehabilitation consultants must be available to clients, and for administrative conferences or hearings during normal business hours. A qualified rehabilitation consultant employed by an employer or insurer that is not registered as a qualified rehabilitation consultant firm is permitted to provide rehabilitation consultation and services only for the claims being handled by the entity by whom the consultant is employed. A qualified rehabilitation consultant shall notify the department immediately upon changing employment. Notification shall include the name of the former place of employment, the name, address, and telephone number of the new place of employment and the effective date of new employment.

Effective January 1, 1995, both registration and renewal of registration shall require current membership in a professional rehabilitation organization which provides in its constitution or bylaws for a process of review by peers of its members' professional conduct and services.

Registration shall require Minnesota residency. The commissioner may grant an exception for persons who reside no more than 100 miles by road from the Minnesota border. Any such qualified rehabilitation consultant agrees, as an additional condition of registration, to appear at any administrative conference or hearing when requested, in the same manner as if subpoenaed. A qualified rehabilitation consultant shall notify the department immediately upon any change in residency to or from Minnesota.

Statutory Authority: *MS s 176.102; 176.83*

History: *8 SR 1777; 9 SR 1478; 10 SR 17; 11 SR 2237; 16 SR 2520; 17 SR 3361*

5220.1500 PROCEDURE FOR REGISTRATION AS QUALIFIED REHABILITATION CONSULTANT.

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

A. completed, signed, and notarized application form;

B. copy of any pertinent license or certification;

C. documentation supporting any applicable experience requirements;

D. official transcripts of all pertinent postsecondary education;

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

F. the annual registration application fee of $100; and

G. a plan of supervision as required by part 5220.1400, subpart 3a.

Qualified rehabilitation consultant applicants employed by the vocational rehabilitation unit of the Department of Labor and Industry are exempt from payment under this subpart.

Subp. 1a. **Approval of registration as qualified rehabilitation consultant intern.** Where the requirements for registration are met, the commissioner shall issue a letter to the applicant so indicating within 60 days of receiving the completed application. After registration has been approved, the registration application fee is not refundable. If the requirements for qualified rehabilitation consultant intern are not met, the commissioner shall issue a decision and order denying registration to the applicant within 60 days of receipt of the completed application. If the application for registration is not approved, one–half of the registration application fee may be refunded.

Subp. 2. **Appeal process.** The appeal process provides a mechanism for applicants to request reconsideration of a decision and order denying registration or renewal of registration.

A written notice of appeal shall be filed with the commissioner within 30 days of filing and service of the order. If the appeal is for denial of renewal of registration, the filing will stay the effect of the denial until final disposition.

The appeal shall be referred to the rehabilitation review panel according to Minnesota Statutes, section 176.102, subdivision 3.

Subp. 3. **Registration number and renewal.** The commissioner shall assign a registration number to each registered rehabilitation provider.

Registration must be renewed annually. A rehabilitation provider shall request renewal on a form prescribed by the commissioner. Application for renewal is due 60 days before expiration of registration, accompanied by the appropriate registration fee. Registration renewal applications that are not complete, are not accompanied by the registration renewal fee, or are not accompanied by documentation of certification or satisfactory documentation of continuing education will be returned to the applicant for completion. Completed registration renewal applications received later than the due date shall be assessed a $25 late fee. Registration renewal applications received more than 30 days after the due date shall be assessed an additional $10 per day late fee for each day after the request is 30 days late. No late fee in excess of $125 may be assessed.

Qualified rehabilitation consultant's employed by the vocational rehabilitation unit of the Department of Labor and Industry are exempt from payment under this subpart.

Failure to meet the standards of performance and professional conduct contained in parts 5220.1800 and 5220.1801, or the violation of any provisions of Minnesota Statutes, chapter 176, parts 5220.0100 to 5220.1900, or orders issued under the statutes or rules, constitute grounds for denial of registration renewal as a qualified rehabilitation consultant or qualified rehabilitation consultant intern under Minnesota Statutes, section 176.102, subdivision 3, discipline under Minnesota Statutes, section 176.102, subdivision 3a, or delay of completion of internship. The decision of the commissioner may be appealed as provided in subpart 2.

Service and fee schedules shall be filed with the commissioner whenever there is a change and no less than once each calendar year at the time of renewal of registration. This filing shall not constitute an approval or disapproval of the services and fees.

Subp. 3a. **Continuing education.** To retain registration, a qualified rehabilitation consultant or qualified rehabilitation consultant intern shall submit satisfactory documentation of current certification required by part 5220.1400, subpart 2. A qualified rehabilitation con-

sultant or qualified rehabilitation consultant intern who is not yet certified shall submit satisfactory documentation of continuing education pertinent to the workers' compensation rehabilitation field equivalent to 20 contact hours each year at the time registration is renewed. Continuing education includes, but is not limited to, the following:

A. postsecondary course work in rehabilitation related fields, including vocational rehabilitation, medical rehabilitation, psychology of disability, and occupational safety;

B. publicly or privately sponsored training in rehabilitation related fields, including vocational rehabilitation, medical rehabilitation, psychology of disability, and occupational safety;

C. continuing legal education courses about workers' compensation law; and

D. rehabilitation related training sponsored and approved by the commissioner.

Satisfactory documentation shall include legible certificates of attendance bearing the name of the participant that are signed and dated by the sponsoring institution or organization. Receipts for tuition are not acceptable as satisfactory documentation of attendance. Continuing education units must be obtained in the 12–month period immediately preceding the date on which registration renewal forms are due.

The department of labor and industry's rehabilitation provider update sessions when held are mandatory for all rehabilitation providers.

Nonattendance at the mandatory orientation or update sessions is prohibited conduct for rehabilitation providers, but may be allowed only for emergency situations and must be reported to the commissioner.

Subp. 4. **Inactive status.** If an interval of one year occurs without providing direct case service to workers' compensation recipients or without providing supervision to qualified rehabilitation consultants or qualified rehabilitation consultant interns who provide direct case service to workers' compensation recipients, the registration will not be renewed upon expiration. A qualified rehabilitation consultant or qualified rehabilitation consultant intern may apply for reinstatement of registration by providing verification to the commissioner of current certification as required by part 5220.1400, continued attendance at all annual update sessions, and fulfillment of continuing education requirements as provided by subpart 3a. The applicant must complete an orientation training session before acceptance is final. An order regarding renewal of registration may be appealed to the rehabilitation review panel according to Minnesota Statutes, section 176.102, subdivision 3.

Subp. 5. **Monitoring.** The commissioner shall review the professional activities and services of rehabilitation providers to determine if they are reasonable and comply with the standards of performance and professional conduct contained in parts 5220.1800 and 5220.1801, the provisions of Minnesota Statutes, chapter 176, parts 5220.0100 to 5220.1900, and orders issued under the statutes or rules.

Subp. 6. **Revocation.** The revocation process shall be conducted as provided in Minnesota Statutes, section 176.102, subdivision 3a.

Statutory Authority: *MS s 16A.128; 176.102; 176.83*

History: *8 SR 1777; 9 SR 1478; 11 SR 2237; 14 SR 375; 16 SR 2520; 17 SR 3361*

5220.1600 PROCEDURE FOR APPROVAL AS QUALIFIED REHABILITATION CONSULTANT FIRM.

Subpart 1. **Criteria.** The qualified rehabilitation consultant firm shall be licensed to do business in Minnesota and shall maintain an administrative office within the state. Each office of the qualified rehabilitation consultant firm that provides services to injured employees under Minnesota Statutes, chapter 176, shall be listed on the application described in subpart 2 and shall employ on the premises at least one qualified rehabilitation consultant or qualified rehabilitation consultant intern.

The management staff shall consist of at least one employee who is registered as a qualified rehabilitation consultant.

At least 60 percent of qualified rehabilitation consultant firm employees providing rehabilitation services to qualified employees shall be qualified rehabilitation consultants or qualified rehabilitation consultant interns.

Any firm employing four or fewer full–time qualified rehabilitation consultants or qualified rehabilitation consultant interns may employ up to two employees who are not qualified rehabilitation consultants or qualified rehabilitation interns who may, under the direct supervision of the assigned qualified rehabilitation consultant or qualified rehabilitation consultant intern, provide the services of job analysis, job seeking skills training, job development, and job placement. However, as restricted by part 5220.1250, employees who are not qualified rehabilitation consultants or qualified rehabilitation consultant interns may provide these prescribed services only in cases for which a qualified rehabilitation consultant or qualified rehabilitation consultant intern employed by the same firm is the assigned qualified rehabilitation consultant. Any branch office openings or closings shall be reported to the department within two weeks of the occurrence. Any change of staff who provide direct services to injured workers under a rehabilitation plan or of staff who directly supervise those persons shall be reported to the department within two weeks of the change.

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

A. a completed, signed, and notarized application;

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

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

D. the annual registration application fee of $200 per firm.

The vocational rehabilitation unit of the Department of Labor and Industry is exempt from payment under this subpart.

Subp. 2a. **Approval of registration as a qualified rehabilitation consultant firm.** The approval process shall be conducted the same as provided in part 5220.1500, subpart 1a.

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

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

Subp. 5. **Revocation.** The revocation process shall be conducted as provided in Minnesota Statutes, section 176.102, subdivision 3a.

Statutory Authority: *MS s 16A.128; 176.102; 176.83*

History: *9 SR 1478; 11 SR 2237; 14 SR 375; 16 SR 2520; 17 SR 3361*

5220.1700 PROCEDURE FOR APPROVAL AS REGISTERED REHABILITATION VENDOR.

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

A. A completed, signed, and notarized application.

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

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

D. The annual registration application fee of $200 for each registered rehabilitation vendor.

Subp. 1a. **Approval as registered rehabilitation vendor.** The approval process shall be conducted the same as provided in part 5220.1500, subpart 1a.

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

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

Subp. 4. **Revocation.** The revocation process herein shall be conducted as provided in Minnesota Statutes, section 176.102, subdivision 3a.

Subp. 5. **Restriction.** Registered rehabilitation vendors shall not employ or otherwise engage the services of qualified rehabilitation consultants.

Statutory Authority: *MS s 16A.128; 176.102; 176.83*

History: *8 SR 1777; 14 SR 375; 16 SR 2520*

5220.1800 STANDARDS OF PERFORMANCE.

Monitoring and supervision of rehabilitation providers by the commissioner shall include an assessment of rehabilitation provider professional competence and effectiveness of rehabilitation services based upon substantial noncompliance with prevailing norms of the profession to be established by rule from data collected by the department regarding duration of service, cost of service, and case outcomes.

In addition, the standards of conduct described in parts 5220.1801 to 5220.1806 which establish minimum standards concerning the professional activities and services of rehabilitation providers shall be taken into account.

The administration of rehabilitation provider discipline under Minnesota Statutes, section 176.102, subdivision 3a, will also be based upon the standards in parts 5220.1801 to 5220.1806, as well as on adherence to Minnesota Statutes, chapter 176, rules adopted to administer it, and orders of the commissioner or a compensation judge.

Statutory Authority: *MS s 176.102; 176.83*

History: *8 SR 1777; 16 SR 2520; 17 SR 3361*

5220.1801 PROFESSIONAL CONDUCT.

Subpart 1. **Prompt provision of service and assessment of progress.** The assigned qualified rehabilitation consultant and any registered rehabilitation vendor providing services under a plan shall provide prompt and necessary rehabilitation services to assist a qualified employee to return to suitable gainful employment. The qualified rehabilitation consultant shall periodically assess progress toward plan objectives.

Subp. 2. **Assigned qualified rehabilitation consultant.** Only the assigned qualified rehabilitation consultant, or a qualified rehabilitation consultant designated by the assigned qualified rehabilitation consultant to function in an advisory capacity to the assigned consultant, shall be involved at any given time in the employee's rehabilitation plan, except as stated in subparts 5 and 7. The assigned qualified rehabilitation consultant shall advise the insurer before involving or requesting advisory services from any other qualified rehabilitation consultant. No qualified rehabilitation consultant or qualified rehabilitation consultant firm shall provide rehabilitation services to a case that has an assigned qualified rehabilitation consultant employed by another qualified rehabilitation consultant firm. This subpart shall not apply to a qualified rehabilitation consultant acting on behalf of the reinsurance association in a monitoring or advisory capacity on a reinsurance claim file.

Subp. 3. [Repealed, 16 SR 2520]

Subp. 4. [Repealed, 16 SR 2520]

Subp. 4a. **Objectivity.** Good faith disputes may arise among parties about rehabilitation services or about the direction of a rehabilitation plan. A rehabilitation provider shall remain professionally objective in conduct and in recommendations on all cases.

Subp. 5. **Evaluation of employee by other than assigned qualified rehabilitation consultant.** Except as provided in subpart 7, where retraining has been recommended, or in Minnesota Statutes, section 176.102, subdivision 13 as ordered, a rehabilitation provider is prohibited from performing an independent evaluation of an employee at any time unless litigation pursuant to part 1415.0100, is pending. If that litigation is pending, a qualified rehabilitation consultant who is not the assigned qualified rehabilitation consultant may perform an evaluation of the employee at the request of one of the parties solely for the purpose of the proceeding.

Subp. 6. [Repealed, 17 SR 3361]

Subp. 7. **Referrals.** An assigned qualified rehabilitation consultant may make recommendations for referrals to appropriate resources.

Subp. 8. **Separate roles and functions.** The roles and functions of a claims agent and a rehabilitation provider are separate. A qualified rehabilitation consultant, qualified rehabi-

litation consultant intern, registered rehabilitation vendor, or an agent of a rehabilitation provider, shall engage only in those activities designated in Minnesota Statutes, section 176.102, and rules adopted thereunder. A qualified rehabilitation consultant, qualified rehabilitation consultant intern, or registered rehabilitation vendor shall not act as an advocate for or advise any party about a claims or entitlement issue. Qualified rehabilitation consultants, qualified rehabilitation consultant interns, and registered rehabilitation vendors shall not engage in claims adjustment, claims investigation, or related activities. Activities unrelated to rehabilitation services include, but are not limited to, making recommendations about the determination of workers' compensation monetary benefits, the reasonableness of medical charges, or arranging for an independent medical examination and are prohibited. This part shall not prohibit a qualified rehabilitation consultant acting on behalf of the reinsurance association from consulting with the assigned qualified rehabilitation consultant regarding the rehabilitation plan.

Subp. 9. **Prohibited conduct.** The conditions and restrictions of practice as a rehabilitation provider are contained in parts 5220.0100 to 5220.1900 and Minnesota Statutes, section 176.102. The following conduct is specifically prohibited and is also grounds for discipline:

A. Reporting or filing false or misleading information or a statement in connection with a rehabilitation case or in procuring registration or renewal of registration as a rehabilitation provider, whether for oneself or for another.

B. Conviction of a felony or a gross misdemeanor reasonably related to the provision of rehabilitation services.

C. Conviction of crimes against persons. For purposes of this chapter, a crime against a person means a violation of any of the following sections: Minnesota Statutes, section 609.185, 609.19, 609.195, 609.20, 609.205, 609.21, 609.215, 609.221, 609.222, 609.223, 609.224, 609.23, 609.231, 609.235, 609.24, 609.245, 609.25, 609.255, 609.265, 609.26, 609.342, 609.343, 609.344, 609.345, 609.365, 609.498, 609.50, 609.561, 609.562, or 609.595.

D. Restriction, limitation, or other disciplinary action against the rehabilitation provider's certification, registration, or right to practice as a rehabilitation provider in another jurisdiction for offenses that would be subject to disciplinary action in this state, or failure to report to the department the charges which have been brought in another state or jurisdiction against the rehabilitation provider's certification, registration, or right to practice.

E. Failure or inability to perform professional rehabilitation services with reasonable skill because of negligence, habits, or other cause, including the failure of a qualified rehabilitation consultant to monitor a vendor or qualified rehabilitation consultant intern, or the failure of a rehabilitation provider to adequately monitor the performance of services provided by a person working at the rehabilitation provider's direction.

F. Engaging in conduct likely to deceive, defraud, or harm the public or demonstrating a willful or careless disregard for the health, welfare, or safety of a rehabilitation client.

G. Engaging in conduct with a client that is sexual or may be reasonably interpreted by the client as sexual or in any verbal behavior that is seductive or sexually demeaning to a client or engaging in sexual exploitation of a client or a former client.

H. Obtaining money, property, or services other than reasonable fees for services provided to the client through the use of undue influence, harassment, duress, deception, or fraud.

I. Engaging in fraudulent billing practice.

J. Knowingly aiding, assisting, advising, or allowing an unqualified person to engage in providing rehabilitation services.

K. Engaging in adversarial communication or activity. Adversarial communication includes, but is not limited to:

(1) requesting or reporting information not directly related to an employee's rehabilitation plan;

(2) deliberate failure or delay to report to all parties pertinent information regarding an employee's rehabilitation;

(3) misrepresentation of any fact or information about rehabilitation; or

(4) failure to comply with an authorized request for information about an employee's rehabilitation.

L. Providing an opinion on settlement and recommending entering into a settlement agreement.

M. Making a recommendation about retirement; however, a rehabilitation provider may assist an employee in contacting resources about a choice of retirement or return to work.

N. Failure to take due care to ensure that a rehabilitation client is placed in a job that is within the client's physical restrictions.

O. Failure to maintain service activity on a case without advising the parties of the reason why service activity might be stopped or reduced.

P. Failure to recommend plan amendment, closure, or another alternative when it may be reasonably known that the plan's objective is not likely to be achieved.

Q. Unlawful discrimination against any person on the basis of age, gender, religion, race, disability, nationality, or sexual preference, or the imposition on a rehabilitation client of any stereotypes of behavior related to these categories.

Subp. 10. **Professional competence.** Rehabilitation providers shall limit themselves to the performance of only those services for which they have the education, experience, and qualifications.

Rehabilitation providers shall accurately represent their level of skill and competency to the department, the public, and colleagues.

Rehabilitation providers shall not administer or interpret tests without proper training, experience, or credentials. Administration of tests must be supervised by a person who is so trained, experienced, or credentialed.

A rehabilitation provider shall understand the areas of competence of other professional persons with whom the rehabilitation client establishes relationships, and act with due regard for the needs, privileged nature, special competencies, and obligations of colleagues and other professionals and not disparage their qualifications.

Subp. 11. **Impaired objectivity.** A rehabilitation provider shall not use alcoholic beverages, medication, or controlled substances in a manner that impairs the provider's ability to perform the rehabilitation services.

Rehabilitation providers shall not use a professional relationship to further personal, religious, political, or financial interests, although adherence to ethical norms shall not be construed as personal or religious interest.

A rehabilitation provider must not undertake or continue a professional relationship in which the objectivity of the provider is or would be impaired due to a familial, social, emotional, economic, supervisory, or political interpersonal relationship.

The rehabilitation provider shall disclose any potential conflicts of interest to the parties to the case and their attorneys.

Adjudication of a rehabilitation provider as mentally incompetent, mentally ill, chemically dependent, or dangerous to the public by a court in any state is grounds for suspension or revocation of registration.

Statutory Authority: *MS s 176.102; 176.83*

History: *8 SR 1777; 9 SR 1478; 16 SR 2520; 17 SR 3361*

5220.1802 COMMUNICATIONS.

Subpart 1. **Legibility and content of required reports.** All required rehabilitation reports and required progress records prepared by a rehabilitation provider shall be legible and show the employee's name, department file number, and date of injury.

Subp. 2. **Submission of reports.** All required rehabilitation reports shall be submitted on department forms prescribed by the commissioner.

Subp. 3. **Copies of reports and records.** The assigned qualified rehabilitation consultant shall file all required rehabilitation reports with the commissioner, and provide copies to all parties and their attorneys as the reports are created by the consultant. The qualified rehabilitation consultant shall also provide a copy of required progress records to any party and

their attorney upon that party's request. The qualified rehabilitation consultant may not charge for the initial copy or photocopy of required rehabilitation reports or required progress records. If additional copies are requested by any party, the qualified rehabilitation consultant is entitled to reasonable compensation for cost from the requesting party. A dispute about cost is not a basis for a provider to withhold required reports or records when requested.

The requesting party shall pay for reasonable costs incurred by a rehabilitation provider in creating a report not required by rule or requested by the commissioner or compensation judge.

Subp. 4. **Registered rehabilitation vendor reporting.** At least each 30 days, the registered rehabilitation vendor shall submit all required progress records, required rehabilitation reports and cost information on an employee's case directly to the assigned qualified rehabilitation consultant.

Subp. 4a. **Transfer of information.** Whenever there is a change of assigned qualified rehabilitation consultants or consultant firms, the former qualified rehabilitation consultant firm shall cooperate in transferring to the new assigned qualified rehabilitation consultant or qualified rehabilitation consultant firm all data, required rehabilitation reports, required progress records, and incurred rehabilitation cost information along with other relevant information within 15 days from the receipt of notice that a new consultant is assigned under part 5220.0710 and Minnesota Statutes, section 176.102. The former qualified rehabilitation consultant firm may not charge a party for the transfer of information to the new assigned qualified rehabilitation consultant or qualified consultant firm.

Subp. 5. **Data privacy.** A rehabilitation provider must comply with Minnesota Statutes, chapters 175 and 176, the rules adopted under those chapters, Code of Federal Regulations, title 42, part 2, Minnesota Statutes, sections 129A.05; 144.335; 144.651; 147.091; 181.954; 181.960; 268A.05; 363.03, subdivision 1a; and 595.02, as applicable, and all other applicable data privacy laws.

A rehabilitation provider shall not engage in communications with health care providers about an employee without the written consent of the employee.

A rehabilitation provider shall safeguard and maintain under conditions of security all information obtained in the course of providing rehabilitation consultation and services and shall limit records access to those parties for whom access is prescribed by Minnesota Statutes, section 176.102, subdivision 7, this chapter, or other applicable law.

When permitted by data privacy laws, disclosure of information obtained in the course of providing rehabilitation services is restricted to what is necessary, verified, and relevant to implementation of the rehabilitation plan.

A rehabilitation provider shall request only the information and data that will assist the parties in developing and carrying out the rehabilitation plan.

Subp. 6. [Repealed, 16 SR 2520]

Subp. 7. [Repealed, 16 SR 2520]

Subp. 8. [Repealed, 16 SR 2520]

Subp. 9. [Repealed, 16 SR 2520]

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

Subp. 11. **Access to medical and rehabilitation reports.** The assigned qualified rehabilitation consultant shall furnish other rehabilitation providers designated by the rehabilitation plan with copies of all appropriate medical and rehabilitation reports necessary for effective service provision by the other providers.

Statutory Authority: *MS s 176.102; 176.83*

History: *8 SR 1777; 9 SR 1478; 16 SR 2520; 17 SR 3361*

5220.1803 RESPONSIBILITIES.

Subpart 1. **Instruction by qualified rehabilitation consultant.** The assigned qualified rehabilitation consultant shall, at the first in-person contact, instruct employees of their rights and responsibilities relating to rehabilitation and of the purpose of rehabilitation services. The assigned qualified rehabilitation consultant shall sign and date the prescribed rehabilitation rights and responsibilities form at the first in-person contact with the employee, and provide the employee, insurer, and commissioner with a copy.

Subp. 1a. **Disclosure of information.** The disclosures required by Minnesota Statutes, section 176.102, subdivision 4, must be made at the first meeting or written communication with an employee. For purposes of the disclosures, the following terms shall have the meanings given them.

A. "Ownership interest" includes, but is not limited to, any partnership or holding, subsidiary, or corporate relationship as well as ordinary ownership interest.

B. "Business referral" means any referral arrangement, whether documented or not.

Subp. 2. **Knowledge of laws and rules.** A rehabilitation provider shall be knowledgeable and informed regarding portions of the workers' compensation law and rules that directly relate to the provision of rehabilitation services. Communication of inaccurate information regarding workers' compensation is grounds for discipline.

Subp. 3. [Repealed, 16 SR 2520]

Subp. 4. [Repealed, 16 SR 2520]

Subp. 5. **Reporting requirements.** The assigned qualified rehabilitation consultant shall file with the commissioner, by attaching to all rehabilitation plans, an initial evaluation narrative report about the employee that includes the following information in summary fashion: medical status, vocational history, educational history, social history, relevant economic factors, transferable skills, employment barriers, and recommendations. The qualified rehabilitation consultant shall file additional progress summaries, if requested by the commissioner.

The assigned qualified rehabilitation consultant shall periodically report progress and case activity in writing to the parties at reasonable intervals or as requested by the parties.

The rehabilitation provider registration number assigned by the commissioner shall be on all reports submitted by the rehabilitation provider.

The assigned qualified rehabilitation consultant shall maintain individual employee files containing required rehabilitation reports and required progress records about an employee's case and shall provide copies to the commissioner, a compensation judge, or the parties at their request or as required by rule. For the purpose of Minnesota Statutes, chapter 176, and parts 5220.0100 to 5220.1900, individual employee files containing all required rehabilitation reports and required progress records must be maintained by the qualified rehabilitation consultant firm for five years after the date of file closure. This requirement is in addition to and does not otherwise change or alter any other data retention time period required by law.

The assigned qualified rehabilitation consultant must provide the commissioner with any other requested pertinent information about a qualified employee's rehabilitation for purposes of rehabilitation monitoring by the department.

Statutory Authority: *MS s 176.102; 176.83*

History: *8 SR 1777; 16 SR 2520; 17 SR 3361*

5220.1804 [Repealed, 11 SR 2237]

5220.1805 BUSINESS PRACTICES.

All rehabilitation providers shall abide by the following rules concerning a provider's business practices:

A. Rehabilitation providers shall adhere to all federal, state, and local laws.

B. Rehabilitation providers shall not misrepresent themselves, their duties, or credentials. Rehabilitation providers must not promise or offer services or results they cannot deliver or have reason to believe they cannot provide. Advertising must be factually accurate and must avoid exaggerating claims as to costs, results, and endorsements by other parties.

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

D. A rehabilitation provider shall not request or authorize a rehabilitation client to solicit other business on behalf of the rehabilitation provider.

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

Rehabilitation providers shall fully disclose to a payer the basis for computing and prorating a fee so that the payer may determine the reasonableness of the fee charged. When more than one employee is served during the same time period, the rehabilitation provider shall prorate the fee.

F. Any fee arrangement which prevents or compromises individualized assessment and services for each employee is grounds for discipline. This may include any fee arrangement which provides employees with standardized services whether or not the services are necessary.

G. A rehabilitation provider shall not incur profit, split fees, or have an ownership interest with another rehabilitation provider outside of the firm that employs the provider.

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

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

Statutory Authority: *MS s 176.102; 176.83*

History: *8 SR 1777; 9 SR 1478; 16 SR 2520; 17 SR 3361*

5220.1806 DISCIPLINARY ACTION.

Subpart 1. **Discipline.** A rehabilitation provider is subject to disciplinary action, including a fine as provided by statute, suspension, and revocation of registration. Failure to comply with the standards of performance and professional conduct contained in parts 5220.1800 and 5220.1801 or the violation of any of the provisions of Minnesota Statutes, chapter 176, parts 5220.0100 to 5220.1900, or orders issued under the statutes or rules constitute grounds for discipline.

Subp. 2. **Complaints.** The commissioner shall review the activities of rehabilitation providers. Complaints about activities or services of rehabilitation providers relating to noncompliance with laws, rules, or orders shall be made in writing to the commissioner. A complaint may be submitted by any party who becomes aware of a violation, including designees of the commissioner, administrative law judges, and presiding officials at judicial proceedings.

If a rehabilitation provider fails to comply with the standards of performance and professional conduct contained in parts 5220.1800 and 5220.1801 or any of the provisions of Minnesota Statutes, chapter 176, parts 5220.0100 to 5220.1900, or orders issued under the statutes or rules, a rehabilitation provider having knowledge of the violation must so advise the commissioner.

Subp. 3. **Review and investigation.** The commissioner shall investigate all complaints to determine whether there has been a violation of the standards of performance and professional conduct contained in parts 5220.1800 and 5220.1801 or any of the provisions of Minnesota Statutes, chapter 176, parts 5220.0100 to 5220.1900, or orders issued under the statutes or rules. If the matter is outside the jurisdiction of the commissioner, the commissioner may refer the matter to a forum or agency that has jurisdiction.

If an investigation indicates that discipline is warranted, the commissioner shall begin a contested case for disciplinary action under Minnesota Statutes, section 176.102, subdivision 3a, and the Minnesota Administrative Procedure Act. The report of the administrative law judge shall be made to the rehabilitation review panel which shall make the determination on disciplinary action.

If the commissioner determines that discipline is not warranted, but if the facts and issues involved warrant instruction of the provider, the commissioner shall issue the instruction in writing. The commissioner shall notify the complaining party of the disposition of the case.

Subp. 4. **Cooperation with disciplinary proceedings.** A rehabilitation provider who is the subject of a complaint investigated by the commissioner under Minnesota Statutes, section 176.102, subdivisions 3 and 3a, shall cooperate fully with the investigation. Cooperation shall include responding fully and promptly to any questions raised by the commissioner relating to the subject of the investigation, and providing copies of records, reports, logs, data, and cost information as requested by the commissioner to assist in the investigation. Cooperation shall also include attending, in person, a meeting scheduled by the commissioner for the purposes in subpart 5.

Subp. 5. **In–person meeting.** When conferring with the parties to a complaint is deemed appropriate for clarification or settlement of issues, the commissioner may schedule a meeting. The commissioner may conduct a meeting for the purpose of obtaining information, instructing parties to the complaint, or for the purpose of resolving issues.

Subp. 6. **Resolution written agreement.** The commissioner may enter into stipulated consent agreements regarding discipline with complaint subjects in lieu of initiating contested case proceedings.

Statutory Authority: *MS s 176.102; 176.83*

History: *16 SR 2520; 17 SR 3361*

5220.1900 REHABILITATION SERVICE FEES AND COSTS.

Subpart 1. **Monitoring.** The insurer has the primary responsibility for monitoring and paying the cost of necessary rehabilitation services provided.

The commissioner shall monitor rehabilitation services and costs and shall also conduct periodic audits of costs, services, case outcomes, and compliance with reporting and record keeping requirements. The insurer and the rehabilitation provider shall furnish the commissioner with itemized listings of case services and costs upon request.

Subp. 1a. **Billing.** All rehabilitation provider billings shall be on the vocational rehabilitation invoice prescribed by the commissioner containing substantially the following:

A. identifying information on the insurer, rehabilitation providers, employee and employer, including the insurer file number;

B. information about the cost and duration of the rehabilitation plan, including the date the plan was filed and cost–to–date amounts billed by the qualified rehabilitation consultant firm, job placement vendor, and previous qualified rehabilitation consultant firms and job placement vendors;

C. a listing of the services billed, including date of service, service description, service category code, time units, mileage, and expenses. Service category codes are available from the department upon request; and

D. a summary of the charges billed, including a total of the professional services provided, the professional hourly rate, a total of the nonprofessional services provided, the nonprofessional hourly rate, the number of miles driven, the mileage rate, and the total expenses.

Sample vocational rehabilitation invoice forms are available from the department upon request. Billing information on job placement costs shall be provided to the qualified rehabilitation consultant who shall report those costs on a monthly basis on the vocational rehabilitation invoice. The job placement vendor shall bill the insurer directly.

Subp. 1b. **Fees.** Fees for rehabilitation services for the period from June 28, 1993 to September 30, 1993, shall not be increased beyond the level of the hourly rates on file with the commissioner as of July 15, 1992. Fees may be increased annually beginning October 1, 1993, but any annual increase is limited by the annual adjustment under Minnesota Statutes, section 176.645.

Subp. 1c. **Consultants.** When billing on an hourly basis for the services of qualified rehabilitation consultants, a qualified rehabilitation consultant or qualified rehabilitation consultant firm shall bill at an hourly rate not to exceed $65 per hour as adjusted under sub-

part 1b. A rehabilitation provider shall bill one–half of the hourly rate for travel and wait time. Travel time shall be prorated as outlined in part 5220.1805, item E.

Subp. 1d. **Interns.** When billing on an hourly basis, the upper billing limit for qualified rehabilitation consultant interns shall be $10 per hour less than the hourly rate charged for services provided by qualified rehabilitation consultants employed by that qualified rehabilitation consultant firm.

Subp. 1e. **Job development and placement services.** Whether provided by registered rehabilitation vendors or qualified rehabilitation consultant firms, job development and job placement services, when billed on an hourly basis, shall be billed at an hourly rate not to exceed $50 per hour as adjusted under subpart 1b.

Subp. 1f. **Fee reduction.** Billing for services by the qualified rehabilitation consultant or qualified rehabilitation consultant intern based upon an hourly rate shall be reduced by $10 per hour when:

A. the duration of the rehabilitation case exceeds 39 weeks from the date of the first in–person visit between an assigned qualified rehabilitation consultant and the employee; or

B. the costs of rehabilitation services billed by the qualified rehabilitation consultant have exceeded $3,500, whichever comes first. Payment exceeding that permitted by this rule is prohibited.

Subp. 1g. **Payment.** As soon as reasonably possible, and no later than 30 calendar days after receiving the rehabilitation provider's bill for rehabilitation services, the employer or insurer shall pay the charge or any portion of the charge that is not denied, deny all or a part of the charge stating the specific service charge and the reason it is excessive or unreasonable, or specify the additional data needed, with written notification to the rehabilitation provider.

Subp. 2. **Reasonable and necessary services.** A rehabilitation provider shall bill for only those necessary and reasonable services which are rendered in accordance with Minnesota Statutes, section 176.102 and the rules adopted to administer that section. A dispute about reasonable and necessary services and costs shall be determined by the commissioner or a compensation judge. The commissioner's or a compensation judge's review must include all the following factors:

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

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

C. an evaluation of whether services provided were unnecessary, duplicated other services, were available at no charge to public, or were excessive relative to the actual needs of the employee; and

D. an evaluation of whether services rendered were expressly called for by the employee's rehabilitation plan.

Subp. 3. [Repealed, 16 SR 2520]

Subp. 4. [Repealed, 16 SR 2520]

Subp. 5. [Repealed, 16 SR 2520]

Subp. 6. [Repealed, 16 SR 2520]

Subp. 6a. **Billing limits on qualified rehabilitation consultant services.** When a rehabilitation provider other than a qualified rehabilitation consultant is providing and billing for job development or job placement services pursuant to an approved rehabilitation plan, the qualified rehabilitation consultant shall limit the qualified rehabilitation consultant's billing to no more than two hours in any 30–calendar–day period. Billing beyond this limit will require specific approval of the parties or a determination by the department or a compensation judge.

Subp. 6b. **Plans; exceptions.** The qualified rehabilitation consultant shall bill no more than eight hours for a rehabilitation consultation as described in Minnesota Statutes, section 176.102, subdivision 4, and part 5220.0100, subpart 26, and the development, preparation, and filing of a rehabilitation plan as described in Minnesota Statutes, section 176.102, subdivision 4, and part 5220.0410. If conditions exist that necessitate traveling over 50 miles to visit the employee, employer, or health care provider, or an unusually difficult medical situa-

tion is documentable, billing beyond this limit is allowed upon the express consent of the parties or a determination by the department or compensation judge.

Subp. 7. **Case activities requiring insurer consent for payment.** The rehabilitation provider must obtain the consent of the insurer before billing for the following case activities, however, the presence or absence of consent shall not preclude the commissioner or a compensation judge from determining the reasonable value or necessity of these case activities:

A. when not directed by the plan, phone calls, or visits to health care providers and accompanying employee to appointments or examinations;

B. follow–up activity with employers during job placement services to verify employee applications or applications not arranged by the rehabilitation provider;

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

D. unanswered attempted phone calls;

E. time spent for report writing not required by rules or requested by a party;

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

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

H. before a determination of eligibility, services rendered when a rehabilitation waiver has been requested and was not denied or when the insurer disputes the employee's eligibility for rehabilitation services;

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

J. time spent by a supervisor, another qualified rehabilitation consultant, or support staff in addition to the assigned qualified rehabilitation consultant;

K. job placement activities beyond 90 days from the start of the job placement effort without a formal plan review or case planning meeting with the employee and insurer;

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

M. services that duplicate services already provided;

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

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

P. services after a request to suspend or terminate the rehabilitation plan has been filed.

Subp. 8. **Disputes.** In the event of a dispute about the reasonableness and necessity or cost of a rehabilitation service, the insurer or a rehabilitation provider may make a request for a determination by the commissioner or a compensation judge of reasonable costs and necessity of services. Such a request may be made by filing a request for assistance according to Minnesota Statutes, chapter 176 or part 5220.0950.

Subp. 9. **Collection prohibited.** No rehabilitation provider shall attempt to collect a fee or reimbursement for an unnecessary or unreasonable service from any party, including the employee, another insurer, the special compensation fund, or any government program. This prohibition shall apply to any fee determined excessive in amount by the commissioner or a compensation judge.

Statutory Authority: *MS s 176.102; 176.83*

History: *8 SR 1777; 9 SR 1478; 16 SR 2520; 17 SR 3361*

5220.1910 [Repealed, 17 SR 3361]

5220.2500 [Repealed, 11 SR 1530]

WORKERS' COMPENSATION RULES OF PRACTICE

5220.2510 SCOPE AND PURPOSE.

Parts 5220.2510 to 5220.2950 together with parts 5220.0100 to 5220.1900 govern all workers' compensation matters before the commissioner of the Department of Labor and Industry except matters which are governed by the joint rules of practice of the Workers' Compensation Division and the Office of Administrative Hearings in parts 1415.0100 to 1415.3600.

Statutory Authority: *MS s 175.17; 176.102; 176.83*

History: *11 SR 1530; 17 SR 3361*

5220.2520 DEFINITIONS.

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

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

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

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

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

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

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

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

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

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

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

History: *11 SR 1530*

5220.2530 FIRST REPORT OF INJURY.

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

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

B. claim numbers or codes;

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

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

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

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

G. information regarding lost time from work;

H. information identifying the treating physician;

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

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

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

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

History: *11 SR 1530*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *11 SR 1530*

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) claim numbers or codes;

(3) the date of the injury;

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

(5) monitoring period information;

(6) instructions to the employee;

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

(8) information regarding previous permanent partial disability payments;

(9) copies of medical reports containing disability ratings;

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

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

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

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

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

History: *11 SR 1530*

5220.2560 ATTACHMENT AND GARNISHMENT OF BENEFITS.

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

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

History: *11 SR 1530*

5220.2570 DENIALS OF LIABILITY.

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

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

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

B. the date of the claimed injury;

C. claim numbers or codes;

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

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

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

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

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

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

B. the date of the claimed injury;

C. claim numbers or codes;

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

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

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

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

B. the date of the claimed injury;

C. claim numbers or codes;

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

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

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

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

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

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

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

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

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

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

History: *11 SR 1530*

5220.2580 CLAIM FOR REFUND FROM EMPLOYEE OR DEPENDENT.

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

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

A. amount of alleged overpayment;

B. what the original payment was made for;

C. the date on which the payment was made;

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

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

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

History: *11 SR 1530*

5220.2590 MEDICAL REPORTS.

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

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

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

B. the state file number;

C. dates of treatment or examination;

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

E. the findings, including test results;

F. a preliminary diagnosis and code number;

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

H. information regarding the need for rehabilitation services;

I. predictions regarding possible permanent disability;

J. information regarding any related preexisting condition;

K. the need for further medical care;

L. information on hospitalizations and surgery, if any;

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

N. any additional remarks or information;

O. certification of the report; and

P. the physician's signature and identification information.

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

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

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

B. the state file number;

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

D. the diagnostic conclusion and code number;

E. information regarding the permanent partial disability rating;

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

G. information regarding any preexisting conditions;

H. information regarding surgery;

I. information regarding further medical treatment;

J. any additional remarks or information;

K. the certification of the report; and

L. the physician's signature and identification information.

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

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

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

History: *11 SR 1530*

5220.2600 [Repealed, 11 SR 1530]

5220.2610 ADMINISTRATIVE CONFERENCES.

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

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

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

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

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

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

History: *11 SR 1530*

5220.2620 MEDICAL CONFERENCES.

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

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

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

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

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

D. the reasonableness and necessity of treatment;

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

F. a request for change of physician;

G. the employee's cooperation with medical treatment;

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

I. the reasonableness and necessity of nursing services;

J. the appropriateness of a medical service;

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

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

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

N. other problems related to medical treatment and supplies.

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

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

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

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

have been resolved, any remaining medical issues shall be scheduled for an administrative conference in accordance with this part.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *11 SR 1530*

5220.2630 DISCONTINUANCE OF COMPENSATION.

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

Subp. 2. **Petition.**

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

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

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

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

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

A. The employer or insurer may discontinue the benefit indicated by the filing of a notice of discontinuance with the division and service of the notice on the other parties at the time that the payment or return–to–work occurs when the discontinuance results from:

(1) a return to work;

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

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

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

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

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

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

(2) the date of the injury or disease;

(3) claim numbers or codes;

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

(5) the effective date of the discontinuance;

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

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

(8) information regarding attorney fees;

(9) information regarding permanent partial disability ratings received;

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

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

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

(13) copies of relevant medical reports; and

(14) copies of any other relevant documents.

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

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

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

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

A. To discontinue temporary total, temporary partial, or permanent total benefits in situations not specified in subpart 3, the employer or insurer must serve upon the employee and file with the division a notice of intention to discontinue benefits or a petition under subpart 2. The notice must be accompanied by a form prescribed by the commissioner with which to request an administrative conference on the proposed discontinuance which contains the employer's name, the date of the injury or disease, and the name, social security number, and address of the employee.

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

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

(2) the date of the injury or disease;

(3) claim numbers or codes;

(4) the type of benefits being discontinued;

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

(6) the effective date of the discontinuance;

(7) information regarding benefits previously paid;

(8) information regarding attorney fees;

(9) information regarding permanent partial disability ratings;

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

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

(12) instructions to the employee;

(13) copies of relevant medical reports; and

(14) copies of any other relevant documents.

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

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

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

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

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

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

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

History: *11 SR 1530*

5220.2640 DISCONTINUANCE CONFERENCES.

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

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

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

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

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

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

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

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

Subp. 4. **Scheduling.** Subject to subpart 5, a discontinuance conference must be set within the time limits set by this subpart. Following a notice of intention to discontinue benefits, the division shall schedule an administrative conference no later than ten calendar days after the division's receipt of a timely request for a conference. If no notice of intention to discontinue benefits was filed as required by part 5220.2630 and the employee requests a conference, the division shall schedule a conference no later than ten calendar days after the division's receipt of the employee's request if the conference request is received within 40 days from the date the employee's last benefit payment was received. If no notice of intention to discontinue benefits has been filed where an employer or insurer requests a conference, the division shall schedule an administrative conference to be held no later than 30 days after receipt of the request.

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

A. Good cause does not include:

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

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

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

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

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

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

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

Subp. 9. **Penalties.** Penalties may be imposed for an improper discontinuance of compensation under Minnesota Statutes, section 176.242, subdivision 10, and part 5220.2720 and for unreasonable or inexcusable delay or other grounds under Minnesota Statutes, section 176.225, subdivisions 1 and 5, and parts 5220.2760 and 5220.2790.

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

History: *11 SR 1530*

5220.2650 RETURN TO WORK CONFERENCES.

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

Subp. 2. **Scope.** This part applies when an employee has received temporary total or temporary partial compensation for a total of at least 45 work days whether continuously or intermittently; and no rehabilitation plan in effect at the time the 14–day check is due has been approved under part 5220.0410, subpart 6. In addition, a return to work conference is also available when properly requested by the employee under subpart 4 and Minnesota Statutes, section 176.2421 because of an inability to work at least 14 work days upon the employee's return to work.

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

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

B. the date of injury or disease;

C. claim numbers or codes;

D. the date on which the employee was contacted;

E. information regarding employment status on the contact date;

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

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

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

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

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

K. instructions to the employee.

Subp. 4. **Request.** The employee may request an administrative conference to discuss the action taken by the insurer upon the employee's return to work. The employee must request a conference no later than ten calendar days from the date the insurer's notice to the commissioner regarding employment status and wages was received by the division. Alternatively, the employee may request a conference no later than ten calendar days from the day

the employee ceased working if the employee ceased working within the first 14 working days following the employee's return to work due to medical reasons associated with the injury. However, if a notice of discontinuance was not filed when the employee returned to work, the employee may request an administrative conference under Minnesota Statutes, section 176.2421 within 40 days after the employee returned to work. Allowance will be made, if appropriate, for nonreceipt or delay under Minnesota Statutes, section 176.285. The employee's request for a conference must be personally delivered, mailed, or telephoned to the division within the ten–, 40–, or 64–day period described in this subpart. The request is presumed mailed on the date indicated by the United States postmark. A request which does not include a legible Unites States postmark is presumed timely requested if received by the division no later than three days following the ten–, 40–, or 64–day request period. The request must include the employee's name, address, and social security number; the date of injury or disease; the employer's name and address, and the insurer's claim number, if known. If a notice regarding employment and wages was required under subpart 3, but has not been filed, the employee may request a return to work conference within 64 days of the employee's return to work but if the notice is later filed no later than ten days after the notice is served and filed by the insurer.

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

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

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

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

Statutory Authority: *MS s 175.17 cl (2); 176.102; 176.83*

History: *11 SR 1530; 16 SR 2520*

5220.2660 REHABILITATION CONFERENCES.

Subpart 1. **Governing rules.** Administrative conferences under Minnesota Statutes, section 176.102, are governed by parts 5220.0100 to 5220.1900, 5220.2610, and this part.

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

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

Subp. 4. **Decision.** A written decision must be issued and must include a statement indicating the right to appeal the decision to obtain a new hearing before the Rehabilitation Review Panel and instructions regarding how to initiate the appeal.

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

Statutory Authority: *MS s 175.17; 176.102; 176.83*

History: *11 SR 1530; 17 SR 3361*

5220.2670 MEDIATION.

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

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

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

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

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

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

History: *11 SR 1530*

5220.2680 SECOND INJURY LAW.

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

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

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

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

Subp. 5. **Notice of intention to claim reimbursement.** Notice of intention to claim reimbursement under Minnesota Statutes, section 176.131, subdivision 6, must be on forms

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

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

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

History: *11 SR 1530*

5220.2690 SUBROGATION INTEREST IN THIRD–PARTY RECOVERY.

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

A. name of the employee;

B. employee's social security number;

C. name of employer;

D. date of injury;

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

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

Subp. 2. **Stipulated agreement**. Where all of the parties have reached agreement with respect to the subrogation interest, a stipulated agreement concerning that interest may be submitted as provided in Minnesota Statutes, section 176.521.

Subp. 3. **Determination of subrogation interest.** The insurer or employee must comply with the procedures in this part in submitting a petition to the workers' compensation division for an order determining subrogation interest and credit.

A. The petition must be on the form prescribed by the commissioner and contain substantially the following:

(1) information identifying both the district court action if any and the workers' compensation claim involved;

(2) the total proceeds of the third–party settlement or award;

(3) the amount of legal fees and costs of the third–party claim;

(4) the subrogation interest of the employer itemized by type of benefits paid such as but not limited to:

(a) temporary total disability;

(b) temporary partial disability;

(c) permanent total disability;

(d) permanent partial disability;

(e) medical expenses where Minnesota Statutes, section 176.061, subdivision 7, claim was not made; and

(f) other;

(5) the name, address, and telephone number of the attorney for each party if any.

B. The petitioner shall serve a copy of the petition and attachments on all parties to both the third–party action and the workers' compensation proceeding. Notice to the special

compensation fund shall be given where a subrogation interest based on payments made pursuant to Minnesota Statutes, section 176.183 or potential interest under Minnesota Statutes, section 176.131 is known.

C. The original petition, together with a copy of the district court order or stipulation for settlement and corresponding order for dismissal or other documentary evidence reflecting the nature and extent of the resolution in district court must be filed with the division with proof of service as required in item B.

D. Upon receipt of the petition, the division will issue an order containing the following:

(1) information identifying both the district court action if any and the workers' compensation claim involved;

(2) the information upon which the subrogation order is based;

(3) the calculation of the subrogation interest, including the future credit amount and the sum payable to the employee; and

(4) an explanation of the effect of the credit upon future benefit entitlement.

The order will be served on all parties and will contain notice of the parties' right to appeal the order within 30 days of its service.

E. If an appeal of the order is not received by the division within 30 days, the order will become the final order.

Subp. 4. **Appeal of order.** A party may appeal the order by filing a written appeal with the division and serving it on all parties within 30 days of the service of the order. The appeal must contain a detailed statement explaining the factual or legal basis for the appeal and include any documentation supporting the appeal.

Upon receipt of a timely appeal, the matter will be referred to a settlement judge for a settlement conference to resolve the issues by agreement.

If agreement is not reached at the settlement conference but the parties agree to a stipulated set of facts, the settlement judge will rule on the subrogation interest under Minnesota Statutes, section 176.322. The determination is appealable as provided in Minnesota Statutes, section 176.322.

If agreement is not reached at the settlement conference and facts remain in dispute, the matter will be certified to the office for hearing.

Statutory Authority: *MS s 175.17 cl (2); 176.129 subd 10; 176.83 subds 1,15*

History: *11 SR 1530; 13 SR 2686*

5220.2700 [Repealed, 11 SR 1530]

5220.2710 ASSESSMENT OF PENALTIES.

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

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

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

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

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

E. the amount of the penalty; and

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

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

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

History: *11 SR 1530*

5220.2720 IMPROPER DISCONTINUANCES; PENALTY.

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

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

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

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

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

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

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

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

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

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

(4) In addition to the penalties assessed under subitems (2) and (3), if these actions are not taken within 30 days after service of the warning notice, a penalty of an additional $200 will be imposed.

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

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

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

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

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

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

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

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

History: *11 SR 1530*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *11 SR 1530*

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

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

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

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

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

A. the amount of the bill;

B. the record of payments by this payer;

C. the timeliness and adequacy of information requests made;

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

E. the complexity of the medical issues; and

F. apportionment or other complicating legal factors.

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

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

History: *11 SR 1530*

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

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

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

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

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

History: *11 SR 1530*

5220.2760 ADDITIONAL AWARD AS PENALTY.

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

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

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

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

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

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

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

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

History: *11 SR 1530*

5220.2770 FAILURE TO PAY OR DENY; PENALTY.

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

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

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

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

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

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

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

(4) amount:

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

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

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

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

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

(1) the length of the delay;

(2) the amount of the claim;

(3) efforts made to comply;

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

(5) the complexity of the issues involved.

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

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

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

History: *11 SR 1530*

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

Subpart 1. **Basis.** Where payment of compensation is not made within 14 days following an order as required by Minnesota Statutes, section 176.221, subdivisions 6a and 8, the division may assess the penalties provided in Minnesota Statutes, section 176.221, subdivisions 3 and 3a. Where rehabilitation services are not provided as required by Minnesota Statutes, sections 176.102, 176.221, subdivision 6a, and part 5220.0410, subpart 2, the division may assess the penalty provided in Minnesota Statutes, section 176.221, subdivision 3a.

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

Subp. 3. **Payable to.** The penalty is payable to the assigned risk safety account.

Statutory Authority: *MS s 175.17; 176.102; 176.83*

History: *11 SR 1530; 16 SR 2520; 17 SR 3361*

5220.2790 INEXCUSABLE DELAY IN MAKING PAYMENT, INCREASE IN PAYMENT.

Subpart 1. **Basis.**

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

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

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

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

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

Subp. 4. **Assessment.**

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

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

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

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

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

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

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

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

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

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

History: *11 SR 1530*

5220.2800 [Repealed, 11 SR 1530]

5220.2810 FAILURE TO RELEASE MEDICAL DATA; PENALTY.

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

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

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

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

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

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

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

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

Subp. 3. **Amount.**

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

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

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

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

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

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

History: *11 SR 1530*

5220.2820 FAILURE TO MAKE TIMELY REPORT OF INJURY; PENALTY.

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

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

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

Subp. 2. **Amount.** If the employer has violated subpart 1 and has had no similar violations in the 12–month period prior to the assessment, an advisory letter informing the employer of the violation and the statutory requirement must be sent. If the employer has had one violation of subpart 1 in the past 12 months, a penalty of $50 must be assessed. If the employer has had two violations in the past 12 months, a penalty of $100 must be assessed. If the employer has had three violations in the past 12 months, a penalty of $150 must be assessed. If the employer has had four or more violations in the past 12 months, a penalty of $200 must be assessed.

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

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

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

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

History: *11 SR 1530*

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

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

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

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

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

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

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

History: *11 SR 1530*

5220.2840 FAILURE TO MAKE PAYMENT TO SPECIAL FUND; PENALTY.

Subpart 1. **Due date.** For workers' compensation benefits paid from January 1 through June 30, the due date of the completed assessment form and corresponding assessment amount is August 15 of the same calendar year.

For workers' compensation benefits paid from July 1 through December 31, the due date of the corresponding assessment amount is March 1 of the following calendar year.

Notice of the assessment rate and instructions for payment will be issued by the fund 45 or more days before the due date.

Subp. 2. **Basis.** A penalty will be assessed under Minnesota Statutes, section 176.129, subdivision 10, where either:

A. the completed assessment form and payment of the special compensation fund assessment; or

B. written certification that the assessment report and assessment payment will not be made by the due date because of reasons beyond the control of the insurer, is not received by the special compensation fund on or before the due date.

Subp. 3. **Amount.** Within 30 days of the due date, the special compensation fund will give notice of penalty to those who have neither filed the completed assessment form and paid the assessment amount, nor submitted a certified reason for nonpayment by the due date as follows:

A. Either:

(1) 2.5 percent of the assessment amount due if the assessment payment is received at the fund within five days after the due date; or

(2) five percent of the assessment amount due if the assessment payment is received at the fund within six to 30 days after the due date; or

(3) ten percent of the assessment amount due if the assessment payment is received at the fund within 31 to 60 days after the due date; or

(4) 15 percent of the assessment amount due if the assessment payment is received at the fund 61 or more days after the due date; or

B. $500, whichever is greater.

Subp. 4. **Payable to.** Both the assessment amount and any penalty due under this part are payable to the special compensation fund.

Subp. 5. **Continued nonpayment.** If the insurer penalized does not make payment within six months of the due date, the fund director shall refer the file to the Department of Commerce for consideration of license or permit revocation.

Statutory Authority: *MS s 175.17 cl (2); 176.129 subd 10; 176.83 subds 1,15*

History: *11 SR 1530; 13 SR 2686*

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

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

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

History: *11 SR 1530*

5220.2860 FAILURE TO INSURE; PENALTY.

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

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

History: *11 SR 1530*

5220.2870 PENALTY OBJECTION AND HEARING.

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

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

History: *11 SR 1530*

5220.2880 EXAMINATION OF WORKERS' COMPENSATION FILES.

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

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

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

History: *11 SR 1530*

5220.2890 SERVICE.

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

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

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

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

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

History: *11 SR 1530*

5220.2900 [Repealed, 11 SR 1530]

5220.2910 EXHIBITS.

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

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

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

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

History: *11 SR 1530*

5220.2920 ATTORNEY FEES.

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

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

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

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

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

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

F. In determining what amount of fee is reasonable for services rendered in connection with rehabilitation and medical services, the factors of Minnesota Statutes, section 176.081, subdivision 5, must be applied.

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

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

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

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

(2) claim numbers or codes;

(3) the date of injury or disease;

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

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

(6) information concerning expense advancement;

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

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

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

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

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

(12) information identifying the employee's attorney.

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

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

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

(2) claim numbers or codes;

(3) date of the injury or disease;

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

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

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

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

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

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

(10) information concerning any retainer;

(11) the amount the employee advanced for expenses;

(12) the specific dollar amount claimed in fees;

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

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

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

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

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

(18) information identifying the employee's attorney.

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

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

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

History: *11 SR 1530*

5220.2930 DEPENDENT'S BENEFITS.

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

A. A party may petition for an allocation of benefits under Minnesota Statutes, section 176.111, subdivision 10. The petition may contain a proposed allocation. The petition must be served on all parties and filed with the division within one year after the date of death or one year after March 9, 1987, whichever is later. If a petition for allocation is not filed in a timely manner and the death occurred after June 30, 1981, the allocation will be as provided in subpart 2.

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

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

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

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

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

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

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

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

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

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

B. Deaths after June 30, 1981.

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

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

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

History: *11 SR 1530*

5220.2940 PEACE OFFICER DEATH BENEFITS.

Subpart 1. **Application for benefits.** The application for payment from the peace officers benefit fund of Minnesota Statutes, section 176B.02 shall be submitted to the commissioner on a form prescribed by the commissioner. The form shall require at least the following:

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

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

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

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

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

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

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

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

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

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

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

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

History: *11 SR 1530*

5220.2950 SEVERABILITY.

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

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

History: *11 SR 1530*

5220.3000 [Repealed, 11 SR 1530]

5220.3100 [Repealed, 9 SR 333]

5220.3200 [Repealed, 11 SR 1530]

5220.3300 [Repealed, 9 SR 333]

5220.3400 [Repealed, 9 SR 333]

5220.3500 [Repealed, 9 SR 333]

5220.3600 [Repealed, 11 SR 1530]

5220.3700 [Repealed, 9 SR 333]

5220.3800 [Repealed, 9 SR 333]

5220.3900 [Repealed, 9 SR 333]

5220.4000 [Repealed, 9 SR 333]

5220.4100 [Repealed, 9 SR 333]

5220.4200 [Repealed, 9 SR 333]

5220.4300 [Repealed, 9 SR 333]

5220.4301 [Repealed, 9 SR 333]

5220.4302 [Repealed, 9 SR 333]

5220.4303 [Repealed, 9 SR 333]

5220.4304 [Repealed, 9 SR 333]

5220.4305 [Repealed, 9 SR 333]

5220.4800 [Repealed, 9 SR 333]

5220.4900 [Repealed, 9 SR 333]

5220.5000 [Repealed, 11 SR 1530]

5220.5100 [Repealed, 9 SR 333]

5220.5200 [Repealed, 9 SR 333]

5220.5300 [Repealed, 9 SR 333]

5220.5400 [Repealed, 9 SR 333]

5220.5500 [Repealed, 9 SR 333]

5220.5600 [Repealed, 9 SR 333]

5220.5700 [Repealed, 9 SR 333]

5220.6500 [Repealed, 9 SR 333]

5220.6600 [Repealed, 9 SR 333]

5220.6700 [Repealed, 9 SR 333]

5220.6800 [Repealed, 9 SR 333]

5220.6900 [Repealed, 9 SR 333]

5220.7000 [Repealed, 9 SR 333]

5220.7100 [Repealed, 9 SR 333]

5220.7200 [Repealed, 9 SR 333]