CHAPTER 176

WORKERS' COMPENSATION

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176.011 DEFINITIONS.

[For text of subds 1 to 14, see M.S.1996]

Subd. 15. **Occupational disease.** (a) "Occupational disease" means a disease arising out of and in the course of employment peculiar to the occupation in which the employee is engaged and due to causes in excess of the hazards ordinary of employment and shall include undulant fever. Ordinary diseases of life to which the general public is equally exposed outside of employment are not compensable, except where the diseases follow as an incident of an occupational disease, or where the exposure peculiar to the occupation makes the disease an occupational disease hazard. A disease arises out of the employment only if there be a direct causal connection between the conditions under which the work is performed and if the occupational disease follows as a natural incident of the work as a result of the exposure occasioned by the nature of the employment. An employer is not liable for compensation for any occupational disease which cannot be traced to the employment as a direct and proximate cause and is not recognized as a hazard characteristic of and peculiar to the trade, occupation, process, or employment or which results from a hazard to which the worker would have been equally exposed outside of the employment.

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

(c) A firefighter on active duty with an organized fire department who is unable to perform duties in the department by reason of a disabling cancer of a type caused by exposure to heat, radiation, or a known or suspected carcinogen, as defined by the International Agency for Research on Cancer, and the carcinogen is reasonably linked to the disabling cancer, is presumed to have an occupational disease under paragraph (a). If a firefighter who enters the service after August 1, 1988, is examined by a physician prior to being hired and the examination discloses the existence of a cancer of a type described in this paragraph, the fire-

fighter is not entitled to the presumption unless a subsequent medical determination is made that the firefighter no longer has the cancer.

[For text of subds 16 to 27, see M.S.1996]

History: *1997 c 128 s 3*

176.081 LEGAL SERVICES OR DISBURSEMENTS; LIEN; REVIEW.

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

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

For the purposes of applying the formula where the employer or insurer is liable for attorney fees, the amount of compensation awarded for obtaining disputed medical and rehabilitation benefits under sections 176.102, 176.135, and 176.136 shall be the dollar value of the medical or rehabilitation benefit awarded, where ascertainable.

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

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

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

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

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

(e) Employers and insurers may not pay attorney fees or wages for legal services of more than $13,000 per case.

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

[For text of subds 3 to 12, see M.S.1996]

History: *1997 c 7 art 1 s 80*

176.102 REHABILITATION.

[For text of subds 1 and 1a, see M.S.1996]

Subd. 2. **Administrators.** The commissioner shall hire a director of rehabilitation services in the classified service. The commissioner shall monitor and supervise rehabilitation services, including, but not limited to, making determinations regarding the selection and delivery of rehabilitation services and the criteria used to approve qualified rehabilitation consultants and rehabilitation vendors. The commissioner may also make determinations regarding fees for rehabilitation services and shall by rule establish a fee schedule or otherwise limit fees charged by qualified rehabilitation consultants and vendors. The commissioner shall annually review the fees and give notice of any adjustment in the State Register. By March 1, 1993, the commissioner shall report to the legislature on the status of the commission's monitoring of rehabilitation services. The commissioner may hire qualified personnel to assist in the commissioner's duties under this section and may delegate the duties and performance.

[For text of subds 3 to 14, see M.S.1996]

History: *1997 c 187 art 3 s 26*

176.108 LIGHT–DUTY WORK POOLS.

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

History: *1997 c 7 art 5 s 13*

176.1351 MANAGED CARE.

[For text of subds 1 to 4, see M.S.1996]

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

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

subdivision. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

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

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

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

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

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

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

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

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

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

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

Subd. 6. **Rules.** The commissioner may adopt rules necessary to implement this section.

History: *1997 c 7 art 5 s 14,15*

176.136 MEDICAL FEE REVIEW.

[For text of subd 1, see M.S.1996]

Subd. 1a. **Relative value fee schedule.** The liability of an employer for services included in the medical fee schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee, whichever is lower. The

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

After permanent rules have been adopted to implement this section, the conversion factors must be adjusted annually on October 1 by no more than the percentage change computed under section 176.645, but without the annual cap provided by that section. The commissioner shall annually give notice in the State Register of the adjusted conversion factors and may also give annual notice of any additions, deletions, or changes to the relative value units or service codes adopted by the federal Medicare program. The relative value units may be statistically adjusted in the same manner as for the original workers' compensation relative value fee schedule. The notices of the adjusted conversion factors and additions, deletions, or changes to the relative value units and service codes is in lieu of the requirements of chapter 14. The commissioner shall follow the requirements of section 14.386, paragraph (a). The annual adjustments to the conversion factors and the medical fee schedules adopted under this section, including all previous fee schedules, are not subject to expiration under section 14.386, paragraph (b).

[For text of subds 1b to 3, see M.S.1996]

History: *1997 c 187 art 5 s 26*

176.181 INSURANCE.

[For text of subds 1 and 2, see M.S.1996]

Subd. 2a. **Application fee.** Every initial application filed pursuant to subdivision 2 requesting authority to self–insure shall be accompanied by a nonrefundable fee of $2,500. When an employer seeks to be added as a member of an existing approved group under section 79A.03, subdivision 6, the proposed new member shall pay a nonrefundable $250 application fee to the commissioner at the time of application. Each annual report due August 1 under section 79A.03, subdivision 9, shall be accompanied by an annual fee of $200.

[For text of subds 2b to 8, see M.S.1996]

History: *1997 c 200 art 1 s 64*

176.1812 COLLECTIVE BARGAINING AGREEMENTS.

[For text of subds 1 to 6, see M.S.1996]

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

History: *1997 c 7 art 5 s 16*

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

Subdivision 1. **Order; employer, insurer, or special compensation fund payment.** Where compensation benefits are payable under this chapter, and a dispute exists between two or more employers or two or more insurers or the special compensation fund as to which is liable for payment, the commissioner, compensation judge, or court of appeals upon appeal shall direct that one or more of the employers or insurers or the special compensation

fund make payment of the benefits pending a determination of which has liability. The special compensation fund may be ordered to make payment only if it has been made a party to the claim because the petitioner has alleged that one or more of the employers is uninsured for workers' compensation under section 176.183. A temporary order may be issued under this subdivision whether or not the employers, insurers, or special compensation fund agree to pay under the order, and whether or not they agree that benefits are payable under this chapter. A temporary order shall be issued if the commissioner or compensation judge determines based on evidence submitted by the employee that benefits are payable under this chapter and if two or more employers, insurers, or the special compensation fund deny liability based on an assertion that another employer, insurer, or the special compensation fund is liable. A temporary order shall not be withheld where the denials of liability are frivolous as defined in section 176.225, subdivision 1, or nonspecific as defined in section 176.84, subdivision 1.

If the parties do not agree to a temporary order, the commissioner or compensation judge shall summarily hear and determine the issues and issue an order without the need for a formal evidentiary hearing. At any time after a temporary order is issued, the paying party may request to discontinue payment of benefits based on new evidence that benefits are not payable under this chapter by following the procedures of section 176.238 or 176.239.

At any time after a temporary order is issued, the paying party may also petition for a formal hearing before a compensation judge for a determination of liability among the parties. If the petition is filed within one year after a temporary order was issued, the hearing shall be held within 45 days after the petition was filed. Payments under a temporary order shall continue pending the determination of the compensation judge. The compensation judge shall have jurisdiction to resolve all issues properly raised, including equitable apportionment. The procedures and monetary thresholds contained in section 176.191, subdivisions 1a and 5, shall not apply to these proceedings. This subdivision applies to all dates of injury.

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

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

[For text of subds 1a to 4, see M.S.1996]

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

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

[For text of subds 6 to 8, see M.S.1996]

History: *1997 c 128 s 4,5*

176.611 MAINTENANCE OF STATE COMPENSATION REVOLVING FUND.

[For text of subds 1 and 2, see M.S.1996]

Subd. 2a. **Settlement and contingency reserve account.** To reduce long–term costs, minimize impairment to agency operations and budgets, and distribute risk of one–time catastrophic claims, the commissioner of employee relations shall maintain a separate account within the state compensation revolving fund. The account shall be used to pay for lump–sum or annuitized settlements, structured claim settlements, and one–time large, legal, catastrophic medical, indemnity, or other irregular claim costs that might otherwise pose a significant burden for agencies. The commissioner of employee relations, with the approval of the commissioner of finance, may establish criteria and procedures for payment from the account on an agency's behalf. The commissioner of employee relations may assess agencies on a reimbursement or premium basis from time to time to ensure adequate account reserves. The account consists of appropriations from the general fund, receipts from billings to agencies, and credited investment gains or losses attributable to balances in the account. The state board of investment shall invest the assets of the account according to section 11A.24.

[For text of subds 3a and 6a, see M.S.1996]

History: *1997 c 202 art 2 s 41*

176.83 RULES.

[For text of subds 1 to 4, see M.S.1996]

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

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

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

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

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

(4) criteria for diagnostic imaging procedures;

(5) criteria for inpatient hospitalization; and

(6) criteria for treatment of chronic pain.

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

trative conference that the level, frequency, or cost was not excessive under the rules in which case the insurer, self–insurer, or group self–insurer shall make the payment deemed reasonable.

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

[For text of subds 5a to 15, see M.S.1996]

History: *1997 c 7 art 5 s 17*