CHAPTER 176

WORKERS' COMPENSATION

176.0001 MS 2006 [Renumbered 15.001]

INTENT

176.001 INTENT OF THE LEGISLATURE.

It is the intent of the legislature that chapter 176 be interpreted so as to assure the quick and efficient delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter. It is the specific intent of the legislature that workers' compensation cases shall be decided on their merits and that the common law rule of "liberal construction" based on the supposed "remedial" basis of workers' compensation legislation shall not apply in such cases. The workers' compensation system in Minnesota is based on a mutual renunciation of common law rights and defenses by employers and employees alike. Employees' rights to sue for damages over and above medical and health care benefits and wage loss benefits are to a certain degree limited by the provisions of this chapter, and employers' rights to raise common law defenses such as lack of negligence, contributory negligence on the part of the employee, and others, are curtailed as well. Accordingly, the legislature hereby declares that the workers' compensation laws are not remedial in any sense and are not to be given a broad liberal construction in favor of the claimant or employee on the one hand, nor are the rights and interests of the employer to be favored over those of the employee on the other hand.

History: *1981 c 346 s 52; 1983 c 290 s 25*

176.01 [Repealed, 1953 c 755 s 83]

DEFINITIONS

176.011 DEFINITIONS.

Subdivision 1. **Terms.** For the purposes of this chapter the terms described in this section have the meanings ascribed to them.

Subd. 1a. **Administrative conference.** An "administrative conference" is a meeting conducted by a commissioner's designee or a compensation judge where parties can discuss on an expedited basis and in an informal setting their viewpoints concerning disputed issues arising under section 176.102, 176.103, 176.135, 176.136, or 176.239. If the parties are unable to resolve the dispute, the commissioner's designee or a compensation judge shall issue an administrative decision under section 176.106 or 176.239.

Subd. 1b. **Average weekly wage.** The statewide average weekly wage for any year means that wage determined by the commissioner in the following manner: On or before July 1 preceding the year in which the wage is to be applicable, the total wages reported on wage detail reports to the Department of Employment and Economic Development for the preceding 12 months ending on December 31 of that year shall be divided by the average monthly number of covered workers (determined by dividing the total covered workers reported for the year ending December 31 by 12). The average annual wage thus obtained shall be divided by 52 and the average weekly wage thus determined rounded to the next highest dollar.

Subd. 1c. **Agency.** "Agency" means, unless the context indicates otherwise, the commissioner of the Department of Labor and Industry, the Department of Labor and Industry, the Department's workers' compensation division, the Office of Administrative Hearings, the chief administrative law judge, and the Workers' Compensation Court of Appeals.

Subd. 1d. **CAMPUS.** "CAMPUS" means the workers' compensation Claims Access and Management Platform User System, developed pursuant to the appropriations in Laws 2015, First Special Session chapter 1, article 1, section 5, as amended by Laws 2017, chapter 94, article 2, section 17, and Laws 2017, chapter 94, article 1, section 4, and referenced as the workers' compensation modernization program in section 176.2611 and as described in section 176.2612.

Subd. 2. **Child.** "Child" includes a posthumous child, a child entitled by law to inherit as a child of a deceased person, a child of a person adjudged by a court of competent jurisdiction to be the parent of the child, and a stepchild, grandchild, or foster child who was a member of the family of a deceased employee at the time of injury and dependent upon the employee for support. A stepchild is a "child" within the meaning of section 176.041.

Subd. 2a. **Closely held corporations.** "Closely held corporation" means a corporation whose stock is held by no more than ten persons. The determination of ownership shall be made annually on the effective date of the policy issued under this chapter. In case of self-insureds the determination shall be made annually on the date of approval of self-insurance or renewal of self-insurance.

Subd. 3. MS 2006 [Renumbered subd 8a]

Subd. 4. **Commercial baler.** "Commercial baler" means a person going from place to place baling hay or straw as a business, but does not include a farmer owning a baling machine not engaged in such business generally and doing the farmer's own baling and casually doing such work for other farmers in the same community or exchanging work with another farmer.

Subd. 5. **Commercial thresher.** "Commercial thresher" means a person going from place to place threshing grain or shredding or shelling corn as a business, but does not include a farmer owning a threshing, shredding, or shelling machine not engaged in such business generally and doing the farmer's own threshing, shredding, or shelling and casually doing such work for other farmers in the same community or exchanging work with another farmer.

Subd. 5a. **Commissioner.** "Commissioner," unless the context clearly indicates otherwise, means the commissioner of labor and industry.

Subd. 6. (1) [Renumbered subd 7b]

(2) [Renumbered subd 8c]

(3) [Renumbered subd 8b]

(4) [Renumbered subd 5a]

(5) [Renumbered subd 15a]

Subd. 6a. **Compensation.** "Compensation" includes all benefits provided by this chapter on account of injury or death.

Subd. 7. MS 2006 [Renumbered subd 12c]

Subd. 7a. **Compensation judge.** "Compensation judge" means a workers' compensation judge at the Office of Administrative Hearings.

Compensation judges may conduct settlement conferences, issue summary decisions, approve settlements and issue awards thereon, determine petitions for attorney fees and costs, and make other determinations, decisions, orders, and awards as may be delegated to them by law or the commissioner. Compensation judges must be learned in the law.

Subd. 7b. **Court of appeals.** "Court of appeals" means the Workers' Compensation Court of Appeals of Minnesota.

Subd. 8. [Renumbered subd 6a]

Subd. 8a. **Daily wage.** "Daily wage" means the daily wage of the employee in the employment engaged in at the time of injury but does not include tips and gratuities paid directly to an employee by a customer of the employer and not accounted for by the employee to the employer. If the amount of the daily wage received or to be received by the employee in the employment engaged in at the time of injury was irregular or difficult to determine, or if the employment was part time, the daily wage shall be computed by dividing the total amount of wages, vacation pay, and holiday pay the employee actually earned in such employment in the last 26 weeks, by the total number of days in which such wages, vacation pay, and holiday pay was earned, provided further, that in the case of the construction industry, mining industry, or other industry where the hours of work are affected by seasonal conditions, the weekly wage shall not be less than five times the daily wage. If the employee worked or earned less than a full day's worth of wages, vacation pay, or holiday pay, the total amount earned shall be divided by the corresponding proportion of that day. Where board or allowances other than tips and gratuities are made to an employee in addition to wages as a part of the wage contract they are deemed a part of earnings and computed at their value to the employee. In the case of persons performing services for municipal corporations in the case of emergency, then the normal working day shall be considered and computed as eight hours, and in cases where such services are performed gratis or without fixed compensation the daily wage of the person injured shall, for the purpose of calculating compensation payable under this chapter, be taken to be the usual going wage paid for similar services in municipalities where such services are performed by paid employees. If, at the time of injury, the employee was regularly employed by two or more employers, the employee's earnings in all such employments shall be included in the computation of daily wage.

Subd. 8b. **Department.** "Department" means the Department of Labor and Industry.

Subd. 8c. **Division.** "Division" means the Workers' Compensation Division of the Department of Labor and Industry.

Subd. 8d. **Division file.** "Division file" means the official file created and maintained by the department within CAMPUS to retain imaged or electronic documents and data related to an employee's workers' compensation claim or injury under chapter 176, including documents transmitted to the commissioner under sections 176.281 and 176.2611. The division file does not include:

(1) paper, images, or electronic data created, used, or maintained for internal operational purposes by an agency, the special compensation fund, or the vocational rehabilitation unit;

(2) a confidential mediation statement, including any documents submitted with the statement for the mediator's review and any additional documents submitted to or sent by the mediator in furtherance of mediation efforts; and

(3) work product of a compensation judge, mediator, or commissioner that is not issued or sent to a party to a claim. Examples of work product include personal notes of hearings or conferences and draft decisions or orders.

Subd. 8e. **Document.** "Document" includes a form, record, report, notice, order, and paper. Document also includes information and data, regardless of format, that are required or authorized by this chapter to be filed with or served on or by an agency. Document excludes physical objects such as clothing, flash drives, compact discs, or physical objects used as demonstrative evidence.

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

(1) an alien;

(2) a minor;

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

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

(5) a county assessor;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(17) a worker performing services under section 256B.0659 for a recipient in the home of the recipient or in the community under section 256B.0625, subdivision 19a, who is paid from government funds through a fiscal intermediary under section 256B.0659, subdivision 33. For purposes of maintaining workers'

compensation insurance, the employer of the worker is as designated in law by the commissioner of the Department of Human Services, notwithstanding any other law to the contrary;

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

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

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

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

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

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

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

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

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

(25) a Minnesota Responds Medical Reserve Corps volunteer, as provided in sections 145A.04 and 145A.06, responding at the request of or engaged in training conducted by the commissioner of health. The daily wage of the volunteer for the purposes of calculating compensation payable under this chapter is established in section 145A.06. A person who qualifies under this clause and who may also qualify under another clause of this subdivision shall receive benefits in accordance with this clause.

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

(b) For purposes of this chapter "employee" does not include farmers or members of their family who exchange work with other farmers in the same community.

Subd. 9a. [Renumbered subd 9, para (b)]

Subd. 10. **Employer.** "Employer" means any person who employs another to perform a service for hire; and includes corporation, partnership, limited liability company, association, group of persons, state, county, town, city, school district, or governmental subdivision.

Subd. 11. **Executive officer of a corporation.** "Executive officer of a corporation" means any officer of a corporation elected or appointed in accordance with its charter or bylaws.

Subd. 11a. **Family farm.** (a) "Family farm" means any farm operation which pays or is obligated to pay cash wages, exclusive of machine hire, to farm laborers for services rendered during the preceding calendar year in an amount:

(1) less than $8,000; or

(2) less than the statewide average annual wage as described in subdivision 1b when the farm operation has total liability and medical payment coverage equal to $300,000 and $5,000, respectively, under a farm liability insurance policy, and the policy covers injuries to farm laborers.

(b) For purposes of this subdivision, farm laborer does not include any spouse, parent or child, regardless of age, of a farmer employed by the farmer, or any executive officer of a family farm corporation as defined in section 500.24, subdivision 2, or any spouse, parent or child, regardless of age, of such an officer employed by that family farm corporation, or other farmers in the same community or members of their families exchanging work with the employer. Notwithstanding any law to the contrary, a farm laborer shall not be considered as an independent contractor for the purposes of this chapter; provided that a commercial baler or commercial thresher shall be considered an independent contractor.

Subd. 12. **Farm laborer.** "Farm laborer" does not include an employee of a commercial thresher or commercial baler.

Subd. 12a. **Health care provider.** "Health care provider" means a physician, podiatrist, chiropractor, dentist, optometrist, osteopathic physician, psychologist, psychiatric social worker, physician assistant, or any other person who furnishes a medical or health service to an employee under this chapter but does not include a qualified rehabilitation consultant or approved vendor.

Subd. 12b. **Household worker.** "Household worker" means one who is a domestic, repairer, groundskeeper, or maintenance worker in, for, or about a private home or household, but the term shall not include independent contractors nor shall it include persons performing labor for which they may elect workers' compensation coverage under section 176.041, subdivision 1a.

Subd. 12c. **Judge.** "Judge" means a member of the Workers' Compensation Court of Appeals.

Subd. 13. [Repealed, 1987 c 49 s 20]

Subd. 13a. **Maximum medical improvement.** "Maximum medical improvement" means the date after which no further significant recovery from or significant lasting improvement to a personal injury can reasonably be anticipated, based upon reasonable medical probability, irrespective and regardless of subjective

complaints of pain. Except where an employee is medically unable to continue working under section 176.101, subdivision 1, paragraph (e), clause (2), once the date of maximum medical improvement has been determined, no further determinations of other dates of maximum medical improvement for that personal injury is permitted. The determination that an employee has reached maximum medical improvement shall not be rendered ineffective by the worsening of the employee's medical condition and recovery therefrom.

Subd. 14. **Member.** "Member" includes leg, foot, toe, hand, finger, thumb, arm, back, eye, and ear when used with reference to the anatomy.

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

(b) If immediately preceding the date of disablement or death, an employee was employed on active duty with an organized fire or police department of any municipality, as a member of the Minnesota State Patrol, conservation officer service, state crime bureau, as a forest officer by the Department of Natural Resources, correctional officer or security counselor employed by the state or a political subdivision at a corrections, detention, or secure treatment facility, 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; correctional officer or security counselor employed by the state or a political subdivision at a corrections, detention, or secure treatment facility; emergency medical technician; or licensed nurse providing emergency medical care; and who contracts an infectious or communicable disease to which the employee was exposed in the course of employment outside of a hospital, then the disease is presumptively an occupational disease and shall be presumed to have been due to the nature of employment and the presumption may be rebutted by substantial factors brought by the employer or insurer. Any substantial factors which shall be used to rebut this presumption and which are known to the employer or insurer at the time of the denial of liability shall be communicated to the employee on the denial of liability.

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

(d) For the purposes of this chapter, "mental impairment" means a diagnosis of post-traumatic stress disorder by a licensed psychiatrist or psychologist. For the purposes of this chapter, "post-traumatic stress disorder" means the condition as described in the most recently published edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association. For purposes of section 79.34, subdivision 2, one or more compensable mental impairment claims arising out of a single event or occurrence shall constitute a single loss occurrence.

(e) If, preceding the date of disablement or death, an employee who was employed on active duty as: a licensed police officer; a firefighter; a paramedic; an emergency medical technician; a licensed nurse employed to provide emergency medical services outside of a medical facility; a public safety dispatcher; a correctional officer or security counselor employed by the state or a political subdivision at a corrections, detention, or secure treatment facility; a sheriff or full-time deputy sheriff of any county; or a member of the Minnesota State Patrol is diagnosed with a mental impairment as defined in paragraph (d), and had not been diagnosed with the mental impairment previously, then the mental impairment is presumptively an occupational disease and shall be presumed to have been due to the nature of employment. This presumption may be rebutted by substantial factors brought by the employer or insurer. Any substantial factors that are used to rebut this presumption and that are known to the employer or insurer at the time of the denial of liability shall be communicated to the employee on the denial of liability. The mental impairment is not considered an occupational disease if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer.

Subd. 15a. **Office.** "Office" means the Office of Administrative Hearings.

Subd. 16. **Personal injury.** "Personal injury" means any mental impairment as defined in subdivision 15, paragraph (d), or physical injury arising out of and in the course of employment and includes personal injury caused by occupational disease; but does not cover an employee except while engaged in, on, or about the premises where the employee's services require the employee's presence as a part of that service at the time of the injury and during the hours of that service. Where the employer regularly furnished transportation to employees to and from the place of employment, those employees are subject to this chapter while being so transported. Physical stimulus resulting in mental injury and mental stimulus resulting in physical injury shall remain compensable. Mental impairment is not considered a personal injury if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer. Personal injury does not include an injury caused by the act of a third person or fellow employee intended to injure the employee because of personal reasons, and not directed against the employee as an employee, or because of the employment. An injury or disease resulting from a vaccine in response to a declaration by the Secretary of the United States Department of Health and Human Services under the Public Health Service Act to address an actual or potential health risk related to the employee's employment is an injury or disease arising out of and in the course of employment.

Subd. 17. **Physician.** "Physician" means one authorized by law to practice the medical profession within one of the United States and in good standing in the profession, and includes surgeon.

Subd. 17a. **Retraining.** "Retraining" means a formal course of study in a school setting which is designed to train an employee to return to suitable gainful employment.

Subd. 17b. **Relative value fee schedule.** "Relative value fee schedule" means the medical fee schedule adopted by rule under section 176.136, subdivision 1a, using the Physician Fee Schedule tables adopted for the federal Medicare program.

Subd. 18. **Weekly wage.** "Weekly wage" is arrived at by multiplying the daily wage by the number of days and fractional days normally worked in the business of the employer for the employment involved. If the employee normally works less than five days per week or works an irregular number of days per week, the number of days normally worked shall be computed by dividing the total number of days in which the employee actually performed any of the duties of employment in the last 26 weeks by the number of weeks in which the employee actually performed such duties, provided that the weekly wage for part time employment during a period of seasonal or temporary layoff shall be computed on the number of days and fractional days normally worked in the business of the employer for the employment involved. If, at the time of the injury, the employee was regularly employed by two or more employers, the employee's days of work for all such employments shall be included in the computation of weekly wage. An employee injured while engaged in agricultural employment fewer than 30 days in a calendar year, and who is regularly employed by two or more employers, shall have their average weekly wage calculated based on the agricultural wages at five times the employee's daily wage, or based only on the employee's other employment, whichever is higher. Occasional overtime is not to be considered in computing the weekly wage, but if overtime is regular or frequent throughout the year it shall be taken into consideration. The maximum weekly compensation payable to an employee, or to the employee's dependents in the event of death, shall not exceed 66-2/3 percent of the product of the daily wage times the number of days normally worked, provided that the compensation payable for permanent partial disability under section 176.101, subdivision 2a, and for permanent total disability under section 176.101, subdivision 4, or death under section 176.111, shall not be computed on less than the number of hours normally worked in the employment or industry in which the injury was sustained, subject also to such maximums as are specifically otherwise provided.

Subd. 19. **Worker.** "Worker" means employee.

Subd. 20. MS 2006 [Renumbered subd 1b]

Subd. 21. MS 2006 [Renumbered subd 12b]

Subd. 22. MS 2006 [Renumbered subd 2a]

Subd. 23. MS 2006 [Renumbered subd 17a]

Subd. 24. MS 2006 [Renumbered subd 12a]

Subd. 25. MS 2006 [Renumbered subd 13a]

Subd. 26. [Repealed, 1995 c 231 art 1 s 36; art 2 s 110]

Subd. 27. MS 2006 [Renumbered subd 1a]

History: *1953 c 443 s 1; 1953 c 755 s 1; 1955 c 206 s 1; 1955 c 652 s 1; 1955 c 765 s 1; 1957 c 834 s 1; 1959 c 20 s 1; 1959 c 283 s 1; 1963 c 493 s 1; 1963 c 497 s 1; 1967 c 701 s 1; 1967 c 806 s 1; 1967 c 905 s 9; Ex1967 c 1 s 6; Ex1967 c 40 s 1,2; 1969 c 9 s 53; 1969 c 148 s 2; 1969 c 276 s 1; 1969 c 936 s 2; 1973 c 123 art 5 s 7; 1973 c 388 s 12; 1973 c 420 s 2; 1973 c 657 s 1; 1975 c 271 s 6; 1975 c 359 s 3,4,23; 1976 c 331 s 36; 1977 c 342 s 1,2; 1977 c 429 s 63; 1977 c 430 s 25 subd 1; 1978 c 574 s 1; 1978 c 702 s*

1; 1978 c 757 s 1; 1978 c 764 s 99; 1979 c 92 s 2; Ex1979 c 3 s 28,29; 1980 c 384 s 2; 1980 c 385 s 1,2; 1980 c 414 s 2; 1980 c 556 s 12; 1981 c 37 s 2; 1981 c 346 s 53,54,139; 1983 c 193 s 2; 1983 c 290 s 26-30; 1984 c 469 s 1; 1984 c 544 s 85; 1984 c 654 art 5 s 58; 1985 c 247 s 20; 1Sp1985 c 14 art 9 s 75; 1986 c 444; 1987 c 332 s 5-9; 1987 c 348 s 33; 1987 c 384 art 1 s 54; 1988 c 652 s 1; 1988 c 717 s 3; 1989 c 209 art 2 s 1; 1990 c 556 s 4; 1992 c 510 art 1 s 1,2; 1993 c 137 s 5; 1994 c 483 s 1; 1994 c 583 s 2; 1994 c 631 s 31; 1995 c 224 s 69; 1995 c 231 art 1 s 13; art 2 s 44; 1997 c 128 s 3; 1998 c 366 s 89; 1998 c 398 art 5 s 55; 2000 c 447 s 1-3; 2003 c 130 s 12; 2004 c 183 s 1; 2004 c 257 s 10,11; 2005 c 10 art 2 s 4; 2005 c 56 s 1; 2005 c 90 s 1; 2008 c 202 s 8; 2008 c 250 s 1; 2009 c 79 art 6 s 2; 2013 c 70 art 2 s 1,2; 2014 c 182 s 1; 2016 c 110 art 3 s 1; 2016 c 119 s 7; 2016 c 158 art 1 s 214; 2017 c 40 art 1 s 121; 2018 c 185 art 5 s 1; 1Sp2019 c 7 art 12 s 1-4; 2020 c 72 s 1; 7Sp2020 c 1 art 2 s 6; 2021 c 12 s 12; 2022 c 58 s 94; 2023 c 51 art 6 s 1,2; 2024 c 79 art 10 s 3; 2024 c 85 s 47; 2024 c 97 s 1-3

176.012 [Repealed, 1987 c 332 s 117]

176.02 [Repealed, 1953 c 755 s 83]

GENERAL APPLICATION AND LIABILITY

176.021 APPLICATION TO EMPLOYERS AND EMPLOYEES.

Subdivision 1. **Liability for compensation.** Except as excluded by this chapter all employers and employees are subject to the provisions of this chapter.

Every employer is liable for compensation according to the provisions of this chapter and is liable to pay compensation in every case of personal injury or death of an employee arising out of and in the course of employment without regard to the question of negligence. The burden of proof of these facts is upon the employee.

If the injury was intentionally self-inflicted or the intoxication of the employee is the proximate cause of the injury, then the employer is not liable for compensation. The burden of proof of these facts is upon the employer.

Subd. 1a. **Burden of proof.** All disputed issues of fact arising under this chapter shall be determined by a preponderance of the evidence, and in accordance with the principles laid down in section 176.001. Preponderance of the evidence means evidence produced in substantiation of a fact which, when weighed against the evidence opposing the fact, has more convincing force and greater probability of truth.

Questions of law arising under chapter 176 shall be determined on an even-handed basis in accordance with the principles laid down in section 176.001.

Subd. 2. **Parties liable.** The liability imposed by subdivision 1 upon the employer extends to and binds those conducting the employer's business during insolvency, assignment for the benefit of creditors, and insofar as agreeable with the controlling federal law during bankruptcy.

Subd. 3. **Compensation, commencement of payment.** All employers shall commence payment of compensation at the time and in the manner prescribed by this chapter without the necessity of any agreement or any order of the division. Except for medical, burial, and other nonperiodic benefits, payments shall be made as nearly as possible at the intervals when the wage was payable, provided, however, that payments for permanent partial disability shall be governed by section 176.101. If doubt exists as to the eventual permanent partial disability, payment shall be then made when due for the minimum permanent partial disability ascertainable, and further payment shall be made upon any later ascertainment of greater permanent

partial disability. Prior to or at the time of commencement of the payment of permanent partial compensation, the employee and employer shall be furnished with a copy of the medical report upon which the payment is based and all other medical reports which the insurer has that indicate a permanent partial disability rating, together with a statement by the insurer as to whether the tendered payment is for minimum permanent partial disability or final and eventual disability. After receipt of all reports available to the insurer that indicate a permanent partial disability rating, the employee shall make available or permit the insurer to obtain any medical report that the employee has or has knowledge of that contains a permanent partial disability rating which the insurer does not already have. Permanent partial compensation pursuant to section 176.101 is payable in addition to but not concurrently with compensation for temporary total disability but is payable pursuant to section 176.101. Impairment compensation is payable concurrently and in addition to compensation for permanent total disability pursuant to section 176.101. Permanent partial compensation pursuant to section 176.101 shall be withheld pending completion of payment for temporary total disability, and no credit shall be taken for payment of permanent partial compensation against liability for temporary total or future permanent total disability. Liability on the part of an employer or the insurer for disability of a temporary total, temporary partial, and permanent total nature shall be considered as a continuing product and part of the employee's inability to earn or reduction in earning capacity due to injury or occupational disease and compensation is payable accordingly, subject to section 176.101. Permanent partial compensation is payable for functional loss of use or impairment of function, permanent in nature, and payment therefore shall be separate, distinct, and in addition to payment for any other compensation, subject to section 176.101. The right to receive temporary total, temporary partial, or permanent total disability payments vests in the injured employee or the employee's dependents under this chapter or, if none, in the employee's legal heirs at the time the disability can be ascertained and the right is not abrogated by the employee's death prior to the making of the payment.

The right to receive permanent partial compensation vests in an injured employee at the time the disability can be ascertained provided that the employee lives for at least 30 days beyond the date of the injury. Upon the death of an employee who is receiving economic recovery compensation or impairment compensation, further compensation is payable pursuant to section 176.101. Impairment compensation is payable under this paragraph if vesting has occurred, the employee dies prior to reaching maximum medical improvement, and the requirements and conditions under section 176.101, subdivision 3e, are not met.

Disability ratings for permanent partial disability shall be based on objective medical evidence.

Subd. 3a. **Permanent partial benefits, payment.** Payments for permanent partial disability as provided in section 176.101, subdivision 2a, shall be made in the following manner:

(a) If the employee returns to work, payment shall be made at the same intervals as temporary total payments were made;

(b) If temporary total payments have ceased, but the employee has not returned to work, payment shall be made at the same intervals as temporary total payments were made;

(c) If temporary total disability payments cease because the employee is receiving payments for permanent total disability or because the employee is retiring or has retired from the work force, then payment shall be made at the same intervals as temporary total payments were made;

(d) If the employee completes a rehabilitation plan pursuant to section 176.102, but the employer does not furnish the employee with work the employee can do in a permanently partially disabled condition, and the employee is unable to procure such work with another employer, then payment shall be made at the same intervals as temporary total payments were made.

Subd. 3b. **Temporary and permanent partial.** If an employee has returned to work for at least six months and has, if applicable, completed a rehabilitation plan, this section does not prevent the payment of compensation for permanent partial disability because the employee is receiving compensation for temporary partial disability. This subdivision is procedural and applies regardless of the date of injury.

Subd. 4. **Void agreements.** Any agreement by any employee or dependent to take as compensation an amount less than that prescribed by this chapter is void.

Subd. 5. **Accumulated credits, additional payments.** If employees of the state or a county, city or other political subdivision of the state who are entitled to the benefits of the workers' compensation law have, at the time of compensable injury, accumulated credits under a vacation, sick leave or overtime plan or system maintained by the governmental agency by which they are employed, the appointing authority may provide for the payment of additional benefits to such employees from their accumulated vacation, sick leave or overtime credits. Such additional payments to an employee may not exceed the amount of the total sick leave, vacation or overtime credits accumulated by the employee and shall not result in the payment of a total weekly rate of compensation that exceeds the weekly wage of the employee. Such additional payments to any employee shall be charged against the sick leave, vacation and overtime credits accumulated by such employee. Employees of a county, city or other political subdivision entitled to the benefits of the workers' compensation law may receive additional benefits pursuant to a collective bargaining agreement or other plan, entered into or in effect on or after January 1, 1980, providing payments by or on behalf of the employer and these additional benefits may be unrelated to any accumulated sick leave, holiday or overtime credits and need not be charged against any accumulation; provided that the additional payments shall not result in the payment of a total weekly rate of compensation that exceeds the weekly wage of the employee. The commissioner of the Department of Labor and Industry for the state or the governing body of any county, city or other political subdivision to which the provisions of this chapter apply, may adopt rules not inconsistent with this chapter for carrying out the provisions hereof relating to payment of additional benefits to employees from accumulated sick leave, vacation, overtime credits or other sources.

Subd. 6. **Compensation under city charter.** Where, in any city operating under a home rule charter, a mode and manner of compensation is provided by the charter which is different from that provided by this chapter, and the amount of compensation provided by the charter would, if taken thereunder, exceed the amount the employee is entitled to under this chapter for the same period, the employee shall, in addition to compensation under this chapter, receive under the charter an amount equal to the excess in compensation provided by the charter over what the employee is entitled to by this chapter; if the amount of compensation provided by the charter would, if taken thereunder, be equal to or less than the amount of compensation the employee is entitled to under this chapter for the same period, the employee shall take only under this chapter.

Subd. 7. **Public officer.** If an employee who is a public officer of the state or governmental subdivision continues to receive the compensation of office during a period when receiving benefits under the workers' compensation law for temporary total or temporary partial disability or permanent total disability and the compensation of office exceeds $100 a year, the amount of that compensation attributable to the period for which benefits under the workers' compensation law are paid shall be deducted from such benefits. If an employee covered by the Minnesota State Retirement System receives total and permanent disability benefits pursuant to section 352.113 or disability benefits pursuant to sections 352.95 and 352B.10, the amount of disability benefits shall be deducted from workers' compensation benefits otherwise payable. If an employee covered by the teachers retirement fund receives total and permanent disability benefits pursuant to section 354.48, the amount of disability benefits must be deducted from workers' compensation benefits otherwise payable. Notwithstanding the provisions of Minnesota Statutes 1994, section 176.132, a deduction under this subdivision does not entitle an employee to supplemental benefits under section 176.132.

Subd. 8. **Amounts adjusted.** Amounts of compensation payable by an employer or an employer's insurer under this chapter may be rounded to the nearest dollar amount. An employer or insurer who elects to make such adjustments shall do so for all compensation payments under this chapter.

Subd. 9. **Employer responsibility for wellness programs.** Injuries incurred while participating in voluntary recreational programs sponsored by the employer, including health promotion programs, athletic events, parties, and picnics, do not arise out of and in the course of the employment even though the employer pays some or all of the cost of the program. This exclusion does not apply in the event that the injured employee was ordered or assigned by the employer to participate in the program.

History: *1953 c 755 s 2; 1967 c 701 s 2; Ex1967 c 40 s 3,5; 1973 c 123 art 5 s 7; 1973 c 388 s 13,14; 1973 c 623 s 1; 1974 c 486 s 1; 1975 c 359 s 23; 1977 c 342 s 4; Ex1979 c 3 s 30; 1981 c 346 s 55-59; 1982 c 610 s 1; 1983 c 290 s 32,33; 1985 c 234 s 3,4; 1985 c 248 s 70; 1Sp1985 c 7 s 3; 1986 c 444; 1991 c 340 s 2; 1995 c 231 art 1 s 14,15; 1996 c 305 art 1 s 44*

176.03 [Repealed, 1953 c 755 s 83]

176.031 EMPLOYER'S LIABILITY EXCLUSIVE.

The liability of an employer prescribed by this chapter is exclusive and in the place of any other liability to such employee, personal representative, surviving spouse, parent, any child, dependent, next of kin, or other person entitled to recover damages on account of such injury or death. If an employer other than the state or any municipal subdivision thereof fails to insure or self-insure liability for compensation to injured employees and their dependents, an injured employee, or legal representatives or, if death results from the injury, any dependent may elect to claim compensation under this chapter or to maintain an action in the courts for damages on account of such injury or death. In such action it is not necessary to plead or prove freedom from contributory negligence. The defendant may not plead as a defense that the injury was caused by the negligence of a fellow servant, that the employee assumed the risk of employment, or that the injury was due to the contributory negligence of the employee, unless it appears that such negligence was willful on the part of the employee. The burden of proof to establish such willful negligence is upon the defendant. For the purposes of this chapter the state and each municipal subdivision thereof is treated as a self-insurer when not carrying insurance at the time of the injury or death of an employee.

History: *1953 c 755 s 3; 1986 c 444*

176.04 [Repealed, 1953 c 755 s 83]

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

Subdivision 1. **Employments excluded.** This chapter does not apply to any of the following:

(1) a person employed by a common carrier by railroad engaged in interstate or foreign commerce and who is covered by the Federal Employers' Liability Act, United States Code, title 45, sections 51 to 60, or other comparable federal law;

(2) a person employed by a family farm as defined by section 176.011, subdivision 11a;

(3) the spouse, parent, and child, regardless of age, of a farmer-employer working for the farmer-employer;

(4) a sole proprietor, or the spouse, parent, and child, regardless of age, of a sole proprietor;

(5) a partner engaged in a farm operation or a partner engaged in a business and the spouse, parent, and child, regardless of age, of a partner in the farm operation or business;

(6) an executive officer of a family farm corporation;

(7) an executive officer of a closely held corporation having less than 22,880 hours of payroll in the preceding calendar year, if that executive officer owns at least 25 percent of the stock of the corporation;

(8) a spouse, parent, or child, regardless of age, of an executive officer of a family farm corporation as defined in section 500.24, subdivision 2, and employed by that family farm corporation;

(9) a spouse, parent, or child, regardless of age, of an executive officer of a closely held corporation who is referred to in clause (7);

(10) another farmer or a member of the other farmer's family exchanging work with the farmer-employer or family farm corporation operator in the same community;

(11) a person whose employment at the time of the injury is casual and not in the usual course of the trade, business, profession, or occupation of the employer;

(12) persons who are independent contractors as defined by sections 176.043 and 181.723, and any rules adopted by the commissioner pursuant to section 176.83 except that these exclusions do not apply to an employee of an independent contractor;

(13) an officer or a member of a veterans' organization whose employment relationship arises solely by virtue of attending meetings or conventions of the veterans' organization, unless the veterans' organization elects by resolution to provide coverage under this chapter for the officer or member;

(14) a person employed as a household worker in, for, or about a private home or household who earns less than $1,000 in cash in a three-month period from a single private home or household provided that a household worker who has earned $1,000 or more from the household worker's present employer in a three-month period within the previous year is covered by this chapter regardless of whether or not the household worker has earned $1,000 in the present quarter;

(15) persons employed by a closely held corporation who are related by blood or marriage, within the third degree of kindred according to the rules of civil law, to an officer of the corporation, who is referred to in clause (7), if the corporation files a written election with the commissioner to exclude such individuals. A written election is not required for a person who is otherwise excluded from this chapter by this section;

(16) a nonprofit association which does not pay more than $1,000 in salary or wages in a year;

(17) persons covered under the Domestic Volunteer Service Act of 1973, as amended, United States Code, title 42, sections 5011, et seq.;

(18) a manager of a limited liability company having ten or fewer members and having less than 22,880 hours of payroll in the preceding calendar year, if that manager owns at least a 25 percent membership interest in the limited liability company;

(19) a spouse, parent, or child, regardless of age, of a manager of a limited liability company described in clause (18);

(20) persons employed by a limited liability company having ten or fewer members and having less than 22,880 hours of payroll in the preceding calendar year who are related by blood or marriage, within

the third degree of kindred according to the rules of civil law, to a manager of a limited liability company described in clause (18), if the company files a written election with the commissioner to exclude these persons. A written election is not required for a person who is otherwise excluded from this chapter by this section; or

(21) members of limited liability companies who satisfy the requirements of clause (12).

Subd. 1a. **Election of coverage.** The persons, partnerships, limited liability companies, and corporations described in this subdivision may elect to provide the insurance coverage required by this chapter.

(a) An owner or owners of a business or farm may elect coverage for themselves.

(b) A partnership owning a business or farm may elect coverage for any partner.

(c) A family farm corporation as defined in section 500.24, subdivision 2, clause (c), may elect coverage for any executive officer.

(d) A closely held corporation which had less than 22,880 hours of payroll in the previous calendar year may elect coverage for any executive officer if that executive officer is also an owner of at least 25 percent of the stock of the corporation.

(e) A limited liability company which had less than 22,880 hours of payroll in the previous calendar year may elect coverage for any manager if that manager is also an owner of at least 25 percent membership interest in the limited liability company.

(f) A person, partnership, limited liability company, or corporation hiring an independent contractor, as defined by rules adopted by the commissioner, may elect to provide coverage for that independent contractor. A person, partnership, limited liability company, or corporation may charge the independent contractor a fee for providing the coverage only if the independent contractor (1) elects in writing to be covered, (2) is issued an endorsement setting forth the terms of the coverage, the name of the independent contractors, and the fee and how it is calculated.

(g) The persons, partnerships, limited liability companies, and corporations described in this subdivision may also elect coverage for an employee who is a spouse, parent, or child, regardless of age, of an owner, partner, manager, or executive officer, who is eligible for coverage under this subdivision. Coverage may be elected for a spouse, parent, or child whether or not coverage is elected for the related owner, partner, manager, or executive director and whether or not the person, partnership, limited liability company, or corporation employs any other person to perform a service for hire. Any person for whom coverage is elected pursuant to this subdivision shall be included within the meaning of the term employee for the purposes of this chapter.

(h) Notice of election of coverage or of termination of election under this subdivision shall be provided in writing to the insurer. Coverage or termination of coverage is effective the day following receipt of notice by the insurer or at a subsequent date if so indicated in the notice. The insurance policy shall be endorsed to indicate the names of those persons for whom coverage has been elected or terminated under this subdivision. An election of coverage under this subdivision shall continue in effect as long as a policy or renewal policy of the same insurer is in effect.

(i) Nothing in this subdivision shall be construed to limit the responsibilities of owners, partnerships, limited liability companies, or corporations to provide coverage for their employees, if any, as required under this chapter.

Subd. 2. **Extraterritorial application.** If an employee who regularly performs the primary duties of employment within this state receives an injury while outside of this state in the employ of the same employer, the provisions of this chapter shall apply to such injury. If a resident of this state is transferred outside the territorial limits of the United States as an employee of a Minnesota employer, the resident shall be presumed to be temporarily employed outside of this state while so employed.

Subd. 3. **Temporary out-of-state employment.** If an employee hired in this state by a Minnesota employer receives an injury while temporarily employed outside of this state, such injury shall be subject to the provisions of this chapter.

Subd. 4. **Out-of-state employment.** If an employee who regularly performs the primary duties of employment outside of this state or is hired to perform the primary duties of employment outside of this state receives an injury within this state in the employ of the same employer, such injury shall be covered within the provisions of this chapter if the employee chooses to forgo any workers' compensation claim resulting from the injury that the employee may have a right to pursue in some other state, provided that the special compensation fund is not liable for payment of benefits pursuant to section 176.183 if the employer is not insured against workers' compensation liability pursuant to this chapter and the employee is a nonresident of Minnesota on the date of the personal injury.

Subd. 5. [Repealed, 1974 c 486 s 6]

Subd. 5a. **Out-of-state injuries.** Except as specifically provided by subdivisions 2 and 3, injuries occurring outside of this state are not subject to this chapter.

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

Subd. 6. **Commissioner of labor and industry; additional powers.** Whenever an employee is covered by subdivision 2, 3 or 4, the commissioner may enter into agreements with the appropriate agencies of other states for the purpose of resolving conflicts of jurisdiction or disputes concerning workers' compensation coverage. An agreement entered into pursuant to this subdivision may be appealed in the same manner and within the same time as if the appeal were from an order or decision of a compensation judge to the Workers' Compensation Court of Appeals or the district court.

History: *1953 c 755 s 4; Ex1967 c 40 s 6; 1971 c 669 s 1; 1973 c 657 s 2; 1974 c 286 s 1; 1975 c 271 s 2; 1975 c 359 s 5; 1977 c 342 s 5; 1978 c 722 s 2; 1979 c 15 s 1; 1979 c 74 s 2; 1979 c 92 s 4; 1981 c 346 s 60; 1983 c 290 s 34; 1983 c 311 s 8; 1984 c 432 art 1 s 3; 1986 c 444; 1986 c 461 s 3-6; 1987 c 332 s 10-12; 1993 c 137 s 6; 1994 c 512 s 1,2; 2005 c 90 s 2; 2008 c 250 s 2; 2009 c 89 s 1*

176.042 MS 2006 [Repealed, 2007 c 135 art 3 s 42]

176.043 TRUCKING AND MESSENGER/COURIER INDUSTRIES; INDEPENDENT CONTRACTORS.

In the trucking and messenger/courier industries, an operator of a car, van, truck, tractor, or truck-tractor that is licensed and registered by a governmental motor vehicle agency is an employee unless each of the following factors is present, and if each factor is present, the operator is an independent contractor:

(1) the individual owns the equipment or holds it under a bona fide lease arrangement;

(2) the individual is responsible for the maintenance of the equipment;

(3) the individual is responsible for the operating costs, including fuel, repairs, supplies, vehicle insurance, and personal expenses. The individual may be paid the carrier's fuel surcharge and incidental costs, including, but not limited to, tolls, permits, and lumper fees;

(4) the individual is responsible for supplying the necessary personal services to operate the equipment;

(5) the individual's compensation is based on factors related to the work performed, such as a percentage of any schedule of rates, and not on the basis of the hours or time expended;

(6) the individual substantially controls the means and manner of performing the services, in conformance with regulatory requirements and specifications of the shipper; and

(7) the individual enters into a written contract that specifies the relationship to be that of an independent contractor and not that of an employee.

History: *2009 c 89 s 2*

176.05 [Repealed, 1953 c 755 s 83]

176.051 ASSUMPTION OF LIABILITY; FARM AND HOUSEHOLD WORKERS.

Subdivision 1. **Farm and household workers.** An employer of workers on a farm operation or household workers not otherwise covered by this chapter may assume the liability for compensation imposed by this chapter and the employer's procurement of a workers' compensation policy constitutes an assumption by the employer of liability unless the employer elects in writing not to have those persons covered and the policy states that election. This assumption of liability takes effect and continues from the effective date of the policy and only as long as the policy remains in force. If during the life of the insurance policy, an employee, who is a worker on a farm operation or a household worker, suffers personal injury or death arising out of and in the course of employment, the exclusive remedy of the employee or the employee's dependents is under this chapter. For purposes of this section, farm worker does not include a spouse, parent, or child, regardless of age, of a farmer, a partner in a farm operation, or an officer of a family farm corporation as defined in section 500.24, subdivision 1, nor does it include other farmers in the same community or members of their family exchanging work with the farmer-employer or family farm corporation operator.

Subd. 2. [Repealed, 1984 c 432 art 1 s 4]

Subd. 3. [Repealed, 1984 c 432 art 1 s 4]

Subd. 4. [Repealed, 1984 c 432 art 1 s 4]

History: *1953 c 755 s 5; 1973 c 657 s 3; 1975 c 359 s 6; 1977 c 342 s 6; 1983 c 311 s 9*

176.06 [Repealed, 1953 c 755 s 83]

176.061 THIRD-PARTY LIABILITY.

Subdivision 1. **Election of remedies.** If an injury or death for which benefits are payable occurs under circumstances which create a legal liability for damages on the part of a party other than the employer and at the time of the injury or death that party was insured or self-insured in accordance with this chapter, the

employee, in case of injury, or the employee's dependents, in case of death, may proceed either at law against that party to recover damages or against the employer for benefits, but not against both.

Subd. 2. **Action for recovery of damages.** If the employee, in case of injury, or the employee's dependents, in case of death, brings an action for the recovery of damages, the amount of the damages, the manner in which they are paid, and the persons to whom they are payable, are as provided in this chapter. In no case shall the party be liable to any person other than the employee or the employee's dependents for any damages resulting from the injury or death.

Subd. 3. **Election to receive benefits from employer; subrogation.** If the employee or the employee's dependents elect to receive benefits from the employer, or the special compensation fund, the employer or the special compensation fund has a right of indemnity or is subrogated to the right of the employee or the employee's dependents to recover damages against the other party. The employer, or the attorney general on behalf of the special compensation fund, may bring legal proceedings against the party and recover the aggregate amount of benefits payable to or on behalf of the employee or the employee's dependents, regardless of whether such benefits are recoverable by the employee or the employee's dependents at common law or by statute together with costs, disbursements, and reasonable attorney fees of the action.

If an action as provided in this chapter is prosecuted by the employee, the employer, or the attorney general on behalf of the special compensation fund, against the third person, and results in judgment against the third person, or settlement by the third person, the employer has no liability to reimburse or hold the third person harmless on the judgment or settlement in absence of a written agreement to do so executed prior to the injury.

Subd. 4. **Application of subdivisions 1, 2, and 3.** The provisions of subdivisions 1, 2, and 3 apply only if the employer liable for benefits and the other party legally liable for damages are insured or self-insured and engaged, in the due course of business in, (1) furtherance of a common enterprise, or (2) in the accomplishment of the same or related purposes in operations on the premises where the injury was received at the time of the injury.

Subd. 5. **Cumulative remedies.** (a) If an injury or death for which benefits are payable is caused under circumstances which created a legal liability for damages on the part of a party other than the employer, that party being then insured or self-insured in accordance with this chapter, and the provisions of subdivisions 1, 2, 3, and 4 do not apply, or the party other than the employer is not then insured or self-insured as provided by this chapter, legal proceedings may be taken by the employee or the employee's dependents in accordance with paragraph (b), or by the employer, or by the attorney general on behalf of the special compensation fund, in accordance with paragraph (c), against the other party to recover damages, notwithstanding the payment of benefits by the employer or the special compensation fund or their liability to pay benefits.

(b) If an action against the other party is brought by the injured employee or the employee's dependents and a judgment is obtained and paid or settlement is made with the other party, the employer or the special compensation fund may deduct from the benefits payable the amount actually received by the employee or dependents or paid on their behalf in accordance with subdivision 6. If the action is not diligently prosecuted or if the court deems it advisable in order to protect the interests of the employer or the special compensation fund, upon application the court may grant the employer or the special compensation fund the right to intervene in the action for the prosecution of the action. If the injured employee or the employee's dependents or any party on their behalf receives benefits from the employer or the special compensation fund or institutes proceedings to recover benefits or accepts from the employer or the special compensation fund any payment on account of the benefits, the employer or the special compensation fund is subrogated to the rights of the employee or the employee's dependents or has a right of indemnity against a third party regardless of whether

such benefits are recoverable by the employee or the employee's dependents at common law or by statute. The employer or the attorney general on behalf of the special compensation fund may maintain a separate action or continue an action already instituted. This action may be maintained in the name of the employee or the names of the employee's dependents, or in the name of the employer, or in the name of the attorney general on behalf of the special compensation fund, against the other party for the recovery of damages. If the action is not diligently prosecuted by the employer or the attorney general on behalf of the special compensation fund, or if the court deems it advisable in order to protect the interest of the employee, the court, upon application, may grant to the employee or the employee's dependents the right to intervene in the action for the prosecution of the action. The proceeds of the action or settlement of the action shall be paid in accordance with subdivision 6.

(c) If an employer, being then insured, sustains damages due to a change in workers' compensation insurance premiums, whether by a failure to achieve a decrease or by a retroactive or prospective increase, as a result of the injury or death of an employee which was caused under circumstances which created a legal liability for damages on the part of a party other than the employer, the employer, notwithstanding other remedies provided, may maintain an action against the other party for recovery of the premiums. This cause of action may be brought either by joining in an action described in paragraph (b) or by a separate action. Damages recovered under this clause are for the benefit of the employer and the provisions of subdivision 6 are not applicable to the damages.

(d) The third party is not liable to any person other than the employee or the employee's dependents, or the employer, or the special compensation fund, for any damages resulting from the injury or death.

(e) A coemployee working for the same employer is not liable for a personal injury incurred by another employee unless the injury resulted from the gross negligence of the coemployee or was intentionally inflicted by the coemployee.

Subd. 6. **Costs, attorney fees, expenses.** (a) The proceeds of all actions for damages or of a settlement of an action under this section, except for damages received under subdivision 5, paragraph (c), received by the injured employee or the employee's dependents or by the employer or the special compensation fund, as provided by subdivision 5, shall be divided as follows:

(1) after deducting the reasonable cost of collection, including but not limited to attorney fees and burial expense in excess of the statutory liability, then

(2) one-third of the remainder shall in any event be paid to the injured employee or the employee's dependents, without being subject to any right of subrogation.

(b) Out of the balance remaining, the employer or the special compensation fund shall be reimbursed in an amount equal to all benefits paid under this chapter to or on behalf of the employee or the employee's dependents by the employer or special compensation fund, less the product of the costs deducted under paragraph (a), clause (1), divided by the total proceeds received by the employee or dependents from the other party multiplied by all benefits paid by the employer or the special compensation fund to the employee or the employee's dependents.

(c) Any balance remaining shall be paid to the employee or the employee's dependents, and shall be a credit to the employer or the special compensation fund for any benefits which the employer or the special compensation fund is obligated to pay, but has not paid, and for any benefits that the employer or the special compensation fund is obligated to make in the future.

(d) There shall be no reimbursement or credit to the employer or to the special compensation fund for interest or penalties.

Subd. 7. **Medical treatment.** The liability of an employer or the special compensation fund for medical treatment or payment of any other compensation under this chapter is not affected by the fact that the employee was injured through the fault or negligence of a third party, against whom the employee may have a cause of action which may be sued under this chapter, but the employer, or the attorney general on behalf of the special compensation fund, has a separate additional cause of action against the third party to recover any amounts paid for medical treatment or for other compensation payable under this section resulting from the negligence of the third party regardless of whether such other compensation is recoverable by the employee or the employee's dependents at common law or by statute. This separate cause of action of the employer or the attorney general on behalf of the special compensation fund may be asserted in a separate action brought by the employer or the attorney general on behalf of the special compensation fund against the third party, or in the action commenced by the employee or the employer or the attorney general on behalf of the special compensation fund under this chapter, but in the latter case the cause of action shall be separately stated, the amount awarded in the action shall be separately set out in the verdict, and the amount recovered by suit or otherwise as reimbursement for medical expenses or other compensation shall be for the benefit of the employer or the special compensation fund to the extent that the employer or the special compensation fund has paid or will be required to pay compensation or pay for medical treatment of the injured employee and does not affect the amount of periodic compensation to be paid.

Subd. 8. [Repealed, 1983 c 290 s 35]

Subd. 8a. **Notice to employer.** In every case arising under subdivision 5, a settlement between the third party and the employee is not valid unless prior notice of the intention to settle is given to the employer within a reasonable time. If the employer or insurer pays compensation to the employee under the provisions of this chapter and becomes subrogated to the right of the employee or the employee's dependents or has a right of indemnity, any settlement between the employee or the employee's dependents and the third party is void as against the employer's right of subrogation or indemnity. When an action at law is instituted by an employee or the employee's dependents against a third party for recovery of damages, a copy of the complaint and notice of trial or note of issue in the action shall be served on the employer or insurer. Any judgment rendered in the action is subject to a lien of the employer for the amount to which it is entitled to be subrogated or indemnified under the provisions of subdivision 5.

Subd. 9. **Service of notice on attorney general.** In every case in which the state is liable to pay compensation or is subrogated to the rights of the employee or the employee's dependents or has a right of indemnity, all notices required to be given the state shall be served on the attorney general and the commissioner.

Subd. 10. MS 1974 [Repealed, 1976 c 2 s 70; 1976 c 154 s 3]

Subd. 10. **Indemnity.** Notwithstanding the provisions of chapter 65B or any other law to the contrary, an employer has a right of indemnity for any compensation paid or payable pursuant to this chapter, regardless of whether such compensation is recoverable by the employee or the employee's dependents at common law or by statute, including temporary total compensation, temporary partial compensation, permanent partial compensation, medical compensation, rehabilitation, death, and permanent total compensation.

Subd. 11. **Right of contribution.** To the extent the employer has fault, separate from the fault of the injured employee to whom workers' compensation benefits are payable, any nonemployer third party who is liable has a right of contribution against the employer in an amount proportional to the employer's percentage

of fault but not to exceed the net amount the employer recovered pursuant to subdivision 6, paragraphs (b) and (c). The employer may avoid contribution exposure by affirmatively waiving, before selection of the jury, the right to recover workers' compensation benefits paid and payable, thus removing compensation benefits from the damages payable by any third party.

Procedurally, if the employer waives or settles the right to recover workers' compensation benefits paid and payable, the employee or the employee's dependents have the option to present all common law or wrongful death damages whether they are recoverable under the Workers' Compensation Act or not. Following the verdict, the trial court will deduct any awarded damages that are duplicative of workers' compensation benefits paid or payable.

History: *1953 c 755 s 6; Ex1967 c 1 s 6; Ex1967 c 40 s 4; 1969 c 199 s 1,2; 1969 c 936 s 3,4; 1973 c 388 s 15; 1976 c 154 s 1,2; 1979 c 81 s 1,2; Ex1979 c 3 s 31; 1981 c 346 s 61-66; 1983 c 290 s 35; 1986 c 444; 1995 c 231 art 1 s 16; 2000 c 447 s 4-8*

176.07 [Repealed, 1953 c 755 s 83]

176.071 JOINT EMPLOYERS; CONTRIBUTION.

When compensation is payable under this chapter for the injury or death of an employee employed and paid jointly by two or more employers at the time of the injury or death these employers shall contribute to the payment of the compensation in the proportion of their wage liabilities to the employee. If any such employer is excluded from the provisions of this chapter and is not liable for compensation, the liability of those employers who are liable for compensation is the proportion of the entire compensation which their wage liability bears to the employee's entire wages. As between themselves such employers may arrange for a different distribution of payment of the compensation for which they are liable.

History: *1953 c 755 s 7*

176.08 [Repealed, 1953 c 755 s 83]

176.081 LEGAL SERVICES OR DISBURSEMENTS; LIEN; REVIEW.

Subdivision 1. **Limitation of fees.** (a) A fee for legal services of 20 percent of the first $275,000 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 $55,000 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 $55,000. 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 20 percent of the first $275,000 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 available to an attorney who procures a benefit on behalf of the employee and 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 for services with respect to a medical or rehabilitation issue arising under section 176.102, 176.135, or 176.136 performed before the attorney has filed with the commissioner and served on the employer or insurer and the attorney representing the employer or insurer, if any, a request for certification of dispute containing the name of the employer and its insurer, the date of the injury, and a description of the benefits claimed, and the department certifies that there is a dispute and that it has tried to resolve the dispute. If within 30 days of the filing of the request the department has not issued a determination of whether a dispute exists, the dispute shall be certified if all of the following apply:

(1) the insurer has not approved the requested benefit;

(2) the employee, the employee's attorney, or the employee's treating provider has submitted any and all additional information requested by the insurer necessary to determine whether the requested benefit is disputed or approved; and

(3) the insurer has had at least seven calendar days to review any additional information submitted.

In cases of nonemergency surgery, if the employer or insurer has requested a second opinion under section 176.135, subdivision 1a, or an examination under section 176.155, subdivision 1, a dispute shall be certified if 45 days have passed following a written request for an examination or second opinion and the conditions in clauses (1) to (3) have been met.

(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 office. A copy of the signed retainer agreement shall

also be filed. The employee, employer or insurer, and the attorney representing the employer or insurer, if any, shall receive a copy of the statement of attorney fees. 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 $55,000 per case.

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

Subd. 2. [Repealed, 1995 c 231 art 2 s 110]

Subd. 3. **Review.** A party that is dissatisfied with attorney fees awarded by the commissioner or a compensation judge may file a petition for review by the Workers' Compensation Court of Appeals. The petition shall state the basis for the need of review and whether or not a hearing is requested. A copy of the petition shall be served by the court upon the attorney awarded or denied attorney fees. The Workers' Compensation Court of Appeals shall have the authority to raise the issue of the attorney fees at any time upon its own motion and shall have continuing jurisdiction over attorney fees.

Subd. 4. [Repealed, 1985 c 234 s 22]

Subd. 5. [Repealed, 1995 c 231 art 2 s 110]

Subd. 6. **Rules.** The commissioner, Office of Administrative Hearings, and the Workers' Compensation Court of Appeals may adopt reasonable and proper joint rules to effect each of their obligations under this section.

Subd. 7. **Award; additional amount.** If the employer or insurer files a denial of liability, notice of discontinuance, or fails to make payment of compensation or medical expenses within the statutory period after notice of injury or occupational disease, or otherwise unsuccessfully resists the payment of compensation or medical expenses, or unsuccessfully disputes the payment of rehabilitation benefits or other aspects of a rehabilitation plan, and the injured person has employed an attorney at law, who successfully procures payment on behalf of the employee or who enables the resolution of a dispute with respect to a rehabilitation plan, the compensation judge, commissioner, or the Workers' Compensation Court of Appeals upon appeal, upon application, shall award to the employee against the insurer or self-insured employer or uninsured employer, in addition to the compensation benefits paid or awarded to the employee, an amount equal to 30 percent of that portion of the attorney's fee which has been awarded pursuant to this section that is in excess of $250. This subdivision shall apply only to contingent fees payable from the employee's compensation benefits, and not to other fees paid by the employer and insurer, including but not limited to those fees payable for resolution of a medical dispute or rehabilitation dispute, or pursuant to section 176.191.

Subd. 7a. **Settlement offer.** At any time prior to one day before a matter is to be heard, a party litigating a claim made pursuant to this chapter may serve upon the adverse party a reasonable offer of settlement of the claim, with provision for costs and disbursements then accrued. If before the hearing the adverse party serves written notice that the offer is accepted, either party may then file the offer and notice of acceptance, together with the proof of service thereof, and thereupon judgment shall be entered.

If an offer by an employer or insurer is not accepted by the employee, it shall be deemed withdrawn and evidence thereof is not admissible, except in a proceeding to determine attorney's fees.

If an offer by an employee is not accepted by the employer or insurer, it shall be deemed withdrawn and evidence thereof is not admissible, except in a proceeding to determine attorney's fees.

The fact that an offer is made but not accepted does not preclude a subsequent offer.

Subd. 8. [Repealed, 1995 c 231 art 2 s 110]

Subd. 9. **Retainer agreement.** An attorney who is hired by an employee to provide legal services with respect to a claim for compensation made pursuant to this chapter shall prepare a retainer agreement in which the provisions of this section are specifically set out and provide a copy of this agreement to the employee. The retainer agreement shall provide a space for the signature of the employee. A signed agreement shall raise a conclusive presumption that the employee has read and understands the statutory fee provisions. No fee shall be awarded pursuant to this section in the absence of a signed retainer agreement.

The retainer agreement shall contain a notice to the employee regarding the maximum fee allowed under this section in ten-point type, which shall read:

Notice of Maximum Fee

The maximum fee allowed by law for legal services is 20 percent of the first $130,000 of compensation awarded to the employee subject to a cumulative maximum fee of $26,000 for fees related to the same injury.

The employee shall take notice that the employee is under no legal or moral obligation to pay any fee for legal services in excess of the foregoing maximum fee.

Subd. 10. **Violation; penalty.** An attorney who knowingly violates any of the provisions of this chapter with respect to authorized fees for legal services in connection with any demand made or suit or proceeding brought under the provisions of this chapter is guilty of a gross misdemeanor.

Subd. 11. **When fees due.** Attorney fees and other disbursements for a proceeding under this chapter shall not be due or paid until the issue for which the fee or disbursement was incurred has been resolved.

Subd. 12. **Sanctions; failure to prepare, appear, or participate.** If a party or party's attorney fails to appear at any conference or hearing scheduled under this chapter, is substantially unprepared to participate in the conference or hearing, or fails to participate in good faith, the commissioner or compensation judge, upon motion or upon its own initiative, shall require the party or the party's attorney or both to pay the reasonable expenses including attorney fees, incurred by the other party due to the failure to appear, prepare, or participate. Attorney fees or other expenses may not be awarded if the commissioner or compensation judge finds that the noncompliance was substantially justified or that other circumstances would make the sanction unjust. The Department of Labor and Industry, and the Office of Administrative Hearings may by rule establish additional sanctions for failure of a party or the party's attorney to appear, prepare for, or participate in a conference or hearing.

History: *1953 c 755 s 8; 1973 c 388 s 16; 1975 c 271 s 6; 1975 c 359 s 7; 1976 c 134 s 78; 1977 c 342 s 7-11; Ex1979 c 3 s 32; 1981 c 346 s 67-74; 1983 c 290 s 36-41; 1986 c 444; 1986 c 461 s 7; 1987 c 332 s 13; 1989 c 209 art 2 s 23; 1992 c 510 art 2 s 1-3; 1995 c 231 art 2 s 45-49; 1997 c 7 art 1 s 80; 2000 c 447 s 9; 2005 c 90 s 3; 2013 c 70 art 2 s 3,4; 2014 c 275 art 1 s 34; 2016 c 110 art 1 s 1,2; 2023 c 51 art 2 s 1; 2024 c 97 s 4*

NOTE: The parts of section 176.081 regulating attorney fees without permitting review by the court were found unconstitutional in *Irwin v. Surdyks Liquor*, 599 N.W.2d 132 (Minn. 1999).

176.09 [Repealed, 1953 c 755 s 83]

176.091 MINOR EMPLOYEES.

Except as provided in section 176.092, a minor employee has the same power to enter into a contract, make election of remedy, make any settlement, and receive compensation as an adult employee.

History: *1953 c 755 s 9; 1957 c 781 s 1; 1973 c 388 s 17; 1975 c 271 s 6; 1975 c 359 23; 1976 c 134 s 78; 1993 c 194 s 3*

176.092 GUARDIAN; CONSERVATOR.

Subdivision 1. **When required.** An injured employee or a dependent under section 176.111 who is a minor or an incapacitated person as that term is defined in section 524.5-102, subdivision 6, shall have a guardian or conservator to represent the interests of the employee or dependent in obtaining compensation according to the provisions of this chapter. This section applies if the employee receives or is eligible for permanent total disability benefits, supplementary benefits, or permanent partial disability benefits totaling more than $3,000 or a dependent receives or is eligible for dependency benefits, or if the employee or dependent receives or is offered a lump sum that exceeds five times the statewide average weekly wage.

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

Subd. 2. **Appointment.** If an injured employee or dependent under section 176.111 does not have a guardian or conservator and the attorney representing the employee or dependent knows or has reason to believe the employee or dependent is a minor or an incapacitated person, the attorney shall, within 30 days, seek a district court order appointing a guardian or conservator. If the employer, insurer, or special compensation fund in a matter involving a claim against the fund knows or has reason to believe the employee or dependent is a minor or is incapacitated, the employer, insurer, or special compensation fund shall notify the attorney representing the employee or dependent. If the employee or dependent has no attorney or the attorney fails to seek appointment of a guardian or conservator within 30 days of being notified under this subdivision, the employer or insurer shall seek the appointment in district court and the special compensation fund shall notify the commissioner or a compensation judge for referral of the matter under subdivision 3. In the case of a minor who is not represented by an attorney, the commissioner shall refer the matter under subdivision 3.

Subd. 3. **Referral.** When, in a proceeding before them, it appears to the commissioner, compensation judge, or, in cases upon appeal, the Workers' Compensation Court of Appeals, that an injured employee or a dependent is a minor or an incapacitated person without a guardian or conservator, the commissioner, compensation judge, or court of appeals shall refer the matter to district court. The commissioner has no duty to monitor files at the department but must review a file for referral upon receiving a complaint that an injured employee or dependent is a minor or an incapacitated person without a guardian or conservator.

Subd. 4. **Guardian, conservator; powers, duties.** A guardian or conservator of an injured employee or dependent shall have the powers and duties granted by the district court including, but not limited to:

(1) representing the interests of the employee or dependent in obtaining compensation according to the provisions of this chapter;

(2) receiving monetary compensation benefits, including the amount of any award, settlement, or judgment; and

(3) acting as a fiduciary in distributing, managing, and investing monetary workers' compensation benefits.

History: *1993 c 194 s 4; 1995 c 189 s 8; 1996 c 277 s 1; 2002 c 262 s 1,2; 2004 c 146 art 3 s 12; 2005 c 90 s 4*

BENEFITS

176.095 LEGISLATIVE FINDINGS.

The legislature finds that workers' compensation benefits for total disabilities should exceed those benefits provided for partial disabilities in order to fairly compensate the person unable to engage in gainful employment or suffering an injury described in section 176.101, subdivision 5. It is the policy of the legislature that any change in the benefit schedule for total disability be accompanied by an appropriate change in the benefit schedule for partial disability.

History: *1969 c 936 s 1; 1975 c 359 s 23*

176.10 [Repealed, 1953 c 755 s 83]

176.101 COMPENSATION SCHEDULE.

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

(b)(1) Commencing on October 1, 2024, and each October 1 thereafter, the maximum weekly compensation payable is 108 percent of the statewide average weekly wage for the period ending December 31 of the preceding year.

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

(c) The minimum weekly compensation payable is $130 per week or the injured employee's actual weekly wage, whichever is less. Beginning on October 1, 2021, and each October 1 thereafter, the minimum weekly compensation shall be 20 percent of the maximum weekly compensation payable or the employee's actual weekly wage, whichever is less.

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

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

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

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

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

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

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

(i) Temporary total disability compensation shall cease if the employee refuses an offer of work that is consistent with a plan of rehabilitation filed with the commissioner which meets the requirements of section 176.102, subdivision 4, or, if no plan has been filed, the employee refuses an offer of gainful employment that the employee can do in the employee's physical condition. Once temporary total disability compensation has ceased under this paragraph, it may not be recommenced.

(j) Temporary total disability compensation shall cease 90 days after the employee has reached maximum medical improvement, except as provided in section 176.102, subdivision 11, paragraph (b). For purposes of this subdivision, the 90-day period after maximum medical improvement commences on the earlier of: (1) the date that the employee receives a written medical report indicating that the employee has reached maximum medical improvement; or (2) the date that the employer or insurer serves the report on the employee

and the employee's attorney, if any. Once temporary total disability compensation has ceased under this paragraph, it may not be recommenced except if the employee returns to work and is subsequently medically unable to continue working as provided in paragraph (e), clause (2).

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

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

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

Subd. 2. **Temporary partial disability.** (a) In all cases of temporary partial disability the compensation shall be 66-2/3 percent of the difference between the weekly wage of the employee at the time of injury and the wage the employee is able to earn in the employee's partially disabled condition. This compensation shall be paid during the period of disability except as provided in this section, payment to be made at the intervals when the wage was payable, as nearly as may be, and subject to the maximum rate for temporary total compensation.

(b) Temporary partial compensation may be paid only while the employee is employed, earning less than the employee's weekly wage at the time of the injury, and the reduced wage the employee is able to earn in the employee's partially disabled condition is due to the injury. Except as provided in section 176.102, subdivision 11, paragraphs (b) and (c), temporary partial compensation may not be paid for more than 275 weeks, or after 450 weeks after the date of injury, whichever occurs first.

(c) Temporary partial compensation must be reduced to the extent that the wage the employee is able to earn in the employee's partially disabled condition plus the temporary partial disability payment otherwise payable under this subdivision exceeds 500 percent of the statewide average weekly wage.

Subd. 2a. **Permanent partial disability.** (a) Compensation for permanent partial disability is as provided in this subdivision. Permanent partial disability must be rated as a percentage of the whole body in accordance with rules adopted by the commissioner under section 176.105. During the 2026 regular legislative session, and every even-year legislative session thereafter, the Workers' Compensation Advisory Council must consider whether the permanent partial disability schedule in paragraph (b) represents adequate compensation for permanent impairment.

(b) The percentage determined pursuant to the rules adopted under section 176.105 must be multiplied by the corresponding amount in the following table:

Impairment Rating (percent)		Amount
less than 5.5	$	114,260

5.5 to less than 10.5	121,800
10.5 to less than 15.5	129,485
15.5 to less than 20.5	137,025
20.5 to less than 25.5	139,720
25.5 to less than 30.5	147,000
30.5 to less than 35.5	150,150
35.5 to less than 40.5	163,800
40.5 to less than 45.5	177,450
45.5 to less than 50.5	177,870
50.5 to less than 55.5	181,965
55.5 to less than 60.5	209,475
60.5 to less than 65.5	237,090
65.5 to less than 70.5	264,600
70.5 to less than 75.5	292,215
75.5 to less than 80.5	347,340
80.5 to less than 85.5	402,465
85.5 to less than 90.5	457,590
90.5 to less than 95.5	512,715
95.5 up to and including 100	567,840

An employee may not receive compensation for more than a 100 percent disability of the whole body, even if the employee sustains disability to two or more body parts.

(c) Permanent partial disability is payable upon cessation of temporary total disability under subdivision 1. If the employee requests payment in a lump sum, then the compensation must be paid within 30 days. This lump-sum payment may be discounted to the present value calculated up to a maximum five percent basis. If the employee does not choose to receive the compensation in a lump sum, then the compensation is payable in installments at the same intervals and in the same amount as the employee's temporary total disability rate on the date of injury. Permanent partial disability is not payable while temporary total compensation is being paid.

Subd. 3. [Repealed, 1983 c 290 s 173]

Subd. 3a. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3b. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3c. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3d. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3e. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3f. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3g. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3h. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3i. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3j. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3k. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3l. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3m. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3n. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3o. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3p. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3q. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3r. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3s. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3t. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3u. [Repealed, 1995 c 231 art 1 s 36]

Subd. 3v. [Repealed, 1987 c 332 s 117]

Subd. 4. **Permanent total disability.** For permanent total disability, as defined in subdivision 5, the compensation shall be 66-2/3 percent of the daily wage at the time of the injury, subject to a maximum weekly compensation equal to the maximum weekly compensation for a temporary total disability and a minimum weekly compensation equal to 65 percent of the statewide average weekly wage. This compensation shall be paid during the permanent total disability of the injured employee but after a total of $25,000 of weekly compensation has been paid, the amount of the weekly compensation benefits being paid by the employer shall be reduced by the amount of any disability benefits being paid by any government disability benefit program if the disability benefits are occasioned by the same injury or injuries which give rise to payments under this subdivision. This reduction shall also apply to any old age and survivor insurance benefits. Payments shall be made at the intervals when the wage was payable, as nearly as may be. In case an employee who is permanently and totally disabled becomes an inmate of a public institution, no compensation shall be payable during the period of confinement in the institution, unless there is wholly dependent on the employee for support some person named in section 176.111, subdivision 1, 2 or 3, in which case the compensation provided for in section 176.111, during the period of confinement, shall be paid for the benefit of the dependent person during dependency. The dependency of this person shall be determined as though the employee were deceased. Permanent total disability shall cease at age 72, except

that if an employee is injured after age 67, permanent total disability benefits shall cease after five years of those benefits have been paid.

Subd. 4a. **Preexisting condition or disability; apportionment.** (a) If a personal injury results in a disability which is attributable in part to a preexisting disability that arises from a congenital condition or is the result of a traumatic injury or incident, whether or not compensable under this chapter, the compensation payable for the permanent partial disability pursuant to this section shall be reduced by the proportion of the disability which is attributable only to the preexisting disability. An apportionment of a permanent partial disability under this subdivision shall be made only if the preexisting disability is clearly evidenced in a medical report or record made prior to the current personal injury. Evidence of a copy of the medical report or record upon which apportionment is based shall be made available to the employee by the employer at the time compensation for the permanent partial disability is begun.

(b) The compensable portion of the permanent partial disability under this section shall be paid at the rate at which the entire disability would be compensated but for the apportionment.

Subd. 5. **Definition.** For purposes of subdivision 4, "permanent total disability" means only:

(1) the total and permanent loss of the sight of both eyes, the loss of both arms at the shoulder, the loss of both legs so close to the hips that no effective artificial members can be used, complete and permanent paralysis, total and permanent loss of mental faculties; or

(2) any other injury which totally and permanently incapacitates the employee from working at an occupation which brings the employee an income, provided that the employee must also meet the criteria of one of the following items:

(i) the employee has at least a 17 percent permanent partial disability rating of the whole body;

(ii) the employee has a permanent partial disability rating of the whole body of at least 15 percent and the employee is at least 50 years old at the time of injury; or

(iii) the employee has a permanent partial disability rating of the whole body of at least 13 percent and the employee is at least 55 years old at the time of the injury, and has not completed grade 12 or obtained a commissioner of education-selected high school equivalency certification.

For purposes of this clause, "totally and permanently incapacitated" means that the employee's physical disability in combination with any one of item (i), (ii), or (iii) causes the employee to be unable to secure anything more than sporadic employment resulting in an insubstantial income. Other factors not specified in item (i), (ii), or (iii), including the employee's age, education, training and experience, may only be considered in determining whether an employee is totally and permanently incapacitated after the employee meets the threshold criteria of item (i), (ii), or (iii). The employee's age, level of physical disability, or education may not be considered to the extent the factor is inconsistent with the disability, age, and education factors specified in item (i), (ii), or (iii).

Subd. 6. **Minors; apprentices.** (a) If any employee entitled to the benefits of this chapter is an apprentice of any age and sustains a personal injury arising out of and in the course of employment resulting in permanent total or a compensable permanent partial disability, for the purpose of computing the compensation to which the employee is entitled for the injury, the compensation rate for temporary total, temporary partial, or permanent total disability shall be the maximum rate for temporary total disability under subdivision 1.

(b) If any employee entitled to the benefits of this chapter is a minor and sustains a personal injury arising out of and in the course of employment resulting in permanent total disability, for the purpose of

computing the compensation to which the employee is entitled for the injury, the compensation rate for a permanent total disability shall be the maximum rate for temporary total disability under subdivision 1.

Subd. 7. [Repealed, Ex1979 c 3 s 70]

Subd. 8. **Cessation of benefits.** Temporary total disability payments shall cease at retirement. "Retirement" means that a preponderance of the evidence supports a conclusion that an employee has retired. The subjective statement of an employee that the employee is not retired is not sufficient in itself to rebut objective evidence of retirement but may be considered along with other evidence.

For injuries occurring after January 1, 1984, an employee who receives Social Security old age and survivors insurance retirement benefits under the Social Security Act, Public Law 98-21, as amended, is presumed retired from the labor market. For injuries occurring after October 1, 2000, an employee who receives any other service-based government retirement pension is presumed retired from the labor market. The term "service-based government retirement pension" does not include disability-based government pensions. These presumptions are rebuttable by a preponderance of the evidence.

History: *1953 c 755 s 10; 1955 c 615 s 1-5; 1957 c 781 s 2-5; Ex1967 c 40 s 7-11; 1969 c 186 s 1; 1969 c 276 s 2; 1969 c 936 s 5-8; 1971 c 422 s 1,2; 1971 c 475 s 1-4; 1973 c 388 s 18-20; 1973 c 600 s 1; 1973 c 643 s 1-4; 1974 c 486 s 2-4; 1975 c 271 s 6; 1975 c 359 s 8,23; 1976 c 134 s 78; 1977 c 342 s 12; 1977 c 347 s 30; Ex1979 c 3 s 33-35; 1981 c 346 s 75; 1983 c 290 s 42-68; 1984 c 432 art 2 s 1-12; 1985 c 234 s 5-7; 1986 c 444; 1986 c 461 s 8,9; 1989 c 209 art 2 s 24; 1992 c 510 art 1 s 3-7; 1994 c 488 s 8; 1995 c 231 art 1 s 17-23; 2000 c 447 s 10-12,25; 2002 c 220 art 13 s 9; 2008 c 250 s 3; 2009 c 75 s 1; 2013 c 70 art 2 s 5; 1Sp2017 c 5 art 10 s 7; 2018 c 185 art 5 s 2-4; 2021 c 12 s 1; 2022 c 55 art 1 s 107; 2023 c 25 s 104; 2023 c 51 art 3 s 1; 2024 c 97 s 5,6*

176.1011 [Repealed, 1996 c 310 s 1]

REHABILITATION

176.102 REHABILITATION.

Subdivision 1. **Scope.** (a) This section applies only to vocational rehabilitation of injured employees and their spouses as provided under subdivision 1a. Physical rehabilitation of injured employees is considered treatment subject to section 176.135.

(b) Rehabilitation is intended to restore the injured employee so the employee may return to a job related to the employee's former employment or to a job in another work area which produces an economic status as close as possible to that the employee would have enjoyed without disability. Rehabilitation to a job with a higher economic status than would have occurred without disability is permitted if it can be demonstrated that this rehabilitation is necessary to increase the likelihood of reemployment. Economic status is to be measured not only by opportunity for immediate income but also by opportunity for future income.

Subd. 1a. **Surviving spouse.** Upon the request of a qualified dependent surviving spouse, rehabilitation services shall be provided through the rehabilitation services section of the Workers' Compensation Division. For the purposes of this subdivision a qualified dependent surviving spouse is a dependent surviving spouse, as determined under section 176.111, who is in need of rehabilitation assistance to become self-supporting. A spouse who is provided rehabilitation services under this subdivision is not entitled to compensation under subdivision 11.

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. The commissioner may hire qualified personnel to assist in the commissioner's duties under this section and may delegate the duties and performance.

Subd. 3. **Review panel.** There is created a rehabilitation review panel composed of the commissioner or a designee, who shall serve as an ex officio member and two members each from employers, insurers, and rehabilitation, two licensed or registered health care providers, one chiropractor, and four members representing labor. The members shall be appointed by the commissioner and shall serve four-year terms which may be renewed. Terms, compensation, and removal for members shall be governed by section 15.0575. Notwithstanding section 15.059, this panel does not expire unless the panel no longer fulfills the purpose for which the panel was established, the panel has not met in the last 18 months, or the panel does not comply with the registration requirements of section 15.0599, subdivision 3. The panel shall select a chair. The panel shall review and make a determination with respect to appeals from orders of the commissioner regarding certification approval of qualified rehabilitation consultants, qualified rehabilitation consultant firms, and vendors. The hearings are de novo and initiated by the panel under the contested case procedures of chapter 14, and are appealable to the Workers' Compensation Court of Appeals in the manner provided by section 176.421.

Subd. 3a. **Disciplinary actions.** The panel has authority to discipline qualified rehabilitation consultants and vendors and may impose a penalty of up to $3,000 per violation, payable to the commissioner for deposit in the assigned risk safety account, and may suspend or revoke certification. Complaints against registered qualified rehabilitation consultants and vendors shall be made to the commissioner who may investigate complaints. If the investigation indicates a violation of this chapter or rules adopted under this chapter, the commissioner may initiate a contested case proceeding under the provisions of chapter 14. In these cases, the rehabilitation review panel shall make the final decision following receipt of the report of an administrative law judge. The decision of the panel is appealable to the Workers' Compensation Court of Appeals in the manner provided by section 176.421. The panel shall continuously study rehabilitation services and delivery, develop and recommend rehabilitation rules to the commissioner, and assist the commissioner in accomplishing public education.

The commissioner may appoint alternates for one-year terms to serve as a member when a member is unavailable. The number of alternates shall not exceed one labor member, one employer or insurer member, and one member representing a licensed or registered health care provider, chiropractic, or rehabilitation.

Subd. 3b. **Review panel determinations.** Recommendations from the administrative law judge following a contested case hearing shall be determined by the panel. The panel may adopt rules of procedure which may be joint rules with the Medical Services Review Board.

Subd. 3c. **Rehabilitation review panel meetings.** (a) Except where the rehabilitation review panel is making a decision in a contested case matter under subdivision 3, 3a, or 3b, the panel may conduct a meeting of its members by telephone or other electronic means so long as the following conditions are met:

(1) all members of the panel participating in the meeting, wherever their physical location, can hear one another and can hear all discussion and testimony;

(2) members of the public present at the regular meeting location of the panel can hear clearly all discussion and testimony and all votes of members of the panel and, if needed, receive those services required by sections 15.44 and 15.441;

(3) at least one member of the panel is physically present at the regular meeting location; and

(4) all votes are conducted by roll call, so each member's vote on each issue can be identified and recorded.

(b) Each member of the panel participating in a meeting by telephone or other electronic means is considered present at the meeting for purposes of determining a quorum and participating in all proceedings.

(c) If telephone or other electronic means are used to conduct a regular, special, or emergency meeting, the panel, to the extent practical, shall allow a person to monitor the meeting electronically from a remote location. The panel or the Department of Labor and Industry may require the person making such a connection to pay for documented costs that the panel or the Department of Labor and Industry incurs as a result of the additional connection.

(d) If telephone or other electronic means are used to conduct a regular, special, or emergency meeting, the panel shall provide notice of the regular meeting location, of the fact that some members may participate by telephone or other electronic means, and that a person may monitor the meeting electronically from a remote location. The timing and method of providing notice is governed by section 13D.04.

Subd. 4. **Rehabilitation plan; development.** (a) A rehabilitation consultation must be provided by the employer to an injured employee upon request of the employee, the employer, or the commissioner. When the commissioner has received notice or information that an employee has sustained an injury that may be compensable under this chapter, the commissioner must notify the injured employee of the right to request a rehabilitation consultation to assist in return to work. The notice may be included in other information the commissioner gives to the employee under section 176.235, and must be highlighted in a way to draw the employee's attention to it. If a rehabilitation consultation is requested, the employer shall provide a qualified rehabilitation consultant. If the injured employee objects to the employer's selection, the employee may select a qualified rehabilitation consultant of the employee's own choosing within 60 days following the filing of a copy of the employee's rehabilitation plan with the commissioner. If the consultation indicates that rehabilitation services are appropriate under subdivision 1, the employer shall provide the services. If the consultation indicates that rehabilitation services are not appropriate under subdivision 1, the employer shall notify the employee of this determination within 14 days after the consultation.

(b) In order to assist the commissioner in determining whether or not to request rehabilitation consultation for an injured employee, an employer shall notify the commissioner whenever the employee's temporary total disability will likely exceed 13 weeks. The notification must be made within 90 days from the date of the injury or when the likelihood of at least a 13-week disability can be determined, whichever is earlier, and must include a current physician's report.

(c) The qualified rehabilitation consultant shall disclose in writing at the first meeting or written communication with the employee any ownership interest or affiliation between the firm which employs the qualified rehabilitation consultant and the employer, insurer, adjusting or servicing company, including the nature and extent of the affiliation or interest. The consultant shall also disclose to all parties any affiliation, business referral or other arrangement between the consultant or the firm employing the consultant and any other party, attorney, or health care provider involved in the case.

(d) After the initial provision or selection of a qualified rehabilitation consultant as provided under paragraph (a), the employee may request a different qualified rehabilitation consultant which shall be granted or denied by the commissioner or compensation judge according to the best interests of the parties.

(e) The employee and employer shall enter into a program if one is prescribed in a rehabilitation plan within 30 days of the rehabilitation consultation if the qualified rehabilitation consultant determines that rehabilitation is appropriate. A copy of the plan, including a target date for return to work, shall be submitted to the commissioner within 15 days after the plan has been developed.

(f) If the employer does not provide rehabilitation consultation requested under paragraph (a), the commissioner or compensation judge shall notify the employer that if the employer fails to provide a qualified rehabilitation consultant within 15 days to conduct a rehabilitation consultation, the commissioner or compensation judge shall appoint a qualified rehabilitation consultant to provide the consultation at the expense of the employer unless the commissioner or compensation judge determines the consultation is not required.

(g) In developing a rehabilitation plan consideration shall be given to the employee's qualifications, including but not limited to age, education, previous work history, interest, transferable skills, and present and future labor market conditions.

(h) The commissioner or compensation judge may waive rehabilitation services under this section if the commissioner or compensation judge is satisfied that the employee will return to work in the near future or that rehabilitation services will not be useful in returning an employee to work.

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

(b) For purposes of this subdivision, job development means systematic contact with prospective employers resulting in opportunities for interviews and employment that might not otherwise have existed, and includes identification of job leads and arranging for job interviews. Job development facilitates a prospective employer's consideration of a qualified employee for employment. Job development services provided by a qualified rehabilitation consultant firm or a registered rehabilitation vendor must not exceed 20 hours per month or 26 consecutive or intermittent weeks. When 13 consecutive or intermittent weeks of job development services have been provided, the qualified rehabilitation consultant must consult with the parties and either file a plan amendment reflecting an agreement by the parties to extend job development services for up to an additional 13 consecutive or intermittent weeks, or file a request for a rehabilitation conference under section 176.106. The commissioner or compensation judge may issue an order modifying the rehabilitation plan or make other determinations about the employee's rehabilitation, but must not order more than 26 total consecutive or intermittent weeks of job development services.

Subd. 6. **Plan, eligibility for rehabilitation, approval and appeal.** (a) The commissioner or a compensation judge shall determine eligibility for rehabilitation services and shall review, approve, modify, or reject rehabilitation plans developed under subdivision 4. The commissioner or a compensation judge shall also make determinations regarding rehabilitation issues not necessarily part of a plan including, but not limited to, determinations regarding whether an employee is eligible for further rehabilitation and the benefits under subdivisions 9 and 11 to which an employee is entitled.

(b) A rehabilitation consultant must file a progress report on the plan with the commissioner six months after the plan is filed. The progress report must include a current estimate of the total cost and the expected duration of the plan. The commissioner may require additional progress reports. Based on the progress

reports and available information, the commissioner may take actions including, but not limited to, redirecting, amending, suspending, or terminating the plan.

Subd. 6a. [Repealed, 1987 c 332 s 117]

Subd. 7. **Plan implementation; reports.** Upon request by the commissioner, insurer, employer or employee, medical and rehabilitation reports shall be made by the provider of the medical and rehabilitation service to the commissioner, insurer, employer or employee.

Subd. 8. **Plan modification.** (a) Upon request to the commissioner or compensation judge by the employer, the insurer, or employee, or upon the commissioner's own request, the plan may be suspended, terminated, or altered upon a showing of good cause, including:

(1) a physical impairment that does not allow the employee to pursue the rehabilitation plan;

(2) the employee's performance level indicates the plan will not be successfully completed;

(3) an employee does not cooperate with a plan;

(4) that the plan or its administration is substantially inadequate to achieve the rehabilitation plan objectives;

(5) that the employee is not likely to benefit from further rehabilitation services.

(b) An employee may request a change in a rehabilitation plan once because the employee feels ill-suited for the type of work for which rehabilitation is being provided. If the rehabilitation plan includes retraining, this request must be made within 90 days of the beginning of the retraining program.

Subd. 9. **Plan; costs.** (a) An employer is liable for the following rehabilitation expenses under this section:

(1) cost of rehabilitation evaluation and preparation of a plan;

(2) cost of all rehabilitation services and supplies necessary for implementation of the plan;

(3) reasonable cost of tuition, books, travel, and custodial day care; and, in addition, reasonable costs of board and lodging when rehabilitation requires residence away from the employee's customary residence;

(4) reasonable costs of travel and custodial day care during the job interview process;

(5) reasonable cost for moving expenses of the employee and family if a job is found in a geographic area beyond reasonable commuting distance after a diligent search within the present community. Relocation shall not be paid more than once during any rehabilitation program, and relocation shall not be required if the new job is located within the same standard metropolitan statistical area as the employee's job at the time of injury. An employee shall not be required to relocate and a refusal to relocate shall not result in a suspension or termination of compensation under this chapter; and

(6) any other expense agreed to be paid.

(b) Charges for services provided by a rehabilitation consultant or vendor must be submitted on a billing form prescribed by the commissioner. No payment for the services shall be made until the charges are submitted on the prescribed form.

(c) Except as provided in this paragraph, an employer is not liable for charges for services provided by a rehabilitation consultant or vendor unless the employer or its insurer receives a bill for those services

within 45 days of the provision of the services. The commissioner or a compensation judge may order payment for charges not timely billed under this paragraph if the rehabilitation consultant or vendor can prove that the failure to submit the bill as required by this paragraph was due to circumstances beyond the control of the rehabilitation consultant or vendor. A rehabilitation consultant or vendor may not collect payment from any other person, including the employee, for bills that an employer is relieved from liability for paying under this paragraph.

Subd. 10. **Rehabilitation; consultants, interns, and vendors.** (a) The commissioner shall approve rehabilitation consultants who may propose and implement plans if they satisfy rules adopted by the commissioner for rehabilitation consultants. A consultant may be an individual or public or private entity, and except for rehabilitation services, Department of Employment and Economic Development, a consultant may not be a vendor or the agent of a vendor of rehabilitation services. The commissioner shall also approve rehabilitation vendors if they satisfy rules adopted by the commissioner. An employer or insurer must be approved by the commissioner as a qualified rehabilitation firm and create an account in CAMPUS as a firm to employ a qualified rehabilitation consultant to provide rehabilitation services to an employee under this section.

(b) An applicant to be a qualified rehabilitation consultant intern must file in CAMPUS a plan of supervision prescribed by the commissioner and signed by the supervisor at the time the application is filed. The supervisor must be employed as a qualified rehabilitation consultant by the same firm as the intern applicant and meet experience requirements prescribed in rule by the commissioner. In the plan of supervision, the supervisor must agree to verify that the intern complies with all rehabilitation rules and statutes during the internship. All documents related to an employee's rehabilitation prepared by the intern that are filed with the commissioner must be reviewed by the supervisor before they are filed. The supervisor need not sign the intern's written work, but the intern must verify that the supervisor has reviewed the document at the time the document is filed with the commissioner in CAMPUS. An intern must file a new signed plan of supervision if there is a change of supervisors.

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

Subd. 11. **Retraining; compensation.** (a) Retraining is limited to 156 weeks. An employee who has been approved for retraining may petition the commissioner or compensation judge for additional compensation not to exceed 25 percent of the compensation otherwise payable. If the commissioner or compensation judge determines that this additional compensation is warranted due to unusual or unique circumstances of the employee's retraining plan, the commissioner may award additional compensation in an amount not to exceed the employee's request. This additional compensation shall cease at any time the commissioner or compensation judge determines the special circumstances are no longer present.

(b) If the employee is not employed during a retraining plan that has been specifically approved under this section, temporary total compensation is payable for up to 90 days after the end of the retraining plan; except that, payment during the 90-day period is subject to cessation in accordance with section 176.101. If the employee is employed during the retraining plan but earning less than at the time of injury, temporary partial compensation is payable at the rate of 66-2/3 percent of the difference between the employee's weekly wage at the time of injury and the weekly wage the employee is able to earn in the employee's partially disabled condition, subject to the maximum rate for temporary total compensation. Temporary partial compensation is not subject to the 275-week or 450-week limitations provided by section 176.101, subdivision 2, during the retraining plan, but is subject to those limitations before and after the plan.

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

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

Subd. 11a. **Applicability of section.** This section is applicable to all employees injured prior to or on and after October 1, 1979, except for those provisions which affect an employee's monetary benefits.

Subd. 12. [Repealed, 1983 c 290 s 173]

Subd. 13. **Discontinuance.** (a) All benefits payable under chapter 176 may, after a determination and order by the commissioner or compensation judge, be discontinued or forfeited for any time during which the employee refuses to submit to any reasonable examinations and evaluative procedures ordered by the commissioner or compensation judge to determine the need for and details of a plan of rehabilitation, or refuses to participate in rehabilitation evaluation as required by this section or does not make a good faith effort to participate in a rehabilitation plan. A discontinuance under this section is governed by sections 176.238 and 176.239.

(b) Once the employer or insurer has accepted liability for a claim and a rehabilitation plan has been approved, the employer or insurer may not discontinue payment of rehabilitation services until notice has been filed with the commissioner and served on the qualified rehabilitation consultant, the employee, and the attorney representing the employee, if any. The notice shall state the date of intended discontinuance and set forth a statement of facts clearly indicating the reason for the action. Copies of whatever medical reports or other written reports in the employer's or insurer's possession which are relied on for the discontinuance shall be attached to the notice.

Subd. 14. **Fees.** The commissioner shall impose fees sufficient to cover the cost of approving and monitoring qualified rehabilitation consultants, consultant firms, and vendors of rehabilitation services. These fees are payable to the commissioner for deposit in the special compensation fund.

History: *Ex1979 c 3 s 36; 1981 c 346 s 76; 1983 c 290 s 69-83; 1984 c 432 art 2 s 13,14; 1985 c 234 s 8,9; 1Sp1985 c 13 s 273; 1986 c 444; 1987 c 332 s 14-21; 1992 c 510 art 1 s 8; art 4 s 1-5; 1994 c 483 s 1; 1994 c 632 art 4 s 57,58; 1995 c 231 art 2 s 50,51; 1997 c 187 art 3 s 26; 1999 c 250 art 3 s 22; 2000 c 447 s 13,14; 2001 c 123 s 2-4; 2001 c 161 s 33; 2004 c 206 s 52; 2005 c 90 s 5; 2008 c 250 s 4,5; 2009 c 75 s 2-4; 2013 c 70 art 1 s 1; art 2 s 6,7; 2018 c 185 art 5 s 5; 2019 c 50 art 1 s 60; 7Sp2020 c 1 art 2 s 7; 2023 c 51 art 6 s 3; 2024 c 97 s 7*

176.1021 [Repealed, 2009 c 75 s 17]

REVIEW OF SERVICES

176.103 MEDICAL HEALTH CARE REVIEW.

Subdivision 1. **Purpose.** It is the purpose of this section to provide for review of clinical health care providers who render services to injured employees. This review shall be achieved by establishing a quality control system within the Department of Labor and Industry.

The commissioner shall hire a medical consultant to assist in the administration of this section.

The medical consultant shall be a doctor of medicine licensed under the laws of Minnesota.

The medical consultant shall perform all duties assigned by the commissioner relating to the supervision of the total continuum of care of injured employees and shall also advise the department on matters on which the commissioner requests the consultant's advice or if the consultant deems it appropriate.

Subd. 2. **Scope.** The commissioner shall monitor the medical and surgical treatment provided to injured employees, the services of other health care providers and shall also monitor hospital utilization as it relates to the treatment of injured employees. This monitoring shall include determinations concerning the appropriateness of the service, whether the treatment is necessary and effective, the proper cost of services, the quality of the treatment, the right of providers to receive payment under this chapter for services rendered or the right to receive payment under this chapter for future services. Insurers and self-insurers must assist the commissioner in this monitoring by reporting to the commissioner cases of suspected excessive, inappropriate, or unnecessary treatment. The commissioner in consultation with the Medical Services Review Board shall adopt rules defining standards of treatment including inappropriate, unnecessary, or excessive treatment and the sanctions to be imposed for inappropriate, unnecessary, or excessive treatment. The sanctions imposed may include, without limitation, a warning, a restriction on providing treatment, requiring preauthorization by the board for a plan of treatment, and suspension from receiving compensation for the provision of treatment under chapter 176. The commissioner's authority under this section also includes the authority to make determinations regarding any other activity involving the questions of utilization of medical services, and any other determination the commissioner deems necessary for the proper administration of this section, but does not include the authority to make the initial determination of primary liability, except as provided by section 176.305.

Subd. 2a. [Repealed, 1995 c 231 art 2 s 110]

Subd. 3. **Medical Services Review Board; selection; powers.** (a) There is created a Medical Services Review Board composed of the commissioner or the commissioner's designee as an ex officio member and the following health care providers: two chiropractors, one physical therapist, one registered nurse, one occupational therapist, and six physicians representing different specialties which the commissioner determines are the most frequently utilized by injured employees. All health care provider members must maintain a license in the state of Minnesota to furnish medical or health services under their specific designation throughout their appointment period. The board shall also have one person representing hospitals, one person representing employees, and one person representing employers or insurers. The members shall be appointed by the commissioner and shall be governed by section 15.0575. Terms of the board's members may be renewed. The board may appoint from its members whatever subcommittees it deems appropriate. Notwithstanding section 15.059, this board does not expire unless the board no longer fulfills the purpose for which the board was established, the board has not met in the last 18 months, or the board does not comply with the registration requirements of section 15.0599, subdivision 3.

The commissioner may appoint alternates for one-year terms to serve as a member when a member is unavailable. The number of alternates shall not exceed one chiropractor, one physical therapist, one registered nurse, one hospital representative, three physicians, one employee representative, one employer or insurer representative, and one occupational therapist.

(b) The board shall review clinical results for adequacy and recommend to the commissioner scales for disabilities and apportionment.

(c) The board shall review and recommend to the commissioner rates for individual clinical procedures and aggregate costs. The board shall assist the commissioner in accomplishing public education.

(d) In evaluating the clinical consequences of the services provided to an employee by a clinical health care provider, the board shall consider the following factors in the priority listed:

(1) the clinical effectiveness of the treatment;

(2) the clinical cost of the treatment; and

(3) the length of time of treatment.

(e) The board shall advise the commissioner on the adoption of rules regarding all aspects of medical care and services provided to injured employees.

(f) The Medical Services Review Board may upon petition from the commissioner and after hearing, issue a warning, a penalty of $200 per violation, a restriction on providing treatment that requires preauthorization by the board, commissioner, or compensation judge for a plan of treatment, disqualify, or suspend a provider from receiving payment for services rendered under this chapter if a provider has violated any part of this chapter or rule adopted under this chapter, or where there has been a pattern of, or an egregious case of, inappropriate, unnecessary, or excessive treatment by a provider. Any penalties collected under this subdivision shall be payable to the commissioner for deposit in the assigned risk safety account. The hearings are initiated by the commissioner under the contested case procedures of chapter 14. The board shall make the final decision following receipt of the recommendation of the administrative law judge. The board's decision is appealable to the Workers' Compensation Court of Appeals in the manner provided by section 176.421.

(g) The board may adopt rules of procedure. The rules may be joint rules with the rehabilitation review panel.

(h) Except where the board is making a decision in a contested case matter under paragraph (b), the board may conduct a meeting of its members by telephone or other electronic means so long as the following conditions are met:

(1) all members of the board participating in the meeting, wherever their physical location, can hear one another and can hear all discussion and testimony;

(2) members of the public present at the regular meeting location of the board can hear clearly all discussion and testimony and all votes of members of the board and, if needed, receive those services required by sections 15.44 and 15.441;

(3) at least one member of the board is physically present at the regular meeting location; and

(4) all votes are conducted by roll call, so each member's vote on each issue can be identified and recorded.

(i) Each member of the board participating in a meeting by telephone or other electronic means is considered present at the meeting for purposes of determining a quorum and participating in all proceedings.

(j) If telephone or other electronic means are used to conduct a regular, special, or emergency meeting, the board, to the extent practical, shall allow a person to monitor the meeting electronically from a remote location. The board or the Department of Labor and Industry may require the person making such a connection to pay for documented costs that the board or the Department of Labor and Industry incurs as a result of the additional connection.

(k) If telephone or other electronic means are used to conduct a regular, special, or emergency meeting, the board shall provide notice of the regular meeting location, of the fact that some members may participate by telephone or other electronic means, and that a person may monitor the meeting electronically from a remote location. The timing and method of providing notice is governed by section 13D.04.

Subd. 4. [Repealed, 1987 c 332 s 117]

History: *1983 c 290 s 84; 1984 c 432 art 2 s 15,16; 1985 c 234 s 10; 1986 c 461 s 10; 1987 c 329 s 21; 1987 c 332 s 23,24; 1992 c 510 art 4 s 6-8; 1995 c 231 art 2 s 52,53; 2001 c 123 s 5; 2001 c 161 s 34; 2002 c 262 s 3; 2009 c 75 s 5; 2022 c 32 art 1 s 1*

176.104 REHABILITATION PRIOR TO DETERMINATION OF LIABILITY.

Subdivision 1. **Dispute.** If there exists a dispute regarding medical causation or whether an injury arose out of and in the course and scope of employment and an employee is otherwise eligible for rehabilitation services under section 176.102 prior to determination of liability, the employee shall be referred by the commissioner to the department's Vocational Rehabilitation Unit which shall provide rehabilitation consultation if appropriate. If the sole dispute is regarding discontinuance of compensation, an employee eligible for rehabilitation services may be referred to the Vocational Rehabilitation Unit only after the employee or employer has filed an objection under section 176.238, subdivision 6, to the administrative decision on discontinuance. The services provided by the department's Vocational Rehabilitation Unit and the scope and term of the rehabilitation are governed by section 176.102 and rules adopted pursuant to that section. Rehabilitation costs and services under this subdivision shall be monitored by the commissioner.

Subd. 2. **Liability for rehabilitation; lien.** (a) If liability is determined after the employee has commenced rehabilitation under this section the liable party is responsible for the cost of rehabilitation provided. Future rehabilitation after liability is established is governed by section 176.102.

(b) If the employer, insurer, or defendant is given written notice by the department of a claim for rehabilitation services or disbursements, the claim is a lien against the amount paid or payable as compensation.

Subd. 3. **Reimbursements.** All money received under this section must be credited to the special compensation fund.

Subd. 4. **Vocational Rehabilitation Unit funding.** The cost of the Vocational Rehabilitation Unit shall be financed by the special compensation fund beginning July 1, 1992.

History: *1983 c 290 s 85; 1984 c 432 art 2 s 17,18; 1986 c 461 s 11; 1991 c 292 art 10 s 2; 1992 c 513 art 3 s 34-36; 1995 c 231 art 2 s 54; 2024 c 97 s 8*

176.1041 [Repealed, 2008 c 250 s 18]

DISABILITY SCHEDULES

176.105 COMMISSIONER TO ESTABLISH DISABILITY SCHEDULES.

Subdivision 1. **Schedule; rules.** (a) The commissioner of labor and industry shall by rule establish a schedule of degrees of disability resulting from different kinds of injuries. Disability ratings under the schedule for permanent partial disability must be based on objective medical evidence. The commissioner, in consultation with the Medical Services Review Board, shall periodically review the rules adopted under this paragraph to determine whether any injuries omitted from the schedule should be included and amend the rules accordingly.

(b) No permanent partial disability compensation shall be payable except in accordance with the disability ratings established under this subdivision, except as provided in paragraph (c). The schedule may provide that minor impairments receive a zero rating.

(c) If an injury for which there is objective medical evidence is not rated by the permanent partial disability schedule, the unrated injury must be assigned and compensated for at the rating for the most similar condition that is rated.

Subd. 2. **Rules; internal organs.** The commissioner shall by rule establish a schedule of internal organs that are compensable and indicate in the schedule to what extent the organs are compensable under section 176.101, subdivision 2a.

Subd. 3. **Study.** In order to accomplish the purposes of this section, the commissioner shall study disability or permanent impairment schedules set up by other states, the American Medical Association and other organizations.

Subd. 4. **Legislative intent; rules; loss of more than one body part.** (a) For the purpose of establishing a disability schedule, the legislature declares its intent that the commissioner establish a disability schedule which shall be determined by sound actuarial evaluation and shall be based on the benefit level which exists on January 1, 1983.

(b) The commissioner shall by rulemaking adopt procedures setting forth rules for the evaluation and rating of functional disability and the schedule for permanent partial disability and to determine the percentage of loss of function of a part of the body based on the body as a whole, including internal organs and any other body part which the commissioner deems appropriate.

(c) The rules shall promote objectivity and consistency in the evaluation of permanent functional impairment due to personal injury and in the assignment of a numerical rating to the functional impairment.

(d) Prior to adoption of rules the commissioner shall conduct an analysis of the current permanent partial disability schedule for the purpose of determining the number and distribution of permanent partial disabilities and the average compensation for various permanent partial disabilities. The commissioner shall consider setting the compensation under the proposed schedule for the most serious conditions higher in comparison to the current schedule and shall consider decreasing awards for minor conditions in comparison to the current schedule.

(e) The commissioner may consider, among other factors, and shall not be limited to the following factors in developing rules for the evaluation and rating of functional disability and the schedule for permanent partial disability benefits:

(1) the workability and simplicity of the procedures with respect to the evaluation of functional disability;

(2) the consistency of the procedures with accepted medical standards;

(3) rules, guidelines, and schedules that exist in other states that are related to the evaluation of permanent partial disability or to a schedule of benefits for functional disability provided that the commissioner is not bound by the degree of disability in these sources but shall adjust the relative degree of disability to conform to the expressed intent of this section;

(4) rules, guidelines, and schedules that have been developed by associations of health care providers or organizations provided that the commissioner is not bound by the degree of disability in these sources but shall adjust the relative degree of disability to conform to the expressed intent of this section;

(5) the effect the rules may have on reducing litigation;

(6) the treatment of preexisting disabilities with respect to the evaluation of permanent functional disability provided that any preexisting disabilities must be objectively determined by medical evidence; and

(7) symptomatology and loss of function and use of the injured member.

The factors in clauses (1) to (7) shall not be used in any individual or specific workers' compensation claim under this chapter but shall be used only in the adoption of rules pursuant to this section.

Nothing listed in clauses (1) to (7) shall be used to dispute or challenge a disability rating given to a part of the body so long as the whole schedule conforms with the expressed intent of this section.

(f) If an employee suffers a permanent functional disability of more than one body part due to a personal injury incurred in a single occurrence, the percent of the whole body which is permanently partially disabled shall be determined by the following formula so as to ensure that the percentage for all functional disability combined does not exceed the total for the whole body:

$$A + B (1 - A)$$

where: A is the greater percentage whole body loss of the first body part; and B is the lesser percentage whole body loss otherwise payable for the second body part. A + B (1-A) is equivalent to A + B - AB.

For permanent partial disabilities to three body parts due to a single occurrence or as the result of an occupational disease, the above formula shall be applied, providing that A equals the result obtained from application of the formula to the first two body parts and B equals the percentage for the third body part. For permanent partial disability to four or more body parts incurred as described above, A equals the result obtained from the prior application of the formula, and B equals the percentage for the fourth body part or more in arithmetic progressions.

History: *Ex1979 c 3 s 62; 1981 c 346 s 77; 1983 c 290 s 86; 1984 c 640 s 32; 1986 c 461 s 12; 1992 c 510 art 2 s 4; 1995 c 231 art 1 s 24; 2016 c 158 art 1 s 75,214*

CONFERENCES

176.106 ADMINISTRATIVE CONFERENCE.

Subdivision 1. **Scope.** All determinations by the commissioner or compensation judge pursuant to section 176.102, 176.103, 176.135, or 176.136 shall be in accordance with the procedures contained in this section. For medical disputes under sections 176.135 and 176.136, the commissioner shall have jurisdiction to hold an administrative conference and issue decisions and orders under this section if the amount in dispute at

the time the medical request is filed is $7,500 or less. The $7,500 limit does not apply if the medical issue to be determined is whether a charge for a service, article, or supply is excessive under section 176.136, subdivision 1, 1a, 1b, or 1c, and corresponding Minnesota Rules.

Subd. 2. **Request for conference.** Any party may request an administrative conference by filing a request on a form prescribed by the commissioner.

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

The commissioner or compensation judge may refuse to hold an administrative conference and refer the matter for a settlement or pretrial conference or may certify the matter to the Office of Administrative Hearings for a full hearing before a compensation judge.

Subd. 4. **Appearances.** All parties shall appear either personally, by telephone, by electronic means, by representative, or by written submission. The commissioner's designee or compensation judge shall determine the method of appearance and issues in dispute based upon the information available at the conference.

Subd. 5. **Decision.** Unless the matter is referred for other proceedings under subdivision 3, a written decision shall be issued by the commissioner or compensation judge determining all issues considered at the conference or if a conference was not held, based on the written submissions. Disputed issues of fact shall be determined by a preponderance of the evidence. The decision must be issued within 30 days after the close of the conference or if no conference was held, within 60 days after receipt of the request for conference. The decision must include a statement indicating the right to request a de novo hearing before a compensation judge and how to initiate the request.

Subd. 6. **Penalty.** At a conference, if the insurer does not provide a specific reason for nonpayment of the items in dispute, the commissioner or compensation judge may assess a penalty of $300 payable to the commissioner for deposit in the assigned risk safety account, unless it is determined that the reason for the lack of specificity was the failure of the insurer, upon timely request, to receive information necessary to remedy the lack of specificity. This penalty is in addition to any penalty that may be applicable for nonpayment.

Subd. 7. **Request for hearing.** (a) Any party aggrieved by the decision of the commissioner or compensation judge may request a formal de novo hearing by filing the request with the office and serving the request on all parties no later than 30 days after the decision. When a compensation judge issues the administrative decision under subdivision 5, the formal de novo hearing must be held before a compensation judge other than the compensation judge who presided over the administrative conference.

(b) Except where the only issues to be determined pursuant to this section involve liability for past treatment or services that will not affect entitlement to ongoing or future proposed treatment or services under section 176.102 or 176.135, the hearing at the office must be held on the first date that all parties are

available, but not later than 60 days after the request for hearing is filed. Following the hearing, the compensation judge must issue the decision within 30 days.

(c) A decision of the compensation judge issued under this subdivision is appealable pursuant to section 176.421.

Subd. 8. **Denial of primary liability.** The commissioner does not have authority to make determinations relating to medical or rehabilitation benefits when there is a genuine dispute over whether the injury initially arose out of and in the course of employment.

Subd. 9. **Subsequent causation issues.** If initial liability for an injury has been admitted or established and an issue subsequently arises regarding causation between the employee's condition and the work injury, the commissioner or compensation judge may make the subsequent causation determination subject to de novo hearing by a compensation judge as provided in subdivision 7.

History: *1986 c 444; 1987 c 332 s 25; 1992 c 510 art 3 s 11; 1995 c 231 art 2 s 55; 2000 c 447 s 15; 2002 c 262 s 4; 2005 c 90 s 6; 2011 c 89 s 5-11; 2013 c 70 art 1 s 2; art 2 s 8; 2022 c 32 art 2 s 1; 2024 c 97 s 9*

176.107 TELECONFERENCES.

The division, department, office, or the court of appeals may, at its discretion, conduct mediation sessions, administrative conferences, settlement conferences, or hearings as provided in this chapter in person, by telephone, or by visual or audio teleconferencing methods.

History: *1995 c 231 art 2 s 56*

MISCELLANEOUS

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: *1995 c 231 art 2 s 57; 1997 c 7 art 5 s 13*

176.11 [Repealed, 1953 c 755 s 83]

176.111 DEPENDENTS, ALLOWANCES.

Subdivision 1. **Persons wholly dependent, presumption.** For the purposes of this chapter the following persons are conclusively presumed to be wholly dependent:

(a) spouse, unless it be shown that the spouse and decedent were voluntarily living apart at the time of the injury or death;

(b) children under 18 years of age, or a child under the age of 25 years who is regularly attending as a full-time student at a high school, college, or university, or regularly attending as a full-time student in a course of vocational or technical training.

Subd. 2. **Children.** Children 18 years of age, or over 18 when physically or mentally incapacitated from earning, are prima facie considered dependent.

Subd. 3. **Persons wholly supported.** A spouse, child, mother, father, grandmother, grandfather, grandchild, sister, brother, mother-in-law, father-in-law, wholly supported by a deceased worker at the time of death and for a reasonable time prior thereto are considered actual dependents of the deceased worker and compensation shall be paid to them in the order named.

Subd. 4. **Persons partially supported.** Any member of a class named in subdivision 3 who regularly derived partial support from the wages of a deceased worker at the time of death and for a reasonable time prior thereto is considered a partial dependent and compensation shall be paid to such dependents in the order named.

Subd. 5. **Payments, to whom made.** In death cases compensation payable to dependents is computed on the following basis and shall be paid to the persons entitled thereto or to a guardian or conservator as required under section 176.092. The minimum amount of dependency compensation that must be paid to persons entitled thereto is $60,000.

Subd. 6. **Spouse, no dependent child.** If the deceased employee leaves a dependent surviving spouse and no dependent child, there shall be paid to the spouse weekly workers' compensation benefits at 50 percent of the weekly wage at the time of the injury for a period of ten years, including adjustments as provided in section 176.645.

Subd. 7. **Spouse, one dependent child.** If the deceased employee leaves a surviving spouse and one dependent child, there shall be paid to the surviving spouse for the benefit of the spouse and child 60 percent of the daily wage at the time of the injury of the deceased until the child is no longer a dependent as defined in subdivision 1. At that time there shall be paid to the dependent surviving spouse weekly benefits at a rate which is 16-2/3 percent less than the last weekly workers' compensation benefit payment, as defined in subdivision 8a, while the surviving child was a dependent, for a period of ten years, including adjustments as provided in section 176.645.

Subd. 8. **Spouse, two dependent children.** If the deceased employee leaves a surviving spouse and two dependent children, there shall be paid to the surviving spouse for the benefit of the spouse and children 66-2/3 percent of the daily wage at the time of the injury of the deceased until the last dependent child is no longer dependent. At that time the dependent surviving spouse shall be paid weekly benefits at a rate which is 25 percent less than the last weekly workers' compensation benefit payment, as defined in subdivision 8a, while the surviving child was a dependent, for a period of ten years, adjusted according to section 176.645.

Subd. 8a. **Last weekly benefit payment.** For the purposes of subdivisions 7 and 8, "last weekly workers' compensation benefit payment" means the workers' compensation benefit which would have been payable without the application of subdivision 21.

Subd. 9. [Repealed, 1975 c 359 s 22]

Subd. 9a. **Remarriage of spouse.** A surviving spouse who remarries and is receiving benefits under subdivision 6, 7, or 8 shall continue to be eligible to receive weekly benefits for the remaining period that the spouse is entitled to receive benefits pursuant to this section.

Subd. 10. **Allocation of compensation.** In all cases where compensation is payable to the surviving spouse for the benefit of the surviving spouse and dependent children, the commissioner, compensation judge, or Workers' Compensation Court of Appeals or district court in cases upon appeal shall determine what portion of the compensation applies for the benefit of dependent children and may order that portion paid to a guardian. This subdivision shall not be construed to increase the combined total of weekly

government survivor benefits and workers' compensation beyond the limitation established in subdivision 21.

Subd. 11. [Repealed, 1981 c 346 s 145]

Subd. 12. **Orphans.** If the deceased employee leaves a dependent orphan, there shall be paid 55 percent of the weekly wage at the time of the injury of the deceased, for two or more orphans there shall be paid 66-2/3 percent of the wages.

Subd. 13. [Repealed, 1977 c 342 s 28]

Subd. 14. **Parents.** If the deceased employee leave no surviving spouse or child entitled to any payment under this chapter, but leaves both parents wholly dependent on deceased, there shall be paid to such parents jointly 45 percent of the weekly wage at the time of the injury of the deceased. In case of the death of either of the wholly dependent parents the survivor shall receive 35 percent of the weekly wage thereafter. If the deceased employee leave one parent wholly dependent on the deceased, there shall be paid to such parent 35 percent of the weekly wage at the time of the injury of the deceased employee. The compensation payments under this section shall not exceed the actual contributions made by the deceased employee to the support of the employee's parents for a reasonable time immediately prior to the injury which caused the death of the deceased employee.

Subd. 15. **Remote dependents.** If the deceased employee leaves no surviving spouse or child or parent entitled to any payment under this chapter, but leaves a grandparent, grandchild, brother, sister, mother-in-law, or father-in-law wholly dependent on the employee for support, there shall be paid to such dependent, if but one, 30 percent of the weekly wage at the time of injury of the deceased, or if more than one, 35 percent of the weekly wage at the time of the injury of the deceased, divided among them share and share alike.

Subd. 16. **Cessation of compensation.** Except as provided in this chapter, compensation ceases upon the death or marriage of any dependent. Cessation of benefits requires notice pursuant to subdivision 23.

Subd. 17. **Partial dependents.** Partial dependents are entitled to receive only that proportion of the benefits provided for actual dependents which the average amount of wages regularly contributed by the deceased to such partial dependents at the time of and for a reasonable time immediately prior to the injury bore to the total income of the dependent during the same time; and if the amount regularly contributed by the deceased to such partial dependents cannot be ascertained because of the circumstances of the case, the commissioner, compensation judge, or court of appeals, in cases upon appeal, shall make a reasonable estimate thereof taking into account all pertinent factors of the case.

Subd. 18. **Burial expense.** In all cases where death results to an employee from a personal injury arising out of and in the course of employment, the employer shall pay the expense of burial, not exceeding in amount $15,000. In case any dispute arises as to the reasonable value of the services rendered in connection with the burial, its reasonable value shall be determined and approved by the commissioner, a compensation judge, or Workers' Compensation Court of Appeals, in cases upon appeal, before payment, after reasonable notice to interested parties as is required by the commissioner. If the deceased leaves no dependents, no compensation is payable, except as provided by this chapter.

Subd. 19. [Repealed, 1975 c 359 s 22]

Subd. 20. **Actual dependents, compensation.** Actual dependents are entitled to take compensation in the order named in subdivision 3 during dependency until 66-2/3 percent of the weekly wage of the deceased at the time of injury is exhausted. The total weekly compensation to be paid to full actual dependents of a

deceased employee shall not exceed in the aggregate an amount equal to the maximum weekly compensation for a temporary total disability.

Subd. 21. **Death, benefits; coordination with governmental survivor benefits.** The following provision shall apply to any dependent entitled to receive weekly compensation benefits under this section as the result of the death of an employee, and who is also receiving or entitled to receive benefits under any government survivor program:

The combined total of weekly government survivor benefits and workers' compensation death benefits provided under this section shall not exceed 100 percent of the weekly wage being earned by the deceased employee at the time of the injury causing death; provided, however, that no state workers' compensation death benefit shall be paid for any week in which the survivor benefits paid under the federal program, by themselves, exceed 100 percent of such weekly wage provided, however, the workers' compensation benefits payable to a dependent surviving spouse shall not be reduced on account of any governmental survivor benefits payable to decedent's children if the support of the children is not the responsibility of the dependent surviving spouse.

For the purposes of this subdivision "dependent" means dependent surviving spouse together with all dependent children and any other dependents. For the purposes of this subdivision, mother's or father's insurance benefits received pursuant to United States Code, title 42, section 402(g), are benefits under a government survivor program.

Subd. 22. **Payments to estate; death of employee.** (a) In every case of death of an employee resulting from personal injury arising out of and in the course of employment where there are no persons entitled to monetary benefits of dependency compensation, the employer shall pay to the estate of the deceased employee the sum of $60,000. This payment must be made within 14 days of notice to the insurer of one of the following:

(1) the appointment of a personal representative of the estate; or

(2) if there is no personal representative, presentation of a certified death record and an affidavit of collection of personal property according to the requirements of sections 524.3-1201 and 524.3-1202.

(b) Within 14 days of notice to the insurer of the death of the employee, the insurer must send notice to the estate, at the deceased employee's last known address, that this payment will be made after receipt of the documentation in paragraph (a), clause (1) or (2).

Subd. 23. **Notice of cessation of dependency benefits.** If an employer intends to discontinue dependency benefits of any individual identified as a dependent in this section, the employer must file with the commissioner, as required under section 176.231, subdivision 6, paragraphs (a) and (e), and serve on the dependent whose benefits are being discontinued written notice within 14 calendar days of discontinuance. The notice shall state the name of the individual whose dependency benefits are being discontinued, the date the individual's benefits will be discontinued, and a statement of facts clearly indicating the reason the individual will no longer receive dependency benefits and is no longer considered a dependent under this section. Any document in the employer's possession which is relied on for the discontinuance shall be attached to the notice. Failure to file this form as required may result in a penalty under section 176.231, subdivision 10.

History: *1953 c 755 s 11; 1955 c 615 s 6-8; 1957 c 781 s 6,7; 1965 c 742 s 1; Ex1967 c 40 s 12,13; 1969 c 936 s 9-12; 1971 c 475 s 5-7; 1973 c 388 s 21-25; 1973 c 643 s 5-7; 1975 c 271 s 6; 1975 c 359 s 9-16,23; 1976 c 134 s 78; 1977 c 342 s 13-15; Ex1979 c 3 s 37; 1981 c 346 s 78-83; 1983 c 290 s 87-91;*

1984 c 655 art 1 s 34; 1986 c 444; 1986 c 461 s 13-16; 1987 c 49 s 3,4; 1987 c 332 s 26; 1992 c 510 art 1 s 9; 1993 c 194 s 5; 2000 c 447 s 16-18; 2002 c 262 s 5; 7Sp2020 c 1 art 2 s 8; 2023 c 51 art 6 s 4,5; 2024 c 101 art 3 s 2

176.12 [Repealed, 1953 c 755 s 83]

176.121 COMMENCEMENT OF COMPENSATION.

In cases of temporary total or temporary partial disability no compensation is allowed for the three calendar days after the disability commenced, except as provided by section 176.135, nor in any case unless the employer has actual knowledge of the injury or is notified thereof within the period specified in section 176.141. If the disability continues for ten calendar days or longer, the compensation is computed from the commencement of the disability. Disability is deemed to commence on the first calendar day or fraction of a calendar day that the employee is unable to work.

History: *1953 c 755 s 12; 1969 c 936 s 13; 1983 c 290 s 92*

176.129 CREATION OF SPECIAL COMPENSATION FUND.

Subdivision 1. **Deposit of funds.** The special compensation fund is created for the purposes provided for in this chapter and chapter 182. The commissioner of management and budget is the custodian of the special compensation fund. Sums paid to the commissioner pursuant to this section shall be deposited with the commissioner of management and budget for the benefit of the fund and used to pay the benefits under this chapter and administrative costs pursuant to subdivision 11. Any interest or profit accruing from investment of these sums shall be credited to the special compensation fund. Subject to the provisions of this section, all the powers, duties, functions, obligations, and rights vested in the special compensation fund immediately prior to January 1, 1984, are transferred to and vested in the special compensation fund recreated by this section. All rights and obligations of employers with regard to the special compensation fund which existed immediately prior to January 1, 1984, continue, subject to the provisions of this section.

Subd. 1a. **Interest.** Interest earned on revenue collected by the special compensation fund shall be deposited into the special compensation fund.

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

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

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

Subd. 2. [Repealed, 2000 c 447 s 28]

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

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

(c) The portion of the total assessment allocated to self-insured employers that shall be paid by each self-insured employer must be based upon paid indemnity losses made by that self-insured employer during the preceding calendar year. The portion of the total assessment allocated to insured employers that is paid by each insurer must be based on standard workers' compensation premium earned in the state by that insurer during the current calendar year. If the current calendar year earned standard workers' compensation premium is not available, the commissioner shall estimate the portion of the total assessment allocated to insured employers that is paid by each insurer using the earned standard workers' compensation premium from the preceding calendar year. The commissioner shall then perform a reconciliation and final determination of the portion of the total assessment to be paid by each insurer when the earned standard workers' compensation premium for the current calendar year is calculable, but the final determination must not be made after December 1 of the following calendar year. An employer who has ceased to be self-insured shall continue to be liable for assessments based on paid indemnity losses arising out of injuries occurring during periods when the employer was self-insured, unless the self-insured employer has purchased a replacement policy covering those losses. An insurer who assumes a self-insured employer's obligation under a replacement policy shall separately report and pay assessments based on indemnity losses paid by the insurer under the replacement policy. The replacement policy may provide for reimbursement of the assessment to the insurer by the self-insured employer.

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

is excluded from the definition of premium for all other purposes, except as otherwise provided in this paragraph.

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

Subd. 3. [Repealed, 2002 c 262 s 23]

Subd. 4. [Repealed, 2002 c 262 s 23]

Subd. 4a. [Repealed, 2002 c 262 s 23]

Subd. 5. [Repealed, 1984 c 432 art 2 s 55]

Subd. 6. **Payments out of fund.** The Workers' Compensation Division, a compensation judge, the Workers' Compensation Court of Appeals, or a district court in cases before them shall direct the distribution of benefits provided by this chapter. These benefits are payable in the same manner as other payments of compensation.

Subd. 7. **Refunds.** In case deposit is or has been made pursuant to subdivision 2a by mistake or inadvertence, or under circumstances that justice requires a refund, the commissioner of management and budget is authorized to refund the deposit under order of the commissioner, a compensation judge, the Workers' Compensation Court of Appeals, or a district court. Claims for refunds must be submitted to the commissioner within three years of the date of reconciliation and final determination under subdivision 2a. There is appropriated to the commissioner from the fund an amount sufficient to make the refund and payment.

Subd. 8. **Commissioner as administrator.** The commissioner is the administrator of the special compensation fund. The special fund shall be designated a party in an action regarding any right, obligation, and liability of the special fund. The commissioner of management and budget, as custodian, does not have standing in an action determining any right, obligation, or liability of the special fund. As requested by the commissioner, the attorney general shall represent the special fund in all legal matters in which the special fund has an interest. The commissioner may designate one or more division employees to appear on behalf of the special fund in proceedings under this chapter. The division employees so designated need not be attorneys-at-law.

Subd. 9. **Powers of fund.** In addition to powers granted to the special compensation fund by this chapter the fund may do the following:

(1) sue and be sued in its own name;

(2) intervene in or commence an action under this chapter or any other law, including, but not limited to, intervention or action as a subrogee to the division's right in a third-party action, any proceeding under this chapter in which liability of the special compensation fund is an issue, or any proceeding which may result in other liability of the fund or to protect the legal right of the fund;

(3) enter into settlements including but not limited to structured, annuity purchase agreements with appropriate parties under this chapter. Notwithstanding any other provision of this chapter, any settlement may provide that the fund partially or totally denies liability for payment of benefits, and no determination of employer insurance status and liability under section 176.183, subdivision 2, shall be required for approval of the stipulation for a settlement;

(4) contract with another party to administer the special compensation fund;

(5) take any other action which an insurer is permitted by law to take in operating within this chapter; and

(6) conduct a financial audit of indemnity claim payments, premium, and assessments reported to the fund. This may be contracted by the fund to a private auditing firm.

Subd. 10. **Penalty.** Sums paid to the commissioner pursuant to this section shall be in the manner prescribed by the commissioner. The commissioner may impose a penalty payable to the commissioner for deposit in the assigned risk safety account of up to 15 percent of the amount due under this section but not less than $1,000 in the event payment is not made or reports are not submitted in the manner prescribed. In addition to a penalty under this subdivision, in the event payment is not made within six months of the due date, the commissioner shall refer the self-insured employer or insurer's file to the Department of Commerce for consideration of license or permit revocation.

Subd. 11. **Administrative provisions.** The accounting, investigation, and legal costs necessary for the administration of the programs financed by the special compensation fund shall be paid from the fund during each biennium commencing July 1, 1981. Staffing and expenditures related to the administration of the special compensation fund shall be approved through the regular budget and appropriations process. All sums recovered by the special compensation fund as a result of action under section 176.061, or recoveries of payments made by the special compensation fund under section 176.183 or 176.191, or sums recovered under chapter 182, shall be credited to the special compensation fund.

Subd. 12. **Report of commissioner.** The commissioner shall report biennially to the governor and to the legislature as to the financial status of the special compensation fund. The report shall include a statement of the receipts and the disbursements for the period covered.

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

(b) Except as provided in paragraph (c), the special compensation fund shall not reimburse an insolvent insurer for subsequent injury or supplementary benefits after a declaration of bankruptcy or order of liquidation or insolvency is issued for the insurer, even if the benefits were paid before the declaration or order. This does not limit the claim distribution or set-off authority of a court, trustee, or liquidator under federal bankruptcy law or under chapter 60B or a similar law in another jurisdiction. For purposes of this paragraph, subsequent injury benefits are the benefits paid pursuant to Minnesota Statutes 1990, section 176.131, and supplementary benefits are the benefits paid pursuant to Minnesota Statutes 1994, section 176.132.

(c) The special compensation fund shall reimburse an insolvent insurer for subsequent injury or supplemental benefits after a declaration of bankruptcy or order of liquidation or insolvency to an insolvent insurer who has filed for reimbursement from the special compensation fund before June 1, 2013. This

includes reimbursement for any past, pending, or future claims that may arise out of the insolvent insurer's coverage.

History: *1983 c 290 s 93; 1984 c 432 art 2 s 20-22; 1986 c 461 s 17; 1987 c 268 art 2 s 28; 1987 c 332 s 27-29; 1992 c 510 art 3 s 12; 1992 c 513 art 3 s 37,38; 1995 c 231 art 2 s 58,59; 1996 c 305 art 1 s 45,46; 2000 c 447 s 19,20; 2001 c 123 s 6-8; 2002 c 262 s 6-11,24; 2003 c 112 art 2 s 50; 2005 c 90 s 7-9; 2009 c 101 art 2 s 109; 2013 c 70 art 1 s 3; 2014 c 182 s 2,3; 2024 c 97 s 10*

176.1292 FORBEARANCE OF AMOUNTS OWED TO THE SPECIAL COMPENSATION FUND.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply.

(a) "Payer" means a workers' compensation insurer, or an employer or group of employers that are self-insured for workers' compensation.

(b) "Retirement benefits" means retirement benefits paid by any government retirement benefit program and received by employees, other than old age and survivor insurance benefits received under the federal Social Security Act, United States Code, title 42, sections 401 to 434. Retirement benefits include retirement annuities, optional annuities received in lieu of retirement benefits, and any other benefit or annuity paid by a government benefit program that is not clearly identified as a disability benefit or disability annuity in the applicable governing statute.

Subd. 2. **Payment of permanent total disability benefits to employees, dependents, and legal heirs.** (a) A payer is entitled to the relief described in subdivisions 3 and 4 only if the payer complies with all of the conditions in paragraphs (b) to (d) for all of the payer's permanently totally disabled employees and documents compliance according to the procedures and forms established by the commissioner under subdivision 7.

(b) Except as provided in paragraph (e), the payer must:

(1) recharacterize supplementary benefits paid to all employees as permanent total disability benefits if the supplementary benefits were paid because the permanent total disability benefits were reduced by retirement benefits received by the employee;

(2) pay all permanently totally disabled employees, regardless of the date of injury, past and future permanent total disability benefits calculated without any reduction for retirement benefits received by the employees, from the date the employees' benefits were first reduced; and

(3) for all deceased employees, pay the employees' dependents or, if none, the employees' legal heirs, the permanent total disability benefits the deceased employees would have received if the benefits had been calculated without any reduction for retirement benefits received by the employees.

(c) A payer may take a credit against its obligations under paragraph (b), clauses (2) and (3), for:

(1) supplementary benefits previously paid to an employee that have been recharacterized as permanent total disability benefits under paragraph (b), clause (1); and

(2) permanent total disability benefits previously paid to an employee.

(d) The payer must pay the permanent total disability benefits as provided in paragraphs (b) and (c) within the time frames described in clauses (1) to (4). More than one time frame may apply to a claim.

(1) No later than 150 days following May 30, 2017, the payer must begin paying the recalculated permanent total disability benefit amounts to employees who are entitled to ongoing permanent total disability benefits.

(2) No later than 210 days following May 30, 2017, the payer must pay employees the amounts that past permanent total disability benefits were underpaid.

(3) No later than 270 days following May 30, 2017, the payer must pay the employees' dependents or legal heirs the amounts that permanent total disability benefits were underpaid.

(4) The commissioner may waive payment under paragraphs (b) and (c) or extend these time frames if the payer, after making a good-faith effort, is unable to: locate an employee; identify or locate the dependents or legal heirs of a deceased employee; or locate documentation to determine the amount of an underpayment.

(e) Paragraphs (a) to (d) do not apply if:

(1) the employee died before January 1, 2008;

(2) the employee's last permanent total disability benefit was paid before January 1, 2000;

(3) the employee's last permanent total disability benefit would have been paid before January 1, 2000, if it had not been reduced by the employee's retirement benefits;

(4) a stipulation for settlement, signed by the employee and approved by a compensation judge, provided for a full, final, and complete settlement of permanent total disability benefits under this chapter in exchange for a lump sum payment amount or a lump sum converted to a structured annuity;

(5) a final court order, or a stipulation for settlement signed by the employee and approved by a compensation judge, explicitly states the employee's permanent total disability benefits may be reduced by specified retirement benefits. Paragraphs (a) to (d) apply if a court order or stipulation for settlement is ambiguous about whether the employee's permanent total disability benefits could be reduced by retirement benefits; or

(6) a final court order or a stipulation for settlement described in clause (4) or (5) was vacated after May 31, 2017.

Subd. 3. **Reimbursement of supplementary benefits.** (a) Except as provided in subdivision 9, paragraph (a), clause (2), a payer that has complied with the requirements of subdivision 2, paragraphs (a) to (d):

(1) is not required to repay supplementary benefits for any claim that the special compensation fund over reimbursed due to the payer's reduction of any employee's permanent total disability benefits by retirement benefits received by the employee;

(2) is entitled to reimbursement of supplementary benefits paid or payable before August 13, 2014, to the extent the special compensation fund denied reimbursement due to the payer's reduction of any employee's permanent total disability benefits by the employee's retirement benefits; and

(3) is entitled to reimbursement of supplementary benefits the special compensation fund withheld under section 176.129, subdivision 13, paragraph (a), to offset supplementary benefits that were over reimbursed due to the payer's reduction of any employee's permanent total disability benefits by the employee's retirement benefits.

(b) Paragraph (a) does not preclude the special compensation fund from denying reimbursement of supplementary benefits, or adjusting the reimbursement amount, for any reason other than reduction of permanent total disability benefits by the employee's retirement benefits.

Subd. 4. **Assessments.** (a) Except as provided in subdivision 6, paragraph (b), clause (2), and subdivision 9, paragraph (a), clause (2), a payer that has complied with the requirements of subdivision 2, paragraphs (a) to (d), is not required to pay past or future assessments under section 176.129 on the amount of increased or additional permanent total disability benefits paid, or on supplementary benefits that are appropriately characterized as permanent total disability benefits, due to the elimination of the retirement benefit reduction.

(b) The special compensation fund shall not recalculate assessments previously paid by any payer because of the assessment adjustments in paragraph (a).

(c) The assessment adjustments described in paragraph (a) do not apply to permanent total disability benefits paid to employees with dates of injury on or after August 13, 2014. Payers must pay full assessments according to section 176.129 on permanent total disability benefits calculated without a reduction for retirement benefits for these employees.

Subd. 5. **Refunds.** (a) A payer is entitled to a refund from the special compensation fund if:

(1) the payer complies with the requirements of subdivision 2, paragraphs (a) to (d); and

(2) due to the elimination of the retirement benefit reduction, the payer repaid the special compensation fund for over reimbursement of supplementary benefits, or paid assessments on the increased permanent total disability benefits for employees with dates of injury before August 13, 2014.

(b) The special compensation fund must issue a refund within 30 days after receiving the payer's documentation of compliance with subdivision 2, paragraphs (a) to (d), and an itemization by claim of the amount repaid or paid to the special compensation fund as described in paragraph (a), clause (2).

(c) The special compensation fund must pay interest on any refunded amount under this section to the payer at an annual rate of four percent, calculated from the date the payer repaid or paid the special compensation fund as described in paragraph (a), clause (2).

Subd. 6. **Applicability.** (a) This section does not preclude any employee, dependent, or legal heir from pursuing additional benefits beyond those paid under subdivision 2, paragraphs (b) to (d); however, the payments under subdivision 2, paragraphs (b) to (d), are not to be construed as an admission of liability by the payer in any proceeding. The payments cannot be used to justify additional claims; they represent a compromise between the payer and the special compensation fund on supplementary benefits and assessments. Payers reserve any and all defenses to claims to which this section does not apply.

(b) If an employee, dependent, or legal heir pursues additional benefits, claims, or penalties related to the benefits paid or payable under subdivision 2, paragraphs (b) to (d), payers may assert any and all defenses including, but not limited to, those specified in subdivision 2, paragraph (e), clauses (4) and (5), with respect to the additional benefits, claims, and penalties, and any future permanent total disability benefits payable, subject to the following conditions:

(1) if it is determined by a compensation judge, the Workers' Compensation Court of Appeals, or the Minnesota Supreme Court that the payer is entitled to reduce the employee's permanent total disability benefits by retirement benefits received by the employee, the payer shall not recover any overpayment that results from benefits the employee, dependent, or legal heir has already received under subdivision 2,

paragraphs (b) to (d). Notwithstanding section 176.129, the payer shall not take a credit against an employee's future benefits for any such overpayment; and

(2) if it is determined by a compensation judge, the Workers' Compensation Court of Appeals, or the Minnesota Supreme Court that the payer is not entitled to reduce the employee's permanent total disability benefits by retirement benefits received by the employee, the payer is not entitled to the relief provided in subdivision 4 as applied to the claim of the specific employee, dependent, or legal heir.

(c) A payer shall not assert defenses related to the offset of retirement benefits against an employee's future permanent total disability benefits if the only additional claims asserted by the employee under paragraph (b) are for attorney fees, costs and disbursements, and an additional award pursuant to section 176.081, subdivision 7.

Subd. 7. **Procedure.** No later than 60 days after May 30, 2017, in consultation with affected payers, the commissioner must establish a procedure, which may include forms, to implement this section.

Subd. 8. **Reporting.** This section does not affect a payer's obligation to report the full amount of permanent total disability benefits paid to the extent required by this chapter or other law. A payer must report supplementary benefits as permanent total disability benefits if the supplementary benefits were paid because the permanent total disability benefits were reduced by retirement benefits received by the employee.

Subd. 9. **Failure to comply.** (a) If a payer reports to the department that it has complied with the requirements of subdivision 2, paragraphs (a) to (d), but the payer has not paid an employee, dependent, or legal heir, as required by subdivision 2, the payer is subject to the following:

(1) the payer must issue payment to the employee, dependent, or legal heir within 14 days of the date the payer discovers the noncompliance or the date the department notifies the payer of the noncompliance;

(2) the payer is not entitled to the relief provided in subdivisions 3 and 4 as applied to the claim of the specific employee, dependent, or legal heir who was not paid as required by subdivision 2;

(3) the special compensation fund may immediately begin collection of any assessments or over-reimbursement owed for the claim;

(4) if the commissioner determines that a payer's failure to comply under this subdivision was not in good faith, the commissioner may assess a penalty, payable to the employee, dependent, or legal heir, of up to 25 percent of the total permanent total disability benefits underpaid; and

(5) if the payer is found after a hearing to be liable for increased or additional permanent total disability benefits because the employee's permanent total disability benefits were improperly reduced by the employee's retirement benefits, the compensation judge shall assess a penalty against the payer, payable to the employee or dependent, up to the total amount of the permanent total disability benefits that were not paid pursuant to subdivision 2. The compensation judge may issue a penalty against the payer, up to the total amount of the permanent total disability benefits underpaid, payable to a legal heir.

(b) The penalties assessed under this subdivision are in addition to any other penalty that may be, or is required to be, assessed under this chapter; however, the commissioner shall not assess a penalty against a payer for late payment of permanent total disability benefits if the employee's benefits have been paid and documented in accordance with subdivision 2.

(c) If a payer and the special compensation fund have agreed to a list of employees required to be paid under subdivision 2, this subdivision does not apply to any claim with a date of injury before October 1, 1995, that is not on the agreed-upon list.

History: *2017 c 94 art 4 s 1; 2024 c 97 s 11,12*

176.13 [Repealed, 1965 c 327 s 2]

176.130 TARGETED INDUSTRY FUND; LOGGERS.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them, except where the context clearly indicates a different meaning.

(a) "Commissioner" means the commissioner of labor and industry, unless otherwise provided.

(b) "Logger" means the following occupations:

(1) timber fellers: those who employ chainsaws or other mechanical devices mounted on logging vehicles to fell or delimb trees;

(2) buckers or chippers: those who cut trees into merchantable lengths with either chainsaws or heavier machinery, including slashers, harvesters, and processors;

(3) skidders or forwarders: those who either drag logs or trees to roadside landings, or load and transport logs or short wood (fuel wood or pulp wood) to similar destinations; and

(4) timber harvesters or processors: those who combine two or more of the operations listed in clauses (1) to (3).

(c) "Logging industry" means loggers and employers of loggers.

(d) "Wood mill" means the primary processors of wood or wood chips including, but not limited to, hard board manufacturers, wafer board or oriented strand board manufacturers, pulp and paper manufacturers, sawmills, and other primary manufacturers who do the initial processing of wood purchased from loggers.

(e) "Insurer" means an insurance company that provides workers' compensation coverage for loggers, including the Minnesota assigned risk plan.

(f) "Qualified employer" means a self-employed logger, or an employer of a logger, who has paid a premium for workers' compensation insurance coverage for the preceding calendar year and who has attended, or whose logger employees have attended, in the preceding calendar year, at least one safety seminar sponsored by or approved by the commissioner.

(g) "Rebate" means amounts allocated and paid to qualified employers under subdivision 6.

Subd. 2. **Administration.** The commissioner shall administer and enforce this section. Payments and reports required by this section must be made with forms provided by the commissioner. The commissioner shall collect all assessments and allocate the rebate as provided in this section.

Subd. 3. **Proof of insurance; logging industry.** Purchasers of wood from the logging industry shall obtain from the logger a certification of compliance with the mandatory insurance requirements of this chapter, or reason for exemption, on a form prescribed by the commissioner. A purchaser includes, but is not limited to, dealers and jobbers buying from the logging industry to sell to wood mills, and wood mills that buy directly from the logging industry. Certificates obtained by the purchaser shall be submitted to the

commissioner on request. The powers of inspection and enforcement pertaining to employers under section 176.184 shall be available with regard to purchasers under this section.

Subd. 4. **Assessment.** There is imposed an assessment, at the rate of 30 cents per cord of wood, for every cord or equivalent measurement of wood in excess of 5,000 cords, purchased or acquired in any calendar year, either inside or outside the state, by a wood mill located in Minnesota. This assessment must be paid by the wood mill to the commissioner on or before February 15 for the previous calendar year and may not, in any way, be recovered by the wood mill from the logging industry. All revenue collected from this assessment must be deposited in a separately maintained account in the special compensation fund for the payment of rebates under subdivision 6 and the loggers safety and education program under subdivision 11.

Subd. 5. **Annual reports; wood mills; qualified employers.** (a) Each wood mill that purchases or acquires more than 5,000 cords or equivalent measurement of wood in a calendar year shall, on or before February 15, make and file with the commissioner a report setting forth the number of cords purchased or acquired in the preceding calendar year, and other information the commissioner may require for the proper administration of this section.

(b) Each qualified employer shall, on or before February 15 each year, make and file with the commissioner a report setting forth the total amount of payroll paid to loggers in the preceding calendar year, together with proof of attendance at an approved safety seminar in the preceding calendar year, and other information the commissioner may require for the proper administration of this section. The commissioner may, for enforcement purposes, share reported payroll data for a particular employer with the workers' compensation insurer for that employer or with the workers' compensation insurance association.

Subd. 6. **Allocation of rebate.** Money collected under this section, less an amount as provided in subdivision 11, is appropriated to and, must be paid by the commissioner, on or before June 1 each year, directly to each qualified employer in a proportion equal to the proportion that the qualified employer's reported payroll dollars for loggers in the preceding calendar year is to the total reported payroll dollars for loggers from all qualified employers in the preceding calendar year. Payment under this section shall be made only to those qualified employers reporting within the time limits provided in subdivision 5, paragraph (b).

Subd. 7. **Inspection.** The commissioner or duly authorized employees may, at all reasonable hours, enter in and upon the premises of a wood mill or a qualified employer and examine books, papers, and records to determine whether the assessment has been properly paid or payroll properly reported.

Subd. 8. **Penalties; wood mills.** If the assessment provided for in this chapter is not paid on or before February 15 of the year when due and payable, the commissioner may impose penalties as provided in section 176.129, subdivision 10, payable to the commissioner for deposit in the assigned risk safety account.

Subd. 9. **False reports.** Any person or entity that, for the purpose of evading payment of the assessment or avoiding the reimbursement, or any part of it, makes a false report under this section shall pay to the commissioner for deposit in the assigned risk safety account, in addition to the assessment, a penalty of 75 percent of the amount of the assessment. A person who knowingly makes or signs a false report, or who knowingly submits other false information, is guilty of a misdemeanor.

Subd. 10. **Employer-employee relationship.** This section does not create an employer-employee relationship nor can it be used as a factor in determining the existence of an employer-employee relationship.

Subd. 11. **Safety program.** The commissioner shall establish or approve a safety and education program for Minnesota loggers. Funding for the program must be in the amount of $125,000 each calendar year

provided from amounts collected in the previous calendar year pursuant to subdivision 4. If the amounts collected under subdivision 4 are less than $125,000 in any calendar year, funding for the safety and education program for the next calendar year must be the actual amount collected.

History: *1990 c 521 s 1,4; 1992 c 510 art 3 s 13,14; 1995 c 224 s 126; 1995 c 231 art 1 s 36; art 2 s 60; 2002 c 262 s 12,13*

176.131 [Repealed, 1992 c 510 art 3 s 36]

176.1311 [Repealed, 2014 c 182 s 8]

176.132 [Repealed, 1995 c 231 art 1 s 35; art 2 s 110]

176.1321 EFFECTIVE DATE OF BENEFIT CHANGES.

Unless otherwise specified in the act making the change, any workers' compensation benefit change shall be effective on the October 1 next following its final enactment.

History: *Ex1979 c 3 s 42*

176.133 [Repealed, 1995 c 231 art 2 s 110]

176.134 [Repealed, 1985 c 234 s 22]

TREATMENT AND SUPPLIES

176.135 TREATMENT; APPLIANCES; SUPPLIES.

Subdivision 1. **Medical, psychological, chiropractic, podiatric, surgical, hospital.** (a) The employer shall furnish any medical, psychological, chiropractic, podiatric, surgical and hospital treatment, including nursing, medicines, medical, chiropractic, podiatric, and surgical supplies, crutches and apparatus, including artificial members, or, at the option of the employee, if the employer has not filed notice as hereinafter provided, Christian Science treatment in lieu of medical treatment, chiropractic medicine and medical supplies, as may reasonably be required at the time of the injury and any time thereafter to cure and relieve from the effects of the injury. This treatment shall include treatments necessary to physical rehabilitation.

(b) The employer shall pay for the reasonable value of nursing services provided by a member of the employee's family in cases of permanent total disability.

(c) Exposure to rabies is an injury and an employer shall furnish preventative treatment to employees exposed to rabies.

(d) The employer shall furnish replacement or repair for artificial members, glasses or spectacles, artificial eyes, podiatric orthotics, dental bridge work, dentures or artificial teeth, hearing aids, canes, crutches, or wheel chairs damaged by reason of an injury arising out of and in the course of the employment. If an item under this paragraph is customized specifically for the injured worker, the item is the property of the injured worker. For the purpose of this paragraph, "injury" includes damage wholly or in part to an artificial member. In case of the employer's inability or refusal to timely provide the items required to be provided under this paragraph, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing the same, including costs of copies of any medical records or medical reports that are in existence, obtained from health care providers, and that directly relate to the items for which payment is sought under this chapter, limited to the charges allowed by subdivision 7, and attorney fees incurred by the employee.

(e) Both the commissioner and the compensation judges have authority to make determinations under this section in accordance with sections 176.106 and 176.305.

(f) An employer may require that the treatment and supplies required to be provided by an employer by this section be received in whole or in part from a managed care plan certified under section 176.1351 except as otherwise provided by that section.

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

(h) Notwithstanding any fees established by rule adopted under section 176.136, an employer may contract for the cost of medication provided to employees. All requests for reimbursement from the special compensation fund formerly codified under section 176.131 for medication provided to an employee must be accompanied by the dispensing pharmacy's invoice showing its usual and customary charge for the medication at the time it was dispensed to the employee. The special compensation fund shall not reimburse any amount that exceeds the maximum amount payable for the medication under Minnesota Rules, part 5221.4070, subparts 3 and 4, notwithstanding any contract under Minnesota Rules, part 5221.4070, subpart 5, that provides for a different reimbursement amount.

[See Note.]

Subd. 1a. **Nonemergency surgery; second surgical opinion.** (a) The employer or insurer is required to furnish surgical treatment pursuant to subdivision 1 when the surgery is reasonably required to cure and relieve the effects of the personal injury or occupational disease. An employee may not be compelled to undergo surgery. If an employee desires a second opinion on the necessity of the surgery, the employer shall pay the costs of obtaining the second opinion. Except in cases of emergency surgery, the employer or insurer may require the employee to obtain a second opinion on the necessity of the surgery, at the expense of the employer or insurer, before the employee undergoes surgery. If an employer or insurer receives a request for nonemergency surgery, the employer or insurer must respond in writing no later than seven calendar days after receiving the request from the health care provider or employee by approving the request, denying authorization, requesting additional information, requesting a second opinion under this section, or requesting an examination by the employer's physician under section 176.155.

(b) An employer or insurer requesting a second opinion must notify the employee and the health care provider of the request for a second opinion within seven calendar days of the request for nonemergency surgery. If the employer or insurer denies authorization within seven calendar days of receiving the second opinion, the health care provider may elect to perform the surgery, subject to a determination of compensability by the commissioner or compensation judge.

(c) Failure to obtain a second surgical opinion is not reason for nonpayment of the charges for the surgery. The employer or insurer is required to pay the reasonable value of the surgery unless the commissioner or compensation judge determines that the surgery is not reasonably required.

Subd. 1b. **Complementary and alternative health care providers.** Any service, article, or supply provided by an unlicensed complementary and alternative health care practitioner as defined in section 146A.01, subdivision 6, is not compensable under this chapter.

Subd. 2. **Change of physicians, podiatrists, or chiropractors.** The commissioner shall adopt rules establishing standards and criteria to be used when a dispute arises over a change of physicians, podiatrists,

or chiropractors in the case that either the employee or the employer desire a change. If a change is agreed upon or ordered, the medical expenses shall be borne by the employer upon the same terms and conditions as provided in subdivision 1.

Subd. 2a. **Definitions.** For the purposes of this section, the word "physicians" shall include persons holding the degree M. D. (Doctor of Medicine) and persons holding the degree D. O. (Doctor of Osteopathic Medicine); and the terms "medical, surgical and hospital treatment" shall include professional services rendered by licensed persons who have earned the degree M. D. or the degree D. O.

Subd. 3. [Repealed, 1992 c 510 art 4 s 26]

Subd. 4. **Christian Science treatment.** Any employee electing to receive Christian Science treatment as provided in subdivision 1 shall notify the employer in writing of the election within 30 days after July 1, 1953, and any person hereafter accepting employment shall give such notice at the time of accepting employment. Any employer may elect not to be subject to the provisions for Christian Science treatment provided for in this section by filing a written notice of such election with the commissioner of the Department of Labor and Industry, in which event the election of the employee shall have no force or effect whatsoever.

Subd. 5. **Occupational disease medical eligibility.** Notwithstanding section 176.66, an employee who has contracted an occupational disease is eligible to receive compensation under this section even if the employee is not disabled from earning full wages at the work at which the employee was last employed.

Payment of compensation under this section shall be made by the employer and insurer on the date of the employee's last exposure to the hazard of the occupational disease. Reimbursement for medical benefits paid under this subdivision or subdivision 1a is allowed from the employer and insurer liable under section 176.66, subdivision 10, only in the case of disablement.

Subd. 6. **Commencement of payment.** As soon as reasonably possible, and no later than 30 calendar days after receiving the bill, the employer or insurer shall pay the charge or any portion of the charge which is not denied, or deny all or a part of the charge with written notification to the employee and the provider explaining the basis for denial, except that the employer or insurer is not required to notify the employee of payment of charges that have been reduced in accordance with section 176.136, subdivision 1, 1a, or 1b. All or part of a charge must be denied if any of the following conditions exists:

(1) the injury or condition is not compensable under this chapter;

(2) the charge or service is excessive under this section or section 176.136;

(3) the charges are not submitted on the prescribed billing form; or

(4) additional medical records or reports are required under subdivision 7 to substantiate the nature of the charge and its relationship to the work injury.

If payment is denied under clause (3) or (4), the employer or insurer shall reconsider the charges in accordance with this subdivision within 30 calendar days after receiving additional medical data, a prescribed billing form, or documentation of enrollment or certification as a provider.

Subd. 7. **Medical bills and records.** (a) Health care providers shall submit to the insurer an itemized statement of charges in the standard electronic transaction format when required by section 62J.536 or, if there is no prescribed standard electronic transaction format, on a billing form prescribed by the commissioner. Health care providers shall also submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury. Pursuant to Minnesota Rules, part 5219.0300, health care

providers may charge for copies of any records or reports that are in existence and directly relate to the items for which payment is sought under this chapter. The commissioner shall adopt, by rule, a schedule of reasonable charges that will apply to charges not covered by paragraphs (d) and (e).

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

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

(b) For medical services provided under this section, the codes from the International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System (ICD-10), must be used to report medical diagnoses and hospital inpatient procedures when required by the United States Department of Health and Human Services for federal programs. The commissioner must replace the codes from the International Classification of Diseases, Ninth Edition, Clinical Modification/Procedure Coding System (ICD-9), with equivalent ICD-10 codes wherever the ICD-9 codes appear in rules adopted under this chapter. The commissioner must use the General Equivalence Mappings established by the Centers for Medicare and Medicaid Services to replace the ICD-9 diagnostic codes with ICD-10 codes in the rules.

(c) The commissioner shall amend rules adopted under this chapter as necessary to implement the ICD-10 coding system in paragraph (b). The amendments shall be adopted by giving notice in the State Register according to the procedures in section 14.386, paragraph (a). The amended rules are not subject to expiration under section 14.386, paragraph (b).

(d) The requirements in this paragraph and paragraph (e) apply to each request for copies of existing medical records fulfilled by a health care provider or the health care provider's agent that are required to be maintained in electronic format by state or federal law.

(1) If an authorized requestor of copies of medical records submits a written request for advance notice of the cost of the copies requested, the health care provider must notify the requestor of the estimated cost before sending the copies. If the requestor approves the cost and copies of the records are provided, the payment is the applicable fee under paragraph (e). If the requestor does not pay for the records, the health care provider may charge a fee, which must not exceed $10.

(2) A health care provider shall not require prepayment for the cost of copies of medical records under this paragraph or Minnesota Rules, chapter 5219, unless there is an outstanding past-due invoice for the requestor concerning a previous request for records from the health care provider.

(3) A health care provider shall provide copies of medical records in electronic format.

(4) The charges under paragraph (e) include any fee for retrieval, download, or other delivery of records.

(e) For any copies of electronic records provided under paragraph (d), a health care provider or the health care provider's agent may not charge more than a total of:

(1) $10 if there are no records available;

(2) $30 for copies of records of up to 25 pages;

(3) $50 for copies of records of up to 100 pages;

(4) $50, plus an additional 20 cents per page for pages 101 and above; or

(5) $500 for any request.

(f) The commissioner may assess a penalty against a health care provider for each violation of this section by the health care provider or the health care provider's agent of $500, payable to the assigned risk safety account.

Subd. 7a. **Electronic transactions.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "workers' compensation payer" means a workers' compensation insurer and an employer, or group of employers, that is self-insured for workers' compensation;

(2) "clearinghouse" has the meaning given in section 62J.51, subdivision 11a; and

(3) "electronic transactions" means the health care administrative transactions described in section 62J.536.

(b) In addition to the requirements of section 62J.536, workers' compensation payers and health care providers must comply with the requirements in paragraphs (c) to (e).

(c) No later than January 1, 2016, each workers' compensation payer must place the following information in a prominent location on its website or otherwise provide the information to health care providers:

(1) the name of each clearinghouse with which the workers' compensation payer has an agreement to exchange or transmit electronic transactions, along with the identification number each clearinghouse has assigned to the payer in order to route electronic transactions through intermediaries or other clearinghouses to the payer;

(2) information about how a health care provider can obtain the claim number assigned by the workers' compensation payer for an employee's claim and how the provider should submit the claim number in the appropriate field on the electronic bill to the payer; and

(3) the name, phone number, and email address of contact persons who can answer questions related to electronic transactions on behalf of the workers' compensation payer and the clearinghouses with which the payer has agreements.

(d) No later than January 1, 2017:

(1) health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the ASC X12N 5010 version of the ASC X12N 275 transaction ("Additional Information to Support Health Care Claim or Encounter"), according to the requirements in the corresponding implementation guide. The ASC X12N 275 transaction is the only one that shall be used to electronically submit attachments unless a national standard is adopted by federal law or rule. If a new version of the attachment transaction is approved, it must be used one year after the approval date;

(2) workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the ASC X12N 5010 version of the ASC X12 electronic acknowledgment for the attachment transaction. If a new version of the acknowledgment transaction is approved, it must be used one year after the approval date; and

(3) if a different national claims attachment or acknowledgment requirement is adopted by federal law or rule, it will replace the ASC X12N 275 transaction, and the new standard must be used on the date that it is required by the federal law or rule.

(e) No later than September 1, 2015, workers' compensation payers must provide the patient's name and patient control number on or with all payments made to a provider under this chapter, whether payment is made by check or electronic funds transfer. The information provided on or with the payment must be sufficient to allow providers to match the payment to specific bills. If a bulk payment is made to a provider for more than one patient, the check or electronic funds transfer statement must also specify the amount being paid for each patient. For purposes of this paragraph, the patient control number is located on the electronic health care claim 837 transaction, loop 2300, segment CLM01, and on the electronic health care claim payment/advice 835 transaction, loop 2100, CLP01.

(f) The commissioner may assess a monetary penalty of $500 for each violation of this section, not to exceed $25,000 for identical violations during a calendar year. Before issuing a penalty for a first violation of this section, the commissioner must provide written notice to the noncompliant payer, clearinghouse, or provider that a penalty may be issued if the violation is not corrected within 30 days. Penalties under this paragraph are payable to the commissioner for deposit in the assigned risk safety account.

Subd. 8. **Data.** Each self-insured employer and insurer shall retain or arrange for the retention of (1) all billing data electronically transmitted by health care providers for payment for the treatment of workers' compensation; and (2) the employer or insurer's electronically transmitted payment remittance advice. The self-insured employer or insurer shall ensure that the data in clauses (1) and (2) shall be retained for seven years in the standard electronic transaction format that is required by rules adopted by the commissioner of the Department of Health under section 62J.536. The data shall be provided in the standard electronic transaction format to the commissioner of labor and industry within 120 days of the commissioner of labor and industry's request, and shall be used to analyze the costs and outcomes of treatment in the workers' compensation system. The data collected by the commissioner of labor and industry under this section is confidential data on individuals and protected nonpublic data, except that the commissioner may publish aggregate statistics and other summary data on the costs and outcomes of treatment in the workers' compensation system.

Subd. 9. **Designated contact person and required training related to submission and payment of medical bills.** (a) For purposes of this subdivision:

(1) "clearinghouse" means a health care clearinghouse as defined in section 62J.51, subdivision 11a, that receives or transmits workers' compensation electronic transactions as described in section 62J.536;

(2) "department" means the Department of Labor and Industry;

(3) "hospital" means a hospital licensed in this state;

(4) "payer" means:

(i) a workers' compensation insurer;

(ii) an employer, or group of employers, authorized to self-insure for workers' compensation liability; and

(iii) a third-party administrator licensed by the Department of Commerce under section 60A.23, subdivision 8, to pay or review workers' compensation medical bills under this chapter; and

(5) "submission or payment of medical bills" includes the submission, transmission, receipt, acceptance, response, adjustment, and payment of medical bills under this chapter.

(b) Effective November 1, 2017, each payer, hospital, and clearinghouse must provide the department with the name and contact information of a designated employee to answer inquiries related to the submission or payment of medical bills. Payers, hospitals, and clearinghouses must provide the department with the name of a new designated employee within 14 days after the previously designated employee is no longer employed or becomes unavailable for more than 30 days. The name and contact information of the designated employee must be provided on forms and at intervals prescribed by the department. The department must post a directory of the designated employees on the department's website.

(c) The designated employee under paragraph (b) must:

(1) complete training, provided by the department, about submission or payment of medical bills; and

(2) respond within 30 days to written department inquiries related to submission or payment of medical bills.

The training requirement in clause (1) does not apply to a payer that has not received any workers' compensation medical bills in the 12 months before the training becomes available.

(d) The commissioner may assess penalties, payable to the assigned risk safety account, against payers, hospitals, and clearinghouses for violation of this subdivision as provided in clauses (1) to (3):

(1) for failure to comply with the requirements in paragraph (b), the commissioner may assess a penalty of $50 for each day of noncompliance after the department has provided the noncompliant payer, clearinghouse, or hospital with a 30-day written warning;

(2) for failure of the designated employee to complete training under paragraph (c), clause (1), within 90 days after the department has notified a payer, clearinghouse, or hospital's designated employee that required training is available, the commissioner may assess a penalty of $3,000;

(3) for failure to respond within 30 days to a department inquiry related to submission or payment of medical bills under paragraph (c), clause (2), the commissioner may assess a penalty of $3,000. The commissioner shall not assess a penalty under both this clause and section 176.194, subdivision 3, clause (6), for failure to respond to the same department inquiry.

History: *1953 c 439 s 1; 1953 c 755 s 13; 1971 c 863 s 1,2; 1973 c 258 s 1; 1973 c 388 s 35-38; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1979 c 107 s 1,2; Ex1979 c 3 s 44; 1983 c 290 s 106,107; 1984 c 432 art 2 s 23,24; 1986 c 444; 1986 c 461 s 20,21; 1987 c 332 s 33-38; 1989 c 335 art 1 s 180; 1990 c 522 s 3; 1992 c 510 art 4 s 9-12; 1995 c 231 art 2 s 61; 2005 c 90 s 10,11; 2008 c 250 s 6; 2009 c 75 s 6-8; 2010 c 382 s 42; 2014 c 182 s 4; 2015 c 43 s 1; 2016 c 110 art 2 s 1; 2016 c 119 s 7; 2017 c 94 art 3 s 1; 7Sp2020 c 1 art 2 s 9; 2023 c 51 art 2 s 2-4; 2024 c 97 s 13*

NOTE: Subdivision 1, to the extent it requires an employer to reimburse an employee for the cost of medical cannabis, was found to be preempted by the federal Controlled Substances Act in *Musta v. Mendota Heights Dental Center*, 965 N.W.2d 312 (Minn. 2021), cert. denied 142 S.Ct. 2834 (2022).

MANAGED CARE

176.1351 MANAGED CARE.

Subdivision 1. **Application.** Any person or entity, other than a workers' compensation insurer or an employer for its own employees, may make written application to the commissioner to have a plan certified that provides management of quality treatment to injured workers for injuries and diseases compensable under this chapter. Specifically, and without limitation, an entity licensed under chapter 62C or 62D or a preferred provider organization that is subject to chapter 72A is eligible for certification under this section. Each application for certification shall be accompanied by a reasonable fee prescribed by the commissioner which shall be deposited in the special compensation fund. A plan may be certified to provide services in a limited geographic area. A certificate is valid for the period the commissioner prescribes unless revoked or suspended. Application for certification shall be made in the form and manner and shall set forth information regarding the proposed plan for providing services as the commissioner may prescribe. The information shall include, but not be limited to:

(1) a list of the names of all health care providers who will provide services under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for those providers to practice in this state; and

(2) a description of the places and manner of providing services under the plan.

Subd. 2. **Certification.** The commissioner shall certify a managed care plan if the commissioner finds that the plan:

(1) proposes to provide quality services that meet uniform treatment standards prescribed by the commissioner and all medical and health care services that may be required by this chapter in a manner that is timely, effective, and convenient for the worker;

(2) is reasonably geographically convenient to employees it serves;

(3) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service;

(4) provides adequate methods of peer review, utilization review, and dispute resolution to prevent inappropriate, excessive, or not medically necessary treatment, and excludes participation in the plan by those individuals who violate these treatment standards;

(5) provides a procedure for the resolution of medical disputes;

(6) provides aggressive case management for injured workers and provides a program for early return to work and cooperative efforts by the workers, the employer, and the managed care plan to promote workplace health and safety consultative and other services;

(7) provides a timely and accurate method of reporting to the commissioner necessary information regarding medical and health care service cost and utilization to enable the commissioner to determine the effectiveness of the plan;

(8) authorizes workers to receive compensable treatment from a health care provider who is not a member of the managed care plan, if that provider maintains the employee's medical records and has a documented history of treatment with the employee and agrees to refer the employee to the managed care plan for any other treatment that the employee may require and if the health care provider agrees to comply with all the rules, terms, and conditions of the managed care plan;

(9) authorizes necessary emergency medical treatment for an injury provided by a health care provider not a part of the managed care plan;

(10) does not discriminate against or exclude from participation in the plan any category of health care provider and includes an adequate number of each category of health care providers to give workers convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan;

(11) provides an employee the right to change health care providers under the plan at least once; and

(12) complies with any other requirement the commissioner determines is necessary to provide quality medical services and health care to injured workers.

The commissioner may accept findings, licenses, or certifications of other state agencies as satisfactory evidence of compliance with a particular requirement of this subdivision.

Subd. 3. **Dispute resolution.** An employee must exhaust the dispute resolution procedure of the certified managed care plan prior to filing a petition or otherwise seeking relief from the commissioner or a compensation judge on an issue related to managed care. If an employee has exhausted the dispute resolution procedure of the managed care plan on the issue of a rating for a disability, the employee may seek a disability rating from a health care provider outside of the managed care organization. The employer is liable for the reasonable fees of the outside provider as limited by the medical fee schedule adopted under this chapter.

Subd. 4. **Access to all health care disciplines.** The commissioner may refuse to certify or may revoke or suspend the certification of a managed care plan that unfairly restricts direct access within the managed care plan to any health care provider profession. Direct access within the managed care plan is unfairly restricted if direct access is denied and the treatment or service sought is within the scope of practice of the profession to which direct access is sought and is appropriate under the standards of treatment adopted by the managed care plan or, in instances where the commissioner has adopted standards of treatment, the standards adopted by the commissioner.

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

(b) In lieu of or in addition to suspension or revocation under paragraph (a), the commissioner may, for any noncompliance with the managed care plan as certified or any violation of a statute or rule applicable to a managed care plan, assess an administrative penalty payable to the commissioner for deposit in the assigned risk safety account in an amount up to $25,000 for each violation or incidence of noncompliance. The commissioner may adopt rules necessary to implement this subdivision. In determining the level of an administrative penalty, the commissioner shall consider the following factors:

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

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

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

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

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

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

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

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

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

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

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

History: *1992 c 510 art 4 s 13; 1995 c 231 art 2 s 62,63; 1997 c 7 art 5 s 14,15; 2001 c 123 s 9; 2005 c 90 s 12*

FEES FOR SERVICES

176.136 MEDICAL FEE REVIEW.

Subdivision 1. **Schedule.** (a) The commissioner shall by rule establish procedures for determining whether or not the charge for a health service is excessive. In order to accomplish this purpose, the

commissioner shall consult with insurers, associations and organizations representing the medical and other providers of treatment services and other appropriate groups.

(b) The procedures established by the commissioner must limit, in accordance with subdivisions 1a, 1b, and 1c, the charges allowable for medical, chiropractic, podiatric, surgical, hospital and other health care provider treatment or services, as defined and compensable under section 176.135. The procedures established by the commissioner for determining whether or not the charge for a health service is excessive must be structured to encourage providers to develop and deliver services for rehabilitation of injured workers. The procedures must incorporate the provisions of sections 144.701, 144.702, and 144.703 to the extent that the commissioner finds that these provisions effectively accomplish the intent of this section or are otherwise necessary to ensure that quality hospital care is available to injured employees.

Subd. 1a. **Relative value fee schedule.** (a) The liability of an employer for services included in the medical fee schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee, whichever is lower. The 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. The commissioner may adopt by reference, according to the procedures in paragraph (d), clause (2), the relative value fee schedule tables adopted for the federal Medicare program. The relative value fee schedule must contain reasonable classifications including, but not limited to, classifications that differentiate among health care provider disciplines. The conversion factors for the original relative value fee schedule must reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in effect. The reduction need not be applied equally to all treatment or services, but must represent a gross 15 percent reduction.

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

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

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

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

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

(c) The conversion factors shall be adjusted as follows:

(1) After permanent rules have been adopted to implement this section, the conversion factors must be adjusted annually on October 1 by no more than the percentage change computed under section 176.645, but without the annual cap provided by that section.

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

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

(1) The commissioner shall annually give notice in the State Register of the adjusted conversion factors and any amendments to rules to implement Medicare relative value tables incorporated by reference under this subdivision. The notices of the adjusted conversion factors and amended rules to implement the relative value tables are subject to the requirements of section 14.386, paragraph (a). The annual adjustments to the conversion factors and the medical fee schedules adopted under this section, including all previous fee schedules, are not subject to expiration under section 14.386, paragraph (b).

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

Subd. 1b. **Limitation of liability.** (a) The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a Critical Access Hospital certified by the Centers for Medicare and Medicaid Services shall be the hospital's usual and customary charge, unless the charge is determined by the commissioner or a compensation judge to be unreasonably excessive.

(b) The liability of the employer for the treatment, articles, and supplies that are not limited by paragraph (a), subdivision 1a or 1c, section 176.1362, 176.1363, or 176.1364, shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower, except as provided in paragraph (e). On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph. A prevailing charge established under Minnesota Rules, part 5221.0500, subpart 2, must be based on no more than two years of billing data immediately preceding the date of the service.

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

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

(e) The limitation of the employer's liability based on 85 percent of prevailing charge does not apply to charges by an ambulatory surgical center as defined in section 176.1363, subdivision 1, paragraph (b), or a hospital as defined in section 176.1364, subdivision 1, paragraph (e).

(f) For purposes of this chapter, "inpatient" means a patient that has been admitted to a hospital by an order from a physician or dentist. If there is no inpatient admission order, the patient is deemed an outpatient. The hospital must provide documentation of an inpatient order upon the request of the employer.

Subd. 1c. **Charges for independent medical examinations.** The commissioner shall adopt rules that reasonably limit amounts which may be charged for, or in connection with, independent or adverse medical examinations requested by any party, including the amount that may be charged for depositions, witness fees, or other expenses. No party may pay fees above the amount in the schedule.

Subd. 2. **Excessive fees.** If the employer or insurer determines that the charge for a health service or medical service is excessive, no payment in excess of the reasonable charge for that service shall be made under this chapter nor may the provider collect or attempt to collect from the injured employee or any other insurer or government amounts in excess of the amount payable under this chapter unless the commissioner, compensation judge, or court of appeals determines otherwise. In such a case, the health care provider may initiate an action under this chapter for recovery of the amounts deemed excessive by the employer or insurer. A charge for a health service or medical service is excessive if it:

(1) exceeds the maximum permissible charge pursuant to subdivision 1, 1a, 1b, or 1c;

(2) is for a service provided at a level, duration, or frequency that is excessive, based upon accepted medical standards for quality health care and accepted rehabilitation standards;

(3) is for a service that is outside the scope of practice of the particular provider or is not generally recognized within the particular profession of the provider as of therapeutic value for the specific injury or condition treated; or

(4) is otherwise deemed excessive or inappropriate pursuant to rules adopted pursuant to this chapter.

Subd. 2a. **Penalties, costs, and expenses for improper collection or attempts to collect payment for medical services from an employee.** (a) The commissioner may assess penalties, costs, and expenses against a health care provider who collects or attempts to collect payment from an employee in violation of subdivision 2; section 176.135, subdivision 7; or 176.83, subdivision 5, paragraph (c), as provided in this subdivision. For purposes of paragraphs (b) and (c):

(1) A violation occurs only if the health care provider or the provider's representative was informed that the treatment or service was for a claimed workers' compensation injury or that the bill should be submitted to a workers' compensation insurer.

(2) Once the health care provider has been provided the information described in clause (1), a violation occurs each time the health care provider, or any person acting on the provider's behalf or direction, collects or attempts to collect payment from the employee for charges on a bill for medical treatment or services. An attempt to collect payment from an employee includes:

(i) each contact made in person or by United States mail, telephone, text, email, or any other type of contact seeking payment;

(ii) engaging a collection agency or other third party to collect from the employee;

(iii) filing a claim in conciliation court;

(iv) attaching the employee's tax refund; or

(v) submitting a report to a credit agency.

(b) The penalty assessed against a health care provider for each violation shall be $1,000, payable to the assigned risk safety account, except that:

(1) the penalty shall be $2,000, payable to the assigned risk safety account, for each violation if the employee paid the health care provider as a result of the violation, or for the violations described in paragraph (a), clause (2), items (ii) to (v); and

(2) the commissioner shall not assess a penalty under this paragraph unless the commissioner has documentation that the health care provider or the health care provider's representative has been provided with written notice that the attempted collection or collection from an employee is prohibited by workers' compensation law and that penalties may be assessed for a violation of the law. The notice required by this clause may be provided by any agency or person, including an employee, self-insured employer, insurer, third-party administrator, or attorney. The written notice required by this clause must only be provided once and once provided, the commissioner may assess penalties under this paragraph for a health care provider's or the health care provider's representative's improper collection or attempts to collect payment for medical services from any employee without provision of written notice required by this paragraph. Written notice provided before August 1, 2021, satisfies the notice requirement. The commissioner shall post on the department's website a model notice. The model notice is presumed to provide sufficient notice for purposes of this clause when provided to a health care provider's billing office by any agency or person.

(c) In addition to any penalty assessed under paragraph (b), the commissioner has the authority to order the health care provider to pay the employee the following amounts as reasonable reimbursement of costs and expenses incurred by the employee as a result of one or more violations, as provided in clauses (1) and (2), and to take all reasonable action to restore the employee's credit rating if it has been damaged as a result of the violation:

(1) the health care provider must reimburse the employee all amounts that the employee paid to the health care provider as a result of a violation, with interest, as specified in section 176.221, subdivision 7; and

(2) for violations described in paragraph (a), clause (2), items (ii) to (v), the health care provider must reimburse the employee a minimum lump-sum payment of $500 for which no supporting documentation is required to be provided, in addition to costs or expenses documented by the employee over that amount.

Nonexclusive examples of costs and expenses incurred as a result of a violation include attorney fees, lost wages, filing fees, court costs, courier fees, photocopying or facsimile charges, telephone and postage charges, computer or research costs, witness fees, records, and travel expenses. Costs and expenses incurred by the employee as a result of a violation are payable whether or not the health care provider has been provided with the notice described in paragraph (b), clause (2).

Subd. 3. [Repealed, 2014 c 182 s 8]

Subd. 4. [Repealed, 1987 c 332 s 117]

Subd. 5. [Repealed, 1992 c 510 art 4 s 26]

History: *Ex1979 c 3 s 45; 1981 c 346 s 87; 1982 c 424 s 130; 1983 c 289 s 114 subd 1; 1983 c 290 s 108; 1984 c 432 art 2 s 25; 1984 c 640 s 32; 1984 c 655 art 1 s 92; 1985 c 234 s 11; 1987 c 332 s 39; 1989 c 282 art 2 s 51,52; 1992 c 510 art 4 s 14-18; 1993 c 194 s 6; 1995 c 231 art 2 s 64-66; 1996 c 374 s 4; 1997 c 187 art 5 s 26; 1Sp2005 c 1 art 4 s 40; 2008 c 250 s 7,8; 2013 c 70 art 2 s 9; 2014 c 182 s 5; 2015 c 43 s 2; 2016 c 110 art 2 s 2; 2018 c 185 art 3 s 1; 2021 c 12 s 2*

MISCELLANEOUS

176.1361 TESTIMONY OF PROVIDERS.

When the commissioner, a compensation judge, or the court of appeals has reason to believe that a medical or other provider of treatment services has submitted false testimony or a false report in any proceeding under this chapter, the commissioner, compensation judge, or the court of appeals shall refer the matter to an appropriate licensing body or other professional certifying organization for review and recommendations. Based upon their recommendation, the Medical Services Review Board, after hearing, may bar the provider from making an appearance, and disallow the admission into evidence of written reports of the provider, in any proceeding under this chapter for a period not to exceed one year in the first instance and three years in the second instance, and may permanently bar the provider from appearance and the provider's reports from admission in evidence thereafter.

History: *1981 c 346 s 88; 1986 c 444; 1987 c 332 s 40*

176.1362 INPATIENT HOSPITAL PAYMENT.

Subdivision 1. **Payment based on Medicare MS-DRG system.** (a) Except as provided in subdivisions 2 and 3, reimbursement for inpatient hospital services, articles, and supplies is the lesser of the hospital's total usual and customary charge or 200 percent of the amount calculated for each hospital under the federal Inpatient Prospective Payment System developed for Medicare, using the inpatient Medicare PC-Pricer program or the inpatient PPS Web Pricer for the applicable MS-DRG as provided in this subdivision. All adjustments included in the PC-Pricer program or the inpatient PPS Web Pricer are included in the amount calculated, including but not limited to any outlier payments.

(b) Payment under this section is effective for services, articles, and supplies provided to patients discharged from the hospital on or after January 1, 2016. Payment for services, articles, and supplies provided to patients discharged on January 1, 2016, through December 31, 2016, must be based on the Medicare PC-Pricer program in effect on January 1, 2016.

(c) For patients discharged on or after May 31, 2017, payment for inpatient services, articles, and supplies must be calculated according to the PC-Pricer program identified on Medicare's website as FY 2016.1, updated on January 19, 2016.

(d) For patients discharged on or after October 1, 2017, payment for inpatient services, articles, and supplies must be calculated according to the PC-Pricer program or the inpatient PPS Web Pricer posted on the Department of Labor and Industry's website as follows:

(1) No later than October 1, 2017, and October 1 of each subsequent year until October 1, 2021, the commissioner must post on the department's website the version of the PC-Pricer program that is most recently available on Medicare's website as of the preceding July 1. If no PC-Pricer program is available on the Medicare website on any July 1, the PC-Pricer program most recently posted on the department's website remains in effect.

The commissioner must publish notice of the applicable PC-Pricer program in the State Register no later than October 1 of each year.

(2) Beginning on October 1, 2021, payment for inpatient services, articles, and supplies must be calculated using the inpatient PPS Web Pricer available on Medicare's website using the applicable dates of inpatient hospitalization. The department must publish the link to the inpatient PPS Web Pricer on its website.

(e) The MS-DRG grouper software or program that corresponds to or is included with the applicable version of the PC-Pricer program or inpatient PPS Web Pricer must be used to determine payment under this subdivision.

(f) Hospitals must bill workers' compensation insurers using the same codes, formats, and details that are required for billing for hospital inpatient services by the Medicare program. The bill must be submitted to the insurer within the time period required by section 62Q.75, subdivision 3. For purposes of this section, "insurer" includes both workers' compensation insurers and self-insured employers.

Subd. 2. **Payment for catastrophic, high-cost injuries.** (a) If the hospital's total usual and customary charges for services, articles, and supplies for a patient's hospitalization exceed a threshold of $175,000, annually adjusted as provided in paragraph (b), reimbursement must not be based on the MS-DRG system, but must instead be paid at 75 percent of the hospital's usual and customary charges. The threshold amount in effect on the date of discharge determines the applicability of this paragraph.

(b) On January 1, 2017, the commissioner must adjust the previous year's threshold by the percent change in average total charges per inpatient case, using data available as of October 1 for non-Critical Access Hospitals from the Health Care Cost Information System maintained by the Department of Health pursuant to chapter 144. Beginning October 1, 2017, and each October 1 thereafter, the commissioner must adjust the previous threshold using the data available as of the preceding July 1. The commissioner must publish notice of the updated threshold in the State Register.

Subd. 3. **Critical Access Hospitals.** Hospitals certified by the Centers for Medicare and Medicaid Services as Critical Access Hospitals shall be reimbursed as provided in section 176.136, subdivision 1b, paragraph (a).

Subd. 4. **Submission of information when payment is by MS-DRG.** Except when a postpayment audit is allowed under subdivision 6, an insurer must not require an itemization of charges or additional documentation to support a bill from a non-Critical Access Hospital when all of the following requirements are met:

(1) the hospital must submit its charges to the insurer on the 837 institutional standard electronic transaction required by section 62J.536;

(2) an MS-DRG must apply to the hospitalization; and

(3) the hospital's total charges must be less than the threshold amount in subdivision 2, as annually adjusted.

Subd. 5. **Prompt payment requirement when MS-DRG payment is made.** (a) When the requirements in subdivision 4 have been met, the insurer must take one of the following actions within 30 days of receipt of the hospital's bill:

(1) pay the hospital's bill as provided in subdivision 1, with no reductions based on a review of charges for specific services, articles, or supplies; or

(2) deny payment for the entire hospitalization for one of the following reasons:

(i) the patient's workers' compensation injury claim is denied;

(ii) the diagnosis for which the patient was hospitalized is not related to the insurer's admitted workers' compensation injury; or

(iii) the hospitalization was not reasonably required to cure and relieve the employee from the effects of the injury under section 176.135 or rules adopted under section 176.83, subdivision 5.

(b) When the requirements of subdivision 4 are met, an insurer must not deny payment for one or more charges on the basis that the charge should have been bundled into another charge, or on the basis that a particular service, article, or supply was not reasonably required, except that the insurer may raise these issues during a postpayment audit under subdivision 6.

Subd. 6. **Postpayment audits; records; interest.** (a) The insurer may conduct a postpayment audit if both of the following requirements are met:

(1) the insurer paid the hospital's bill within 30 days according to the PC-Pricer program or inpatient PPS Web Pricer amount described in subdivision 1; and

(2) the amount paid according to the PC-Pricer program or inpatient PPS Web Pricer in subdivision 1 included an outlier payment.

(b) If an audit is permitted under paragraph (a), the insurer must request any additional records needed to conduct the audit within six months after payment. The records requested may include an itemized statement of charges. Within 30 days of the insurer's request, the hospital must provide the additional documentation requested. An insurer must not request additional information from a hospital more than three times per audit.

(c) An insurer must pay the hospital interest at an annual rate of four percent if it is determined that the insurer is liable for additional hospital charges following a postpayment audit. A hospital must pay the insurer interest at an annual rate of four percent if it is determined that the hospital owes the insurer reimbursement following the insurer's audit. Interest is payable by the insurer from the date payment was due under this section or section 176.135. Interest is payable by the hospital from the date the overpayment was made.

Subd. 7. **Study.** The commissioner of labor and industry shall conduct a study analyzing the impact of the reforms under this section to determine whether the objectives have been met and whether further changes are needed. The commissioner must report the results of the study to the Workers' Compensation Advisory Council and the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over workers' compensation by January 15, 2018.

Subd. 8. **Rulemaking.** The commissioner may adopt or amend rules using the authority in section 14.389, including subdivision 5, to: (1) implement this section and the Medicare Inpatient Prospective Payment System for workers' compensation; and (2) implement the Medicare Hospital Outpatient Prospective Payment System, or other fee schedule, for payment of outpatient services provided under this chapter by a hospital or ambulatory surgical center, not to take effect before January 1, 2017.

History: *2015 c 43 s 3; 2017 c 94 art 3 s 2,3; 2021 c 12 s 3,4; 2023 c 51 art 6 s 6*

176.1363 AMBULATORY SURGICAL CENTER PAYMENT.

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

(b) "Ambulatory surgical center" or "ASC" means a facility that is: (1) certified as an ASC by the Centers for Medicare and Medicaid Services; or (2) licensed by the Department of Health as a freestanding outpatient surgical center and not owned by a hospital.

(c) "Ambulatory surgical center payment system" or "ASCPS" means the system developed by the Centers for Medicare and Medicaid Services for payment of surgical services provided by federally certified ASCs as specified in:

(1) Code of Federal Regulations, title 42, part 416, including without limitation the geographic adjustment for the ASC;

(2) annual revisions to Code of Federal Regulations, title 42, part 416, as published in the Federal Register;

(3) the corresponding addendum AA (final ASC covered surgical procedures), addendum BB (final covered ancillary services integral to covered surgical procedures), addendum DD1 (final ASC payment indicators), and any successor or replacement addenda; and

(4) the Medicare claims processing manual.

(d) "Conversion factor" means the Medicare ambulatory surgical center payment system (ASCPS) conversion factor used for ASCs that meet the Medicare quality reporting requirements, whether or not the ASC submitting the bill has met the quality reporting requirements.

(e) "Covered surgical procedures and ancillary services" means the procedures listed in ASCPS, addendum AA, and the ancillary services integral to covered surgical procedures listed in ASCPS, addendum BB.

(f) "Insurer" includes workers' compensation insurers and self-insured employers.

(g) "Medicare ASCPS payment" means the Medicare ASCPS payment used for ASCs that meet the Medicare quality reporting requirements, whether or not the ASC submitting the bill has met the Medicare quality reporting requirements.

Subd. 2. **Payment for covered surgical procedures and ancillary services based on Medicare ASCPS.** (a) Except as provided in subdivision 3, the payment to the ASC for covered surgical procedures and ancillary services shall be the lesser of:

(1) the ASC's total usual and customary charge for all services, supplies, and implantable devices provided; or

(2) the Medicare ASCPS payment on the total bill, times a multiplier of 320 percent.

(i) The amount payable under this clause includes payment for all implantable devices, even if the Medicare ASCPS would otherwise allow separate payment for the implantable device.

(ii) The 320 percent described in this clause must be adjusted if, on July 1, 2019, or any subsequent July 1, the conversion factor is less than 98 percent of the conversion factor in effect on the previous July 1. When this occurs, the multiplier must be 320 percent times 98 percent divided by the percentage that the current Medicare conversion factor bears to the Medicare conversion factor in effect on the prior July 1. In subsequent years, the multiplier is 320 percent, unless the Medicare ASCPS conversion factor declines by more than two percent.

(iii) When more than one covered surgical procedure is included on a bill, payment shall be: (A) 100 percent of the applicable ASCPS payment amount under paragraph (a), clause (2), for the procedure with the highest ASC payment rate; and (B) 50 percent of the applicable ASC payment amount under paragraph (a), clause (2), for all other covered surgical procedures. However, the total payment must still not exceed the ASC's usual and customary charge for all services, supplies, and implantable devices provided. This

item only applies when more than one procedure on a bill is identified as subject to multiple procedure discounting on Addendum AA.

(b) Payment under this section is effective for covered surgical procedures and ancillary services provided by an ASC on or after October 1, 2018, through September 30, 2019, and shall be based on the addenda AA, BB, and DD1 most recently available on the Centers for Medicare and Medicaid Services website as of July 1, 2018, and the corresponding rules and Medicare claims processing manual described in subdivision 1, paragraph (c).

(1) Payment for covered surgical procedures and ancillary services provided by an ASC on or after each subsequent October 1 shall be based on the addenda AA, BB, and DD1 most recently available on the Centers for Medicare and Medicaid Services website as of the preceding July 1 and the corresponding rules and Medicare claims processing manual.

(2) If the Centers for Medicare and Medicaid Services has not updated addendum AA, BB, or DD1 on its website since the commissioner's previous notice under paragraph (c), the addenda identified in the notice published by the commissioner in paragraph (c) and the corresponding rules and Medicare claims processing manual shall remain in effect.

(3) Addenda AA, BB, and DD1 under this subdivision include successor or replacement addenda.

(c) The commissioner shall annually give notice in the State Register of any adjustment to the multiplier under paragraph (a), clause (2), and of the applicable addenda in paragraph (b) no later than October 1. The notice must identify and include a link to the applicable addenda. The notices and any adjustment to the multiplier are not rules subject to chapter 14, but have the force and effect of law as of the effective date published in the State Register.

Subd. 3. **Payment for compensable surgical services not covered under ASCPS.** (a) If a surgical procedure provided by an ASC is compensable under this chapter but is not listed in addendum AA or BB of the Medicare ASCPS, payment must be 75 percent of the ASC's usual and customary charge for the procedure with the highest charge. Payment for each subsequent surgical procedure not listed in addendum AA or BB must be paid at 50 percent of the ASC's usual and customary charge.

(b) Payment must be 75 percent of the ASC's usual and customary charge for a surgical procedure or ancillary service if the procedure or service is listed in Medicare ASCPS addendum AA or BB and: (1) the payment indicator provides it is paid at a reasonable cost; or (2) the payment indicator provides it is contractor priced.

Subd. 4. **Study.** The commissioner shall conduct a study analyzing the impact of the reforms, including timeliness and accuracy of payment under this section, and recommend further changes if needed. The commissioner must report the results of the study to the Workers' Compensation Advisory Council and the chairs and ranking minority members of the legislative committees with jurisdiction over workers' compensation by January 15, 2021.

Subd. 5. **Rulemaking.** The commissioner may adopt or amend rules using the authority in section 14.386, paragraph (a), to implement this section and the Medicare ASCPS for workers' compensation. The rules are not subject to expiration under section 14.386, paragraph (b).

History: *2018 c 185 art 4 s 1; 2021 c 12 s 5-7*

176.1364 WORKERS' COMPENSATION HOSPITAL OUTPATIENT FEE SCHEDULE.

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

(b) "Addendum A" means the addendum entitled "OPPS APCs for CY 2018," or its successor, developed by the Centers for Medicare and Medicaid Services (Medicare) for use in the Medicare Hospital Outpatient Prospective Payment System (OPPS) system under Code of Federal Regulations, title 42, part 419, as may be amended from time to time.

(c) "Addendum B" means the addendum entitled "OPPS Payment by HCPCS Codes for CY 2018," or its successor, developed by the Centers for Medicare and Medicaid Services (Medicare) for use in the Medicare Hospital Outpatient Prospective Payment System (OPPS) system under Code of Federal Regulations, title 42, part 419, as may be amended from time to time.

(d) "HCPCS code" means a numeric or alphanumeric code included in the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System. A HCPCS code is used to identify a specific medical service.

(e) "Hospital" means a facility that is licensed by the Department of Health under section 144.50.

(f) "HOFS" means the workers' compensation hospital outpatient fee schedule established under subdivision 3.

(g) "Insurer" includes workers' compensation insurers and self-insured employers.

(h) "Services" includes articles, supplies, procedures, and implantable devices provided by the hospital with the service. Services are identified by a code described in subdivision 3.

Subd. 2. **Applicability.** (a) This section only applies to payment of charges for hospital outpatient services if the charges include a service listed in the workers' compensation hospital outpatient fee schedule established by the commissioner under subdivision 3. If the charges do not include a service listed in the HOFS, payment shall be:

(1) the liability for each service that is included in the workers' compensation relative value fee schedule as provided in section 176.136, subdivision 1a, and corresponding rules adopted by the commissioner to implement the relative value fee schedule; or

(2) the liability as provided in section 176.136, subdivision 1b, paragraphs (b) and (c), for each service that is not included in the workers' compensation relative value fee schedule.

(b) This section does not apply to outpatient services provided at a hospital that is certified by Medicare as a critical access hospital. Outpatient services provided by these hospitals shall be paid as provided in section 176.136, subdivision 1b, paragraph (a).

Subd. 3. **Hospital outpatient fee schedule (HOFS).** (a) Effective for hospital outpatient services on or after October 1, 2018, the commissioner shall establish a workers' compensation hospital outpatient fee schedule (HOFS) to establish the payment for hospital bills with charges for services with a J1 or J2 status indicator as listed in the status indicator (SI) column of Addendum B and the comprehensive observation services Ambulatory Payment Classification (APC) 8011 with a J2 status indicator in Addendum A. The commissioner shall publish a link to the HOFS in the State Register before October 1, 2018, and shall maintain the current HOFS on the department's website.

(b) The amount listed for each of the procedures in the HOFS as described in paragraph (a) shall be the relative weight for the procedure multiplied by a HOFS conversion factor that results in the same overall payment for hospital outpatient services under this section as the actual payments made in the most recent 12-month period available before October 1, 2018. The commissioner must establish separate conversion factors to achieve the same overall payment for noncritical access hospitals of 100 or fewer licensed beds and hospitals with more than 100 licensed beds. The commissioner shall establish the two conversion factors according to the requirements in clauses (1) to (4) in consultation with insurer and hospital representatives.

(1) The commissioner shall obtain a suitable sample of de-identified data for Minnesota workers' compensation outpatient cases at Minnesota hospitals for the most recently available 12-month period. The commissioner may obtain de-identified data from any reliable source, including Minnesota hospitals and insurers, or their representatives. Any data provided to the commissioner by a hospital, insurer, or their representative under this subdivision is nonpublic data under section 13.02, subdivision 9.

(2) The sample must be divided into a data set for hospitals over 100 licensed beds, and 100 or fewer licensed beds, excluding critical access hospitals.

(3) For each data set the commissioner shall:

(i) calculate the total amount of the actual payments made in the most recent 12-month period available before October 1, 2018, adjusted for inflation to July 2018; and

(ii) apply all of the payment provisions in this section to each claim including, as applicable, payment under the relative value fee schedule or 85 percent of the hospital's usual and customary charge under section 176.136, subdivisions 1a and 1b, to determine the total payment amount using the Medicare conversion factor in effect for the OPPS in effect on July 1, 2018.

(4) The commissioner shall calculate the Minnesota conversion factor to equal the Medicare conversion factor multiplied by the ratio of total payments under clause (3), item (i), divided by the total payments under clause (3), item (ii).

(c) For purposes of this section:

(1) the relative weight is the amount in the "relative weight" column in Addendum B and Addendum A for comprehensive observation services;

(2) references to J1, J2, and H status indicators; Addenda A and B; APC 8011; and HCPCS code G0378 includes any successor status indicators, addenda, APC, or HCPCS code established by the Centers for Medicare and Medicaid Services.

(d) On October 1 of each year, the commissioner shall adjust the HOFS conversion factors based on the market basket index for inpatient hospital services calculated by Medicare and published on its website. The adjustment on each October 1 shall be a percentage equal to the value of that index averaged over the four quarters of the most recent calendar year divided by the value of that index over the four quarters of the prior calendar year.

(e) No later than October 1, 2021, and at least once every three years thereafter, the commissioner shall update the HOFS established under this subdivision by incorporating services with a J1 or J2 status indicator, and the corresponding relative weights, listed in the Addenda A and B most recently available on Medicare's website as of the preceding July 1. If Addenda A and B are not available on Medicare's website on the preceding July 1, the HOFS most recently published on the department's website remains in effect.

(1) Each time the HOFS is updated under this paragraph, the commissioner shall adjust the conversion factors so that there is no difference between the overall payment under the new HOFS and the overall payment under the HOFS most recently in effect, for services in both HOFSs.

(2) The conversion factor adjustments under this paragraph shall be made separately for each hospital category in paragraph (b).

(3) The conversion factor adjustments under this paragraph must be made before making any additional adjustment under paragraph (d).

(f) The commissioner shall give notice in the State Register of the adjusted conversion factor in paragraph (d) no later than October 1 annually. The commissioner shall give notice in the State Register of an updated HOFS under paragraph (e) no later than October 1 of the year in which the HOFS becomes effective. The notice must include a link to the HOFS published on the department's website. The notices, the updated fee schedules, and the adjusted conversion factors are not rules subject to chapter 14, but have the force and effect of law as of the effective date published in the State Register.

(g) Beginning October 1, 2023, to October 1, 2025, the commissioner shall adjust the conversion factors calculated under this subdivision to result in the following:

(1) for services effective October 1, 2023, a three percent overall reduction in total payments for hospital outpatient services;

(2) for services effective October 1, 2024, a three percent overall reduction in total payments for hospital outpatient services; and

(3) for services effective October 1, 2025, a four percent overall reduction in total payments for hospital outpatient services.

Subd. 4. **Payment under the hospital outpatient fee schedule.** (a) Services in the HOFS, and other hospital outpatient services provided with or as part of service in the HOFS, are paid according to paragraphs (b) and (c).

(b) If a hospital bill includes a charge for one or more services with a J1 status indicator, payment shall be as provided in this paragraph.

(1) If the bill includes a charge for only one service with only a J1 status indicator, payment shall be the amount listed in the HOFS for that service, regardless of the amount charged by the hospital.

(2) If the bill includes charges for more than one service with a J1 status indicator, the service with the highest listed fee in the HOFS shall be paid at 100 percent of the listed fee. Each additional service listed in the hospital outpatient fee shall be paid at 50 percent of the listed fee. Payment under this clause shall be based on the applicable percentage of the listed fee, regardless of the amount charged by the hospital.

(3) If the bill includes an additional charge for a service that does not have a J1 status indicator listed in the HOFS, no separate payment is made for the additional service. Payment for the additional service, including any service with a J2 status indicator, is packaged into and is not paid separately from the payment amount listed in the HOFS for the service with the J1 status indicator. Implantable devices are paid separately only as provided in subdivision 5.

(4) The insurer must not deny payment for any additional service packaged into payment for a service listed in the HOFS on the basis that the additional service was not reasonably required or causally related to an admitted work injury.

(c) If a hospital bill includes one or more charges for services with a J2 status indicator, and does not include any charges for services with a J1 status indicator, payment shall be as provided in this paragraph.

(1) Except for services packaged into an observation service as provided in clause (4), payment for each service with a J2 status indicator shall be the amount listed in the HOFS, regardless of the amount charged by the hospital.

(2) If a service without a HCPCS code is billed with a service with a J2 status indicator, payment is packaged into the payment for the J2 service.

(3) Payment for drugs with a HCPCS code is separate from payment for the service with the J2 code as provided in this clause.

(i) If the drug is delivered by injection or infusion, payment for the drug is packaged into payment for the injection or infusion service.

(ii) If the drug is not delivered by injection or infusion, payment for the drug is paid at the Medicare Average Sales Price (ASP) of the drug on the day the drug is dispensed. No later than October 1, 2018, and October 1 of each subsequent year, the commissioner must publish on the department's website a link to the ASP most recently available as of the preceding July 1. If no ASP is available, the most recently posted ASP linked on the department's website remains in effect.

(4) If a bill includes eight or more units of service with the HCPCS code G0378 (observation services, per hour), and there is a physician's or dentist's order for observation, payment shall be the amount listed in the HOFS for the comprehensive observation services Ambulatory Payment Classification 8011, regardless of the amount charged by the hospital. All other services billed by the hospital, including other services with a J2 status indicator, are packaged into the payment amount and are not paid separately from the payment amount listed in the fee schedule for HCPCS code G0378.

(5) For any other service on the same bill as the service with a J2 status indicator, payment shall be as provided in subdivision 2, paragraph (a).

Subd. 5. **Implantable devices.** The maximum fee for any service in the HOFS includes payment for all implantable devices, even if the Medicare OPPS would otherwise allow separate payment for the implantable device. However, separate payment in the amount of 85 percent of the hospital's usual and customary charge for an implantable device is allowed if the implantable device:

(1) has an H status indicator in Addendum B;

(2) is properly charged on a bill with a service with a J1 status indicator in the HOFS; and

(3) is properly billed with another HCPCS code, if required by Medicare's OPPS system.

The commissioner shall update the HOFS each October 1 to include any HCPCS codes that are payable under this section according to the Addendum B most recently available on the preceding July 1.

Subd. 6. MS 2022 [Repealed, 2023 c 51 art 4 s 2]

Subd. 7. **Rulemaking.** The commissioner may adopt or amend rules, using the authority in section 14.386, paragraph (a), to implement this section. The rules are not subject to expiration under section 14.386, paragraph (b).

History: *2018 c 185 art 2 s 1; 2023 c 51 art 4 s 1*

176.1365 OUTPATIENT BILLING, PAYMENT, AND DISPUTE RESOLUTION.

Subdivision 1. **Scope.** This section applies to billing, payment, and dispute resolution for services provided by an ambulatory surgical center (ASC) under section 176.1363 and hospital outpatient services under section 176.1364. For purposes of this section, "insurer" includes self-insured employer and "services" is as defined in section 176.1364.

Subd. 2. **Outpatient billing, coding, and prior notification.** (a) Ambulatory surgical centers and hospitals must bill workers' compensation insurers for services governed by sections 176.1363 and 176.1364 using the same codes, formats, and details that are required for billing the Medicare program, including coding consistent with the American Medical Association Current Procedural Terminology coding system and Medicare's Ambulatory Surgical Center Payment System, Outpatient Prospective Payment System, Outpatient Code Editor, Healthcare Current Procedural Terminology Coding System, and the National Correct Coding Initiative Policy Manual for Medicare Services and associated web page and tables.

(b) All charges for ASC or hospital outpatient fee schedule services governed by sections 176.1363 and 176.1364 must be submitted to the insurer on the appropriate electronic transaction required by section 176.135, subdivisions 7 and 7a. ASCs must submit charges on the electronic 837P form. ASCs must not separately bill for the services and items included in the ASC facility fee under Code of Federal Regulations, title 42, section 416.164(a). Minnesota Rules, part 5221.4033, subpart 1a, does not apply to ASCs under this section, but does apply to hospital outpatient facility fees to the extent they are not covered by the hospital outpatient fee schedule under section 176.1364.

(c) Hospitals, ASCs, and insurers must comply with the prior notification and approval or authorization requirements specified in Minnesota Rules, part 5221.6050, subpart 9. Prior notification may be provided by either the hospital, ASC, or the surgeon. For purposes of prior notification under Minnesota Rules, part 5221.6050, subpart 9, "inpatient" has the meaning as provided under section 176.136, subdivision 1b, paragraph (d).

(d) ASC or hospital bills must be submitted to insurers as required by section 176.135, subdivisions 7 and 7a, and within the time period required by section 62Q.75, subdivision 3. Insurers must respond to the initial bill as provided in section 176.135, subdivisions 6 and 7a. Copies of any records or reports relating to the items for which payment is sought are separately payable as provided in section 176.135, subdivision 7, paragraph (a).

Subd. 3. **ASC or hospital request for reconsideration; insurer response; time frames.** (a) Following receipt of the insurer's explanation of review (EOR) or explanation of benefits (EOB), the ASC or hospital may request reconsideration of a payment denial or reduction. The ASC or hospital must submit its request for reconsideration in writing to the insurer within one year of the date of the EOR or EOB.

(b) The insurer must issue a written response to the ASC or hospital's request for reconsideration within 30 days, as provided in section 176.135, subdivision 6. The written response must address the issues raised by the request for reconsideration and not simply reiterate the information on the EOR or EOB.

Subd. 4. **Insurer request for reimbursement of overpayment; time frame.** If the payer determines it has overpaid an ASC or hospital's charges based on workers' compensation statutes and rules, the payer must submit its request for reimbursement in writing to the ASC or hospital within one year of the date of the payment.

Subd. 5. **Medical requests for administrative conference; time frame to file.** (a) An ASC, hospital, or insurer must notify the provider or payer, as applicable, of its intent to file a medical request for an

administrative conference under section 176.106 at least 20 days before filing one with the department. The insurer, or the ASC or hospital if permitted by section 176.136, subdivision 2, must file the medical request for an administrative conference no later than the latest of:

(1) one year after the date of the initial EOR or EOB if the ASC or hospital does not request a reconsideration of a payment denial or reduction under subdivision 3;

(2) one year after the date of the insurer's response to the ASC or hospital's request for reconsideration under subdivision 3; or

(3) one year after the insurer's request for reimbursement of an overpayment from an ASC or hospital under subdivision 4.

(b) Paragraph (a) does not prohibit an employee from filing a medical request for assistance or claim petition for the payment denied or reduced by the insurer. However, the ASC or hospital may not bill the employee for the denied or reduced payment when prohibited by this chapter.

Subd. 6. **Interest.** (a) An insurer must pay the ASC or hospital interest at an annual rate of four percent if it is determined that the insurer is liable for additional ASC or hospital charges following a denial of payment. Interest is payable by the insurer on the additional amount owed from the date payment was due.

(b) An ASC or hospital must pay the insurer interest at an annual rate of four percent if it is determined that the hospital owes the insurer reimbursement following the insurer's request for reimbursement of an overpayment. Interest is payable by the ASC or hospital on the amount of the overpayment from the date the overpayment was made.

History: *2018 c 185 art 3 s 2*

176.137 REMODELING OF RESIDENCE; DISABLED EMPLOYEES.

Subdivision 1. **Requirement; determination.** The employer shall furnish to an employee who is permanently disabled because of a personal injury suffered in the course of employment with that employer such alteration or remodeling of the employee's principal residence as is reasonably required to enable the employee to move freely into and throughout the residence and to otherwise adequately accommodate the disability. Any remodeling or alteration shall be furnished only when the division determines that the injury is to such a degree that the employee is substantially prevented from functioning within the principal residence.

Subd. 2. **Cost.** The pecuniary liability of an employer for remodeling or alteration required by this section is limited to prevailing costs in the community for remodeling or alteration of that type. The costs of obtaining the architectural certification and supervision required by this section, or the costs of obtaining approval by a certified building official or certified accessibility specialist under subdivision 4, paragraph (b), clause (3), are included in the $150,000 limit in subdivision 5.

Subd. 3. **New residence.** Where the alteration or remodeling of the employee's residence is not practicable, the award may be to purchase or lease a new or different residence if the new or different residence would better accommodate the disability.

Subd. 4. **Certification required; exceptions.** (a) Except as provided in paragraph (b), no award may be made except upon the certification of a licensed architect to the division that the proposed alteration or remodeling of an existing residence or the building or purchase of a new or different residence is reasonably required for the purposes specified in subdivision 1. The Council on Disability shall advise the division as provided in section 256.482, subdivision 5, clause (7). The alteration or remodeling of an existing residence,

or the building or purchase of a new home must be done under the supervision of a licensed architect relative to the specific needs to accommodate the disability.

(b) Remodeling or alteration projects do not require an architect's certification and supervision if the project is:

(1) approved by the Council on Disability;

(2) performed by a residential building contractor or residential remodeler licensed under section 326B.805, subdivision 1; and

(3) approved by a certified building official or certified accessibility specialist under section 326B.133, subdivision 3a, paragraphs (b) and (d), who states in writing that the proposed remodeling or alterations are reasonably required to enable the employee to move freely into and throughout the residence and to otherwise accommodate the disability.

Subd. 5. **Limitation.** An employee is limited to $150,000 under this section for each personal injury.

Subd. 6. **Disputes.** A proceeding to resolve a dispute under this section shall be initiated by petition under sections 176.271 and 176.291 and decided by a compensation judge at the office under section 176.305, 176.322, or 176.341. The decision of the compensation judge is appealable to the Workers' Compensation Court of Appeals under section 176.421.

History: *1977 c 177 s 1; 1986 c 444; 1987 c 354 s 8; 1992 c 510 art 4 s 19; 2005 c 56 s 1; 2011 c 89 s 12-14; 2016 c 110 art 3 s 2-4; 2024 c 97 s 14,15*

176.138 MEDICAL DATA; ACCESS.

(a) Notwithstanding any other state laws related to the privacy of medical data or any private agreements to the contrary, the release in writing, by telephone discussion, or otherwise of medical data related to a current claim for compensation under this chapter to the employee, employer, or insurer who are parties to the claim, or to the Department of Labor and Industry, shall not require prior approval of any party to the claim. This section does not preclude the release of medical data under section 175.10 or 176.231, subdivision 9. Requests for pertinent data shall be made, and the date of discussions with medical providers about medical data shall be confirmed, in writing to the person or organization that collected or currently possesses the data. Written medical data that exists at the time the request is made shall be provided by the collector or possessor within seven working days of receiving the request. Nonwritten medical data may be provided, but is not required to be provided, by the collector or possessor. In all cases of a request for the data or discussion with a medical provider about the data, except when it is the employee who is making the request, the employee shall be sent written notification of the request by the party requesting the data at the same time the request is made or a written confirmation of the discussion. This data shall be treated as private data by the party who requests or receives the data and the party receiving the data shall provide the employee or the employee's attorney with a copy of all data requested by the requester.

(b) Medical data which is not directly related to a current injury or disability shall not be released without prior authorization of the employee.

(c) The commissioner may impose a penalty of up to $600 payable to the commissioner for deposit in the assigned risk safety account against a party who does not timely release data as required in this section. A party who does not treat this data as private pursuant to this section is guilty of a misdemeanor. This paragraph applies only to written medical data which exists at the time the request is made.

(d) Workers' compensation insurers and self-insured employers may, for the sole purpose of identifying duplicate billings submitted to more than one insurer, disclose to health insurers, including all insurers writing insurance described in section 60A.06, subdivision 1, clause (5)(a), nonprofit health service plan corporations subject to chapter 62C, health maintenance organizations subject to chapter 62D, and joint self-insurance employee health plans subject to chapter 62H, computerized information about dates, coded items, and charges for medical treatment of employees and other medical billing information submitted to them by an employee, employer, health care provider, or other insurer in connection with a current claim for compensation under this chapter, without prior approval of any party to the claim. The data may not be used by the health insurer for any other purpose whatsoever and must be destroyed after verification that there has been no duplicative billing. Any person who is the subject of the data which is used in a manner not allowed by this paragraph has a cause of action for actual damages and punitive damages for a minimum of $5,000.

(e) Medical data collected, stored, used, or disseminated by or filed with the commissioner in connection with a claim for workers' compensation benefits governed by this chapter does not constitute genetic information for the purposes of section 13.386.

History: *1983 c 290 s 109; 1984 c 432 art 2 s 26; 1985 c 234 s 12; 1986 c 461 s 22; 1990 c 522 s 4; 1992 c 510 art 3 s 15; 1995 c 231 art 2 s 67; 2001 c 123 s 10; 2013 c 70 art 1 s 4*

NOTICE

176.139 NOTICE OF RIGHTS POSTED.

Subdivision 1. **Posting requirement.** All employers required or electing to carry workers' compensation coverage in the state of Minnesota shall post and display in a conspicuous location a notice, in a form approved by the commissioner, advising employees of their rights and obligations under this chapter, assistance available to them, and the operation of the workers' compensation system, the name and address of the workers' compensation carrier insuring them or the fact that the employer is self-insured.

The notice shall be displayed at all locations where the employer is engaged in business.

Subd. 2. **Failure to post; penalty.** The commissioner may assess a penalty of $500 against the employer payable to the commissioner for deposit in the assigned risk safety account if, after notice from the commissioner, the employer violates the posting requirement of this section.

History: *Ex1979 c 3 s 46; 1987 c 332 s 41; 1992 c 510 art 3 s 16; 1995 c 231 art 2 s 68; 2002 c 262 s 14*

176.14 [Repealed, 1953 c 755 s 83]

176.141 NOTICE OF INJURY.

Unless the employer has actual knowledge of the occurrence of the injury or unless the injured worker, or a dependent or someone in behalf of either, gives written notice thereof to the employer within 14 days after the occurrence of the injury, then no compensation shall be due until the notice is given or knowledge obtained. If the notice is given or the knowledge obtained within 30 days from the occurrence of the injury, no want, failure, or inaccuracy of a notice shall be a bar to obtaining compensation unless the employer shows prejudice by such want, defect, or inaccuracy, and then only to the extent of the prejudice. If the notice is given or the knowledge obtained within 180 days, and if the employee or other beneficiary shows that failure to give prior notice was due to the employee's or beneficiary's mistake, inadvertence, ignorance

of fact or law, or inability, or to the fraud, misrepresentation, or deceit of the employer or agent, then compensation may be allowed, unless the employer shows prejudice by failure to receive the notice, in which case the amount of compensation shall be reduced by a sum which fairly represents the prejudice shown. Unless knowledge is obtained or written notice given within 180 days after the occurrence of the injury no compensation shall be allowed, except that an employee who is unable, because of mental or physical incapacity, to give notice to the employer within 180 days from the injury shall give the prescribed notice within 180 days from the time the incapacity ceases.

History: *1953 c 755 s 14; 1977 c 342 s 19; Ex1979 c 3 s 47; 1986 c 444*

176.145 SERVICE OF NOTICE, FORM.

The notice referred to in section 176.141 may be served personally upon the employer, or upon any agent of the employer upon whom a summons may be served in a civil action, or by sending it by certified mail to the employer at the last known residence or business place thereof within the state, and may be substantially in the following form:

"NOTICE

You are hereby notified that an injury was received by (Name) ....., who was in your employment at (place) ....., while engaged as (kind of work) ....., on or about the ..... day of ....., ..., and who is now located at (give town, street, and number) .....; that, so far as now known, the nature of the injury was ....., and that compensation may be claimed therefor.

Dated ....., ... (signed) .....

(giving address)"

No variation from this form shall be material if the notice is sufficient to advise the employer that a certain employee, by name, received a specified injury in the course of employment on or about a specified time, at or near a certain place specified.

History: *1953 c 755 s 15; 1978 c 674 s 60; 1986 c 444; 1998 c 254 art 1 s 107*

176.15 [Repealed, 1953 c 755 s 83]

TIME LIMITS

176.151 TIME LIMITATIONS.

The time within which the following acts shall be performed shall be limited to the following periods, respectively:

(a) Actions or proceedings by an injured employee to determine or recover compensation, three years after the employer has made written report of the injury to the commissioner of the Department of Labor and Industry, but not to exceed six years from the date of the accident.

(b) Actions or proceedings by dependents to determine or recover compensation, three years after the receipt by the commissioner of the Department of Labor and Industry of written notice of death, given by the employer, but not to exceed six years from the date of injury, provided, however, if the employee was paid compensation for the injury from which the death resulted, such actions or proceedings by dependents must be commenced within three years after the receipt by the commissioner of the Department of Labor and Industry of written notice of death, given by the employer, but not to exceed six years from the date of

death. In any such case, if a dependent of the deceased, or any one in the dependent's behalf, gives written notice of such death to the commissioner of the Department of Labor and Industry, the commissioner shall forthwith give written notice to the employer of the time and place of such death. In case the deceased was a native of a foreign country and leaves no known dependent within the United States, the commissioner of the Department of Labor and Industry shall give written notice of the death to the consul or other representative of the foreign country forthwith.

(c) In case of physical or mental incapacity, other than minority, of the injured person or dependents to perform or cause to be performed any act required within the time specified in this section, the period of limitation in any such case shall be extended for three years from the date when the incapacity ceases.

(d) In the case of injury caused by x-rays, radium, radioactive substances or machines, ionizing radiation, or any other occupational disease, the time limitations otherwise prescribed by Minnesota Statutes 1961, chapter 176, and acts amendatory thereof, shall not apply, but the employee shall give notice to the employer and commence an action within three years after the employee has knowledge of the cause of such injury and the injury has resulted in disability.

History: *1953 c 755 s 16; 1965 c 419 s 1; Ex1967 c 40 s 14; 1973 c 388 s 39; 1973 c 643 s 10; 1975 c 359 s 17; 1986 c 444*

176.152 [Repealed, 1983 c 290 s 173]

EXAMS

176.155 EXAMINATIONS.

Subdivision 1. **Employer's physician.** (a) The injured employee must submit to examination by the employer's physician, if requested by the employer, and at reasonable times thereafter upon the employer's request. Examinations shall not be conducted in hotel or motel facilities. The examination must be scheduled at a location within 150 miles of the employee's residence unless the employer can show cause to the office to order an examination at a location further from the employee's residence. The employee is entitled upon request to have a personal physician or witness present at any such examination. Each party shall defray the cost of that party's physician.

(b) Any report or written statement made by the employer's physician as a result of an examination of the employee, regardless of whether the examination preceded the injury or was made subsequent to the injury or whether litigation is pending, must be served upon the employee and the attorney representing the employee, if any, no later than 14 calendar days within the issuance of the report or written statement.

(c) The employer shall pay reasonable travel expenses incurred by the employee in attending the examination including mileage, parking, and, if necessary, lodging and meals. The employer shall also pay the employee for any lost wages resulting from attendance at the examination.

(d) A self-insured employer or insurer who is served with a claim petition pursuant to section 176.271, subdivision 1, or 176.291, shall schedule any necessary examinations of the employee, if an examination by the employer's physician or health care provider is necessary to evaluate benefits claimed. The examination shall be completed and the report of the examination shall be served on the employee and filed with the commissioner within 120 days of service of the claim petition. Any request for a good cause extension pursuant to paragraph (e) must be made within 120 days of service of the claim petition, except that a request may be made after 120 days of service of a claim petition in the following circumstances:

(1) a change to the employee's claim regarding the nature and extent of the injury;

(2) a change to the permanency benefits claimed by the employee, including a change in permanent partial disability percentage;

(3) a new claim for indemnity benefits; or

(4) the employment relationship is not admitted by the uninsured employer.

(e) No evidence relating to the examination or report shall be received or considered by the commissioner, a compensation judge, or the court of appeals in determining any issues unless the report has been served and filed as required by this section, unless a written extension has been granted by the commissioner or compensation judge. The commissioner or a compensation judge shall extend the time for completing the adverse examination and filing the report upon good cause shown. The extension must not be for the purpose of delay and the insurer must make a good faith effort to comply with this subdivision. Good cause shall include but is not limited to:

(1) that the extension is necessary because of the limited number of physicians or health care providers available with expertise in the particular injury or disease, or that the extension is necessary due to the complexity of the medical issues, or

(2) that the extension is necessary to gather additional information which was not included on the petition as required by section 176.291.

Subd. 2. **Neutral physician.** In each case of dispute as to the injury the commissioner of labor and industry, or in case of a hearing the compensation judge conducting the hearing, or the Workers' Compensation Court of Appeals if the matter is before it, may with or without the request of any interested party, designate a neutral physician to make an examination of the injured worker and report the findings to the commissioner of labor and industry, compensation judge, or the Workers' Compensation Court of Appeals; provided that the request of the interested party must comply with the rules of the commissioner of labor and industry, the office, or the Workers' Compensation Court of Appeals, regulating the proper time and forms for the request, and further provided that when an interested party requests, not later than 30 days prior to a scheduled prehearing conference, that a neutral physician be designated, the compensation judge shall make such a designation. When a party has requested the designation of a neutral physician prior to a prehearing conference, that party may withdraw the request at any time prior to the hearing. The commissioner of labor and industry, compensation judge, or the Workers' Compensation Court of Appeals, may request the neutral physician to answer any particular question with reference to the medical phases of the case, including questions calling for an opinion as to the cause and occurrence of the injury insofar as medical knowledge is relevant in the answer. A copy of the signed certificate of the neutral physician shall be mailed to the parties in interest and either party, within five days from date of mailing, may demand that the physician be produced for purposes of cross-examination. The signed certificate of a neutral physician is competent evidence of the facts stated therein. The expense of the examination shall be paid as ordered by the commissioner of labor and industry, compensation judge, or the Workers' Compensation Court of Appeals.

Subd. 3. **Refusal to be examined.** If the injured employee refuses to comply with any reasonable request for examination, the right to compensation may be suspended by order of the commissioner or a compensation judge, and no compensation shall be paid while the employee continues in the refusal.

Subd. 4. **Autopsies.** In all death claims where the cause of death is obscure or disputed any interested party may request an autopsy and, if denied, the compensation judge, or Workers' Compensation Court of Appeals upon appeal, upon petition and proper showing, shall order an autopsy. If any dependent claiming

compensation or benefits does not consent to such autopsy within the time fixed by the order, all dependents shall forfeit all rights to compensation. The party demanding an autopsy shall bear the cost thereof.

Subd. 5. **Testimony of health care provider.** Any physician or other health care provider designated by the commissioner or compensation judge, or whose services are furnished or paid for by the employer, or who treats, examines, or is present at any examination, of an injured employee, may be required to testify as to any knowledge acquired by the physician or health care provider in the course of the treatment or examination relative to the injury or disability resulting from the injury only in cases involving occupational disease, cardiopulmonary injuries or diseases, injuries resulting from cumulative trauma, issues of apportionment of liability, and mental disorders, or upon an order of a compensation judge. In all other cases all evidence related to health care must be submitted by written report as prescribed by the chief administrative law judge. A party may cross-examine by deposition a physician or health care provider who has examined or treated the employee. If a physician or health care provider is not available for cross-examination prior to the hearing and the physician's or health care provider's written report is submitted at the hearing, the compensation judge shall, upon request of the adverse party, require the physician or health care provider to testify at the hearing or to be present at a posthearing deposition for the purpose of being cross-examined by the adverse party. All written evidence relating to health care must be submitted prior to or at the time of the hearing and no evidence shall be considered which was submitted after the hearing unless the compensation judge orders otherwise, and, in no case later than 30 days following the final hearing date unless an extension is granted by the chief administrative law judge. Existing medical reports must be submitted with a claim petition or answer as provided in sections 176.291 and 176.321. All reports shall substantially conform to rules prescribed by the chief administrative law judge. When a written report is used to present the testimony, it shall be admitted into evidence without the necessity for foundational testimony and shall be considered as prima facie evidence of the opinions it contains.

History: *1953 c 755 s 17; 1969 c 276 s 2; 1973 c 388 s 40-43; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1977 c 342 s 20; Ex1979 c 3 s 48; 1983 c 290 s 110,111; 1984 c 640 s 32; 1986 c 444; 1987 c 332 s 42-44; 1992 c 510 art 4 s 20; 2002 c 262 s 15; 2009 c 75 s 9; 2023 c 51 art 2 s 5; 2024 c 97 s 16,17*

176.16 [Repealed, 1953 c 755 s 83]

PAYMENTS

176.161 ALIEN DEPENDENTS.

Subdivision 1. **Residing outside United States.** In case a deceased employee for whose injury or death compensation is payable leaves surviving an alien dependent residing outside the United States the commissioner shall direct the payment of all compensation due the dependent to be made to the duly accredited consular officer of the country of which the beneficiary is a citizen residing within the state, or to a designated representative residing within the state; or, if the commissioner believes that the interests of the dependent will be better served and at any time prior to the final settlement the dependent files with the commissioner a power of attorney designating any other suitable person residing in this state to act as attorney in fact in such proceedings, the commissioner may appoint such person. If it appears necessary to institute proceedings to enforce payment of compensation due the dependent, the commissioner may permit the consular officer to institute these proceedings. If during the pendency of these proceedings, such power of attorney is filed by the alien dependent, the commissioner shall then determine whether such attorney in fact be substituted to represent such dependent or if the consular officer or a representative continue therein. The person so appointed may carry on proceedings to settle all claims for compensation and receive for distribution to such dependent all compensation arising under this chapter. The settlement and distribution of the funds shall be

made only on the written order of the commissioner. The person so appointed shall furnish a bond satisfactory to the commissioner, conditioned upon the proper application of the money received. Before the bond is discharged, the person so appointed shall file with the commissioner a verified account of receipts and disbursements of such compensation.

Subd. 2. **List of dependents.** Before receiving the first payment of such compensation and thereafter when ordered so to do by the commissioner of the Department of Labor and Industry, the person so appointed shall furnish to the commissioner of the Department of Labor and Industry a sworn statement containing a list of the dependents showing the name, age, residence, extent of dependency, and relationship to the deceased of each dependent.

Subd. 3. **Certain proceedings legalized.** In any proceedings heretofore taken to recover compensation for any alien dependent carried on for at least five years in the name of a person as petitioner, designated by power of attorney from the alien dependent, the right of this designated petitioner to conclude the proceedings or final settlement and to fully bind all parties thereby is hereby legalized in all respects.

History: *1953 c 755 s 18; 1973 c 388 s 44,45; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 90; 1986 c 444*

176.165 LUMP-SUM PAYMENTS.

The amounts of compensation payable periodically may be commuted to one or more lump-sum payments only by order of the commissioner of the Department of Labor and Industry, compensation judge, or Workers' Compensation Court of Appeals in cases upon appeal, and on such terms and conditions as the commissioner of the Department of Labor and Industry, compensation judge, or Workers' Compensation Court of Appeals prescribes. In making these commutations the lump-sum payments shall amount, in the aggregate, to a sum equal to the present value of all future installments of the compensation calculated on a five percent basis.

History: *1953 c 755 s 19; 1973 c 388 s 46; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78*

176.17 [Repealed, 1953 c 755 s 83]

176.171 PAYMENT TO TRUSTEE.

At any time after the amount of any award or commutation is finally determined, a sum equal to the present value of all future installments of the compensation, calculated on a five percent basis, where death or the nature of the injury renders the amount of future payments certain, may be paid by the employer to any bank, mutual savings bank, savings association, or trust company in this state approved and designated by the commissioner of the Department of Labor and Industry, compensation judge, or Workers' Compensation Court of Appeals in cases upon appeal. Such sum, together with all interest thereon, shall be held in trust for the employee or for the dependents of the employee, who shall have no further recourse against the employer. The employer's payment of this sum evidenced by a receipt of the trustee filed with the commissioner of the Department of Labor and Industry, operates as a satisfaction of the compensation liability as to the employer. The trustee shall make payments from the fund in the same amounts and at the same time as are required of the employer until the fund and interest is exhausted, except when otherwise ordered by the commissioner of the Department of Labor and Industry. In the appointment of trustee the preference shall be given to the choice of the injured employee or the choice of the dependents of the deceased employee.

History: *1953 c 755 s 20; 1971 c 422 s 3; 1973 c 388 s 47; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1995 c 202 art 1 s 25*

176.175 RIGHT TO COMPENSATION, AWARD.

Subdivision 1. **Preferred claim.** The right to compensation and all compensation awarded any injured employee or for death claims to dependents have the same preference against the assets of the employer as unpaid wages for labor. This compensation does not become a lien on the property of third persons by reason of this preference.

Subd. 2. **Nonassignability.** No claim for compensation or settlement of a claim for compensation owned by an injured employee or dependents is assignable. Except as otherwise provided in this chapter, any claim for compensation owned by an injured employee or dependents is exempt from seizure or sale for the payment of any debt or liability, up to a total amount of $1,000,000 per claim and subsequent award.

History: *1953 c 755 s 21; 1986 c 444; 1999 c 212 s 1; 2024 c 114 art 3 s 30*

FRAUD

176.178 FRAUD.

Subdivision 1. **Intent.** Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to section 609.52, subdivision 3.

Subd. 2. **Forms.** The text of subdivision 1 shall be placed on all forms prescribed by the commissioner for claims or responses to claims for workers' compensation benefits under this chapter. The absence of the text does not constitute a defense against prosecution under subdivision 1.

History: *1992 c 510 art 2 s 6; 1995 c 231 art 1 s 25*

OVERPAYMENTS

176.179 RECOVERY OF OVERPAYMENTS.

Notwithstanding section 176.521, subdivision 3, or any other provision of this chapter to the contrary, except as provided in this section, no lump-sum or weekly payment, or settlement, which is voluntarily paid to an injured employee or the survivors of a deceased employee in apparent or seeming accordance with the provisions of this chapter by an employer or insurer, or is paid pursuant to an order of the workers' compensation division, a compensation judge, or court of appeals relative to a claim by an injured employee or the employee's survivors, and received in good faith by the employee or the employee's survivors shall be refunded to the paying employer or insurer in the event that it is subsequently determined that the payment was made under a mistake in fact or law by the employer or insurer. When the payments have been made to a person who is entitled to receive further payments of compensation for the same injury, the mistaken compensation may be taken as a partial credit against future periodic benefits. The credit applied against further payments of temporary total disability, temporary partial disability, permanent partial disability, permanent total disability, retraining benefits, death benefits, or weekly payments of economic recovery or impairment compensation shall not exceed 20 percent of the amount that would otherwise be payable.

An employer or insurer may not offset an overpayment of benefits against:

(1) medical expenses due or payable; or

(2) a penalty awarded to the employee for late payment or underpayment of benefits.

Where the commissioner or compensation judge determines that the mistaken compensation was not received in good faith, the commissioner or compensation judge may order reimbursement of the compensation. For purposes of this section, a payment is not received in good faith if it is obtained through fraud, or if the employee knew that the compensation was paid under mistake of fact or law, and the employee has not refunded the mistaken compensation.

History: *1974 c 486 s 5; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; Ex1979 c 3 s 49; 1983 c 290 s 112; 1986 c 461 s 23; 1987 c 332 s 45; 1992 c 510 art 1 s 11; 1995 c 231 art 1 s 26; 2009 c 75 s 10*

176.18 [Repealed, 1953 c 755 s 83]

INSURANCE

176.181 INSURANCE.

Subdivision 1. **Authorization.** Any employer responsible for compensation may insure the risk in any manner authorized by law.

Subd. 2. **Compulsory insurance; self-insurers.** (a) Every employer, except the state and its municipal subdivisions, liable under this chapter to pay compensation shall insure payment of compensation with some insurance carrier authorized to insure workers' compensation liability in this state, or obtain a written order from the commissioner of commerce exempting the employer from insuring liability for compensation and permitting self-insurance of the liability. The terms, conditions and requirements governing self-insurance shall be established by the commissioner pursuant to chapter 14. The commissioner of commerce shall also adopt, pursuant to paragraph (d), rules permitting two or more employers, whether or not they are in the same industry, to enter into agreements to pool their liabilities under this chapter for the purpose of qualifying as group self-insurers. With the approval of the commissioner of commerce, any employer may exclude medical, chiropractic and hospital benefits as required by this chapter. An employer conducting distinct operations at different locations may either insure or self-insure the other portion of operations as a distinct and separate risk. An employer desiring to be exempted from insuring liability for compensation shall make application to the commissioner of commerce, showing financial ability to pay the compensation, whereupon by written order the commissioner of commerce, on deeming it proper, may make an exemption. An employer may establish financial ability to pay compensation by providing financial statements of the employer to the commissioner of commerce. Upon ten days' written notice the commissioner of commerce may revoke the order granting an exemption, in which event the employer shall immediately insure the liability. As a condition for the granting of an exemption the commissioner of commerce may require the employer to furnish security the commissioner of commerce considers sufficient to insure payment of all claims under this chapter, consistent with subdivision 2b. If the required security is in the form of currency or negotiable bonds, the commissioner of commerce shall deposit it with the commissioner of management and budget. In the event of any default upon the part of a self-insurer to abide by any final order or decision of the commissioner of labor and industry directing and awarding payment of compensation and benefits to any employee or the dependents of any deceased employee, then upon at least ten days' notice to the self-insurer, the commissioner of commerce may by written order to the commissioner of management and budget require the commissioner of management and budget to sell the pledged and assigned securities or a part thereof necessary to pay the full amount of any such claim or award with interest thereon. This authority to sell may be exercised from time to time to satisfy any order or award of the commissioner of labor and industry or any judgment obtained thereon. When securities are sold the money obtained shall be deposited in the state treasury to the credit of the commissioner of commerce and awards made against any such self-insurer by the commissioner of commerce shall be paid to the persons entitled thereto by the commissioner of

management and budget upon payments requested by the commissioner of commerce out of the proceeds of the sale of securities. Where the security is in the form of a surety bond or personal guaranty the commissioner of commerce, at any time, upon at least ten days' notice and opportunity to be heard, may require the surety to pay the amount of the award, the payments to be enforced in like manner as the award may be enforced.

(b) No association, corporation, partnership, sole proprietorship, trust or other business entity shall provide services in the design, establishment or administration of a group self-insurance plan under rules adopted pursuant to this subdivision unless it is licensed, or exempt from licensure, pursuant to section 60A.23, subdivision 8, to do so by the commissioner of commerce. An applicant for a license shall state in writing the type of activities it seeks authorization to engage in and the type of services it seeks authorization to provide. The license shall be granted only when the commissioner of commerce is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. The commissioner of commerce may issue a license subject to restrictions or limitations, including restrictions or limitations on the type of services which may be supplied or the activities which may be engaged in.

(c) To assure that group self-insurance plans are financially solvent, administered in a fair and capable fashion, and able to process claims and pay benefits in a prompt, fair and equitable manner, entities licensed to engage in such business are subject to supervision and examination by the commissioner of commerce.

(d) To carry out the purposes of this subdivision, the commissioner of commerce may promulgate administrative rules pursuant to sections 14.001 to 14.69. These rules may:

(1) establish reporting requirements for administrators of group self-insurance plans;

(2) establish standards and guidelines consistent with subdivision 2b to assure the adequacy of the financing and administration of group self-insurance plans;

(3) establish bonding requirements or other provisions assuring the financial integrity of entities administering group self-insurance plans;

(4) establish standards, including but not limited to minimum terms of membership in self-insurance plans, as necessary to provide stability for those plans;

(5) establish standards or guidelines governing the formation, operation, administration, and dissolution of self-insurance plans; and

(6) establish other reasonable requirements to further the purposes of this subdivision.

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 $4,000. 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 $400 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 $500.

Subd. 2b. MS 2006 [Renumbered 79A.04, subd 3a]

Subd. 3. **Failure to insure, penalty.** (a) The commissioner, having reason to believe that an employer is in violation of subdivision 2, may issue an order directing the employer to comply with subdivision 2, to refrain from employing any person at any time without complying with subdivision 2, and to pay a penalty of up to $1,000 per employee per week during which the employer was not in compliance.

(b) An employer shall have ten working days to contest such an order by filing a written objection with the commissioner, stating in detail its reasons for objecting. If the commissioner does not receive an objection within ten working days, the commissioner's order shall constitute a final order not subject to further review, and violation of that order shall be enforceable by way of civil contempt proceedings in district court. If the commissioner does receive a timely objection, the commissioner shall refer the matter to the Office of Administrative Hearings for an expedited hearing before a compensation judge. The compensation judge shall issue a decision either affirming, reversing, or modifying the commissioner's order within ten days of the close of the hearing. If the compensation judge affirms the commissioner's order, the compensation judge may order the employer to pay an additional penalty if the employer continued to employ persons without complying with subdivision 2 while the proceedings were pending.

(c) All penalties assessed under this subdivision shall be payable to the commissioner for deposit in the assigned risk safety account. Penalties assessed under this section shall constitute a lien for government services pursuant to section 514.67, on all the employer's property and shall be subject to the Revenue Recapture Act in chapter 270A.

(d) For purposes of this subdivision, the term "employer" includes any owners or officers of a corporation who direct and control the activities of employees.

Subd. 4. **Gross misdemeanor.** In addition to being subject to the penalty prescribed in subdivision 3, any employer willfully and intentionally failing to comply with the provisions of subdivision 2 is guilty of a gross misdemeanor.

Subd. 5. **Indemnification.** A political subdivision or association of political subdivisions which is self-insured, may be indemnified by the special compensation fund for payments for which the political subdivision or association is liable under this chapter. This indemnification shall be made only if all other assets together with the interest earned thereon which have been contributed by the subdivision pursuant to rules adopted by the commissioner of commerce as provided for in this section have been exhausted.

The commissioner of management and budget, as custodian of the fund, has a cause of action for all money paid out or to be paid out if the political subdivisions or association of subdivisions fail to meet a repayment schedule which the commissioner of management and budget establishes at the time the request for indemnification is granted.

Subd. 6. MS 2020 [Repealed, 7Sp2020 c 1 art 2 s 22]

Subd. 7. **Penalty.** Any entity that is self-insured pursuant to subdivision 2, and that knowingly violates any provision of subdivision 2 or any rule adopted pursuant thereto is subject to a civil penalty of not more than $10,000 for each offense.

Subd. 8. **Data sharing.** (a) The Departments of Labor and Industry, Employment and Economic Development, Human Services, Agriculture, Transportation, and Revenue are authorized to share information regarding the employment status of individuals, including but not limited to Social Security numbers and payroll and withholding and income tax information, and may use that information for purposes consistent with this section and regarding the employment or employer status and federal employer identification numbers of individuals, partnerships, limited liability companies, corporations, or employers, including, but not limited to, general contractors, intermediate contractors, and subcontractors. The commissioner shall request data in writing or pursuant to a state agency agreement, and the responding department shall respond to the request by producing the requested data within 30 days.

(b) The commissioner is authorized to inspect and to order the production of all payroll and other business records and documents of any alleged employer in order to determine the employment status of persons and compliance with this section. If any person or employer refuses to comply with such an order, the commissioner may apply to the district court of the county where the person or employer is located or may apply to Ramsey County or the county where the nearest office of the Department of Labor and Industry is located, for an order compelling production of the documents.

History: *1953 c 755 s 22; 1959 c 265 s 1; 1971 c 863 s 3; 1973 c 388 s 48,49; 1973 c 492 s 14; 1978 c 797 s 4; Ex1979 c 3 s 50,51; 1981 c 346 s 91-93; 1982 c 424 s 130; 1983 c 289 s 114 subd 1; 1983 c 290 s 113; 1984 c 592 s 80,81; 1984 c 655 art 1 s 92; 1986 c 444; 1987 c 332 s 46; 1987 c 384 art 2 s 1; 1988 c 674 s 18; 1990 c 422 s 10; 1992 c 510 art 3 s 17,18; 1992 c 545 art 2 s 1,2; 1994 c 483 s 1; 1994 c 485 s 60; 1995 c 231 art 2 s 69,70; 1995 c 233 art 2 s 56; 1995 c 258 s 62; 1997 c 200 art 1 s 64; 1999 c 223 art 2 s 33; 2002 c 262 s 16; 2003 c 112 art 2 s 25,50; 2004 c 206 s 52; 2008 c 250 s 17; 2009 c 75 s 11; 2009 c 101 art 2 s 109; 1Sp2019 c 10 art 3 s 25; 7Sp2020 c 1 art 2 s 10*

MISCELLANEOUS

176.1812 COLLECTIVE BARGAINING AGREEMENTS.

Subdivision 1. **Requirements.** Upon appropriate filing, the commissioner, compensation judge, Workers' Compensation Court of Appeals, and courts shall recognize as valid and binding a provision in a collective bargaining agreement between a qualified employer or qualified groups of employers and the certified and exclusive representative of its employees to establish certain obligations and procedures relating to workers' compensation. For purposes of this section, "qualified employer" means any employer that is self-insured for workers' compensation in compliance with this chapter, or any employer that is insured for workers' compensation in compliance with this chapter. For purposes of this section, a "qualified group of employers" means a group of employers, in which each employer is insured for workers' compensation in compliance with this chapter or is self-insured for workers' compensation in compliance with this chapter. This agreement must be limited to, but need not include, all of the following:

(a) an alternative dispute resolution system to supplement, modify, or replace the procedural or dispute resolution provisions of this chapter. The system may include mediation, arbitration, or other dispute resolution proceedings, the results of which may be final and binding upon the parties. A system of arbitration shall provide that the decision of the arbiter is subject to review either by the Workers' Compensation Court of Appeals in the same manner as an award or order of a compensation judge or, in lieu of review by the Workers' Compensation Court of Appeals, by the Office of Administrative Hearings, by the district court, by the Minnesota Court of Appeals, or by the supreme court in the same manner as the Workers' Compensation Court of Appeals and may provide that any arbiter's award disapproved by a court be referred back to the arbiter for reconsideration and possible modification;

(b) an agreed list of providers of medical treatment that may be the exclusive source of all medical and related treatment provided under this chapter which need not be certified under section 176.1351;

(c) the use of a limited list of impartial physicians to conduct independent medical examinations;

(d) the creation of a light duty, modified job, or return to work program;

(e) the use of a limited list of individuals and companies for the establishment of vocational rehabilitation or retraining programs which list is not subject to the requirements of section 176.102;

(f) the establishment of safety committees and safety procedures; or

(g) the adoption of a 24-hour health care coverage plan if a 24-hour plan pilot project is authorized by law, according to the terms and conditions authorized by that law.

Subd. 2. **Filing and review.** (a) A copy of the agreement and the approximate number of employees who will be covered under it must be filed with the commissioner. Within 21 days of receipt of an agreement, the commissioner shall review the agreement for compliance with this section and the benefit provisions of this chapter and notify the parties of any additional information required or any recommended modification that would bring the agreement into compliance. Upon receipt of any requested information or modification, the commissioner must notify the parties within 21 days whether the agreement is in compliance with this section and the benefit provisions of this chapter.

(b) After an agreement is approved by the commissioner under paragraph (a), a qualified employer may join or withdraw from a qualified group of employers without commissioner review or approval. The commissioner must be notified within 30 days when a qualified employer joins or withdraws from a qualified group of employers.

(c) In order for any agreement to remain in effect, it must provide for a timely and accurate method of reporting to the commissioner the individual claims covered by the agreement and claim-specific dispute resolution data, in the form and manner prescribed by the commissioner. Dispute resolution data includes information about facilitation, mediation, and arbitration and shall be provided annually to the commissioner to enable the commissioner to report aggregate dispute data to the legislature.

Subd. 3. **Refusal to recognize.** A person aggrieved by the commissioner's decision concerning an agreement may request in writing, within 30 days of the date the notice is issued, the initiation of a contested case proceeding under chapter 14. The request to initiate a contested case must be received by the department by the 30th day after the commissioner's decision. An appeal from the commissioner's final decision and order may be taken to the Workers' Compensation Court of Appeals pursuant to sections 176.421 and 176.442.

Subd. 4. **Void agreements.** Nothing in this section shall allow any agreement that diminishes an employee's entitlement to benefits as otherwise set forth in this chapter. For the purposes of this section, the procedural rights and dispute resolution agreements under subdivision 1, clauses (a) to (g), are not agreements which diminish an employee's entitlement to benefits. Any agreement that diminishes an employee's entitlement to benefits as set forth in this chapter is null and void.

Subd. 5. **Notice to insurance carrier.** If the employer is insured under this chapter, the collective bargaining agreement provision shall not be recognized by the commissioner, compensation judge, Workers' Compensation Court of Appeals, and other courts unless the employer has given notice to the employer's insurance carrier, in the manner provided in the insurance contract, of intent to enter into an agreement with its employees as provided in this section.

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

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

History: *1995 c 231 art 2 s 71; 1996 c 374 s 5,6; 1997 c 7 art 5 s 16; 2001 c 123 s 11; 2005 c 90 s 13; 2008 c 250 s 9; 1Sp2019 c 7 art 12 s 5*

176.182 BUSINESS LICENSES OR PERMITS; COVERAGE REQUIRED.

Every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business in Minnesota until the applicant presents acceptable evidence of compliance with the

workers' compensation insurance coverage requirement of section 176.181, subdivision 2, by providing the name of the insurance company, the policy number, and dates of coverage or the permit to self-insure. The commissioner shall assess a penalty to the employer of $2,000 payable to the commissioner for deposit in the assigned risk safety account, if the information is not reported or is falsely reported.

Neither the state nor any governmental subdivision of the state shall enter into any contract for the doing of any public work before receiving from all other contracting parties acceptable evidence of compliance with the workers' compensation insurance coverage requirement of section 176.181, subdivision 2.

This section shall not be construed to create any liability on the part of the state or any governmental subdivision to pay workers' compensation benefits or to indemnify the special compensation fund, an employer, or insurer who pays workers' compensation benefits.

History: *1981 c 346 s 94; 1983 c 290 s 114; 1987 c 332 s 47; 1992 c 510 art 3 s 19; 1995 c 231 art 2 s 72; 2002 c 262 s 17*

176.183 UNINSURED AND SELF-INSURED EMPLOYERS; BENEFITS TO EMPLOYEES AND DEPENDENTS; LIABILITY OF EMPLOYER.

Subdivision 1. **Uninsured and self-insured employers; special compensation fund.** When any employee sustains an injury arising out of and in the course of employment while in the employ of an employer, other than the state or its political subdivisions, not insured or self-insured as provided for in this chapter, the employee or the employee's dependents shall nevertheless receive benefits as provided for in this chapter from the special compensation fund. The commissioner is not required to comply with the procedures in chapter 16C before purchasing, paying for, or reimbursing the employee for medical treatment, equipment, or supplies that are compensable under this chapter. As used in subdivision 1 or 2, "employer" includes any owners or officers of a corporation who direct and control the activities of employees. In any petition for benefits under this chapter, the naming of an employer corporation not insured or self-insured as provided for in this chapter, as a defendant, shall constitute without more the naming of the owners or officers as defendants, and service of notice of proceeding under this chapter on the corporation shall constitute service upon the owners or officers. An action to recover benefits paid shall be instituted unless the commissioner determines that no recovery is possible. There shall be no payment from the special compensation fund if there is liability for the injury under the provisions of section 176.215, by an insurer or self-insurer.

Subd. 1a. [Repealed, 1988 c 674 s 22]

Subd. 2. **Special compensation fund; penalties.** After a hearing on a petition for benefits and prior to issuing an order against the special compensation fund to pay compensation benefits to an employee, a compensation judge shall first make findings regarding the insurance status of the employer and its liability. The special compensation fund shall not be found liable in the absence of a finding of liability against the employer. Where the liable employer is found after the hearing to be not insured or self-insured as provided for in this chapter, the compensation judge shall assess and order the employer to pay all compensation benefits to which the employee is entitled, the amount for any actual and necessary disbursements expended by the special compensation fund, any actual and necessary disbursements of the employee paid or reimbursed by the special compensation fund, any attorney fees paid to the employee's attorney by the special compensation fund, and a penalty in the amount of 65 percent of all compensation benefits ordered to be paid. The award issued against an employer after the hearing shall constitute a lien for government services pursuant to section 514.67 on all property of the employer and shall be subject to the provisions of the Revenue Recapture Act in chapter 270A. The special compensation fund may enforce the terms of that award in the same manner as a district court judgment. The commissioner of labor and industry, in accordance

with the terms of the order awarding compensation, shall pay compensation to the employee or the employee's dependent from the special compensation fund. The commissioner of labor and industry shall certify to the commissioner of management and budget and to the legislature annually the total amount of compensation paid from the special compensation fund under subdivision 1. Compensation paid under this section shall remain a liability of the special compensation fund and shall be financed by the percentage assessed under section 176.129.

Subd. 3. **Commissioner-directed payments.** (a) Notwithstanding subdivision 2, the commissioner may direct payment from the special compensation fund for compensation payable pursuant to subdivision 1, including benefits payable under sections 176.102 and 176.135, prior to issuance of an order of a compensation judge or the Workers' Compensation Court of Appeals directing payment or awarding compensation. Where payment is issued pursuant to a petition for a temporary order, the terms of any resulting order shall have the same status and be governed by the same provisions as an award issued pursuant to subdivision 2.

(b) The commissioner may suspend or terminate an order under paragraph (a) for good cause as determined by the commissioner.

Subd. 4. **Notice by commissioner; rights of parties.** (a) If the commissioner authorizes the special compensation fund to commence payment without the issuance of a temporary order, the commissioner shall serve by first class mail notice upon the employer and other interested parties of the intention to commence payment. This notice shall be served at least ten calendar days before commencing payment and shall be mailed to the last known address of the employer. The notice shall include a statement that failure of the employer to respond within ten calendar days of the date of service will be deemed acceptance by the employer of the proposed action by the special compensation fund and will be deemed a waiver of defenses the employer has to the special compensation fund's action to recover amounts specified under subdivision 2. At any time prior to final determination of liability, the employer may appear as a party and present defenses the employer has, whether or not an appearance by the employer has previously been made in the matter. The special compensation fund has a cause of action against the employer to recover amounts specified under subdivision 2.

(b) The commissioner shall notify the employer by first class mail if the special compensation fund intends to enter into a settlement agreement with the employee for the payment of benefits under this section. This notice shall be sent by first class mail to the last known address of the employer at least 15 calendar days before executing the settlement agreement, and shall include:

(1) a copy of the proposed settlement agreement;

(2) a statement that within 15 calendar days the employer must notify the special compensation fund in writing of its objection to the proposed settlement; and

(3) a statement that if the special compensation fund does not receive the employer's written objection within 15 calendar days, the employer must be deemed to have waived all defenses to the special compensation fund's claim for amounts specified under subdivision 2.

(c) If a settlement agreement is approved by the commissioner or compensation judge after the commissioner has provided notice to the employer under paragraph (b), and if the employer did not provide timely written notification to the special compensation fund of the employer's objection, then the employer

must be deemed to have waived all defenses to the special compensation fund's claim for amounts specified under subdivision 2.

History: *1967 c 330 s 1; 1969 c 372 s 1; 1969 c 399 s 49; 1973 c 388 s 50; 1973 c 750 s 1,2; 1974 c 355 s 22; 1977 c 403 s 6; 1981 c 356 s 328; 1983 c 290 s 115-118; 1983 c 301 s 147; 1984 c 432 art 2 s 27; 1986 c 444; 1987 c 332 s 48,49; 1988 c 674 s 19,20; 1992 c 510 art 3 s 20; 1992 c 513 art 3 s 39; 1995 c 231 art 2 s 73,74; 1998 c 294 s 1; 2008 c 250 s 10; 2009 c 75 s 12; 2009 c 101 art 2 s 109; 2013 c 70 art 1 s 5*

176.184 INSPECTIONS; ENFORCEMENT.

Subdivision 1. **Proof of insurance.** The commissioner of labor and industry, in order to carry out the purpose of section 176.181, may request satisfactory proof of authority to self-insure workers' compensation liability or satisfactory proof of insurance coverage for workers' compensation liability. If an employer does not provide satisfactory proof as requested within seven working days of the mailing of the request, the commissioner may proceed in accordance with the provisions of subdivisions 2 to 7.

Subd. 2. **At place of employment.** In order to carry out the purposes of section 176.181, the commissioner, upon presenting appropriate credentials to the owner, operator, or agent in charge, is authorized to enter without delay and at reasonable times any place of employment and to inspect and investigate during regular working hours and at other reasonable times, within reasonable limits, and in a reasonable manner, any records pertaining to that employer's workers' compensation insurance policy, number of employees, documents governing conditions and benefits of employment, contracts with employees and their authorized representatives, and any other documents which may be relevant to the enforcement of section 176.181 and to question privately any employer, owner, operator, agent, or employee with respect to matters relevant to the enforcement of section 176.181.

Subd. 3. **Powers; commissioner and district court.** In making inspections and investigations under this chapter, the commissioner shall have the power to administer oaths, certify official acts, take and cause to be taken depositions of witnesses, issue subpoenas, and compel the attendance of witnesses and production of papers, books, documents, records, and testimony. In case of failure of any person to comply with any subpoena lawfully issued, or on the refusal of any witness to produce evidence or to testify to any matter regarding which the person may be lawfully interrogated, the district court shall, upon application of the commissioner, compel obedience in proceedings for contempt, as in the case of disobedience of the requirements of a subpoena issued by the court or a refusal to testify.

Subd. 4. **Rights of employer and employee representative.** A representative of the employer and a representative authorized by employees shall be given an opportunity to participate in any conference or discussion held prior to, during, or after any inspection. Where there is no authorized employee representative, the commissioner shall consult with a reasonable number of employees. No employee as a consequence of aiding an inspection shall lose any privilege or payment that the employee would otherwise earn.

Subd. 5. **Request for investigation by employee.** (a) Any employee or representative of an employee who believes that their employer is uninsured against workers' compensation liability, may request an inspection by giving notice to the commissioner of the belief and grounds for the belief. Any notice shall be written, shall set forth with reasonable particularity the grounds for the notice, and shall be signed by the employee or representative of employees. A copy of the notice shall be provided the employer, representative, or agent no later than the time of inspection, except that, upon the request of a person giving the notice, the employee's name and the names of individual employees referred to in the notice shall not appear in the copy or on any record published, released, or made available. If upon receipt of the notification the

commissioner determines that reasonable grounds exist to believe that the employer is uninsured against workers' compensation liability, the commissioner shall make an inspection in accordance with this section as soon as practicable. If the commissioner determines that there are not reasonable grounds to believe that a violation exists, the commissioner shall so notify the employee or representative of employees in writing. Upon notification, the employee or the employee representative may request the commissioner to reconsider the determination. Upon receiving the request, the commissioner shall review the determination.

(b) The commissioner, upon receipt of a report of violation of the mandatory insurance provisions of section 176.181 or 176.185 verified by review of the department's insurance registration records and other relevant information, shall initiate a preliminary investigation to determine if reasonable grounds exist to believe that the employer is uninsured against workers' compensation liability, and upon certification of reasonable belief that the employer is uninsured the commissioner shall make an inspection in accordance with paragraph (a).

Subd. 6. **Order permitting entry.** Upon the refusal of an owner, operator, or agent in charge to permit entry as specified in this section, the commissioner may apply for an order in the district court in the county which entry was refused, to compel the employer to permit the commissioner to enter and inspect the place of employment.

Subd. 7. **Advance notice.** Advance notice may not be authorized by the commissioner except:

(1) in circumstances where the inspection can most effectively be conducted after regular business hours or where special preparations are necessary for an inspection;

(2) where necessary to assure the presence of representatives of the employer and employees or the appropriate personnel needed to aid in the inspection; and

(3) in other circumstances where the commissioner determines that the giving of advance notice would enhance the probability of an effective and thorough inspection.

When advance notice is given to an employer, notice shall also be given by the commissioner to the authorized representative of employees if the identity of the representative is known to the employer.

History: *1987 c 332 s 50*

176.185 POLICY OF INSURANCE.

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

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

(b) The notice must include the following statement, which must be placed on or sent with the premium invoice or other document sent by the insurer to notify the insured of the intended cancellation or termination: "You must maintain workers' compensation insurance, or obtain permission to self-insure for workers'

compensation from the Minnesota Department of Commerce. The failure to maintain workers' compensation coverage is a violation of section 176.181, and could result in criminal prosecution and civil penalties of up to $1,000 per week per uninsured employee." This statement must be in at least 12-point font, boldfaced type, and be set out in a separate paragraph.

(c) The notice must be mailed or delivered to the insured as follows, notwithstanding any contrary time frame for notice to the policyholder in section 60A.36 or 60A.37:

(1) at least 60 days before the actual date the policy is due to expire or be terminated or canceled for any reason other than as provided in clause (2);

(2) if the cancellation is due to nonpayment of premium, the notice must be sent at least 30 days before the actual date of cancellation and shall state the amount of premium due and the due date.

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

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

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

(d) If the notice required by subdivision 1 is not sent to the insured or does not meet all of the requirements of subdivision 1, the cancellation or termination shall not be effective until 60 days after the notice of cancellation or termination has been sent to the insured and received by the commissioner, except as otherwise provided in paragraph (e).

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

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

Subd. 1c. **Cancellation by employer.** Notice of cancellation or termination by the insured shall be served upon the insurer by written statement mailed or delivered to the insurer. Upon receipt of the notice,

the insurer shall notify the commissioner of the cancellation or termination and the commissioner shall ask the employer for the reasons for the cancellation or termination and notify the employer of the duty under this chapter to insure the employer's employees.

Subd. 2. **Conditions.** A policy of insurance covering the liability to pay compensation under this chapter written by any insurer licensed to insure such liability in this state shall in every case be subject to the conditions of this section hereinafter named.

Subd. 3. **Provision for benefits conferred by this chapter.** Where the employer's risk is carried by an insurer the insurance policy shall provide compensation for injury or death in accordance with the full benefits conferred by this chapter.

Subd. 4. **Compulsory provisions.** Every insurance policy which insures the payment of compensation shall contain provisions declaring the following:

(1) Notice to or knowledge by the employer is notice to or knowledge by the insurer.

(2) Jurisdiction of the employer for any purpose is jurisdiction of the insurer.

(3) The insurer is bound by an award rendered against the employer.

(4) The employee has an equitable lien upon any amount which the insurer owes under the policy to the employer. Where the employer is legally incapacitated or otherwise unable to receive this amount and pay it over to the employee or the employee's dependent, the insurer will pay the amount directly to the employee or dependent. This payment by the insurer directly to the employee or dependent discharges the obligation of the insurer to the employee, and the obligations of the insurer and the employer to the employee or dependent.

(5) The insolvency or bankruptcy of the employer does not relieve the insurer from its obligation to pay compensation.

Subd. 5. **Agreement that employee pay part of cost of insurance.** Subject to the provisions of subdivision 6, an agreement between an employee and employer under which the employee is to pay any part of the cost of insuring the employer's risk is void. An employer who makes a charge or deduction prohibited by this subdivision is guilty of a misdemeanor.

Subd. 5a. **Penalty for improper withholding.** An employer who violates subdivision 5 after notice from the commissioner is subject to a penalty of 400 percent of the amount withheld from or charged the employee. The penalty shall be imposed by the commissioner. Forty percent of this penalty is payable to the commissioner for deposit in the assigned risk safety account and 60 percent is payable to the employee.

Subd. 6. **Joining risks with other risks in policy.** Where the agreement has been approved by the commissioner of the Department of Labor and Industry the employer and employee may agree to carry the risk provided for in this chapter in conjunction with other and greater risks providing other and greater benefits in the form of additional compensation, or accident, sickness, or old age insurance or benefits. This agreement may provide for appropriate contribution by the employee.

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

Subd. 8. [Repealed, 1977 c 342 s 28]

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

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

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

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

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

(3) determines that the employer is insolvent; or

(4) issues a certificate of default against the employer for failure to pay workers' compensation benefits as required under this chapter.

The commissioner of labor and industry shall notify the commissioner of commerce and the Insurance Guaranty Association if the commissioner of labor and industry has knowledge that any employer has failed to pay, and will likely continue to fail to pay, workers' compensation benefits as required by this chapter. If clauses (1) to (3) do not apply, but the employer refuses or fails to pay benefits required under this chapter, or if there is a dispute about an employer's liability for the claims, the commissioner of commerce shall issue a certificate of default.

The commissioner of commerce shall immediately notify, by certified mail, the Insurance Guaranty Association of the occurrence of any of the circumstances in clauses (1) to (4), and shall order the association to assume the employer's obligations under this chapter. The association shall commence payment of these obligations as soon as possible upon receipt of the employer's claim files. Upon the assumption of obligations by the association pursuant to the commissioner of commerce's notification and order, the association has the right to immediate possession of all relevant workers' compensation claim files and data of the employer or other possessor of the files and data. The possessor of the files and data must provide the files and data, or complete copies of them, to the association within five days of the notification provided under this subdivision.

If the possessor of the files and data fails to timely provide the files and data to the association, it is liable to the commissioner of commerce for a penalty of $500 per day for each day after the five-day period has expired. The association is also entitled to recover from the employer reasonable attorney fees and costs in administering and paying benefits owed under this chapter. If the association's payments are made pursuant to a certificate of default as provided in clause (4), the employer is also liable for and shall pay a penalty in the amount of 300 percent of all benefits the association pays to or on behalf of the employee. The commissioner of commerce shall assess the penalties under this paragraph.

An appeal from the commissioner of commerce's order or penalties under this paragraph may be instituted pursuant to the contested case procedures of chapter 14. Payment of claims by the association shall not be stayed pending the resolution of the disputes.

(c) If the employer contracts with an entity or person to administer the claims under paragraph (a), the entity or person must be a licensed workers' compensation insurer or a licensed third-party administrator under section 60A.23, subdivision 8. The commissioner of commerce may require the employer to contract with a licensed third-party administrator when the commissioner determines it is necessary to ensure proper payment of compensation under this chapter.

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

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

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

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

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

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

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

(f) An employer who is liable for claims under paragraph (a) shall be eligible for reimbursement from the Workers' Compensation Reinsurance Association under chapter 79 for those claims to the extent they

exceed the applicable retention limit selected by the insolvent insurer and if the employer has complied with the requirements for reimbursement established by the Workers' Compensation Reinsurance Association for its self-insured members. The employer is not responsible for payment of premiums to the reinsurance association to the extent the premiums have been paid by the insolvent insurer.

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

(h) The Workers' Compensation Reinsurance Association and the special compensation fund, as a condition of directly reimbursing an employer eligible for reimbursement, may require the employer to hold it harmless from any claims by a liquidator, receiver, or statutory successor to the insolvent insurer that the Workers' Compensation Reinsurance Association or special compensation fund improperly indemnified or reimbursed the employer. In no event shall the Workers' Compensation Reinsurance Association or the special compensation fund be required to reimburse any amounts for any claim more than once.

Subd. 9. **Application of section.** Where an employer, who has been exempted from the requirement to insure liability for compensation under this chapter, insures any part of that liability, this section applies to such an employer to the extent that its provisions are applicable.

Subd. 10. **Data collection contracts.** The commissioner may contract with other parties regarding the collection of appropriate data to assist in meeting the requirements of this section.

Subd. 11. **Employment and insurance data.** (a) The following workers' compensation insurance coverage data reported to or collected by the department under this section, or otherwise created or received by the department, is public data, subject to the limitations provided in paragraph (b):

(1) all action on an insurance policy, but not including the policy itself. Examples of action on a policy are the date of issuance of a new policy, the date of cancellation, or copies of a correction, binder, reinstatement, expiration, cancellation, termination, or declaration page;

(2) the employer's legal name;

(3) every "doing business as" name used by the employer;

(4) the employer's legal form of ownership, such as corporation, partnership, limited partnership, or government entity, and the names of all owners and partners including, for limited partnerships, the names of general partners;

(5) the employer's complete mailing and physical addresses;

(6) the nature of the employer's business;

(7) the policy number;

(8) the effective and expiration dates of the policy;

(9) the name of the insurance carrier;

(10) if the policy has been canceled, the type of cancellation, reason for cancellation, and effective date of cancellation; and

(11) the employer's unemployment account number.

(b) The commissioner shall release the insurance coverage data listed in paragraph (a) only in response to an inquiry about an employer in which the requester provides employer identifying information required by the commissioner. The commissioner or an entity with whom the department has contracted pursuant to subdivision 10 shall provide a website for such public inquiries and may impose access restrictions necessary to limit access to individual inquiries and to otherwise deter the use of the website for purposes other than insurance verification. Persons who obtain the data prescribed in paragraph (a) from the department are prohibited from using the data for commercial purposes.

(c) For purposes of this subdivision, "employer" includes a policyholder and any other entities listed on the same insurance policy as the employer.

(d) For purposes of this subdivision, "commercial purposes" means the sale or use of insurance coverage data listed in paragraph (a) for marketing or profit.

(e) An entity with whom the department has contracted pursuant to subdivision 10 has a private right of action to enforce the prohibition in paragraph (b) against a person who uses the data for commercial purposes. The entity may bring a civil action to recover damages and costs and disbursements, including reasonable attorney fees, from the person, and for other equitable relief as determined by the court.

History: *1953 c 755 s 23; Ex1967 c 1 s 6; 1969 c 178 s 1; 1973 c 388 s 51-53; 1983 c 289 s 114 subd 1; 1983 c 290 s 119,120; 1984 c 655 art 1 s 92; 1985 c 248 s 70; 1986 c 444; 1987 c 332 s 51; 1990 c 522 s 5; 1992 c 510 art 3 s 21; 1995 c 231 art 2 s 75; 2002 c 262 s 18; 2005 c 90 s 14-16; 2006 c 178 s 1; 2008 c 250 s 11; 7Sp2020 c 1 art 2 s 11*

176.186 RECORDS FROM OTHER STATE AGENCIES.

Notwithstanding any other state law to the contrary except chapter 270B, the commissioner may obtain from the Department of Employment and Economic Development, and Office of the Secretary of State, or any other state agency, upon request, names or lists of employers doing business in the state. This information shall be treated by the commissioner in the manner provided by chapter 13.

History: *1983 c 290 s 121; 1984 c 514 art 3 s 2; 1Sp1985 c 14 art 9 s 75; 1989 c 184 art 2 s 8; 1994 c 483 s 1; 2004 c 206 s 52; 2009 c 75 s 13*

176.19 [Repealed, 1953 c 755 s 83]

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.

Subd. 1a. **Equitable apportionment.** Equitable apportionment of liability for an injury under this chapter is not allowed except that apportionment among employers and insurers is allowed in a settlement agreement filed pursuant to section 176.521, and an employer or insurer may request equitable apportionment of liability for workers' compensation benefits among employer and insurers by arbitration pursuant to subdivision 5. For purposes of this subdivision, the term "equitable apportionment of liability" shall include all attempts to obtain contribution and/or reimbursement from other employers or insurers. To the same extent limited by this subdivision, contribution and reimbursement actions based on equitable apportionment are not allowed under this chapter. If the insurers choose to arbitrate apportionment, contribution, or reimbursement issues pursuant to subdivision 5, the arbitration proceeding is for the limited purpose of apportioning liability for workers' compensation benefits payable among employers and insurers. This subdivision applies without regard to whether one or more of the injuries results from cumulative trauma or a specific injury, but does not apply to an occupational disease. In the case of an occupational disease, section 176.66 applies. Apportionment against preexisting disability is allowed only for permanent partial disability as provided in section 176.101, subdivision 4a. Nothing in this subdivision shall be interpreted to repeal or in any way affect the law with respect to special compensation fund statutory liability or benefits.

Subd. 2. [Repealed, 1995 c 231 art 2 s 110]

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

Subd. 4. **Program payments.** If the employee's medical expenses for a personal injury are paid pursuant to any program administered by the commissioner of human services, or if the employee or spouse or dependents living with the employee receive subsistence or other payments pursuant to such a program, and it is subsequently determined that the injury is compensable pursuant to this chapter, the workers' compensation insurer shall reimburse the commissioner of human services for the payments made, including interest at a rate of 12 percent a year.

Amounts paid to an injured employee or spouse or dependents living with the employee pursuant to such a program and attributable to the personal injury shall be deducted from any settlement or award of compensation or benefits under this chapter, including, but not limited to, temporary and permanent disability benefits.

The insurer shall attempt, with due diligence, to ascertain whether payments have been made to an injured employee pursuant to such a program prior to any settlement or issuance of a binding award and shall notify the Department of Human Services, Benefit Recovery Section, when such payments have been made. An employee who has received public assistance payments shall notify the Department of Human Services, Benefit Recovery Section, of its potential intervention claim prior to making or settling a claim for benefits under this chapter. Notice served on local human services agencies is not sufficient to meet the notification requirement in this subdivision.

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.

Subd. 6. **Award.** If the employee commences an action under this chapter for benefits arising out of the same injury which resulted in the dispute arbitrated under subdivision 5, and if the benefits awarded to the employee under the employee's claim are inconsistent with the arbitration decision, any increase in benefits over those paid pursuant to the arbitration proceeding is paid by the party or parties who ordinarily would have been required to pay the increased benefits but for the arbitration. Any reimbursement from the employee of any decrease in benefits from those paid pursuant to the arbitration is paid to the party or parties who previously had paid the increased benefits. The provisions of this subdivision apply regardless of whether more or fewer employers and insurers or the special fund have been added or omitted as parties to the employee's subsequent action after arbitration.

Subd. 7. **Representation.** If an employee brings an action under the circumstances described in subdivision 6, the parties to the previous arbitration may be represented at the new action by a common or joint attorney.

Subd. 8. **Attorney fees.** No attorney's fees shall be awarded under either section 176.081 or 176.191 against any employer or insurer in connection with any arbitration proceeding unless the employee chooses to retain an attorney to represent the employee's interests during arbitration.

History: *1953 c 755 s 24; Ex1967 c 1 s 6; 1973 c 388 s 54; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; Ex1979 c 3 s 52; 1981 c 346 s 95; 1983 c 290 s 122-125; 1984 c 654 art 5 s 58; 1985 c 234 s 13,14; 1986 c 444; 1987 c 332 s 52,53; 1987 c 370 art 2 s 2; 1993 c 13 art 2 s 1; 1995 c 231 art 2 s 76-79; 1997 c 128 s 4,5; 2001 c 123 s 12; 2005 c 132 s 36*

176.192 BOMB DISPOSAL UNIT EMPLOYEES.

For purposes of this chapter, a member of a bomb disposal unit approved by the commissioner of public safety and employed by a municipality defined in section 466.01, is considered an employee of the Department of Public Safety solely for the purposes of this chapter when disposing of or neutralizing bombs or other similar hazardous explosives, as defined in section 299C.063, outside the jurisdiction of the employer-municipality.

History: *1988 c 717 s 2; 1995 c 226 art 4 s 2; 2001 c 123 s 13*

PROHIBITIONS AND PENALTIES

176.194 PROHIBITED PRACTICES.

Subdivision 1. **Application.** This section applies to insurers, self-insurers, group self-insurers, political subdivisions of the state, and the administrator of state employees' claims.

This section also applies to adjusters and third-party administrators who act on behalf of an insurer, self-insurer, group self-insurer, the assigned risk plan, the Minnesota Insurance Guaranty Association, a political subdivision, or any other entity.

This section shall be enforceable only by the commissioner of labor and industry. Evidence of violations under this section shall not be admissible in any civil action.

Subd. 2. **Purpose.** This section is not intended to replace existing requirements of this chapter which govern the same or similar conduct; these requirements and penalties are in addition to any others provided by this chapter.

Subd. 3. **Prohibited conduct.** The following conduct is prohibited:

(1) failing to reply, within 30 calendar days after receipt, to all written communication about a claim from a claimant that requests a response;

(2) failing, within 45 calendar days after receipt of a written request, to commence benefits or to advise the claimant of the acceptance or denial of the claim by the insurer;

(3) failing to pay or deny medical bills within 45 days after the receipt of all information requested from medical providers that is necessary to make a payment determination;

(4) filing a denial of liability for workers' compensation benefits without conducting an investigation;

(5) failing to regularly pay weekly benefits in a timely manner as prescribed by rules adopted by the commissioner once weekly benefits have begun. Failure to regularly pay weekly benefits means failure to pay an employee on more than three occasions in any 12-month period within three business days of when payment was due;

(6) failing to respond to the department within 30 calendar days after receipt of a written inquiry from the department about a matter related to benefits. Responses must be substantive and address the question;

(7) failing to pay pursuant to an order of the department, compensation judge, court of appeals, or the supreme court, within 45 days from the filing of the order unless the order is under appeal;

(8) advising a claimant not to obtain the services of an attorney or representing that payment will be delayed if an attorney is retained by the claimant;

(9) altering information on a document to be filed with the department without the notice and consent of any person who previously signed the document and who would be adversely affected by the alteration;

(10) providing fraudulent written information to the department or an employee pertaining to a workers' compensation matter; or

(11) failing to pay a claim, or otherwise correct behavior on a claim, for which a penalty assessed has been paid or has become a final order.

Subd. 4. **Penalties.** The penalties for violations of subdivision 3, clauses (1) to (6), are as follows:

1st through 5th violation of each paragraph	written warning
6th through 10th violation of each paragraph	$3,000 per violation in excess of five
11 or more violations of each paragraph	$6,000 per violation in excess of ten

For violations of subdivision 3, clauses (7) to (11), the penalties are:

1st through 5th violation of each paragraph	$3,000 per violation
6 or more violations of each paragraph	$6,000 per violation in excess of five

The penalties under this section may be imposed in addition to other penalties under this chapter that might apply for the same violation. The penalties under this section are assessed by the commissioner and are payable to the commissioner for deposit in the assigned risk safety account. A party may object to the penalty and request a formal hearing under section 176.85. If an entity has more than 30 violations within any 12-month period, in addition to the monetary penalties provided, the commissioner may refer the matter

to the commissioner of commerce with recommendation for suspension or revocation of the entity's (a) license to write workers' compensation insurance; (b) license to administer claims on behalf of a self-insured, the assigned risk plan, or the Minnesota Insurance Guaranty Association; (c) authority to self-insure; or (d) license to adjust claims. The commissioner of commerce shall follow the procedures specified in section 176.195.

Subd. 5. **Rules.** The commissioner may, by rules adopted in accordance with chapter 14, specify additional illegal, misleading, deceptive, fraudulent practices or conduct which are subject to the penalties under this section.

History: *1987 c 332 s 54; 1992 c 510 art 3 s 22,23; 1995 c 231 art 2 s 80; 2001 c 123 s 14; 2002 c 262 s 19,20; 2021 c 12 s 8,9*

176.195 REVOCATION OF INSURER'S LICENSE.

Subdivision 1. **Grounds.** Where an insurer, or an agent of an insurer, has been guilty of fraud, misrepresentation, or culpable, persistent, and unreasonable delay in making payments or settlements under this chapter, the commissioner of commerce shall revoke the license of the insurer to write workers' compensation insurance.

Subd. 1a. **Additional grounds.** Where an insurer or agent of an insurer has failed to comply with provisions of this chapter, other than the provisions in subdivision 1, the commissioner of commerce may revoke the license of the insurer to write workers' compensation insurance.

Subd. 2. **Commencement of proceedings.** The commissioner of commerce may act under subdivision 1 or subdivision 1a upon the commissioner's own motion, the recommendation of the commissioner of labor and industry, the chief administrative law judge, or the Workers' Compensation Court of Appeals, or the complaint of any interested person.

Subd. 3. **Complaint, answer; hearing.** A complaint against an insurer shall include a notice and order for hearing, shall be in writing and shall specify clearly the grounds upon which the license is sought to be suspended or revoked. The insurer shall file a written answer to the complaint within 20 days of service of the complaint. The hearing shall be conducted under chapter 14.

Subd. 4. [Repealed, 1987 c 332 s 117]

Subd. 5. [Repealed, 1987 c 332 s 117]

Subd. 6. [Repealed, 1987 c 332 s 117]

Subd. 7. **Report to commissioner of commerce.** The commissioner may send reports to the commissioner of commerce regarding compliance with this chapter by insurers writing workers' compensation insurance. A report may include a recommendation for revocation of an insurer's license under this section and may also recommend the imposition of other penalties which may be imposed upon insurers by the commissioner of commerce.

History: *1953 c 755 s 25; Ex1967 c 1 s 6; 1973 c 388 s 55,56; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1983 c 289 s 114 subd 1; 1983 c 290 s 126-128; 1984 c 640 s 32; 1984 c 655 art 1 s 92; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1987 c 332 s 55*

176.20 [Repealed, 1953 c 755 s 83]

176.201 DISCRIMINATORY RATES.

Subdivision 1. **Physically disabled persons.** An insurer, or an agent or employee of an insurer, shall not make or charge a rate which discriminates against the employment of a person who is physically disabled through the loss or loss of use of a member whether due to accident or other cause.

Subd. 2. **Violation a misdemeanor.** A person who violates subdivision 1 is guilty of a misdemeanor.

Subd. 3. **Conviction of violation, cancellation of license.** Where an insurer, or an agent or employee of an insurer, has been convicted under this section, the fact of conviction is sufficient cause for the commissioner of commerce to cancel the license of the insurer to write workers' compensation insurance.

History: *1953 c 755 s 26; 1975 c 359 s 23; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 2005 c 56 s 1*

176.205 PERSON DEEMED EMPLOYER.

Subdivision 1. **Fraudulent device to evade responsibility to worker.** Subject to subdivision 2, a person who creates or executes any fraudulent scheme, artifice, or device to enable the person to execute work without being responsible to the worker under this chapter, is deemed an "employer" and is subject to the liabilities which this chapter imposes on employers.

Subd. 2. **Contractor, subcontractor.** Subdivision 1 does not apply to an owner who in good faith lets a contract to a contractor. In such case, the contractor or subcontractor is deemed the "employer."

Subd. 3. **Exceptions.** A person shall not be deemed a contractor or subcontractor where:

(1) the person performs work upon another's premises, with the other's tools or appliances, and under the other's direction; or

(2) the person does what is commonly called "piece work"; or

(3) in any way the system of employment merely provides a method of fixing the worker's wages.

Subd. 4. **Calculation of compensation.** Where compensation is claimed against a person under the terms of this section, the compensation shall be calculated with reference to the wages the worker was receiving at the time of the injury or death from the person by whom the worker was immediately employed.

History: *1953 c 755 s 27; 1986 c 444*

176.21 [Repealed, 1953 c 755 s 83]

176.211 ACTS OR OMISSIONS OF THIRD PERSONS.

Except as provided by this chapter the employer need not pay compensation for injuries due to the acts or omissions of third persons who are at the time neither in the service of the employer nor engaged in the work in which the injury occurs.

History: *1953 c 755 s 28*

176.215 SUBCONTRACTOR'S FAILURE TO COMPLY WITH CHAPTER.

Subdivision 1. **Liability for payment of compensation.** Where a subcontractor fails to comply with this chapter, the general contractor, or intermediate contractor, or subcontractor is liable for payment of all

compensation due an employee of a subsequent subcontractor who is engaged in work upon the subject matter of the contract.

Subd. 1a. **Enforcement of order.** If the compensation judge orders the general contractor, intermediate contractor, or subcontractor to pay compensation benefits, the award issued against the general contractor, intermediate contractor, or subcontractor constitutes a lien for government services under section 514.67 on all property of the general contractor, intermediate contractor, or subcontractor and is subject to the provisions of the Revenue Recapture Act under chapter 270A. The special compensation fund may enforce the terms of the award in the same manner as a district court judgment.

Subd. 2. **Subrogation.** A person who has paid compensation under this section is subrogated to the rights of the injured employee against the employee's immediate employer, or any person whose liability for compensation payment to the employee is prior to the liability of the person who paid it.

Subd. 3. **Determination of respective liabilities.** The Workers' Compensation Division may determine the respective liabilities of persons under this section.

History: *1953 c 755 s 29; Ex1967 c 1 s 6; 1973 c 388 s 57; 1975 c 359 s 23; 1986 c 444; 1995 c 231 art 2 s 81*

176.22 [Repealed, 1953 c 755 s 83]

PAYMENTS

176.221 PAYMENT OF COMPENSATION AND TREATMENT CHARGES, COMMENCEMENT.

Subdivision 1. **Commencement of payment.** Within 14 days of notice to or knowledge by the employer of an injury compensable under this chapter the payment of temporary total compensation shall commence. Within 14 days of notice to or knowledge by an employer of a new period of temporary total disability which is caused by an old injury compensable under this chapter, the payment of temporary total compensation shall commence; provided that the employer or insurer may file for an extension with the commissioner within this 14-day period, in which case the compensation need not commence within the 14-day period but shall commence no later than 30 days from the date of the notice to or knowledge by the employer of the new period of disability. Commencement of payment by an employer or insurer does not waive any rights to any defense the employer has on any claim or incident either with respect to the compensability of the claim under this chapter or the amount of the compensation due. Where there are multiple employers, the first employer shall pay, unless it is shown that the injury has arisen out of employment with the second or subsequent employer. Liability for compensation under this chapter may be denied by the employer or insurer by giving the employee written notice of the denial of liability. If liability is denied for an injury which is required to be reported to the commissioner under section 176.231, subdivision 1, the denial of liability must be filed with the commissioner and served on the employee within 14 days after notice to or knowledge by the employer of an injury which is alleged to be compensable under this chapter. If the employer or insurer has commenced payment of compensation under this subdivision but determines within 60 days of notice to or knowledge by the employer of the injury that the disability is not a result of a personal injury, payment of compensation may be terminated upon the filing of a notice of denial of liability within 60 days of notice or knowledge. After the 60-day period, payment may be terminated only by the filing of a notice as provided under section 176.239. Upon the termination, payments made may be recovered by the employer if the commissioner or compensation judge finds that the employee's claim of work related disability was not made in good faith. A notice of denial of liability must state in detail the facts forming the basis for the denial and specific reasons explaining why the claimed injury or occupational disease was determined

not to be within the scope and course of employment and shall include the name and telephone number of the person making this determination.

Subd. 2. [Repealed, 1983 c 290 s 129]

Subd. 3. **Penalty.** If the employer or insurer does not begin payment of compensation within the time limit prescribed under subdivision 1 or 8, the commissioner may assess a penalty, payable to the commissioner for deposit in the assigned risk safety account, which shall be a percentage of the amount of compensation to which the employee is entitled to receive up to the date compensation payment is made.

The amount of penalty shall be determined as follows:

Number of days late	Penalty
1 - 15	30 percent of compensation due, not to exceed $500,
16 - 30	55 percent of compensation due, not to exceed $1,500,
31 - 60	80 percent of compensation due, not to exceed $3,500,
61 or more	105 percent of compensation due, not to exceed $5,000.

The penalty under this section is in addition to any penalty otherwise provided by statute.

Subd. 3a. **Penalty.** In lieu of any other penalty under this section, the commissioner may assess a penalty of up to $2,000 payable to the commissioner for deposit in the assigned risk safety account for each instance in which an employer or insurer does not pay benefits or file a notice of denial of liability within the time limits prescribed under this section.

Subd. 4. [Repealed, 1983 c 290 s 129]

Subd. 5. [Repealed, 1983 c 290 s 129]

Subd. 6. **Assessment of penalties.** The division or compensation judge shall assess the penalty payments provided for by subdivision 3 or 3a and any increase in benefit payments provided by section 176.225, subdivision 5, against the insurer. The insurer is liable for a penalty payment assessed against it even if the delay is attributable to the employer.

An insurer who has paid a penalty under this section may recover from the employer the portion of the penalty attributable to the acts of the employer which resulted in the delay. A penalty paid by an insurer under this section which is attributable to the fault of the employer shall be treated as a loss in an experience rated plan, retrospective rating plan, or dividend calculation where appropriate.

Subd. 6a. **Medical, rehabilitation, and permanent partial compensation.** The penalties provided by this section apply in cases where payment for treatment under section 176.135, rehabilitation expenses under section 176.102, subdivisions 9 and 11, or permanent partial compensation are not made in a timely manner as required by law or by rule adopted by the commissioner.

Subd. 7. **Interest.** Any payment of compensation, charges for treatment under section 176.135, rehabilitation expenses under section 176.102, subdivision 9, or penalties assessed under this chapter not made when due shall bear interest from the due date to the date the payment is made at the rate set by section 549.09, subdivision 1.

For the purposes of this subdivision, permanent partial disability payment is due 14 days after receipt of the first medical report which contains a disability rating if such payment is otherwise due under this chapter, and charges for treatment under section 176.135 are due 30 calendar days after receiving the bill and necessary medical data.

If the claim of the employee or dependent for compensation is contested in a proceeding before a compensation judge or the commissioner, the decision of the judge or commissioner shall provide for the payment of unpaid interest on all compensation awarded, including interest accruing both before and after the filing of the decision.

Subd. 8. **Method and timeliness of payment.** (a) Except as otherwise provided in paragraph (b), payment of compensation under this chapter shall be by immediately payable negotiable instrument, or if by any other method, arrangements shall be available to provide for the immediate negotiability of the payment instrument.

All payment of compensation shall be made within 14 days of the filing of an appropriate order by the division or a compensation judge, unless the order is appealed or if a different time period is provided by this chapter.

(b) An employer or insurer responsible for payment of periodic monetary benefits under this chapter must send the payments by electronic funds transfer to a bank, savings association, or credit union, if requested by the employee or a dependent under section 176.111.

(1) If the employer or insurer has already established an electronic funds transfer arrangement with a bank, savings association, or credit union for the employee's account, the employer or insurer must begin sending periodic monetary benefit payments by electronic funds transfer to the bank, savings association, or credit union within 30 days after the employer or insurer receives a request from the employee or dependent containing the information in paragraph (c).

(2) If the employer or insurer does not already have an arrangement with the bank, savings association, or credit union for electronic funds transfer for the employee or dependent's account at the time of the request, the 30 days to begin sending periodic benefit payments by electronic funds transfer does not start to run until the arrangement has been established. The employer or insurer must make reasonable efforts to establish the electronic funds transfer arrangement within 14 days after receiving a request containing the information in paragraph (c).

(3) Payment of benefits is deemed to have been made on the date the payment is sent by electronic funds transfer to the employee or dependent's account at the bank, savings association, or credit union.

(c) The employee or dependent must provide the employer or insurer with the following information:

(1) a signed and dated written request for electronic funds transfer of benefits;

(2) the name and address of the bank, savings association, or credit union where the benefit payments are to be sent by electronic funds transfer;

(3) the account number to which the payments should be credited; and

(4) any other information or documentation required by the employer or insurer or the bank, savings association, or credit union necessary to implement electronic funds transfer.

(d) The employer or insurer must retain a copy of the request for as long as the benefits are being paid by electronic funds transfer. The employer or insurer paying the benefits must provide a copy of the request to the department upon request.

(e) Paragraph (b) does not apply if the employer or insurer reasonably determines that the periodic monetary benefit payments are likely to end before the electronic funds transfer can be arranged.

(f) The commissioner may assess a monetary penalty of $500 against the employer or insurer for a violation of paragraph (b) or (d). Before issuing a penalty for a first violation of paragraph (b) or (d), the commissioner must provide written notice to the employer or insurer that a penalty may be issued if the violation is not corrected within 30 days. Penalties under this paragraph are payable to the commissioner for deposit in the assigned risk safety account.

Subd. 9. **Payment of full wages.** An employer who pays full wages to an injured employee is not relieved of the obligation for reporting the injury and making a liability determination within the times specified in this chapter. If the full wage is paid the employer's insurer or self-insurer shall report the amount of this payment to the division and determine the portion which is temporary total compensation for purposes of administering this chapter and special compensation fund assessments. The employer shall also make appropriate adjustments to the employee's payroll records to assure that the employee's sick leave or the vacation time is not inappropriately charged against the employee, and to assure the proper income tax treatment for the payments.

History: *1953 c 755 s 30; 1973 c 388 s 58-61; 1977 c 342 s 21; Ex1979 c 3 s 53; 1981 c 346 s 96; 1983 c 290 s 129; 1984 c 432 art 2 s 28-30; 1987 c 332 s 56-58; 1992 c 510 art 3 s 24,25; 1995 c 231 art 1 s 27; art 2 s 82-85; 2001 c 123 s 15-18; 2015 c 43 s 4*

176.222 REPORT ON COLLECTION AND ASSESSMENT OF FINES AND PENALTIES.

The commissioner shall annually, by January 30, submit a report to the legislature detailing the assessment and collection of fines and penalties under this chapter on a fiscal year basis for the immediately preceding fiscal year and for as many prior years as the data is available.

History: *1992 c 510 art 3 s 26*

176.223 MS 2022 [Repealed, 2023 c 51 art 6 s 7]

176.225 ADDITIONAL AWARD AS PENALTY.

Subdivision 1. **Grounds.** Upon reasonable notice and hearing or opportunity to be heard, the commissioner, a compensation judge, or upon appeal, the court of appeals or the supreme court shall award compensation, in addition to the total amount of compensation award, of up to 30 percent of that total amount where an employer or insurer has:

(1) instituted a proceeding or interposed a defense which does not present a real controversy but which is frivolous or for the purpose of delay; or

(2) unreasonably or vexatiously delayed payment; or

(3) neglected or refused to pay compensation; or

(4) intentionally underpaid compensation; or

(5) frivolously denied a claim; or

(6) unreasonably or vexatiously discontinued compensation in violation of sections 176.238 and 176.239.

For the purpose of this section, "frivolously" means without a good faith investigation of the facts or on a basis that is clearly contrary to fact or law.

Subd. 2. **Examination of books and records.** To determine whether an employer or insurer is liable for the payment provided by subdivision 1, the division, a compensation judge, or the Workers' Compensation Court of Appeals upon appeal may examine the books and records of the employer or insurer relating to the payment of compensation, and may require the employer or insurer to furnish any other information relating to the payment of compensation.

The right of the division to review the records of an employer or insurer includes the right of the special compensation fund to examine records for the proper administration of section 176.129, Minnesota Statutes 1990, section 176.131, Minnesota Statutes 1994, section 176.132, and sections 176.181 and 176.183. The special compensation fund may not review the records of the employer or insurer relating to a claim under Minnesota Statutes 1990, section 176.131, until the special compensation fund has accepted liability under that section or a final determination of liability under that section has been made. The special compensation fund may withhold reimbursement to the employer or insurer under Minnesota Statutes 1990, section 176.131, or Minnesota Statutes 1994, section 176.132, if the employer or insurer denies access to records requested for the proper administration of section 176.129, Minnesota Statutes 1990, section 176.131, Minnesota Statutes 1994, section 176.132, section 176.181 or 176.183.

Subd. 3. **Defiance of division, compensation judge, or Workers' Compensation Court of Appeals, complaint.** If an insurer persists in an action or omission listed in subdivision 1, or does not permit the examination of books and records, or fails to furnish information as required, the commissioner or the chief administrative law judge shall file a written complaint with the commissioner of commerce. The complaint shall specify the facts and recommend the revocation of the license of the insurer to do business in this state. The Workers' Compensation Court of Appeals may also file a written complaint.

Subd. 4. **Hearing before commissioner of commerce.** Upon receipt of a complaint filed under subdivision 3, the commissioner of commerce shall hear and determine the matter in the manner provided by chapter 14. On finding that a charge made by the complaint is true, the commissioner of commerce may suspend or revoke the license of the insurer to do business in this state. The insurer may appeal from the action of the commissioner revoking the license in the manner provided in chapter 14.

Subd. 5. **Penalty.** Where the employer is guilty of inexcusable delay in making payments, the payments which are found to be delayed shall be increased by 25 percent. Withholding amounts unquestionably due because the injured employee refuses to execute a release of the employee's right to claim further benefits will be regarded as inexcusable delay in the making of compensation payments. If any sum ordered by the department to be paid is not paid when due, and no appeal of the order is made, the sum shall bear interest at the rate of 12 percent per annum. Any penalties paid pursuant to this section shall not be considered as a loss or expense item for purposes of a petition for a rate increase made pursuant to chapter 79.

History: *1953 c 755 s 31; Ex1967 c 1 s 6; 1973 c 388 s 62-64; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 97; 1983 c 289 s 114 subd 1; 1983 c 290 s 130-132; 1984 c 640 s 32; 1984 c 655 art 1 s 92; 1986 c 444; 1986 c 461 s 24; 1987 c 332 s 59-61; 1995 c 231 art 2 s 87,88; 1996 c 305 art 1 s 47*

176.23 [Repealed, 1953 c 755 s 83]

REPORTS

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

Subdivision 1. **Time limitation.** (a) Where death or serious injury occurs to an employee during the course of employment, the employer shall report the injury or death to the commissioner and insurer within 48 hours after its occurrence. Where any other injury occurs which wholly or partly incapacitates the employee from performing labor or service for more than three calendar days, the employer shall report the injury to the insurer on a form prescribed by the commissioner within ten days from its occurrence.

(b) An insurer and self-insured employer shall report the injury to the commissioner no later than 14 days from its occurrence. If an injury has not previously been required to be reported, the insurer or self-insured employer must report the injury to the commissioner, in the manner and format prescribed by the commissioner, no later than 14 days after the date that:

(1) any document initiating a dispute is filed under this chapter;

(2) a rehabilitation consultation report or a rehabilitation plan is filed under this chapter; or

(3) permanent partial disability is ascertainable under section 176.101, subdivision 2a.

(c) Where an injury has once been reported but subsequently death ensues, the employer shall report the death to the commissioner and insurer within 48 hours after the employer receives notice of this fact.

(d) An employer who provides notice to the Occupational Safety and Health Division of the Department of Labor and Industry of a fatality within the eight-hour time frame required by law, or of an inpatient hospitalization, amputation, or loss of an eye, within the 24-hour time frame required by law, has satisfied the employer's obligation under paragraph (a).

(e) At the time an injury is required to be reported under paragraph (b), the insurer or self-insured employer must also specify whether the injury is covered by a collective bargaining agreement approved by the commissioner under section 176.1812. Notice must be provided in the format and manner prescribed by the commissioner.

Subd. 2. **Initial report, written report.** (a) Where subdivision 1 requires an injury to be reported within 48 hours, the employer may make an initial report to the commissioner by telephone or personal notice, and must report the injury to the insurer within seven days from its occurrence. After receiving this notice, the insurer or self-insured employer must report the injury to the commissioner as provided in subdivision 1. All reports of injury required by subdivision 1 or this subdivision shall include the date of injury. The reports shall be made in the manner and format designated by the commissioner, with one copy to the insurer, and one copy to the employee. The employer must give the employee the "Minnesota Workers' Compensation System Employee Information Sheet" at the time the employee is given a copy of the first report of injury. Within two business days after a report of injury filed by a self-insured employer or insurer is accepted by the commissioner, the self-insured employer or insurer must serve the report on the employee in the manner and format prescribed by the commissioner.

(b) If an insurer or self-insured employer repeatedly fails to pay benefits within three days of the due date, pursuant to section 176.221, the insurer or self-insured employer shall be ordered by the commissioner to explain, in person, the failure to pay benefits due in a reasonable time. If prompt payments are not thereafter

made, the commissioner shall refer the insurer or self-insured employer to the commissioner of commerce for action pursuant to section 176.225, subdivision 4.

Subd. 3. **Physicians, chiropractors, or other health care providers to report injuries.** A physician, chiropractor, or other health care provider who has examined, treated, or has special knowledge of an injury to an employee which may be compensable under this chapter, shall report to the commissioner all facts relating to the nature and extent of the injury and disability, and the treatment provided for the injury or disability, within ten days after the health care provider has received a written request for the information from the commissioner or an authorized representative of the commissioner.

Subd. 4. **Supplementary reports.** The commissioner or an authorized representative may require the filing of supplementary reports of accidents as is deemed necessary to provide information required by law.

Supplementary reports or other documents related to the current nature and extent of the employee's injury, disability, or treatment may be requested from a physician, surgeon, chiropractor, or other health care provider by the commissioner or a representative, an employer or insurer, or the employee.

Subd. 5. **Electronic reports filed under this section.** (a) The commissioner shall prescribe the manner and format for providing the reports and other documents required by this section.

(b) A report or other document that is required to be filed with the commissioner under this section must be filed electronically in the manner and format required by the commissioner. Except as provided in paragraph (d), the commissioner must give at least 60 days' notice to self-insured employers and insurers, and publish notice in the State Register, of the effective date of required electronic filing of the report or other document.

(c) Where specified by the commissioner under paragraph (d), a self-insured employer or insurer must file a report or other document with the commissioner electronically according to the version of the Claims Release Standard published by the International Association of Industrial Accident Boards and Commissions (IAIABC) adopted by the commissioner. The commissioner must publish on the department's website a Minnesota implementation guide that prescribes reporting and service requirements consistent with this chapter.

(d) The commissioner must give notice to self-insured employers and insurers, and publish notice in the State Register, of intent to adopt a version of the Claims Release Standard for a report or other document required to be filed with the commissioner. The notice must include a link to the Minnesota implementation guide. Interested parties must have at least 90 days to submit comments to the commissioner. After considering the comments, the commissioner must publish notice of the adopted version of the Claims Release Standard and Minnesota implementation guide in the State Register at least 90 days before the effective date of the Standard and Guide. The commissioner must also give at least 30 days' notice to self-insured employers and insurers, and publish notice in the State Register, of any updates to the Minnesota implementation guide. The requirements in the adopted versions of the Claims Release Standard and the Minnesota implementation guide supersede any conflicting or obsolete rule. The commissioner may amend or repeal conflicting or obsolete rules, using the procedures in section 14.388 or 14.3895. The adopted versions of the Claims Release Standards and Minnesota implementation guides adopted by the commissioner under this section are not rules under chapter 14, but have the force and effect of law as of the effective date specified in the notice published in the State Register. The commissioner may publish the initial notices in this subdivision before August 31, 2020, to ensure the adopted versions of the Standard and Guide are effective on that date.

Subd. 6. **Commissioner of labor and industry; duty to keep informed.** (a) The commissioner of labor and industry shall keep fully informed of the nature and extent of all injuries compensable under this chapter,

their resultant disabilities, and of the rights of employees to compensation. In addition to other data required to be filed or reported under this chapter, the insurer or self-insured employer must report to the department any payments of compensation and attorney fees; the amounts of payments made; and any amounts withheld from compensation paid, whether paid voluntarily or by order of a compensation judge, the workers' compensation court of appeals, or the Minnesota Supreme Court. The reports must be made within 14 days of the following events: the date of the first payment, a denial of primary liability, a denial of any part of compensation, a change in the compensation amount or type, commencement of an additional compensation type, reinstatement of compensation after previous discontinuance, or final payment of compensation. Additional reporting requirements are as provided in paragraphs (b) to (g).

(b) Starting 180 days after the date of injury and every six months thereafter, the self-insured employer or insurer shall report to the commissioner all compensation paid to an employee, any amounts withheld from compensation paid, and any amounts paid for attorney fees.

(c) A report of permanent partial disability benefits commenced or paid must include a copy of (1) the medical report supporting the permanent partial disability benefit paid; and (2) the form prescribed by the commissioner that was served on the employee showing the permanent partial disability benefit that was or will be paid.

(d) A final report must be filed to show that the self-insured employer or insurer has ceased payment of all indemnity and rehabilitation benefits where no litigation is pending. The report must be filed within 180 days of the cessation.

(e) A self-insured employer or insurer must report a change in the number of dependents receiving benefits within 14 days of the change.

(f) A self-insured employer or insurer must report when a claim is acquired from another self-insured employer or insurer, and whether benefits are currently being paid. A third-party administrator must report when it begins administering a claim and whether benefits are currently being paid. The reports under this paragraph must be filed within 30 days of the acquisition, or a change in the third-party administrator.

(g) The reports required under this section must be filed electronically according to the requirements of subdivision 5 in the form and manner required by the commissioner. The reports must be served on or provided to the employee as follows:

(1) If service is required under this chapter, the self-insured employer or insurer must serve the report on the employee or dependents within the time limits required, and must retain a proof of service as required by section 176.285, subdivision 3.

(2) If the report is not required to be served under this chapter, the self-insured employer or insurer must, no later than two business days of acceptance of the report by the commissioner, send the report to the employee by first class United States mail or another method agreed to by the employee, and specify on the report the date it was sent.

(3) A report served or provided to the employee under this chapter must contain the information designated by the commissioner in the format required by the commissioner, according to the requirements specified under subdivision 5.

Subd. 7. **Medical reports.** If requested by the division, a compensation judge, the Workers' Compensation Court of Appeals, or any member or employee thereof an employer, insurer, or employee shall file with the commissioner a copy suitable for imaging of any medical report or other document in possession which

bears upon the case and shall also file a copy of the same report or document with the agency or individual who made the request.

Subd. 8. **No public inspection of reports.** Subject to subdivision 9, a report or other document, or its copy, which has been filed with the commissioner of the Department of Labor and Industry under this section is not available to public inspection. Any person who has access to such a report shall not disclose its contents to anyone in any manner.

A person who unauthorizedly discloses a report or its contents to another is guilty of a misdemeanor.

Subd. 9. **Uses that may be made of reports; access to division file.** (a) Reports and other documents in the division file are private data on individuals and nonpublic data as those terms are defined in section 13.02, except that the reports and documents in the division file may be used in hearings held under this chapter, and for the purpose of state investigations and for statistics. The reports and documents in the division file are also available without authorization to:

(1) the Department of Revenue for use in enforcing Minnesota income tax and property tax refund laws, and the information shall be protected as provided in chapter 270B;

(2) an agency, as needed to perform its responsibilities under this chapter;

(3) the Workers' Compensation Reinsurance Association for use by the association in carrying out its responsibilities under chapter 79;

(4) the special compensation fund for the purpose of auditing assessments under section 176.129; and

(5) the persons and entities allowed access under subdivisions 9a, 9b, and 9c.

(b) A person with an authorization signed by the employer, insurer, or employee, as described in paragraph (c), has access to reports and other documents in the division file as provided in the authorization. An authorization must:

(1) be in writing;

(2) include the printed name and dated signature of the employee, employer, or insurer representative who is authorizing the documents to be released;

(3) specify the employer, date of injury, and worker identification or Social Security number;

(4) include the name of the individual or entity that is authorized to receive the documents. If the authorization is signed by the employer or insurer, the authorization must specify that the access is granted to a person acting on the employer's or insurer's behalf in performing responsibilities under chapter 176;

(5) specify the time period within which the authorization is valid, which may not exceed one year from the date the authorization was signed, except that access to the division file may exceed one year if provided in subdivision 9a, paragraph (c); and

(6) include a statement that the person signing the authorization may revoke the authorization by filing written notice with the department at any time, which shall be effective upon receipt by the department.

(c) For purposes of authorization to access the division file under this subdivision and access to the division file under subdivision 9a, an "employee" includes an employee's guardian under section 176.092; a dependent of a deceased employee under section 176.111; a representative of the decedent under section

13.10; or legal heir of a deceased employee's estate; if a court order or other legal documentation is submitted that establishes the person's legal status as a guardian, dependent, representative, or legal heir.

Subd. 9a. **Access to division file without an authorization; attorney access.** (a) Access to the division file established for a specific claimed date or dates of injury under this chapter is allowed without an authorization from the employee, employer, or insurer, as described in clauses (1) to (7):

(1) an employee, as described in subdivision 9, paragraph (c), has access to the division file established for the employee's claimed date or dates of injury;

(2) an employer and insurer have access to the division file for a workers' compensation claim to which the employer and insurer are parties;

(3) the Department of Administration under section 13.43, subdivision 18, the assigned risk plan under chapter 79, the special compensation fund established under section 176.129, the self-insurers security fund under chapter 79A, and the Minnesota insurance guaranty association under chapter 60C have access to all of the documents in the division file for a claim to which they are a party or are otherwise providing, paying, or reimbursing workers' compensation benefits under this chapter;

(4) a person who has filed a motion to intervene in a pending dispute at an agency has access to the documents in the division file that are filed in connection with the dispute in which the person has filed a motion to intervene;

(5) a registered rehabilitation provider assigned to provide rehabilitation services to an employee has access to the documents in the division file that are filed in connection with the employee's vocational rehabilitation or a dispute about vocational rehabilitation under section 176.102;

(6) a third-party administrator licensed under section 60A.23, subdivision 8, has access to the division file for a claim it has contracted to administer on behalf of any of the entities listed in this subdivision; and

(7) the program administrator for a collective bargaining agreement approved by the commissioner under section 176.1812 has access to the division file for a claim that is covered by the agreement.

(b) An attorney who has filed with the commissioner in CAMPUS a notice of representation of a person or entity listed in paragraph (a) has the same access to documents in the division file that the represented person or entity has, unless the attorney specifies when filing the notice that access should be limited. If the attorney represents an employee as described in subdivision 9, paragraph (c), one of the following documents signed by the employee must be attached to the notice: a written authorization, a retainer agreement, or a document initiating or responding to a workers' compensation dispute filed under this chapter.

(c) If the attorney's access is not limited by an authorization, notice of representation, or the represented person or entity's access under paragraph (a), the attorney's access continues until one of the following occurs, whichever is later:

(1) one year after an authorization is filed;

(2) three years after the date a retainer agreement or notice of representation was filed where no dispute has been initiated; or

(3) five years after the date a retainer agreement or notice of representation was filed where a dispute has been initiated by filing a document specified in section 176.2611, subdivision 4.

Notwithstanding the time frames in clauses (1) to (3), an attorney no longer has access to the division file as of the date the attorney files a notice of withdrawal from the case, or the date the department receives written notice that the authorization is withdrawn or that the attorney no longer represents the person. However, if a dispute over an attorney's fees is pending at the office, the attorney has continued access to the division file until a final order or award on stipulation resolving the attorney fee dispute is received by the commissioner.

(d) The division may provide the worker identification number assigned under section 176.275, subdivision 1, without a signed authorization required under paragraph (b) to an:

(1) attorney who represents one of the persons described in paragraph (b);

(2) attorney who represents an intervenor or potential intervenor under section 176.361;

(3) intervenor; or

(4) employee's assigned qualified rehabilitation consultant under section 176.102.

(e) If the department receives information that indicates that identifying or contact information for an employee, dependent, employer, insurer, or third-party administrator for an employer or insurer is erroneous or no longer accurate, the department may update the information in all relevant workers' compensation files to reflect:

(1) the current and accurate name, address, Social Security number or worker identification number, and contact information for an employee, unless the employee notifies the commissioner in writing that the information in a workers' compensation file for a specific date of injury may not be updated; and

(2) the current and accurate name, address, and contact information for an employer, insurer, or third-party administrator for an employer or insurer.

Subd. 9b. **Interagency access to documents and data related to workers' compensation disputes.** An agency shall, without the need for an authorization, have full, read-only, real-time, electronic access to view all documents, document contents, dispositions, outcomes, and other data related to a workers' compensation dispute at one of the other agencies, except for the following:

(1) paper, images, or electronic data created, used or maintained for internal operational purposes by an agency, the special compensation fund, or the vocational rehabilitation unit;

(2) a confidential mediation statement, including any documents submitted with the statement for the mediator's review and any additional documents submitted to or sent by the mediator in furtherance of mediation efforts; and

(3) the work product of a compensation judge, a Workers' Compensation Court of Appeals judge, a mediator at the office or department, or the commissioner that is not issued or sent to a party to a claim. Examples of work product include personal notes of hearings or conferences and draft decisions or orders.

This subdivision is not intended to allow interagency access to non-dispute-related paper, images, or electronic data created, used or maintained solely for an agency's internal operational purposes.

Each agency's responsible authority as defined in section 13.02 is responsible for its own employees' use and dissemination of the data and documents in CAMPUS and the office's case management system as required by section 13.05, subdivision 5.

Subd. 9c. **Investigative and enforcement data.** (a) For purposes of this subdivision, the terms in this paragraph have the meanings given.

(1) "Enforcement action" means a proceeding initiated by the department, commissioner, medical services review board under section 176.103, or rehabilitation review panel under section 176.102, that may result in a penalty, fine, or sanction for violation of workers' compensation laws or that may result in an order for compliance with workers' compensation laws.

(2) "Investigation" includes an investigation, inspection, audit, file review, inquiry, or examination performed by the department or commissioner to administer, enforce, and monitor compliance with workers' compensation laws within the department's jurisdiction.

(3) "Final order" or "final penalty assessment," means that:

(i) no objection, appeal, or request for hearing has been filed in the manner and within the time required by law;

(ii) an objection, appeal, or request for hearing has been withdrawn;

(iii) a settlement agreement or stipulation resolving all or part of the matter has been signed by all parties and, if required by law, has been approved by a judge; or

(iv) all appeals have been exhausted or waived.

(b) A claim-specific final order or final penalty assessment issued by the department or commissioner pursuant to a workers' compensation investigation or enforcement proceeding shall be placed in the division file for that employee's claim. Access to the final enforcement order or penalty assessment in the division file shall be as provided in subdivision 9a. Before the enforcement order or penalty assessment is final, only the employee, dependent of a deceased employee, employer, or insurer who are parties to the claim, and any respective attorney representing the party, shall have access to it.

(c) Enforcement orders and penalty assessments issued by the department, commissioner, medical services review board, or rehabilitation review panel pursuant to workers' compensation investigations or enforcement proceedings that are not claim-specific shall not be placed in the division file. The data practices classification of these orders and penalties is as provided in sections 13.39 and 13.41, except that the names, Social Security numbers, and worker identification numbers of employees with workers' compensation claims and their dependents, and the identity of persons filing a complaint with the department about the subject of the investigation or enforcement action, are private or nonpublic data as those terms are defined in section 13.02 when maintained by a government entity.

Subd. 10. **Failure to file required report, penalty.** If an employer, qualified rehabilitation consultant or rehabilitation vendor, insurer, physician, chiropractor, or other health provider fails to file with the commissioner any report or other document required by this chapter in the manner and within the time limitations prescribed, or otherwise fails to provide a report or other document required by this chapter in the manner provided by this chapter, the commissioner may impose a penalty of up to $500 for each failure.

The imposition of a penalty may be appealed to a compensation judge within 30 days of notice of the penalty.

Penalties collected by the state under this subdivision shall be payable to the commissioner for deposit into the assigned risk safety account.

Subd. 11. **Failure to file required report; substitute filing.** Where this section requires the employer to file a report of injury with the commissioner, and the employer is unable or refuses to file the report, the insurer shall file the report within ten days of a request from the division. The report shall be filed in the manner prescribed by this section. If both the employer and the insurer fail to file the report within 30 days of notice of the injury, the commissioner shall file the report.

The filing of a report of injury by the commissioner does not subject an employee or the dependents of an employee to the three-year time limitations under section 176.151, paragraphs (a) and (b).

A substitute filing under this subdivision shall not be a defense to a penalty assessed under subdivision 10.

Subd. 12. **Reports; electronic monitoring.** Beginning July 1, 1995, the commissioner shall monitor electronically all reports of injury, all payments for reported injuries, and compliance with all reporting and payment timelines.

History: *1953 c 755 s 32; 1969 c 583 s 1; 1971 c 422 s 4-9; 1973 c 388 s 65-74; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; Ex1979 c 3 s 54,55; 1981 c 346 s 98,99; 1983 c 15 s 2; 1983 c 289 s 114 subd 1; 1983 c 290 s 133-137; 1984 c 432 art 2 s 31,32; 1984 c 655 art 1 s 92; 1986 c 444; 1986 c 461 s 25,26; 1987 c 332 s 62-64; 1989 c 184 art 2 s 9; 1992 c 510 art 3 s 27; 1995 c 224 s 70; 1995 c 231 art 2 s 89; 1998 c 294 s 2,3; 2000 c 447 s 21; 2001 c 123 s 19-21; 2005 c 90 s 17; 2008 c 250 s 12; 2009 c 75 s 14; 2014 c 182 s 6; 2015 c 43 s 5; 2018 c 185 art 1 s 3; 1Sp2019 c 7 art 12 s 6; 2020 c 83 art 1 s 65; 7Sp2020 c 1 art 2 s 13-16; 2022 c 32 art 1 s 2; 2024 c 97 s 18*

176.232 [Repealed, 1995 c 231 art 2 s 110]

176.234 RELEASE OF DATA FOR EPIDEMIOLOGIC STUDY.

The commissioner of the Department of Labor and Industry shall, upon request, provide the commissioner of health data classified as private data under section 13.02, subdivision 12, which are contained in the initial report of injury under section 176.231, and other workers' compensation records related to any individual's injury or illness. Data to be provided include, but are not limited to, all personal identifiers such as name, address, age, sex, and Social Security number for the injured person, employer identification information, insurance information, compensation payments, and physician and rehabilitation reports which the commissioner of labor and industry determines may pertain to specific epidemiologic investigations being conducted by the Department of Health.

History: *1991 c 202 s 15*

NOTICE

176.235 NOTICE TO EMPLOYERS AND INJURED EMPLOYEE OF RIGHTS AND DUTIES.

Subdivision 1. **Employee brochure.** When the commissioner of labor and industry has received notice or information that an employee has sustained an injury which may be compensable under this chapter, the commissioner of labor and industry shall mail a brochure, written in language easily readable and understandable by a person of average intelligence and education, to the employee explaining the rights and obligations of the employee, the assistance available to the employee, the operation of the workers' compensation system, and whatever other relevant information the commissioner of labor and industry deems necessary.

Subd. 2. **Employer brochure.** The commissioner shall prepare, in language easily readable and understandable by a person of average intelligence and education, a brochure explaining to employers their rights and obligations under this chapter and shall furnish it to employers subject to this chapter.

History: *1953 c 755 s 33; Ex1967 c 1 s 6; 1973 c 388 s 75; Ex1979 c 3 s 56*

176.238 NOTICE OF DISCONTINUANCE OF COMPENSATION.

Subdivision 1. **Necessity for notice and showing; contents.** Except as provided in section 176.221, subdivision 1, once the employer or insurer has commenced payment of benefits, the employer may not discontinue payment of compensation until it provides the employee with notice in writing of intention to do so. A copy of the notice shall be filed with the division by the employer or insurer. The notice to the employee and the copy to the division shall state the date of intended discontinuance and set forth a statement of facts clearly indicating the reason for the action. Copies of whatever medical reports or other written reports in the employer's or insurer's possession which are relied on for the discontinuance shall be attached to the notice.

Subd. 2. **Liability for compensation; discontinuance.** (a) If the reason for discontinuance is that the employee has returned to work, temporary total compensation may be discontinued effective the day the employee returned to work. Written notice shall be served on the employee and filed with the division within 14 days of the date the employer or insurer has notice that the employee has returned to work.

(b) If the reason for the discontinuance is for other than that the employee has returned to work, the liability of the employer or insurer to make payments of compensation continues until the copy of the notice and reports have been filed with the division. When the division has received a copy of the notice of discontinuance, the statement of facts and available medical reports, the duty of the employer or insurer to pay compensation is suspended, except as provided in the following subdivisions and in section 176.239.

Subd. 3. **Interim administrative decision.** An employee may request the office to schedule an administrative discontinuance conference to obtain an expedited interim decision concerning the discontinuance of compensation. Procedures relating to discontinuance conferences are set forth in section 176.239.

Subd. 4. **Objection to discontinuance.** An employee may serve on the employer and insurer and file with the office an objection to discontinuance if:

(1) the employee elects not to request an administrative conference under section 176.239;

(2) if the employee fails to timely proceed under that section;

(3) if the discontinuance is not governed by that section; or

(4) if the employee disagrees with the interim administrative decision issued under that section. Within ten calendar days after receipt of an objection to discontinuance, the office shall schedule the matter for a de novo hearing before a compensation judge to determine the right of the employee to further compensation.

Subd. 5. **Petition to discontinue.** Instead of filing a notice of discontinuance, an employer or insurer may serve on the employee and file with the office a petition to discontinue compensation. A petition to discontinue compensation may also be used when the employer or insurer disagrees with the interim administrative decision under section 176.239. Within ten calendar days after receipt of a petition to discontinue, the office shall schedule the matter for a de novo hearing before a compensation judge to determine the right of the employer or insurer to discontinue compensation.

The petition shall include copies of medical reports or other written reports or evidence in the possession of the employer or insurer bearing on the physical condition or other present status of the employee which relate to the proposed discontinuance. The employer or insurer shall continue payment of compensation until the filing of the decision of the compensation judge and thereafter as the compensation judge, court of appeals, or the supreme court directs, unless, during the interim, occurrences arise justifying the filing of a notice under subdivision 1 or 2 and the discontinuance is permitted by the commissioner's order or no conference under section 176.239 is requested.

Subd. 6. **Expedited hearing before compensation judge.** (a) A hearing before a compensation judge shall be held within 60 calendar days after the filing of the objection to discontinuance or petition to discontinue if:

(1) an objection to discontinuance has been filed under subdivision 4 within 60 calendar days after the notice of discontinuance was filed and where no administrative conference has been held;

(2) an objection to discontinuance has been filed under subdivision 4 within 60 calendar days after an interim administrative decision under this section has been issued;

(3) a petition to discontinue has been filed by the employer or insurer in lieu of filing a notice of discontinuance; or

(4) a petition to discontinue has been filed within 60 calendar days after the interim administrative decision under this section has been issued.

(b) If the petition or objection is filed later than the deadlines listed above, the expedited procedures in this section apply only where the employee is unemployed at the time of filing the objection and shows, to the satisfaction of the chief administrative law judge, by sworn affidavit, that the failure to file the objection within the deadlines was due to some infirmity or incapacity of the employee or to circumstances that are beyond the employee's control. The hearing shall be limited to the issues raised by the notice or petition unless all parties agree to expanding the issues. If the issues are expanded, the time limits for hearing and issuance of a decision by the compensation judge under this subdivision shall not apply.

(c) Once a hearing date has been set, a continuance of the hearing date will be granted only under the following circumstances:

(1) the employer or insurer has agreed, in writing, to a continuation of the payment of benefits pending the outcome of the hearing; or

(2) the employee has agreed, in a document signed by the employee, that benefits may be discontinued pending the outcome of the hearing.

(d) Absent a clear showing of surprise at the hearing or the unexpected unavailability of a crucial witness, all evidence must be introduced at the hearing. If it is necessary to accept additional evidence or testimony after the scheduled hearing date, it must be submitted no later than 14 days following the hearing, unless the compensation judge, for good cause, determines otherwise.

(e) When a compensation judge issued the interim administrative decision, the de novo hearing under paragraph (a), clauses (2) and (4), must be held before a compensation judge other than the compensation judge who presided over the administrative conference. The compensation judge shall issue a decision pursuant to this subdivision within 30 days following the close of the hearing record.

Subd. 7. **Order of compensation judge.** If the order of the compensation judge confirms a discontinuance of compensation, the service and filing of the order relieves the employer and insurer from further liability for compensation subject to the right of review provided by this chapter, and to the right of the compensation judge to set aside the order at any time prior to the review and to grant a new hearing pursuant to this chapter. Once an appeal to the Workers' Compensation Court of Appeals is filed, a compensation judge may not set aside the order. In any appeal from the compensation judge's decision under this section, the court of appeals shall conclude any oral arguments by the parties within 60 days following certification of the record from the office.

Subd. 8. **Notice forms.** Notices under this section shall be on forms prescribed by the commissioner.

Subd. 9. **Service on attorney.** If the employee has been presently represented by an attorney for the same injury, all notices required by this section shall also be served on the last attorney of record.

Subd. 10. **Fines; violation.** An employer or insurer who violates requirements set forth in this section or section 176.239 is subject to a fine of up to $2,500 for each violation payable to the commissioner for deposit in the assigned risk safety account.

Subd. 11. **Application of section.** This section shall not apply to those employees who have been adjudicated permanently totally disabled, or to those employees who have been administratively determined pursuant to division rules to be permanently totally disabled.

History: *1987 c 332 s 65; 1995 c 231 art 2 s 90,91; 2001 c 123 s 22; 2005 c 90 s 18; 2011 c 89 s 15,22; 2024 c 97 s 19-26*

DISCONTINUANCE OF BENEFITS

176.239 ADMINISTRATIVE DECISION CONCERNING DISCONTINUANCE OF COMPENSATION.

Subdivision 1. **Purpose.** The purpose of this section is to provide a procedure for parties to obtain an expedited interim administrative decision in disputes over discontinuance of temporary total, temporary partial, or permanent total compensation.

Subd. 2. **Request for administrative conference.** If the employee disagrees with the notice of discontinuance, the employee may request that the office schedule an administrative conference to be conducted pursuant to this section.

If temporary total, temporary partial, or permanent total compensation has been discontinued because the employee has returned to work, and the employee believes benefits should be reinstated due to occurrences during the initial 14 calendar days of the employee's return to work, the employee's request must be received by the office within 30 calendar days after the employee has returned to work. If the employer has failed to properly serve and file the notice as provided in section 176.238, the employee's time period to request an administrative conference is extended up to and including the 40th calendar day subsequent to the return to work.

If temporary total, temporary partial, or permanent total compensation has been discontinued for a reason other than a return to work, the employee's request must be received by the office within 12 calendar days after the notice of discontinuance is received by the commissioner. If the employer discontinues compensation without giving notice as required by section 176.238, the employee's time period for requesting an

administrative conference is extended up to and including the 40th calendar day after which the notice should have been served and filed.

The office may determine that an administrative conference is not necessary under this section for reasons prescribed by rule and permit the employer to discontinue compensation, subject to the employee's right to file an objection to discontinuance under section 176.238, subdivision 4.

In lieu of making a written request for an administrative conference with the office, an employee may make an in-person or telephone request for the administrative conference.

Subd. 3. **Payment through date of discontinuance conference.** (a) If a notice of discontinuance has been served and filed due to the employee's return to work, and the employee requests a conference, the employer is not obligated to reinstate or otherwise pay temporary total, temporary partial, or permanent total compensation unless so ordered by the compensation judge.

(b) When an administrative conference is conducted under circumstances in which the employee has not returned to work, compensation shall be paid through the date of the administrative conference unless:

(1) the employee has returned to work since the notice was filed;

(2) the employee fails to appear at the scheduled administrative conference; or

(3) due to unusual circumstances or pursuant to the rules of the division, the compensation judge orders otherwise.

Subd. 4. **Scheduling of conference.** If the employee timely requests an administrative conference under this section, the office shall schedule a conference within ten calendar days after receiving the request.

Subd. 5. **Continuances.** An employee or employer may request a continuance of a scheduled administrative conference. If the compensation judge determines there is good cause for a continuance, the compensation judge may grant the continuance for not more than 14 calendar days unless the parties agree to a longer continuance. If compensation is payable through the day of the administrative conference pursuant to subdivision 3, and the employee is granted a continuance, compensation need not be paid during the period of continuance unless the compensation judge orders otherwise. If the employer is granted a continuance and compensation is payable through the day of the administrative conference pursuant to subdivision 3, then compensation shall continue to be paid during the continuance. The compensation judge may grant an unlimited number of continuances provided that payment of compensation during any continuance is subject to this subdivision.

Subd. 6. **Scope of the administrative decision.** If benefits have been discontinued due to the employee's return to work, the compensation judge shall determine whether, as a result of occurrences arising during the initial 14 calendar days after the return to work, the employee is entitled to additional payment of temporary total, temporary partial, or permanent total compensation.

If periodic payment of temporary total, temporary partial, or permanent total compensation has been discontinued for reasons other than a return to work, the compensation judge shall determine whether the employer has reasonable grounds to support the discontinuance. Only reasons specified on the notice of discontinuance shall provide a basis for a discontinuance, unless the parties agree otherwise.

Subd. 7. **Interim administrative decision.** After considering the information provided by the parties at the administrative conference and exhibits filed by the parties with the office, the compensation judge shall issue to all interested parties a written decision on payment of compensation. Administrative decisions

under this section shall be issued within five working days from the close of the conference. Disputed issues of fact shall be determined by a preponderance of the evidence.

Subd. 8. **Disagreement with administrative decision.** An employee who disagrees with the interim administrative decision under this section may file an objection to discontinuance under section 176.238, subdivision 4. An employer who disagrees with the interim administrative decision under this section may file a petition to discontinue under section 176.238, subdivision 5.

Subd. 9. **Administrative decision binding; effect of subsequent determinations.** The interim administrative decision under this section is binding upon the parties and the rights and obligations of the parties are governed by the decision.

If an objection or a petition is filed under subdivision 8, the interim administrative decision remains in effect and the parties' obligations or rights to pay or receive compensation are governed by the interim administrative decision, pending a determination by a compensation judge pursuant to section 176.238, subdivision 6.

If the discontinuance has been denied, the employer shall continue paying compensation until an order is issued by a compensation judge, the court of appeals, or the supreme court, allowing compensation to be discontinued, or unless, during the interim, occurrences arise justifying the filing of a notice under section 176.238, subdivision 1 or 2, and the discontinuance is permitted by the compensation judge or no conference is requested. If a compensation judge after a de novo hearing, the court of appeals, or the supreme court later rules that the discontinuance was proper or that benefits were otherwise not owing the employee, payments made under the interim administrative decision and order shall be treated as an overpayment which the insurer may recover from the employee subject to section 176.179.

If the compensation judge has permitted a discontinuance or otherwise not ordered commencement of benefits, the service and filing of the administrative decision relieves the employer from further liability for compensation subject to the right of review afforded by this chapter.

Subd. 10. **Application of section.** This section is applicable to all cases in which the employee's request for an administrative conference is received by the office after July 1, 1987, even if the injury occurred prior to July 1, 1987. This section shall not apply to those employees who have been adjudicated permanently totally disabled, or to those employees who have been administratively determined pursuant to division rules to be permanently totally disabled.

History: *1987 c 332 s 66; 2011 c 89 s 22; 2023 c 51 art 2 s 6,7; 2024 c 97 s 27-34*

176.24 [Repealed, 1953 c 755 s 83]

176.241 [Repealed, 1987 c 332 s 117]

176.242 [Repealed, 1987 c 332 s 117]

176.2421 [Repealed, 1987 c 332 s 117]

176.243 [Repealed, 1987 c 332 s 117]

176.244 [Repealed, 1987 c 332 s 117]

RECEIPTS

176.245 RECEIPTS FOR PAYMENT OF COMPENSATION, FILING.

An employer shall promptly file with the division receipts for payment of compensation as may be required by the rules of the division.

The commissioner of the Department of Labor and Industry shall periodically check its records to determine whether these receipts have been promptly filed, and if not, shall require the employer to do so. The commissioner may determine the most efficient manner of reviewing or auditing the records filed under this chapter, including using sampling methodology, to determine compliance with this chapter.

History: *1953 c 755 s 35; 1973 c 388 s 80; 2008 c 250 s 13; 2013 c 70 art 1 s 6*

176.25 [Repealed, 1953 c 755 s 83]

DUTIES

176.251 DUTIES OF COMMISSIONER OF DEPARTMENT OF LABOR AND INDUSTRY.

The commissioner of the Department of Labor and Industry shall actually supervise and require prompt and full compliance with all provisions of this chapter relating to the payment of compensation.

History: *1953 c 755 s 36; 1973 c 388 s 81*

176.253 INSURER, EMPLOYER, AND THIRD-PARTY ADMINISTRATOR; PERFORMANCE OF ACTS.

Subdivision 1. **Definitions.** (a) The terms used in this section have the meanings given to them in this subdivision.

(b) "Department" has the meaning in section 176.011, subdivision 8b.

(c) "Employer" means an employer as defined in section 176.011, subdivision 10, against whom a workers' compensation claim has been asserted or who is liable for a workers' compensation injury under this chapter. Employer includes:

(1) an employer authorized to self-insure by the Department of Commerce under chapter 79A; and

(2) the state or a political subdivision that is not required to be authorized to self-insure by the commissioner of commerce in order to pay its workers' compensation claims.

(d) "Insurer" means a workers' compensation insurer licensed by the Department of Commerce under section 60A.

(e) "Third-party administrator" means an administrator that is licensed by the Department of Commerce to administer a workers' compensation self-insurance or insurance plan under section 60A.23, subdivision 8, with a contract to act on behalf of an employer or insurer.

Subd. 2. **General.** Where this chapter requires an employer to perform an act, the insurer of the employer may perform that act. Where the insurer acts on behalf of the employer, the employer is responsible for the authorized acts of the insurer and for any delay, failure, or refusal of the insurer to perform the act. This section does not relieve the employer from any penalty or forfeiture which this chapter imposes on the employer.

Subd. 3. **Authority of third-party administrator.** A third-party administrator that has an active account in CAMPUS under section 176.2612 may act on behalf of the employer or insurer as provided in the contract between the administrator and the employer or insurer. If the department or commissioner issues an order or assesses a penalty against an employer or insurer, the order or penalty must be served on any administrator acting on behalf of the employer or insurer. A third-party administrator has the authority to act on behalf of the employer or insurer in responding to a commissioner or department inquiry, order or penalty assessment, or paying a penalty, until the insurer or administrator notifies the department in writing that the administrator does not have authority.

History: *1953 c 755 s 37; 1986 c 444; 1Sp2019 c 7 art 12 s 7; 2024 c 97 s 35*

176.255 [Repealed, 1953 c 755 s 83]

176.26 [Repealed, 1953 c 755 s 83]

176.261 EMPLOYEE OF COMMISSIONER OF DEPARTMENT OF LABOR AND INDUSTRY MAY ACT FOR AND ADVISE A PARTY TO A PROCEEDING.

When requested by an employer or an employee or an employee's dependent, the commissioner of the Department of Labor and Industry may designate one or more of the division employees to advise that party of rights under this chapter, and as far as possible to assist in adjusting differences between the parties. The person so designated may appear in person in any proceedings under this chapter as the representative or adviser of the party. In such case, the party need not be represented by an attorney at law.

Prior to advising an employee or employer to seek assistance outside of the department, the department must refer employers and employees seeking advice or requesting assistance in resolving a dispute to an attorney or other technical, paraprofessional, or professional Workers' Compensation Division employee, whichever is appropriate.

The department must make efforts to settle problems of employees and employers by contacting third parties, including attorneys, insurers, and health care providers, on behalf of employers and employees and using the department's persuasion to settle issues quickly and cooperatively. The obligation to make efforts to settle problems exists whether or not a formal claim has been filed with the department.

History: *1953 c 755 s 38; Ex1967 c 1 s 6; 1973 c 388 s 82; 1986 c 444; 1992 c 510 art 3 s 29; 1995 c 231 art 2 s 92; 1996 c 374 s 7*

176.2611 COORDINATION OF THE OFFICE OF ADMINISTRATIVE HEARINGS' CASE MANAGEMENT SYSTEM AND THE WORKERS' COMPENSATION IMAGING SYSTEM.

Subdivision 1. **Definitions.** (a) For purposes of this section, the definitions in this subdivision apply unless otherwise specified.

(b) "Commissioner" means the commissioner of labor and industry.

(c) "Department" means the Department of Labor and Industry.

(d) "Document" includes all data, whether in electronic or paper format, that is filed with or issued by the office or department related to a claim-specific dispute resolution proceeding under this section.

(e) "Office" means the Office of Administrative Hearings.

Subd. 2. **Applicability.** Subject to further amendments pursuant to section 176.2612, subdivision 2, this section specifies whether documents must be filed with the office or the commissioner, and governs access to dispute-related documents and data at the office or department. This section prevails over any conflicting provision in this chapter, Laws 1998, chapter 366, or corresponding rules.

Subd. 3. **Documents that must be filed with the office.** Except as provided in subdivision 4 and section 176.421, all documents that require action by the office under this chapter must be filed, electronically or in paper format, with the office as required by the chief administrative law judge. Filing a document that initiates or is filed in preparation for a proceeding at the office satisfies any requirement under this chapter that the document must be filed with the commissioner.

Subd. 4. **Documents that must be filed with the commissioner.** (a) The following documents must be filed directly with the commissioner in the format and manner prescribed by the commissioner:

(1) all requests for an administrative conference under section 176.106, regardless of the amount in dispute;

(2) a motion to intervene in an administrative conference that is pending at the department;

(3) any other document related to an administrative conference that is pending at the department;

(4) an objection to a penalty assessed by the commissioner or the department;

(5) requests for medical and rehabilitation dispute certification under section 176.081, subdivision 1, paragraph (c), including related documents; and

(6) except as provided in this subdivision or subdivision 3, any other document required to be filed with the commissioner.

(b) The filing requirement in paragraph (a), clause (1), makes no changes to the jurisdictional provisions in section 176.106. A claim petition that contains only medical or rehabilitation issues, unless primary liability is disputed, is considered to be a request for an administrative conference and must be filed with the commissioner.

(c) The commissioner must refer a timely, unresolved objection to a penalty under paragraph (a), clause (4), to the office within 60 calendar days.

Subd. 5. **Form revision and access to documents and data.** (a) The commissioner must revise dispute resolution forms, in consultation with the chief administrative law judge, to reflect the filing requirements in this section.

(b) Until August 31, 2020, the office must send the department all documents that are accepted for filing or issued by the office. The office must send the documents to the department, electronically or by courier, within two business days of when the documents are accepted for filing or issued by the office. Beginning August 31, 2020, all dispute-related documents accepted for filing or issued by the office, and all dispute-related documents filed with the department that are referred to the office under section 176.106, must be immediately transmitted between the office's case management system and CAMPUS using application programming interfaces.

Subd. 6. **Data privacy.** (a) All documents filed with or issued by the office under this chapter are private data on individuals and nonpublic data pursuant to chapter 13, except that the documents are available to the following:

(1) the office;

(2) the department;

(3) the employer;

(4) the insurer;

(5) the employee;

(6) the dependent of a deceased employee;

(7) an intervenor in the dispute;

(8) the attorney to a party in the dispute;

(9) a person who furnishes written authorization from the employer, insurer, employee, or dependent of a deceased employee; and

(10) a person, agency, or other entity allowed access to the documents under this chapter or other law.

Once a document filed with or issued by the office under this chapter is transmitted to the commissioner under subdivision 5 or section 176.281, access to the document in the division file is as provided in section 176.231.

(b) The office and department may post notice of scheduled proceedings on the agencies' websites and at their principal places of business in any manner that protects the employee's identifying information. Identifying information includes the employee's name or any part of the employee's name.

Subd. 7. **Workers' Compensation Court of Appeals.** The Workers' Compensation Court of Appeals has authority to amend its rules of procedure to reflect electronic filing with the office under this section for purposes of section 176.421, subdivision 5, and to allow electronic filing with the court under section 176.285. Section 14.125 does not apply to the agency's rulemaking authority under this section and sections 176.281, paragraph (d), and 176.285, subdivision 2a.

History: *2018 c 185 art 1 s 4; 1Sp2019 c 7 art 12 s 8-10; 7Sp2020 c 1 art 2 s 17; 2024 c 97 s 36*

176.2612 WORKERS' COMPENSATION CLAIMS ACCESS AND MANAGEMENT PLATFORM USER SYSTEM (CAMPUS).

Subdivision 1. **Requirements.** (a) The commissioner shall maintain the workers' compensation Claims Access and Management Platform User System (CAMPUS) as defined in section 176.011, subdivision 1d. This section applies to the department and the Workers' Compensation Court of Appeals. Except for paragraph (b), clause (4), this subdivision does not apply to the office.

(b) CAMPUS must:

(1) provide a single filing system for users to electronically file documents required or authorized to be filed under this chapter with the commissioner or the Workers' Compensation Court of Appeals;

(2) maintain and retain the division file and other claim-related documents;

(3) accept filings by electronic data entry and by uploaded images of supplemental documents, such as a medical or narrative report or document;

(4) electronically and securely transmit data, and images of documents, between each agency to allow the agency to perform its statutory functions;

(5) electronically and securely serve documents;

(6) organize electronic data filed in the division file into an image for viewing or printing by parties to a claim and staff at each agency;

(7) provide electronic access to the division file by parties and each agency to workers' compensation documents and other data as authorized or required by this chapter and generate an audit trail when the division file is accessed by a person; and

(8) allow authorized stakeholders, the department, and the Workers' Compensation Court of Appeals to manage and monitor claims and perform statutorily required functions.

Subd. 2. **Plan and proposal for improvement.** By January 11, 2021, the commissioner must recommend to the Workers' Compensation Advisory Council a plan and proposed statutory amendments for the most effective means, based on an assessment of benefits and value, to implement improvements to CAMPUS and the case management system at the office, including ensuring a single calendaring system and a single filing system. The filing requirements in section 176.2611, subdivisions 3 and 4, remain in effect until further amendments related to a single filing system in CAMPUS are enacted pursuant to the recommendations of the Workers' Compensation Advisory Council.

Subd. 3. **Creating a CAMPUS account.** (a) For purposes of this subdivision, "employer," "insurer," and "third-party administrator" have the meanings given in section 176.253, subdivision 1.

(b) Electronic access to view or file documents in CAMPUS shall be granted according to the requirements established by the department and the Department of Information Technology Services to authenticate the identity of the person or entity creating the account and authorize access to the documents that the person or entity is entitled to under this chapter. To create an account in CAMPUS, a person must provide the commissioner of labor and industry with information needed to create the account and authenticate the person's identity. The person must also agree to terms and conditions that are needed to safeguard the security and privacy of data and comply with the requirements of this chapter related to CAMPUS.

(c) The persons or entities in clauses (1) to (12) must create and maintain an account in CAMPUS to electronically access or file documents:

(1) an employee with a workers' compensation claim or other person who has access to the division file under section 176.231, subdivision 9, paragraph (c);

(2) an employer with a workers' compensation claim;

(3) a licensed workers' compensation insurer acting on behalf of an employer with a Minnesota workers' compensation claim;

(4) an intervenor or potential intervenor in a workers' compensation dispute;

(5) a registered rehabilitation provider under section 176.102;

(6) the state or a political subdivision or school district that is not required to be self-insured by the commissioner of the Department of Commerce in order to pay its workers' compensation claims;

(7) the assigned risk plan under chapter 79A;

(8) the Workers' Compensation Reinsurance Association under chapter 79;

(9) the Minnesota insurance guaranty association established under chapter 60C;

(10) the self-insurers' security fund under chapter 79A;

(11) a third-party administrator that has contracted to act on behalf of any of the entities listed in this subdivision; and

(12) an attorney representing a person or entity listed above.

(d) The commissioner may require that any person or entity listed in paragraph (c), clauses (2) to (12), create and maintain an account in CAMPUS if the person or entity is a party to a workers' compensation claim or associated with an enforcement action of the department.

(e) A designated medical contact under section 176.135 and a managed care organization certified by the department under section 176.1351 must create and maintain an account to file and view documents related to the certified managed care plan or designated medical contact. A program administrator for a collective bargaining agreement approved by the commissioner under section 176.1812 must create an account to view documents related to a claim that is covered by the agreement. A health care provider must create an account to file a request for an administrative conference if permitted under section 176.136, subdivision 2.

(f) If a person or entity is required to create and maintain an account under this subdivision and fails to do so:

(1) unless good cause is shown, the commissioner may assess a $500 penalty against the person or entity for each 30-day period that an account is not created or maintained following the commissioner's notice that one is required;

(2) failure to create or maintain an account shall not be a defense to untimely filing where electronic filing is required under this chapter; and

(3) failure to create or maintain an account results in the appointment of the commissioner and successors in office as the person's agent to receive service by the commissioner or the Workers' Compensation Court of Appeals where service is required under this chapter, provided that the commissioner attempts service by United States mail on the party at the last known address.

History: *1Sp2019 c 7 art 12 s 11; 7Sp2020 c 1 art 2 s 18,19; 2021 c 31 art 2 s 16; 2022 c 32 art 1 s 3*

176.2615 [Repealed, 2014 c 182 s 8]

176.262 [Repealed, 1983 c 290 s 173]

176.265 [Repealed, 1986 c 461 s 37]

176.27 [Repealed, 1953 c 755 s 83]

PROCEDURE

176.271 INITIATION OF PROCEEDINGS.

Subdivision 1. **Written petition.** Unless otherwise provided by this chapter or by the commissioner, all proceedings under this chapter are initiated by the filing of a written petition on a prescribed form with the department or office. All claim petitions shall include the information required by section 176.291.

Subd. 2. [Repealed, 1987 c 332 s 117]

History: *1953 c 755 s 40; Ex1967 c 1 s 6; 1973 c 388 s 84; Ex1979 c 3 s 58; 1984 c 432 art 2 s 43; 1986 c 444; 1987 c 332 s 67; 2024 c 97 s 37*

176.275 FILING OF PAPERS; PROOF OF SERVICE.

Subdivision 1. **Filing.** If a document is required to be filed by this chapter or any rules adopted pursuant to authority granted by this chapter, the filing shall be completed upon acceptance of the document by the agency. Any document that lacks information required by statute or rule, or is not filed in the manner and format required by this chapter, may be rejected. A document rejected for any of these reasons is not considered filed. An agency is not required to maintain, and may destroy, a duplicate of a document that has already been filed. If a workers' compensation identification number has been assigned by the department, it must be substituted for the Social Security number on a document. The commissioner may request additional proof of an injured worker's identity before assigning an identification number.

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

Subd. 2. **Proof of service; affidavits and notarized statements.** (a) Whenever a provision of this chapter or rules adopted pursuant to authority granted by this chapter require either a proof of service, an affidavit of service, or a notarized statement on a document, the requirement is satisfied by a document that meets the definition of an affidavit under Rule 15 of the General Rules of Practice for the district courts.

(b) An agency is not required to verify the accuracy of a proof or affidavit of service filed by a party before accepting a document for filing. This does not prevent a party from asserting insufficient or lack of service in a proceeding.

(c) Service on a party's attorney constitutes service on the represented party, unless service on the employee is specifically required by this chapter.

(d) A party is not required to file a proof or affidavit of service of a document on a person when the party uses the agency's electronic system to serve the person.

(e) A party to a claim who uses an agency's electronic system to (1) improperly file a document that is unrelated to the workers' compensation claim in which the document was filed, or (2) send or serve a document on a recipient who is not entitled to receive it under this chapter must, upon discovery or notification of the improper release, promptly notify the recipient, the agency, and the subject whose data was improperly released. The agency whose electronic system was used to send, serve, or file the document is not responsible

under section 3.971 and chapter 13 for the improper release, but must promptly correct its files or remove the document from its electronic system upon discovery or notification.

History: *1953 c 755 s 41; Ex1967 c 1 s 6; 1973 c 388 s 85; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1986 c 444; 1987 c 332 s 68; 1995 c 231 art 2 s 94; 2008 c 250 s 14; 2017 c 94 art 3 s 4; 1Sp2019 c 7 art 12 s 12; 7Sp2020 c 1 art 2 s 20; 2024 c 97 s 38*

176.28 [Repealed, 1953 c 755 s 83]

176.281 ORDERS, DECISIONS, AND AWARDS; FILING; SERVICE.

(a) When the commissioner or compensation judge or Office of Administrative Hearings or the Workers' Compensation Court of Appeals has issued correspondence, a notice, order, decision, award, or other disposition or outcome of a dispute, or an amendment to an order, decision, or award, it shall be filed immediately with the commissioner.

(b) The agencies' systems must be configured so that transmission of data and documents described in paragraph (a) and section 176.2611, subdivision 5, paragraph (b), are immediately transmitted between the Office of Administrative Hearings case management system and CAMPUS using application programming interfaces.

(c) If the commissioner, compensation judge, Office of Administrative Hearings, or Workers' Compensation Court of Appeals has rendered a final order, decision, or award, or amendment thereto, the commissioner or the Office of Administrative Hearings or the Workers' Compensation Court of Appeals shall immediately serve a copy upon every party in interest, together with a notification of the date the order was filed.

(d) On all orders, decisions, awards, and other documents, the commissioner or compensation judge or Office of Administrative Hearings or the Workers' Compensation Court of Appeals may digitize the signatures of all officials, including judges, for the use of electronic data interchange and clerical automation. These signatures shall have the same legal authority of an original signature, provided that proper security is used to safeguard the use of the digitized signatures and each digitized signature has been certified by the division, department, office, or court of appeals before its use, in accordance with rules adopted by that agency or court.

History: *1953 c 755 s 42; 1969 c 276 s 2; 1973 c 388 s 86; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1982 c 405 s 1; 1983 c 290 s 142; 1995 c 231 art 2 s 95; 1Sp2019 c 7 art 12 s 13*

176.285 SERVICE OF PAPERS AND NOTICES; ELECTRONIC FILING.

Subdivision 1. **Service by mail.** Service of documents shall be by first class United States mail or personal service, except where electronic service is authorized or required under this section and section 176.275. An employee cannot be required to accept electronic service where service on the employee is required. Where service is by mail, service is effected at the time mailed if properly addressed and stamped. If it is so mailed, it is presumed the paper or notice reached the party to be served. However, a party may show by competent evidence that that party did not receive it or that it had been delayed in transit for an unusual or unreasonable period of time. In case of nonreceipt or delay, an allowance shall be made for the party's failure to assert a right within the prescribed time.

Subd. 2. **Electronic service and filing on an agency.** (a) Where a statute or rule authorizes or requires a document to be filed with or served on the office, the document must be filed electronically in the manner and in the format specified by the office. Where a statute or rule authorizes or requires a document to be

filed with or served on the commissioner or the Workers' Compensation Court of Appeals, the document must be filed electronically in the manner and format specified by the commissioner. An employee must not be required to file a document electronically at any agency unless the document is filed by an attorney on behalf of the employee.

(b) If electronic filing of a document is required under this subdivision and a statute or rule requires a copy of the document to be provided or served on another person or party, the document filed electronically with the agency and provided or served on the other person or party must contain the same information in the format required by the agency.

(c) For purposes of serving on and filing with an agency under this chapter, "electronic" and "electronically" excludes facsimile and email unless authorized by the agency. A document is deemed filed with an agency on the business day it is accepted for filing on or before 11:59 p.m.

Subd. 2a. **Electronic signatures.** (a) Where a statute or rule authorizes or requires a person's signature on a document to be filed with or served on an agency, the signature may be an electronic signature, as defined by section 325L.02, or transmitted electronically, if authorized by the agency and if the signature is transmitted in the manner and format specified by the agency. The commissioner may require that a document authorized or required to be filed with the commissioner, department, or division be filed electronically in the manner and format specified by the commissioner, except that an employee must not be required to file a document electronically unless the document is filed by an attorney on behalf of an employee. The department, Workers Compensation Court of Appeals, or office may adopt rules for the certification of signatures. Section 14.125 does not apply to the rulemaking authority under this section.

(b) If a rehabilitation provider files a rehabilitation plan or other document that requires the signature of the employee, employer, or insurer pursuant to section 176.102, or rules adopted under section 176.102, the rehabilitation provider shall specify whether each party's signature has been obtained. The rehabilitation provider must retain the document with the original signature or signatures of the employee and insurer or self-insured employer for five years after the rehabilitation plan is closed and must make the signed document available to the commissioner or compensation judge upon request.

Subd. 2b. **Electronic service of documents on party through office case management system or CAMPUS.** (a) The office and a party may electronically serve through the office's case management system a document required to be served on a party or filed with the office on any person with an account in the case management system.

(b) The commissioner, the Workers' Compensation Court of Appeals, and a party may electronically serve through CAMPUS a document required to be served on a party or filed with the commissioner on any person with an account in CAMPUS under section 176.2612. Service through CAMPUS must be either by secure email or by emailing a notice that the document may be accessed through a web portal. Service of a document through CAMPUS on an attorney for a party is considered to be service on the party, except where service on the employee is specifically required by this chapter.

(c) An employee must not be electronically served unless the employee has created an account and has agreed to accept electronic service through the office's case management system or CAMPUS.

(d) The date of electronic service of a document is the date the recipient is sent a document electronically, or the date the recipient is notified that the document is available on a website, whichever occurs first.

Subd. 2c. **Time to assert right when document served or filed electronically.** When the electronic filing of a legal document with an agency marks the beginning of a prescribed time for another party to

assert a right, the prescribed time for another party to assert a right shall be extended by two calendar days when it can be shown that service to another party was by United States mail, and extended by one business day if the document was electronically served on the party in CAMPUS or the office's case management system after 4:30 p.m.

Subd. 3. **Proof of service of documents served by parties and agencies.** (a) The commissioner, the chief administrative law judge, and the chief judge of the Workers' Compensation Court of Appeals shall ensure that proof of service of all papers and notices served by their respective agencies is transmitted to the division file in the manner described in section 176.281.

(b) If a document unrelated to a dispute, such as a first report of injury, is required to be filed with the commissioner and required to be served on the employee or other party, the serving party must retain the proof of service and provide it to the commissioner or compensation judge upon request.

Subd. 4. **Definitions; applicability.** (a) For purposes of this section, "payer" means a workers' compensation insurer, self-insurer employer, or third-party administrator.

(b) Except as otherwise modified by this chapter, the provisions of chapter 325L apply to electronic signatures and the electronic transmission of documents under this chapter.

History: *1953 c 755 s 43; 1973 c 388 s 87; 1983 c 290 s 143; 1984 c 640 s 32; 1995 c 231 art 2 s 96; 2008 c 250 s 15; 2017 c 94 art 3 s 5; 1Sp2019 c 7 art 12 s 14; 7Sp2020 c 1 art 2 s 21; 2024 c 97 s 39-41*

176.29 [Repealed, 1953 c 755 s 83]

176.291 DISPUTES; PETITIONS; PROCEDURE.

(a) Where there is a dispute as to a question of law or fact in connection with a claim for compensation, a party may serve on all other parties and file a petition with the office stating the matter in dispute. The petition shall be on a form prescribed by the commissioner and shall be signed by the petitioner.

(b) The petition shall also state and include, where applicable:

(1) names and residence or business address of parties;

(2) facts relating to the employment at the time of injury, including amount of wages received;

(3) extent and character of each injury;

(4) notice to or knowledge by employer of injury;

(5) copies of written medical reports or medical records supporting each claim asserted;

(6) copies of other information in support of the claim;

(7) names and addresses of all known witnesses intended to be called in support of each injury and claim;

(8) the desired location of any hearing and estimated time needed to present evidence at the hearing;

(9) any requests for a prehearing or settlement conference;

(10) a list of all known third parties, including the Departments of Human Services and Employment and Economic Development, who may have paid any medical bills or other benefits to the employee for the

injuries or disease alleged in the petition or for the time the employee was unable to work due to the injuries or disease, together with a listing of the amounts paid by each;

(11) the nature and extent of each claim; and

(12) a request for an expedited hearing which must include an attached affidavit of significant financial hardship which complies with the requirements of section 176.341, subdivision 6.

(c) Incomplete petitions may be stricken or dismissed from the calendar as provided by section 176.305, subdivision 4. Within 14 days of a request by a party, an employee who has filed a claim petition pursuant to section 176.271 or this section shall furnish a list of physicians and health care providers from whom the employee has received treatment for the same or a similar condition as well as authorizations to release relevant information, data, and records to the requester. The petition may be stricken from the calendar upon motion of a party for failure to timely provide the required list of health care providers or authorizations.

History: *1953 c 755 s 44; 1973 c 388 s 88; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 104; 1987 c 332 s 69; 1994 c 483 s 1; 1995 c 231 art 2 s 97; 2004 c 206 s 52; 2022 c 32 art 2 s 2; 2023 c 51 art 2 s 8*

176.295 NONRESIDENT EMPLOYERS; FOREIGN CORPORATION.

Subdivision 1. **Affidavit of inability to effectuate service.** Where a petitioner, an employee, or an employee's dependent cannot serve a petition for compensation or other notice on an employer because the employer is a nonresident or a foreign corporation, the petitioner may file an affidavit with the chief administrative law judge stating that the petitioner is unable to effectuate service.

Subd. 2. **Action in district court.** When a petitioner has filed an affidavit of inability to effectuate service pursuant to subdivision 1 with the chief administrative law judge, the petitioner may also file a complaint against the employer in district court. The complaint must be filed in the county in which the employee resided at the time of the injury or death. The complaint shall be commenced and pursued in the same manner as other civil actions in district court. The complaint shall state that a petition for compensation has been filed with the office, and shall be accompanied by a verified copy of the affidavit of inability to effectuate service. The complaint shall also state the facts upon which the right to compensation or other relief is based.

Subd. 3. **Attachment, garnishment; service by publication.** The remedies of attachment and garnishment are available to the petitioner in the district court action. Service of summons may be made by publication.

Subd. 4. **General appearances; security, bond.** Where the employer makes a general appearance in the district court action and files a bond or security approved by the commissioner of the Department of Labor and Industry, or where an insurer appears generally in the action and assumes liability for any award which may be rendered against the employer, the district court shall dismiss the action.

History: *1953 c 755 s 45; Ex1967 c 1 s 6; 1973 c 388 s 89-91; 1986 c 444; 2022 c 32 art 2 s 3,4*

176.30 [Repealed, 1953 c 755 s 83]

176.301 DETERMINATION OF ISSUES.

Subdivision 1. **Trial by court; reference to chief administrative law judge.** When a workers' compensation issue is present in the district court action, the court may try the action itself without a jury, or refer the matter to the chief administrative law judge for assignment to a compensation judge. The compensation judge shall report findings and decisions to the district court. The court may approve or

disapprove such decision in the same manner as it approves or disapproves the report of a referee. The court shall enter judgment upon such decision.

Subd. 2. **Appeal from judgment of district court.** An appeal lies from the judgment of the district court as in other cases.

History: *1953 c 755 s 46; 1969 c 276 s 2; 1973 c 388 s 92; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 105; 1984 c 640 s 32; 1986 c 444; 1987 c 332 s 70*

176.305 PETITIONS FILED WITH WORKERS' COMPENSATION DIVISION.

Subdivision 1. **Hearings on petitions.** The petitioner shall serve a copy of the petition on each adverse party and file a copy with the office, together with an appropriate affidavit of service. Service and filing must be made as provided under section 176.285, subdivisions 1 and 2.

Subd. 1a. **Settlement and pretrial conferences; summary decision.** The chief administrative law judge shall promptly assign the petition to a compensation judge under section 176.307, and shall schedule a settlement conference before a compensation judge, to be held no later than 180 days after a claim petition was filed, or 45 days after a petition to discontinue, objection to discontinuance, or request for formal hearing was filed.

All parties must appear at the settlement conference, either personally or by representative, must be prepared to discuss settlement of all issues, and must be prepared to discuss or present the information required by the joint rules of the division and the office. If a representative appears on behalf of a party, the representative must have authority to fully settle the matter. The parties shall serve and file a pretrial statement no fewer than five days before the settlement conference.

If settlement is not reached, the chief administrative law judge shall schedule a hearing to be held within 90 days from the scheduled settlement conference. However, the hearing must be held earlier than 90 days from the scheduled settlement conference if this chapter requires an expedited hearing to be held at an earlier date. The hearing must be held before a compensation judge other than the compensation judge who conducted the settlement conference. The compensation judge assigned to hold the hearing may choose to conduct a pretrial conference to clarify the issues and evidence that will be presented at the hearing.

Cancellations and continuations of proceedings are disfavored but may be granted upon the showing of good cause under section 176.341, subdivision 4.

The compensation judge conducting the settlement conference may require the parties to present copies of all documentary evidence not previously filed and a summary of the evidence they will present at a formal hearing. If appropriate, a written summary decision shall be issued within ten days after the conference stating the issues and a determination of each issue. If a party fails to appear at the conference, all issues may be determined contrary to the absent party's interest, provided the party in attendance presents a prima facie case.

The summary decision is final unless a written request for a formal hearing is served on all parties and filed with the commissioner within 30 days after the date of service and filing of the summary decision. Within ten days after receipt of the request, the commissioner shall certify the matter to the office for a de novo hearing.

Subd. 2. MS 2020 [Repealed, 2022 c 32 art 2 s 13]

Subd. 3. **Testimony.** Where the chief administrative law judge has substituted a compensation judge originally assigned to hear a matter, the testimony taken before the substitute compensation judge shall be considered as though taken before the judge before whom it was originally assigned.

Subd. 4. **Striking from calendar.** A compensation judge, after receiving a properly served motion, may strike a case from the active trial calendar after the employee has been given 30 days to correct a deficient petition if it is shown that the information on the petition or included with the petition is incomplete. Once a case is stricken, it may not be reinstated until the missing information is provided to the adverse parties and filed with the compensation judge. If a case has been stricken from the calendar for 180 days or more and no corrective action has been taken, the compensation judge may, upon the judge's own motion or a motion of a party which is properly served on all parties, dismiss the case. The petitioner must be given at least 30 days' advance notice of the proposed dismissal before the dismissal is effective.

History: *1953 c 755 s 47; 1969 c 9 s 45; 1969 c 276 s 2; 1973 c 388 s 93-95; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 106; 1984 c 640 s 32; 1987 c 332 s 71-74; 1995 c 231 art 2 s 98; 1998 c 294 s 4,5; 2011 c 89 s 16,17; 2014 c 182 s 7; 2022 c 32 art 2 s 5,6; 2023 c 51 art 2 s 9; 2024 c 97 s 42*

176.306 SCHEDULED HEARINGS.

Subdivision 1. **Chief administrative law judge.** The chief administrative law judge shall schedule workers' compensation hearings on as regular a schedule as may be practicable in no fewer than six widely separated locations throughout the state, including at least four locations outside of the seven-county metropolitan area and Duluth, for the purpose of providing a convenient forum for parties to a compensation hearing and shall maintain a permanent office in Duluth staffed by at least one compensation judge. Continuances of the scheduled hearing date may be granted only under section 176.341, subdivision 4.

Subd. 2. **District administrators; clerks of court.** The judicial district administrators or the court administrators of the county or district courts nearest to the locations selected by the chief administrative law judge pursuant to subdivision 1 shall provide suitable hearing rooms at the times and places agreed upon for the purpose of conducting workers' compensation hearings.

Subd. 3. **Scheduling matters.** A compensation judge may schedule a pretrial or settlement conference, whether or not a party requests such a conference.

History: *1981 c 346 s 107; 1982 c 424 s 45; 1984 c 640 s 32; 1Sp1986 c 3 art 1 s 82; 1987 c 332 s 75,76*

176.307 COMPENSATION JUDGES; BLOCK SYSTEM.

The chief administrative law judge may assign workers' compensation cases to compensation judges using a block system type of assignment that, among other things, ensures that a case will remain with the same judge from commencement to conclusion, except that the judge must be removed from the case when:

(1) a party exercises a legal right to do so;

(2) the judge is incapacitated or is otherwise unable to hold a hearing; or

(3) assignment of a different judge is required by section 176.106, subdivision 7; 176.238, subdivision 6; or 176.305, subdivision 1a, or the Minnesota Code of Judicial Conduct.

The block system shall be the preferred means of assigning cases, but it may be supplemented by other systems of case assignment to ensure that cases are timely decided.

History: *1992 c 510 art 2 s 8; 2011 c 89 s 18; 2012 c 187 art 1 s 27*

176.31 [Repealed, 1953 c 755 s 83]

176.311 REASSIGNMENT OF PETITION FOR HEARING.

Where a petition is heard before a compensation judge, at any time before an award or order has been made in such proceeding, the chief administrative law judge may reassign the petition for hearing before another compensation judge.

History: *1953 c 755 s 48; 1969 c 276 s 2; 1973 c 388 s 96; 1981 c 346 s 108; 1984 c 640 s 32*

176.312 AFFIDAVITS OF PREJUDICE AND PETITIONS FOR REASSIGNMENT.

In accordance with rules adopted by the chief administrative law judge, an affidavit of prejudice for cause may be filed by each party to the claim against a compensation judge assigned to hear a case.

A petition for reassignment of a case to a different compensation judge for hearing may be filed once, in any case, by each party to the claim within 20 days after the filing party has received notice of the assigned judge. Upon receipt of a timely petition for reassignment, the chief administrative law judge shall assign the case to another judge.

An affidavit of prejudice or a petition for reassignment shall be filed with the chief administrative law judge and shall not result in the continuance or delay of a hearing scheduled under section 176.341.

This section does not apply to prehearing, settlement conferences, or administrative conferences.

History: *1983 c 290 s 144; 1987 c 332 s 77; 1Sp2019 c 7 art 12 s 15*

176.32 [Repealed, 1953 c 755 s 83]

176.321 ANSWER TO PETITION.

Subdivision 1. **Filing, service.** Within 30 days after service of the petition, an adverse party shall serve and file an answer to the petition. The party shall serve a copy of the answer on the petitioner or the petitioner's attorney.

Subd. 2. **Contents.** The answer shall admit, deny, or affirmatively defend against the substantial averments of the petition, and shall state the contention of the adverse party with reference to the matter in dispute.

Each fact alleged by the petition or answer and not specifically denied by the answer or reply is deemed admitted, but the failure to deny such a fact does not preclude the compensation judge from requiring proof of the fact.

The answer shall include the names and addresses of all known witnesses; whether or not the employer intends to schedule an adverse examination and, if known, the date, time, and place of all adverse examinations; the desired location for a hearing; any request for a prehearing or settlement conference; the estimated time needed to present evidence at a hearing; and, if an affidavit of significant financial hardship and request for an expedited hearing are included with the petition, any objection the employer may have to that request. If the date, time, and place of all adverse examinations is unknown at the time the answer is

filed, the employer must notify the office in writing of the date, time, and place of all adverse examinations within 50 days of the filing of the claim petition.

Subd. 3. **Extension of time in which to file answer.** Upon showing of cause, the office may extend the time in which to file an answer or reply for not more than 30 additional days. The time to file an answer or reply may also be extended upon agreement of the petitioner, and provided that the office must be notified in writing by the employer no later than five days beyond the time required for the filing of the answer of the fact that an agreement has been reached, including the length of the extension. Any case received by the office that does not include an answer, written extension order, or written notification of the extension agreement shall be immediately set for pretrial conference and hearing at the first available date under section 176.331.

History: *1953 c 755 s 49; 1969 c 276 s 2; 1973 c 388 s 97; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 109,110; 1983 c 290 s 145; 1987 c 332 s 78,79; 2022 c 32 art 2 s 7,8; 2024 c 97 s 43,44*

176.322 DECISIONS BASED ON STIPULATED FACTS.

If the parties agree to a stipulated set of facts and only legal issues remain, the compensation judge may determine the matter without a hearing based upon the stipulated facts and the determination is appealable to the court of appeals pursuant to sections 176.421 and 176.442. In any case where a stipulated set of facts has been submitted pursuant to this section, upon receipt of the file or the stipulated set of facts the chief administrative law judge shall immediately assign the case to a compensation judge for a determination. The judge shall issue a determination within 60 days after receipt of the stipulated facts.

History: *1987 c 332 s 80; 2024 c 97 s 45*

176.325 CERTIFIED QUESTION.

Subdivision 1. **When certified.** The chief administrative law judge or commissioner may certify a question of workers' compensation law to the supreme court as important and doubtful under the following circumstances:

(1) all parties to the case have stipulated in writing to the facts; and

(2) the issue to be resolved is a question of workers' compensation law that has not been resolved by the Minnesota Supreme Court.

Subd. 2. **Expedited decision.** It is the legislature's intent that the Minnesota Supreme Court resolve the certified question as expeditiously as possible, after compliance by the parties with any requirements of the Minnesota Supreme Court regarding submission of legal memoranda, oral argument, or other matters, and after the participation of amicus curiae, should the Workers' Compensation Court of Appeals or Minnesota Supreme Court consider such participation advisable.

Subd. 3. **Notice.** The commissioner or chief administrative law judge shall notify all persons who request to be notified of a certification under this section.

History: *1992 c 510 art 2 s 9*

176.33 [Repealed, 1953 c 755 s 83]

176.331 PROCEEDINGS WHEN ANSWER NOT FILED.

Except in cases involving multiple employers or multiple insurers, if an adverse party fails to file and serve an answer or obtain an extension from the office or the petitioner as required by section 176.321, subdivision 3, the office shall set the matter for an immediate pretrial conference and hearing for prompt award or other order. The adverse party that failed to file an answer or appear at a pretrial conference may appear at the hearing, present evidence and question witnesses, but shall not be granted a continuance except upon a showing of good cause.

If an adverse party who fails to serve and file an answer is neither insured for workers' compensation liability nor a licensed self-insured as required by section 176.181 and the special compensation fund is a party to the proceeding, the compensation judge may enter an order awarding benefits to the petitioning party without a hearing if so requested by the special compensation fund.

History: *1953 c 755 s 50; 1973 c 388 s 98; 1981 c 346 s 111; 1983 c 290 s 146; 1984 c 640 s 32; 1987 c 332 s 81; 2016 c 110 art 3 s 5; 2022 c 32 art 2 s 9; 2023 c 51 art 2 s 10*

176.34 [Repealed, 1953 c 755 s 83]

176.341 HEARING ON PETITION.

Subdivision 1. **Time.** Upon the filing of a petition, the chief administrative law judge shall fix a time and place for hearing the petition. The hearing shall be held as soon as practicable and at a time and place determined by the chief administrative law judge to be the most convenient for the parties, keeping in mind the intent of chapter 176 and the requirements of section 176.306. Except where a shorter time period is required under this chapter, all hearings must be held within 26 months after a petition has been filed, unless the chief administrative law judge issues an order for a later date for the hearing explaining why the hearing could not be held within 26 months.

Subd. 2. **Place.** Unless otherwise ordered by the chief administrative law judge, the hearing shall be held in the county where the injury or death occurred.

Subd. 3. **Notice mailed to each party.** Unless subdivision 6 applies, at least 30 days prior to the date of hearing, the chief administrative law judge shall mail a notice of the time and place of hearing to each interested party. This subdivision does not apply to hearings which have been continued from an earlier date. In those cases, the notice shall be given in a manner deemed appropriate by the chief administrative law judge after considering the particular circumstances in each case.

Subd. 4. **Continuances.** Only the chief administrative law judge or designee, on a showing of good cause, may grant a continuance of a hearing at the office. Except in cases of emergency or other good cause shown, any request for a continuance must be signed by both the party and the attorney seeking the continuance.

A continuance of a hearing will be granted only upon a showing of good cause. Good cause is established when the underlying eventuality is unforeseen, is not due to lack of preparation, is relevant, is brought to the chief administrative law judge's attention in a timely manner and does not prejudice the adversary.

Continuances will not be granted for the reason that an attorney for one of the parties has scheduled a vacation for the date set for the hearing unless the attorney has, prior to the setting of the hearing date, notified the office of the unavailable dates.

Continuances which are requested during the course of a hearing are subject to the same standards but may be granted or denied by the compensation judge assigned to the hearing. Continuances of prehearing or settlement conferences at the office are subject to the same standards but may be granted or denied by a compensation judge, the calendar judge, or other presiding officer assigned to the prehearing or settlement conference. Cancellation of settlement conferences shall be granted if all parties agree to cancellation.

Subd. 5. **Evidence.** Absent a clear showing of surprise at the hearing or the unexpected unavailability of a crucial witness, all evidence must be submitted at the time of the hearing. Upon a showing of good cause, the compensation judge may grant an extension not to exceed 30 days following the hearing date.

Subd. 6. **Significant financial hardship; expedited hearings.** An employee may file a request for an expedited hearing which must be granted upon a showing of significant financial hardship. In determining whether a significant financial hardship exists, consideration shall be given to whether the employee is presently employed, the employee's income from all sources, the nature and extent of the employee's expenses and debts, whether the employee is the sole support of any dependents, whether either foreclosure of homestead property or repossession of necessary personal property is imminent, and any other matters which have a direct bearing on the employee's ability to provide food, clothing, and shelter for the employee and any dependents.

A request for an expedited hearing must be accompanied by a sworn affidavit of the employee providing facts necessary to satisfy the criteria for a significant financial hardship. The request may be made at the time a claim petition is filed or any time thereafter. Unless the employer objects to the request in the answer to the claim petition or within 30 calendar days of the filing of a request made subsequent to the filing of the claim petition, the affidavit is a sufficient showing of significant financial hardship.

If a request for an expedited hearing has been served and filed, the compensation judge shall grant or deny the request, provided that where the parties agree that significant financial hardship exists or no objection to the request is timely filed, the request is automatically granted. If it is denied, the matter will be returned to the regular calendar of cases and the request for an expedited hearing may be renewed at a settlement conference.

History: *1953 c 755 s 51; 1969 c 276 s 2; 1973 c 388 s 99-101; 1975 c 359 s 23; 1981 c 346 s 112; 1983 c 290 s 147; 1984 c 640 s 32; 1987 c 332 s 82-85; 1998 c 366 s 89; 2009 c 75 s 15; 2011 c 89 s 19; 2022 c 32 art 2 s 10; 2024 c 97 s 46*

176.35 [Repealed, 1953 c 755 s 83]

176.351 TESTIMONIAL POWERS.

Subdivision 1. **Oaths.** The compensation judge to whom a petition has been assigned for hearing shall administer an oath to each witness. The commissioner may also administer an oath when required in the performance of duties.

Subd. 2. **Subpoenas.** Acting with or without the written request of an interested party, the commissioner or compensation judge before whom a hearing is held may issue a subpoena for the attendance of a witness or the production of such books, papers, records and documents as are material in the cause and are designated in the subpoena. The commissioner may also issue a subpoena for the attendance of a witness or the production of such books, papers, records, and documents as are material in the cause pending and are designated in the subpoena.

Subd. 2a. **Subpoenas not permitted of decision makers.** A member of the rehabilitation review panel or Medical Services Board or an employee of the department who has conducted an administrative or

settlement conference or hearing under section 176.106 or 176.239, or who has certified or has declined to certify a dispute under section 176.081, subdivision 1, paragraph (c), shall not be subpoenaed to testify regarding the conference, hearing, dispute certification, or concerning a mediation session. A member of the rehabilitation review panel, Medical Services Board, or an employee of the department may be required to answer written interrogatories limited to the following questions:

(a) Were all statutory and administrative procedural rules adhered to in reaching the decision?

(b) If the answer to question (a) is no, what deviations took place?

(c) Did the person making the decision consider all the information presented prior to rendering a decision?

(d) Did the person making the decision rely on information outside of the information presented at the conference or hearing in making the decision?

(e) If the answer to question (d) is yes, what other information was relied upon in making the decision?

In addition, for a hearing with a compensation judge and with the consent of the compensation judge, an employee of the department who conducted an administrative conference, hearing, or mediation session, may be requested to answer written interrogatories relating to statements made by a party at the prior proceeding. These interrogatories shall be limited to affirming or denying that specific statements were made by a party.

Subd. 2b. **Subpoenas not permitted of department employees who provide assistance.** The commissioner and any employee of the department shall not be subject to a subpoena for purposes of providing expert testimony or describing the nature of assistance or advice provided under this chapter. This prohibition does not apply to: testimony of a department employee in a workers' compensation enforcement proceeding brought by the commissioner; a dispute in which the commissioner or the special compensation fund is a party; or a qualified rehabilitation consultant, qualified rehabilitation consultant intern, or job placement coordinator employed in the department's vocational rehabilitation unit established under section 176.104, who has provided rehabilitation, job placement, or job development services under a rehabilitation plan for an employee with a workers' compensation claim.

Subd. 3. **Advancement of fees and costs.** The person who applies for issuance of a subpoena shall advance the required service and witness fees. The commissioner shall pay for the attendance of witnesses who are subpoenaed by the commissioner. The chief administrative law judge shall pay for the attendance of witnesses who are subpoenaed by a compensation judge. The fees are the same as the service and witness fees in civil actions in district court.

Subd. 4. **Proceedings as for contempt of court.** Where a person does not comply with an order or subpoena, the commissioner or compensation judge concerned, may apply to the district court in the county in which the petition is pending for issuance of an order compelling obedience. Upon such an application, the district court shall compel obedience to the order or subpoena by attachment proceedings as for contempt in the case of disobedience of a similar order or subpoena issued by the district court.

History: *1953 c 755 s 52; Ex1967 c 1 s 6; 1969 c 276 s 2; 1973 c 388 s 102-105; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 113; 1984 c 432 art 2 s 44; 1984 c 640 s 32; 1986 c 444; 1987 c 332 s 86; 2009 c 75 s 16; 2021 c 12 s 11*

176.36 [Repealed, 1953 c 755 s 83]

176.361 INTERVENTION.

Subdivision 1. **Right to intervene.** A person who has an interest in any matter before the Workers' Compensation Court of Appeals, or commissioner, or office such that the person may either gain or lose by an order or decision may intervene in the proceeding by filing a motion in writing stating the facts which show the interest. The commissioner is considered to have an interest and shall be permitted to intervene at the appellate level when a party relies in its claim or defense upon any statute or rule administered by the commissioner, or upon any rule, order, requirement, or agreement issued or made under the statute or rule.

The commissioner may adopt rules, not inconsistent with this section to govern intervention. The Workers' Compensation Court of Appeals shall adopt rules to govern the procedure for intervention in matters before it. The office may adopt rules to govern the procedure for intervention in matters before it.

If the Department of Human Services or the Department of Employment and Economic Development seeks to intervene in any matter before the division, a compensation judge or the Workers' Compensation Court of Appeals, a nonattorney employee of the department, acting at the direction of the staff of the attorney general, may prepare, sign, serve and file motions for intervention and related documents, attend prehearing conferences, and participate in matters before a compensation judge or the Workers' Compensation Court of Appeals. Any other interested party may intervene using a nonattorney and may participate in any proceeding to the same extent an attorney could. This activity shall not be considered to be the unauthorized practice of law. An intervenor represented by a nonattorney shall be deemed to be represented by an attorney for the purposes of the conclusive presumption of section 176.521, subdivision 2.

Subdivisions 3 to 6 do not apply to the following proceedings conducted by the Department of Labor and Industry or the office: mediation proceedings; discontinuance conferences under section 176.239; or administrative conferences under section 176.106.

Subd. 2. **Written motion.** A person desiring to intervene in a workers' compensation case as a party, including but not limited to a health care provider who has rendered services to an employee or an insurer who has paid benefits under section 176.191, shall submit a timely written motion to intervene to the commissioner, the office, or to the court of appeals, whichever is applicable.

(a) The motion must be served on all parties, except for other intervenors, either personally, by first class mail, or by registered mail, return receipt requested. A motion to intervene must be served and filed within 60 days after a potential intervenor has been served with notice of a right to intervene or within 30 days of notice of an administrative conference or expedited hearing. Upon the filing of a timely motion to intervene, the potential intervenor shall be granted intervenor status without the need for an order. Objections to the intervention may be subsequently addressed by a compensation judge. Where a motion to intervene is not timely filed under this section, the potential intervenor interest shall be extinguished and the potential intervenor may not collect, or attempt to collect, the extinguished interest from the employee, employer, insurer, or any government program.

(b) The motion must show how the applicant's legal rights, duties, or privileges may be determined or affected by the case; state the grounds and purposes for which intervention is sought; and indicate the statutory right to intervene. The motion must be accompanied by the following:

(1) an itemization of disability payments showing the period during which the payments were or are being made; the weekly or monthly rate of the payments; and the amount of reimbursement claimed;

(2) a summary of the medical or treatment payments, or rehabilitation services provided by the Vocational Rehabilitation Unit, broken down by creditor, showing the total bill submitted, the period of treatment or rehabilitation covered by that bill, the amount of payment on that bill, and to whom the payment was made;

(3) copies of all medical or treatment bills for which payment is sought;

(4) copies of the work sheets or other information stating how the payments on medical or treatment bills were calculated;

(5) a copy of the relevant policy or contract provisions upon which the claim for reimbursement is based;

(6) the name and telephone number of the person representing the intervenor who has authority to represent the intervenor, including but not limited to the authority to reach a settlement of the issues in dispute;

(7) proof of service or copy of the registered mail receipt evidencing service on all parties except for other intervenors;

(8) at the option of the intervenor, a proposed stipulation which states that all of the payments for which reimbursement is claimed are related to the injury or condition in dispute in the case and that, if the petitioner is successful in proving the compensability of the claim, it is agreed that the sum be reimbursed to the intervenor; and

(9) if represented by an attorney, the name, address, telephone number, and Minnesota Supreme Court license number of the attorney.

Subd. 3. **Stipulation.** If the person filing a timely motion to intervene has included a proposed stipulation, all parties shall either execute and return the signed stipulation to the intervenor who must file it with the division or judge or serve upon the intervenor and all other parties and file with the division specific and detailed objections to any services rendered or payments made by the intervenor which are not conceded to be correct and related to the injury or condition the petitioner has asserted is compensable. If a party has not returned the signed stipulation or filed specific and detailed objections within 30 days of service of the motion to intervene, the intervenor's right to reimbursement for the amount sought is deemed established provided that the petitioner's claim is determined to be compensable. The office may establish procedures for filing objections if a timely motion to intervene is filed less than 30 days before a scheduled hearing.

Subd. 4. **Attendance by intervenor.** A person who has submitted a timely written motion to intervene, as required by subdivision 2, is not required to attend settlement or pretrial conferences or the hearing, unless attendance is ordered by the compensation judge assigned to the case, pursuant to a motion to require the intervenor's attendance filed by a party or as a matter of the judge's discretion. A motion to require attendance must be served and filed at least 20 days before a scheduled proceeding, and the compensation judge must serve and file an order granting or denying the motion at least ten days before a scheduled proceeding. If attendance is ordered, failure of the intervenor to attend a proceeding either in person or, if approved by the compensation judge, by telephone or some other electronic medium, shall result in the denial of the claim for reimbursement except upon a showing of good cause. If attendance has not been ordered, this subdivision does not prohibit an intervenor from attending a conference or hearing in person, or from requesting permission from the compensation judge to attend a conference or hearing by telephone or other electronic medium.

Subd. 5. **Objections.** If a specific and detailed objection to intervention remains following settlement or pretrial conferences, the issue shall be addressed at the hearing. If the intervenor has not been ordered to attend the hearing pursuant to subdivision 4, or has received permission to attend the hearing by telephone

or other electronic medium, the intervenor may provide a written response to the objection before the hearing according to subdivision 6 for consideration as a matter of discretion by the judge.

Subd. 6. **Presentation of evidence by intervenor.** Unless a stipulation has been signed and filed or the intervenor's right to reimbursement has otherwise been established, the intervenor shall present evidence in support of the claim at or before the hearing. When the intervenor has not been ordered to attend the hearing pursuant to subdivision 4, or has received permission to attend the hearing by telephone or other electronic medium, the office may establish a procedure for submission of the intervenor's evidence and response to outstanding objections to intervention. If the intervenor does not submit a written response to the objection before the hearing, the compensation judge's determination on the objection must be based on the information and evidence submitted prior to or at the hearing, as a matter of judicial discretion.

Subd. 7. **Effects of noncompliance.** Except as provided in subdivisions 2 and 4, failure to comply with this section shall not result in a denial of the claim for reimbursement unless the compensation judge, or commissioner, determines that the noncompliance has materially prejudiced the interests of the other parties.

Subd. 8. **Chief administrative law judge orders.** The chief administrative law judge may issue standing orders to implement this section. The chief administrative law judge has the authority to issue standing orders instead of, or in addition to, the authority granted to the office or compensation judges under this section, provided that any standing order issued by the chief administrative law judge must be consistent with this section.

History: *1953 c 755 s 53; 1969 c 276 s 2; 1973 c 388 s 106; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1983 c 290 s 148; 1984 c 432 art 2 s 45; 1984 c 654 art 5 s 58; 1Sp1985 c 14 art 9 s 75; 1986 c 461 s 30,31; 1987 c 332 s 87-89; 1992 c 464 art 1 s 5; 1994 c 483 s 1; 2002 c 262 s 21; 2004 c 206 s 52; 2016 c 110 art 3 s 6-12; 2017 c 94 art 5 s 1,2; 2024 c 97 s 47,48*

176.37 [Repealed, 1953 c 755 s 83]

176.371 AWARD OR DISALLOWANCE OF COMPENSATION.

The compensation judge to whom a petition has been assigned for hearing, shall hear all competent, relevant evidence produced at the hearing. All questions of fact and law submitted to a compensation judge at the hearing shall be disposed of and the judge's decision shall be filed with the commissioner, except where expedited procedures require a shorter time, within 60 days after the submission, unless sickness or casualty prevents a timely filing, or the chief administrative law judge extends the time for good cause. The compensation judge's decision shall include a determination of all contested issues of fact and law and an award or disallowance of compensation or other order as the pleadings, evidence, this chapter and rule require. A compensation judge's decision shall include a memorandum only if necessary to delineate the reasons for the decision or to discuss the credibility of witnesses. A memorandum shall not contain a recitation of the evidence presented at the hearing but shall be limited to the compensation judge's basis for the decision.

No part of the salary of a compensation judge shall be paid unless the chief administrative law judge determines that all decisions of that judge have been issued within the time limits prescribed by this chapter.

History: *1953 c 755 s 54; 1969 c 276 s 2; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 114; 1983 c 290 s 149; 1984 c 640 s 32; 1987 c 332 s 90*

176.38 [Repealed, 1953 c 755 s 83]

176.381 REFERENCE OF QUESTIONS OF FACT.

Subdivision 1. **Hearing before Workers' Compensation Court of Appeals.** In the hearing of any matter before the Workers' Compensation Court of Appeals, the chief judge of the Workers' Compensation Court of Appeals may refer any question of fact to the chief administrative law judge for assignment to a compensation judge either to hear evidence and report it to the Workers' Compensation Court of Appeals or to hear evidence and make findings of fact and report them to the Workers' Compensation Court of Appeals. The Workers' Compensation Court of Appeals shall notify the commissioner of any matter referred to a compensation judge under this subdivision.

Subd. 2. **Hearing before compensation judge.** In the hearing of any petition before a compensation judge, the chief administrative law judge may refer any question of fact to another compensation judge to hear evidence and report it to the original compensation judge.

History: *1953 c 755 s 55; Ex1967 c 1 s 6; 1969 c 276 s 2; 1973 c 388 s 107,108; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 115; 1984 c 640 s 32*

176.39 [Repealed, 1953 c 755 s 83]

176.391 INVESTIGATIONS.

Subdivision 1. **Power to make.** Before, during, or after any hearing, a compensation judge may make an independent investigation of the facts alleged in the petition or answer.

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

Subd. 3. **Reports.** The report of a physician, surgeon, or other expert requested under this section shall be filed with the compensation judge assigned to the matter if any. The report shall be made a part of the record of the case and be open to inspection as such.

Subd. 4. **Compensation.** The compensation judge shall fix the compensation of a physician, surgeon, or other expert whose services are employed under this section. This compensation shall be paid initially out of the funds appropriated for the maintenance of the Workers' Compensation Division, but shall be taxed as costs to either party, or both, or otherwise, as the compensation judge directs.

Where a sum which has been taxed to a party has not been paid, it may be collected in the same manner as are costs generally.

History: *1953 c 755 s 56; 1969 c 9 s 46; 1969 c 276 s 2; 1973 c 388 s 109-112; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; Ex1979 c 3 s 59; 1981 c 346 s 116; 2005 c 90 s 19; 2022 c 32 art 2 s 11*

176.40 [Repealed, 1953 c 755 s 83]

176.401 HEARINGS PUBLIC.

All hearings before a compensation judge are public.

History: *1953 c 755 s 57; 1969 c 276 s 2; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 117*

176.41 [Repealed, 1953 c 755 s 83]

176.411 RULES OF EVIDENCE, PLEADING, AND PROCEDURE.

Subdivision 1. **Conduct of hearings and investigations.** Except as otherwise provided by this chapter, when a compensation judge makes an investigation or conducts a hearing, the compensation judge is bound neither by the common law or statutory rules of evidence nor by technical or formal rules of pleading or procedure. Hearsay evidence which is reliable is admissible. The investigation or hearing shall be conducted in a manner to ascertain the substantial rights of the parties.

Findings of fact shall be based upon relevant and material evidence only, as presented by competent witnesses, and shall comport with section 176.021.

Subd. 2. **Depositions.** Except where a compensation judge orders otherwise, depositions may be taken in the manner which the law provides for depositions in civil actions in district court.

Subd. 3. **Hospital records as evidence.** A hospital record relating to medical or surgical treatment given an employee is admissible as evidence of the medical and surgical matters stated in the record, but it is not conclusive proof of such matters.

History: *1953 c 755 s 58; 1969 c 276 s 2; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 118,119; 1987 c 332 s 91*

176.42 [Repealed, 1953 c 755 s 83]

APPEALS

176.421 APPEALS TO WORKERS' COMPENSATION COURT OF APPEALS.

Subdivision 1. **Time for taking; grounds.** When a petition has been heard before a compensation judge, within 30 days after a party in interest has been served with notice of an award or disallowance of compensation, or other order affecting the merits of the case, the party may appeal to the Workers' Compensation Court of Appeals on any of the following grounds:

(1) the order does not conform with this chapter; or

(2) the compensation judge committed an error of law; or

(3) the findings of fact and order were clearly erroneous and unsupported by substantial evidence in view of the entire record as submitted; or

(4) the findings of fact and order were procured by fraud, or coercion, or other improper conduct of a party in interest.

Subd. 2. **Extension of time.** Where a party shows cause within the 30-day period referred to in subdivision 1, the Workers' Compensation Court of Appeals may extend the time for taking the appeal for not more than 30 additional days.

Subd. 3. **Notice of appeal.** The appellant or the appellant's attorney shall prepare and sign a written notice of appeal specifying:

(1) the order appealed from;

(2) that appellant appeals from the order to the Workers' Compensation Court of Appeals;

(3) the particular finding of fact or conclusion of law which the appellant claims was unsupported by substantial evidence in view of the entire record as submitted or procured by fraud, coercion, or other improper conduct; and

(4) any other ground upon which the appeal is taken.

An appeal initiates the preparation of a typewritten transcript of the entire record unless the appeal is solely from an award of attorney's fees or an award of costs and disbursements or unless otherwise ordered by the court of appeals. On appeals from an award of attorney's fees or an award of costs and disbursements, the appellant must specifically delineate in the notice of appeal the portions of the record to be transcribed in order for the court of appeals to consider the appeal.

Subd. 3a. **Cross-appeal.** The respondent may cross-appeal within the 30-day period for taking an appeal, or within 15 days after service of the notice of appeal on that respondent, whichever is later.

Subd. 4. **Service and filing of notice; cost of transcript.** Within the 30-day period for taking an appeal, the appellant shall:

(1) serve a copy of the notice of appeal on each adverse party; and

(2) pursuant to section 176.285, file the original notice of appeal, with proof of service by admission or affidavit, with the chief administrative law judge and file a copy with the commissioner.

In order to defray the cost of the preparation of the record of the proceedings appealed from, each appellant and cross-appellant shall pay to the commissioner of management and budget, Office of Administrative Hearings account the sum of $25. The filing fee must be received by the Office of Administrative Hearings within ten business days after the end of the appeal period. If the filing fee is not received within ten days after the appeal period, the appeal is not timely filed.

The first party to file an appeal is liable for the original cost of preparation of the transcript. Cross-appellants or any other persons requesting a copy of the transcript are liable for the cost of the copy. The chief administrative law judge may require payment for transcription costs to be made in advance of the transcript preparation. The cost of a transcript prepared by a nongovernmental source shall be paid directly to that source and shall not exceed the cost that the source would be able to charge the state for the same service.

Upon a showing of cause, the chief administrative law judge may direct that a transcript be prepared without expense to the party requesting its preparation, in which case the cost of the transcript shall be paid by the Office of Administrative Hearings.

All fees received by the Office of Administrative Hearings for the preparation of the record for submission to the Workers' Compensation Court of Appeals or for the cost of transcripts prepared by the office shall be deposited in the Office of Administrative Hearings account in the state treasury and shall be used solely for the purpose of keeping the record of hearings conducted under this chapter and the preparation of transcripts of those hearings.

Subd. 5. **Transcript; certification of the record.** When the notice of appeal has been filed with the chief administrative law judge and the fee for the preparation of the record has been paid, the chief administrative law judge shall immediately order the preparation of a typewritten transcript of that part of the hearing delineated in the notice. The official reporter or other person designated by the chief administrative law judge who transcribes the proceedings shall certify to their correctness.

If the transcript is prepared by a person who is not an employee of the Office of Administrative Hearings, upon completion of the transcript, the original shall be filed with the chief administrative law judge.

When the transcript has been completed and is on file with the chief administrative law judge, the chief judge shall certify the record to the Workers' Compensation Court of Appeals and notify the commissioner of the certification.

Subd. 6. **Powers of Workers' Compensation Court of Appeals on appeal.** On an appeal taken under this section, the Workers' Compensation Court of Appeals' review is limited to the issues raised by the parties in the notice of appeal or by a cross-appeal. In these cases, on those issues raised by the appeal, the Workers' Compensation Court of Appeals may:

(1) grant an oral argument based on the record before the compensation judge;

(2) examine the record;

(3) substitute for the findings of fact made by the compensation judge findings based on the total evidence;

(4) sustain, reverse, make or modify an award or disallowance of compensation or other order based on the facts, findings, and law; and

(5) remand or make other appropriate order.

Subd. 6a. **Time limit for decision.** The court shall issue a decision in each case within 90 days after certification of the record to the court by the chief administrative law judge, the filing of a cross-appeal, oral argument, or a final submission of briefs or memoranda by the parties, whichever is latest. For cases submitted without oral argument, a decision shall be issued within 90 days after assignment of the case to the judges. The chief judge may waive the 90-day limitation for any proceeding before the court for good cause shown. No part of the salary of a Workers' Compensation Court of Appeals judge may be paid unless the judge, upon accepting the payment, certifies that decisions in cases in which the judge has participated have been issued within the time limits prescribed by this subdivision.

Subd. 7. **Record of proceedings.** At the office's own expense, the office shall make a complete record of all formal proceedings before the office.

The office shall furnish a transcript of these proceedings to any person who requests it and who pays a reasonable charge which shall be set by the office. Upon a showing of cause, the chief administrative law judge may direct that a transcript be prepared without expense to the person requesting the transcript, in which case the cost of the transcript shall be paid by the office. Transcript fees received under this subdivision shall be paid to the Workers' Compensation Division account in the state treasury and shall be annually appropriated to the division for the sole purpose of providing a record and transcripts as provided in this subdivision. This subdivision does not apply to any administrative conference or other proceeding before the commissioner which may be heard de novo in another proceeding including but not limited to proceedings under section 176.106 or 176.239.

History: *1953 c 755 s 59; Ex1967 c 1 s 6; 1969 c 276 s 2; 1973 c 388 s 113-115; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 120-124; 3Sp1981 c 2 art 1 s 21-23; 1983 c 290 s 150-153; 1983 c 301 s 148-150; 1984 c 432 art 2 s 46; 1984 c 640 s 32; 1986 c 444; 1986 c 461 s 32; 1987 c 332 s 92,93; 1989 c 209 art 2 s 25; 1990 c 426 art 1 s 23; 1990 c 571 s 38; 1991 c 345 art 1 s 79; 1992 c 510 art 2 s 10; 2003 c 112 art 2 s 50; 2006 c 178 s 2; 2009 c 101 art 2 s 109; 2022 c 32 art 2 s 12; 2024 c 97 s 49*

176.43 [Repealed, 1953 c 755 s 83]

176.431 [Repealed, 1986 c 461 s 37]

176.44 [Repealed, 1953 c 755 s 83]

176.441 Subdivision 1. [Repealed, 1986 c 461 s 37]

Subd. 2. [Repealed, 1981 c 346 s 145; 1986 c 461 s 37]

176.442 APPEALS FROM DECISIONS OF COMMISSIONER.

Except for a commissioner's decision which may be heard de novo in another proceeding including but not limited to a decision from an administrative conference under section 176.102, 176.103, 176.106, 176.239, or a summary decision under section 176.305, any decision or determination of the commissioner affecting a right, privilege, benefit, or duty which is imposed or conferred under this chapter is subject to review by the Workers' Compensation Court of Appeals. A person aggrieved by the determination may appeal to the Workers' Compensation Court of Appeals by filing a notice of appeal with the commissioner in the same manner and within the same time as if the appeal were from an order or decision of a compensation judge to the Workers' Compensation Court of Appeals.

History: *1973 c 388 s 119; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1983 c 290 s 154; 1984 c 432 art 2 s 47; 1987 c 332 s 94; 1987 c 384 art 3 s 3*

176.445 [Repealed, 2001 c 123 s 23]

176.45 [Repealed, 1953 c 755 s 83]

176.451 DEFAULTS.

Subdivision 1. **Application to district court for judgment.** Where there has been a default of more than 30 days in the payment of compensation due under an award, the employee, or the employee's dependent, or other person entitled to the payment of money under the award, may apply to the judge of any district court for the entry of judgment upon the award.

Subd. 2. **Certified copy of award; filing, notice.** The application shall be made by filing a certified copy of the award with the court administrator and by serving a ten days' notice upon adverse parties. Service of the notice shall be made in the manner provided by court rule for service of summons in district court.

Subd. 3. **Court administrator's fees.** The court administrator shall charge $5 for the entire service the court administrator performs under this section.

Subd. 4. **Matters for determination; judgment.** When a judge hears the application for judgment upon the award, the judge has authority to determine only the facts of the award and the regularity of the proceedings upon which the award is based. The judge shall enter judgment accordingly.

Judgment shall not be entered upon an award while an appeal is pending.

Subd. 5. **Effect of district court judgment.** The judgment of the district court entered upon an award has the same force and effect, and may be vacated, set aside, or satisfied as may other judgments of the district court.

History: *1953 c 755 s 62; 1986 c 442 s 1; 1986 c 444; 1Sp1986 c 3 art 1 s 82*

176.46 [Repealed, 1953 c 755 s 83]

176.461 SETTING ASIDE AWARD.

(a) Except when a writ of certiorari has been issued by the supreme court and the matter is still pending in that court or if as a matter of law the determination of the supreme court cannot be subsequently modified, the Workers' Compensation Court of Appeals, for cause, at any time after an award, upon application of either party and not less than five working days after written notice to all interested parties, may set the award aside and grant a new hearing and refer the matter for a determination on its merits to the chief administrative law judge for assignment to a compensation judge, who shall make findings of fact, conclusions of law, and an order of award or disallowance of compensation or other order based on the pleadings and the evidence produced and as required by the provisions of this chapter or rules adopted under it.

(b) As used in this section, the phrase "for cause" is limited to the following:

(1) a mutual mistake of fact;

(2) newly discovered evidence;

(3) fraud; or

(4) a substantial change in medical condition since the time of the award that was clearly not anticipated and could not reasonably have been anticipated at the time of the award.

History: *1953 c 755 s 63; Ex1967 c 40 s 15; 1973 c 388 s 120; 1975 c 271 s 6; 1975 c 359 s 18,23; 1976 c 134 s 78; 1981 c 346 s 127; 1983 c 290 s 155; 1984 c 640 s 32; 1992 c 510 art 2 s 11*

176.47 [Repealed, 1953 c 755 s 83]

176.471 REVIEW BY SUPREME COURT ON CERTIORARI.

Subdivision 1. **Time for seeking review; grounds.** Where the Workers' Compensation Court of Appeals has made an award or disallowance of compensation or other order, a party in interest who acts within 30 days from the date the party was served with notice of the order may have the order reviewed by the supreme court on certiorari upon one of the following grounds:

(1) the order does not conform with this chapter;

(2) the Workers' Compensation Court of Appeals committed any other error of law; or

(3) the findings of fact and order were unsupported by substantial evidence in view of the entire record as submitted.

Subd. 2. **Extension of time for seeking review or for filing other papers.** Where cause is shown within the 30-day period referred to in subdivision 1, the supreme court may extend the time for seeking review on certiorari. The supreme court may also extend the time for filing any other paper which this chapter requires to be filed with that court.

Subd. 3. **Service of writ; filing fee.** To effect a review upon certiorari, the party shall serve a writ of certiorari upon the administrator of the Workers' Compensation Court of Appeals within the 30-day period referred to in subdivision 1. The party shall also at this time pay to the clerk of the appellate courts the fee prescribed by rule 116.03 of the Rules of Civil Appellate Procedure.

Subd. 4. **Contents of writ.** The writ of certiorari required by subdivision 3 shall show that a review is to be had in the supreme court of the proceedings of the Workers' Compensation Court of Appeals upon which the order is based.

Subd. 5. **Bond.** The Workers' Compensation Court of Appeals may, upon motion of any respondent and a showing that extraordinary circumstances warrant the requirement of a cost bond, order that a bond be provided as prescribed by rule 107.02 of the Rules of Civil Appellate Procedure.

Subd. 6. **Transmittal of fee and return.** When the writ of certiorari has been served upon the administrator of the Workers' Compensation Court of Appeals, the bond has been filed, and the filing fee has been paid, the administrator shall immediately transmit to the clerk of the appellate courts that filing fee and the return to the writ of certiorari and bond.

Subd. 7. **Jurisdiction vested.** Filing such return and payment of the filing fee referred to in subdivision 6 vests the supreme court with jurisdiction of the case.

Subd. 8. **Return of proceedings transmitted to court.** Within 30 days after the writ of certiorari, bond, and filing fee have been filed with the administrator of the Workers' Compensation Court of Appeals, the administrator shall transmit to the clerk of the appellate courts a true and complete return of the proceedings of the Workers' Compensation Court of Appeals under review, or the part of those proceedings necessary to allow the supreme court to review properly the questions presented.

The Workers' Compensation Court of Appeals shall certify the return of the proceedings under its seal. The petitioner or relator shall pay to the administrator of the Workers' Compensation Court of Appeals the reasonable expense of preparing the return.

Subd. 9. **Application of rules governing appeals in civil actions.** When the return of the proceedings before the Workers' Compensation Court of Appeals has been filed with the clerk of the appellate courts, the supreme court shall hear and dispose of the matter as in other civil cases.

Subd. 10. **Rules.** The supreme court may adopt rules which are consistent with this chapter and necessary or convenient to the impartial and speedy disposition of these cases.

History: *1953 c 755 s 64; 1971 c 686 s 1; 1973 c 388 s 121-124; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1976 c 239 s 37; 1981 c 346 s 128-131; 1983 c 247 s 72-74; 1983 c 301 s 152; 1986 c 444; 2016 c 110 art 1 s 3,4*

176.48 [Repealed, 1953 c 755 s 83]

176.481 ORIGINAL JURISDICTION OF SUPREME COURT.

On review upon certiorari under this chapter, the supreme court has original jurisdiction. It may reverse, affirm, or modify the order allowing or disallowing compensation and enter such judgment as it deems just and proper. Where necessary the supreme court may remand the cause to the Workers' Compensation Court of Appeals for a new hearing or for further proceedings with such directions as the court deems proper.

History: *1953 c 755 s 65; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78*

176.49 [Repealed, 1953 c 755 s 83]

176.491 STAY OF PROCEEDINGS PENDING DISPOSITION OF CASE.

Where a writ of certiorari has been perfected under this chapter, it stays all proceedings for the enforcement of the order being reviewed until the case has been finally disposed of either in the supreme

court or, where the cause has been remanded for a new hearing before a compensation judge or further proceedings before the Workers' Compensation Court of Appeals.

History: *1953 c 755 s 66; 1973 c 388 s 125; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1981 c 346 s 132*

176.50 [Repealed, 1953 c 755 s 83]

176.501 [Repealed, 1987 c 332 s 117]

176.51 [Repealed, 1953 c 755 s 83]

COSTS

176.511 COSTS.

Subdivision 1. **Parties not awarded costs.** Except as provided otherwise by this chapter and specifically by this section, in appeals before the court of appeals or proceedings before the division or a compensation judge, costs shall not be awarded to any party.

Subd. 2. **Disbursements, taxation.** The commissioner or compensation judge, or the Workers' Compensation Court of Appeals on cases before the court, may award the prevailing party reimbursement for actual and necessary disbursements. Disbursements shall be taxed upon ten days' written notice to adverse parties.

Subd. 3. **Attorney fee, allowance.** Where (1) an award of compensation is affirmed, or modified and affirmed, (2) an order disallowing compensation is reversed, or (3) a petition to vacate an award is granted, the Workers' Compensation Court of Appeals may include in its award an amount to cover a reasonable attorney fee or may allow an attorney fee in a proceeding to tax disbursements.

If the employer or insurer files a notice of discontinuance of an employee's benefits and an administrative conference is held to resolve the dispute, but the employer or insurer fails to attend the administrative conference, the commissioner or compensation judge may order the employer or insurer to pay the employee's attorney fees as a cost under this section if the employee's benefits are continued.

Subd. 4. **Costs and disbursements on certiorari.** On review by the supreme court upon certiorari, costs and disbursements shall be taxed as they are upon appeals in civil actions.

Subd. 5. **Attorney fee on certiorari.** Where upon a review by the supreme court upon certiorari, an award of compensation is affirmed, or modified and affirmed, or an order disallowing compensation is reversed, the court may allow a reasonable attorney fee incident to the review. This allowance of an attorney fee shall be made a part of the judgment order of the supreme court.

History: *1953 c 755 s 68; 1969 c 276 s 2; 1973 c 388 s 126; 1975 c 271 s 6; 1975 c 359 s 19,23; 1976 c 134 s 78; 1977 c 342 s 22; 1981 c 346 s 133; 1985 c 234 s 16,17; 1987 c 332 s 95-97; 2016 c 110 art 1 s 5,6*

176.52 [Repealed, 1953 c 755 s 83]

SETTLEMENTS

176.521 SETTLEMENT OF CLAIMS.

Subdivision 1. **Validity.** (a) An agreement between an employee or an employee's dependent and the employer or insurer to settle any claim for compensation under this chapter is valid where it has been executed in writing and signed by the parties and intervenors in the matter, and, where one or more of the parties is not represented by an attorney, the commissioner or a compensation judge has approved the settlement and made an award thereon. If the matter is upon appeal before the district court, the district court is the approving body. An agreement to settle any claim is not valid if a guardian or conservator is required under section 176.092 and an employee or dependent has no guardian or conservator.

(b) If the matter is on appeal before the Workers' Compensation Court of Appeals, the proposed settlement shall be submitted for approval to a compensation judge at the Office of Administrative Hearings. Before the settlement is submitted to the compensation judge, the parties shall notify the Workers' Compensation Court of Appeals and request that it suspend further action on the appeal pending review of the settlement by the compensation judge. Within 14 days after the compensation judge's final approval or disapproval of the settlement, the parties shall notify the Workers' Compensation Court of Appeals of the compensation judge's action and shall request that the appeal be dismissed or reactivated.

Subd. 2. **Approval.** Settlements shall be approved only if the terms conform with this chapter.

The commissioner, a compensation judge, and the district court shall exercise discretion in approving or disapproving a proposed settlement.

The parties to the agreement of settlement have the burden of proving that the settlement is reasonable, fair, and in conformity with this chapter. A settlement agreement where both the employee or the employee's dependent and the employer or insurer are represented by an attorney shall be conclusively presumed to be reasonable, fair, and in conformity with this chapter except when the settlement purports to be a full, final, and complete settlement of an employee's right to medical compensation under this chapter or rehabilitation under section 176.102. A settlement which purports to do so must be approved by the commissioner or a compensation judge.

The conclusive presumption in this subdivision is not available in cases involving an employee or dependent with a guardian or conservator.

The conclusive presumption in this subdivision applies to a settlement agreement entered into on or after January 15, 1982, whether the injury to which the settlement applies occurred prior to or on or after January 15, 1982.

Subd. 2a. **Settlements not subject to approval.** When a settled case is not subject to approval, upon receipt of the stipulation for settlement, the commissioner or a compensation judge shall immediately sign the award and file it with the commissioner. Payment pursuant to the award shall be made within 14 days after it is filed with the commissioner. The commissioner may correct mathematical or clerical errors at any time.

Subd. 2b. **Partial settlement.** (a) The parties may file a partial stipulation for settlement which resolves the claims of the employee and reserves the claims of one or more intervenors. If the partial stipulation, or a letter of agreement attached to the partial stipulation, is not signed by an intervenor, the partial stipulation must include a statement that the parties were unable to:

(1) obtain a response from the nonsigning intervenor regarding clarification or confirmation of its interest or an offer of settlement within a reasonable time despite good-faith efforts to obtain a response;

(2) reach agreement with the nonsigning intervenor despite the belief that the parties negotiated with the intervenor in good faith and made a reasonable offer to settle the intervention claim; or

(3) obtain the nonsigning intervenor's signature within a reasonable time after an agreement was reached with the intervenor.

The partial stipulation must include detailed and case-specific support for the parties' statements. In addition, the partial stipulation must reserve the nonsigning intervenor's interests to pursue its claim at a hearing on the merits, and must contain a statement that the employee will cooperate at the hearing.

(b) Prior to filing the partial stipulation for approval, a copy of the partial stipulation must be served on all parties, including the nonsigning intervenor, together with a written notification that the settling parties intend to file the partial stipulation for approval by a compensation judge and of the nonsigning intervenor's right to request a hearing on the merits of the intervenor's claim.

(c) Within ten days after service of a partial stipulation for settlement and notice of an intent to file for approval by a compensation judge, a nonsigning intervenor may serve and file a written objection to approval of the partial stipulation, which filing must provide a detailed and case-specific factual basis establishing that approval of the partial stipulation will adversely impact the rights of the intervenor.

(d) After expiration of the ten-day period within which a nonsigning intervenor may serve and file its written objection, any party may file for approval a partial stipulation for settlement which conforms with this section. An affidavit of service must accompany the partial stipulation when it is filed for approval.

(e) Unless the compensation judge has a reasonable belief that approval of the partial stipulation will adversely impact the rights of the nonsigning intervenor, the compensation judge shall immediately issue the award and file it with the commissioner. The issuance of the award shall be accompanied by notice to the intervenors and other parties of their right to request amended findings within a period of 30 days following the date of issuance in conformity with applicable law.

(f) If the compensation judge has a reasonable belief that approval of the partial stipulation will adversely impact the rights of the intervenor, the compensation judge shall disapprove the stipulation by written order detailing a factual basis for the determination of adverse impact.

Subd. 3. **Setting aside award upon settlement.** Notwithstanding the provisions of subdivision 1, 2, or 2a, or any provision in the agreement of settlement to the contrary, upon the filing of a petition by any party to the settlement, the Workers' Compensation Court of Appeals may set aside an award made upon a settlement, pursuant to this chapter. In appropriate cases, the Workers' Compensation Court of Appeals may refer the matter to the chief administrative law judge for assignment to a compensation judge for hearing.

History: *1953 c 755 s 69; 1973 c 388 s 127,128; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1979 c 271 s 1; Ex1979 c 3 s 60; 1981 c 346 s 134,135; 3Sp1981 c 2 art 1 s 24-26; 1983 c 290 s 156-158; 1984 c 640 s 32; 1986 c 444; 1986 c 461 s 33; 1987 c 332 s 98; 1993 c 194 s 7,8; 2013 c 70 art 1 s 7; 2017 c 94 art 5 s 3*

176.522 NOTICE TO EMPLOYER.

An employer shall be notified by the insurer 30 days after any final valid settlement is approved or otherwise made final under any provision of this chapter. The notice shall include all terms of the settlement including the total amount of money required to be reserved in order to pay the claim.

History: *1983 c 290 s 159*

176.53 [Repealed, 1953 c 755 s 83]

GOVERNMENT ISSUES

176.531 AWARD OF COMPENSATION AGAINST A POLITICAL SUBDIVISION OR SCHOOL DISTRICT.

Subdivision 1. **Preferred claim.** Where there has been an award of compensation under this chapter to be paid by a political subdivision or a school district, the entitlement of a person to payment under the award is a preferred claim against the subdivision or district. The award shall be paid when and as ordered from the general fund of the subdivision or district, and from the current tax apportionment received by the subdivision or district for the credit of the general fund.

Subd. 2. **Payment from general fund.** When the political subdivision or school district has issued an order or warrant for payment of compensation, and the order or warrant has not been paid, it is a preferred claim which shall be paid from the general fund and from current tax apportionments received for the credit of the general fund before any subsequent claim for compensation is paid.

Subd. 3. **Prompt payment.** It is the intent of this section that there be prompt payment of compensation.

History: *1953 c 755 s 70; 1973 c 388 s 129; 1981 c 346 s 136*

176.54 [Repealed, 1953 c 755 s 83]

176.540 MS 1992 [Renumbered 176.5401]

176.5401 [Repealed, 2008 c 204 s 43]

176.541 STATE DEPARTMENTS.

Subdivision 1. **Application of chapter to state employees.** This chapter applies to the employees of any department of this state as defined in section 3.732, subdivision 1, clause (1).

Subd. 2. **Defense of claim against state.** When the commissioner of administration believes that a claim against the state for compensation should be contested, the commissioner shall defend the state claim.

Subd. 3. **Duties of attorney general.** At any stage in such a compensation proceeding, the attorney general may assume the duty of defending the state. When the commissioner of administration or a department of this state requests the attorney general to assume the defense, the attorney general shall do so.

Subd. 4. **Medical examination of employee; witnesses; conduct of defense.** In conducting a defense against a claim for compensation, the commissioner of administration or the attorney general, as the case may be, may require that an employee submit to a medical examination, procure the attendance of expert and other witnesses at a hearing, and do any other act necessary to conduct a proper defense.

Subd. 5. **Expenses of conducting defense.** The expenses of conducting a defense shall be charged to the department which employs the employee involved. These expenses shall be paid from the state compensation revolving fund.

Subd. 6. **Legal and clerical help.** The commissioner of administration may employ legal and clerical help. The salaries of these persons shall be paid from the state compensation revolving fund, but shall be apportioned among the several departments of the state in relation to the amount of compensation paid to employees of any department as against the total amount of compensation paid to employees of all departments.

Subd. 7. [Repealed, 2017 c 94 art 3 s 10]

Subd. 7a. **Exceptions.** This section does not apply to the University of Minnesota.

Subd. 8. **State may insure.** The state of Minnesota may elect to insure its liability under the workers' compensation law for persons employed under the federal Workforce Innovation and Opportunity Act, and similar programs, with an insurer properly licensed in Minnesota.

History: *1953 c 755 s 71; 1967 c 8 s 1; 1971 c 422 s 10; 1973 c 388 s 130-133; 1975 c 2 s 2; 1975 c 359 s 23; 1986 c 444; 1987 c 332 s 100-103; 2008 c 204 s 28-31; 2017 c 94 art 3 s 6-8*

176.55 [Repealed, 1953 c 755 s 83]

176.551 REPORTS.

Subdivision 1. **Heads of state departments to report accidents to employees.** Except as provided in subdivision 2, the head of a department of the state shall report each accident which occurs to an employee as and in the manner required by this chapter.

Subd. 2. **Contents.** The report need not contain a statement relating to liability to pay compensation as required by this chapter.

History: *1953 c 755 s 72*

176.56 [Repealed, 1953 c 755 s 83]

176.561 WORKERS' COMPENSATION COURT OF APPEALS POWERS AND DUTIES AS TO STATE EMPLOYEES; PROCEDURE FOR DETERMINING LIABILITY.

The division, a compensation judge and the Workers' Compensation Court of Appeals have the same powers and duties in matters relating to state employees as they have in relation to other employees.

Except as specifically provided otherwise in this chapter, the procedure for determining the liability of the state for compensation is the same as that applicable in other cases.

History: *1953 c 755 s 73; 1973 c 388 s 134; 1975 c 271 s 6; 1975 c 359 s 23; 1976 c 134 s 78; 1983 c 290 s 160*

176.57 [Repealed, 1953 c 755 s 83]

176.571 INVESTIGATIONS OF INJURIES TO STATE EMPLOYEES.

Subdivision 1. **Preliminary investigation.** When the head of a department has filed a report or the commissioner of administration has otherwise received information of the occurrence of an injury to a state

employee for which liability to pay compensation may exist, the commissioner of administration shall make a preliminary investigation to determine the question of probable liability.

In making this investigation, the commissioner of administration may require the assistance of the head of any department or any employee of the state. The commissioner of administration may require that all facts be furnished which appear in the records of any state department bearing on the issue.

Subd. 2. **Determination by department.** When the commissioner of administration has completed an investigation, the commissioner shall inform the claimant, the head of the employing department, and the commissioner of management and budget in writing of the action taken.

Subd. 3. [Repealed, 1987 c 332 s 117]

Subd. 4. [Repealed, 1987 c 332 s 117]

Subd. 5. [Repealed, 1987 c 332 s 117]

Subd. 6. [Repealed, 1987 c 332 s 117]

Subd. 7. [Repealed, 1987 c 332 s 117]

History: *1953 c 755 s 74; 1973 c 388 s 135-141; 1983 c 290 s 161; 1984 c 640 s 32; 1986 c 444; 1987 c 332 s 104,105; 2008 c 204 s 32; 2009 c 101 art 2 s 70,109; 2016 c 110 art 2 s 3*

176.572 CONTRACT WITH INSURANCE CARRIERS.

The commissioner of administration may contract with group health insurance carriers or health maintenance organizations to provide health care services and reimburse health care payments for injured state employees entitled to benefits under this chapter.

History: *1983 c 290 s 162; 1987 c 332 s 106; 2008 c 204 s 33*

176.58 [Repealed, 1953 c 755 s 83]

176.581 PAYMENT TO STATE EMPLOYEES.

Upon a request prepared by the commissioner of administration, and in accordance with the terms of the order awarding compensation, the commissioner of management and budget shall pay compensation to the employee or the employee's dependent. These payments shall be made from money appropriated for this purpose.

History: *1953 c 755 s 75; 1973 c 388 s 142-144; 1973 c 492 s 14; 1986 c 444; 1987 c 332 s 107; 2003 c 112 art 2 s 26; 2008 c 204 s 34; 2009 c 101 art 2 s 109; 1Sp2019 c 10 art 3 s 26*

176.59 [Repealed, 1953 c 755 s 83]

176.591 STATE COMPENSATION REVOLVING FUND.

Subdivision 1. **Establishment.** To facilitate the discharge by the state of its obligations under this chapter, there is established a revolving fund to be known as the state compensation revolving fund.

This fund is comprised of the unexpended balance in the fund on July 1, 1935, and the sums which the several departments of the state pay to the fund.

Subd. 2. **Commissioner of management and budget as custodian.** The commissioner of management and budget is custodian of this fund.

Subd. 3. **Compensation payments upon request.** The commissioner of management and budget shall make compensation payments from the fund only as authorized by this chapter upon request of the commissioner of administration.

History: *1953 c 755 s 76; 1973 c 388 s 145; 1987 c 332 s 108; 2003 c 112 art 2 s 50; 2008 c 204 s 35; 2009 c 101 art 2 s 109; 1Sp2019 c 10 art 3 s 27*

176.60 [Repealed, 1953 c 755 s 83]

176.601 [Repealed, 1974 c 355 s 30]

176.602 [Repealed, 1987 c 332 s 117]

176.603 COST OF ADMINISTERING CHAPTER, PAYMENT.

The annual cost to the commissioner of the Department of Administration of administering this chapter in relation to state employees and the necessary expenses which the Department of Administration or the attorney general incurs in investigating, administering, and defending a claim against the state for compensation shall be paid from the state compensation revolving fund.

History: *1974 c 355 s 32; 1986 c 461 s 34; 1987 c 332 s 109; 2008 c 204 s 36*

176.61 [Repealed, 1953 c 755 s 83]

176.611 MAINTENANCE OF STATE COMPENSATION REVOLVING FUND.

Subdivision 1. **Generally.** The state compensation revolving fund shall be maintained as provided in the following subdivisions.

Subd. 2. **State departments.** Every department of the state shall reimburse the fund for money paid for its claims and the costs of administering the revolving fund at such times and in such amounts as the commissioner of administration shall certify has been paid out of the fund on its behalf. The heads of the departments shall anticipate these payments by including them in their budgets. In addition, the commissioner of administration, with the approval of the commissioner of management and budget, may require an agency to make advance payments to the fund sufficient to cover the agency's estimated obligation for a period of at least 60 days. Reimbursements and other money received by the commissioner of administration under this subdivision must be credited to the state compensation revolving fund.

Subd. 2a. **Alternative cost allocation account.** To reduce long-term costs, minimize impairment to agency operations and budgets, and distribute risk of claims, the commissioner of administration 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 legal, medical, indemnity, or other claim costs that might pose a significant burden for agencies. The commissioner of administration, with the approval of the commissioner of management and budget, may establish criteria and procedures for payment from the account on an agency's behalf. The commissioner of administration 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.

Subd. 3. [Repealed, 1986 c 461 s 37]

Subd. 3a. **Loans.** To maintain an ongoing balance sufficient to pay sums currently due for benefits and administrative costs, the commissioner of management and budget, upon request of the commissioner of administration, may transfer money from the general fund to the state compensation revolving fund. Before requesting the transfer, the commissioner of administration must decide there is not enough money in the fund for an immediate, necessary expenditure. The amount necessary to make the transfer is appropriated from the general fund to the commissioner of management and budget. The commissioner of administration shall make schedules to repay the transferred money to the general fund. The repayment may not extend beyond five years.

Subd. 4. [Repealed, 1986 c 461 s 37]

Subd. 5. [Repealed, 1974 c 355 s 14]

Subd. 6. [Repealed, 1974 c 355 s 14]

Subd. 6a. **Appropriations constituting fund.** The revolving fund consists of $3,437,690 appropriated from the general fund and other funds, along with credited investment gains or losses attributable to balances in the account. The State Board of Investment shall invest the fund's assets according to section 11A.24.

History: *1953 c 755 s 78; 1955 c 744 s 1; 1957 c 656 s 1; 1963 c 551 s 1; 1965 c 57 s 1; 1969 c 399 s 49; 1971 c 907 s 1; 1973 c 388 s 147-149; 1974 c 355 s 15; 1975 c 204 s 77; 1976 c 166 s 7; 1979 c 50 s 19; 1986 c 461 s 35; 1987 c 404 s 151-153; 1988 c 667 s 24,25; 1994 c 632 art 3 s 52; 1997 c 202 art 2 s 41; 2000 c 447 s 22; 2008 c 204 s 37-39; 2009 c 101 art 2 s 109; 2017 c 94 art 3 s 9*

176.62 [Repealed, 1953 c 755 s 83]

176.621 [Repealed, 1975 c 61 s 26]

176.63 [Repealed, 1953 c 755 s 83]

176.631 [Repealed, 1975 c 61 s 26]

176.64 [Repealed, 1953 c 755 s 83]

MISCELLANEOUS

176.641 [Repealed, 2014 c 182 s 8]

176.645 ADJUSTMENT OF BENEFITS.

Subdivision 1. **Amount.** For injuries occurring after October 1, 1975, for which benefits are payable under section 176.101, subdivisions 1, 2 and 4, and section 176.111, subdivision 5, the total benefits due the employee or any dependents shall be adjusted in accordance with this section. On October 1, 1981, and thereafter on the anniversary of the date of the employee's injury the total benefits due shall be adjusted by multiplying the total benefits due prior to each adjustment by a fraction, the denominator of which is the statewide average weekly wage for December 31, of the year two years previous to the adjustment and the numerator of which is the statewide average weekly wage for December 31, of the year previous to the adjustment. For injuries occurring after October 1, 1975, all adjustments provided for in this section shall be included in computing any benefit due under this section. Any limitations of amounts due for daily or weekly compensation under this chapter shall not apply to adjustments made under this section. No adjustment increase made on or after October 1, 1977, but prior to October 1, 1992, under this section shall exceed six

percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be six percent. No adjustment increase made on or after October 1, 1992, under this section shall exceed four percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be four percent. For injuries occurring on and after October 1, 1995, no adjustment increase made on or after October 1, 1995, shall exceed two percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be two percent. For injuries occurring on and after October 1, 2013, no adjustment increase shall exceed three percent a year. If the adjustment under the formula of this section would exceed three percent, the increase shall be three percent. No adjustment under this section shall be less than zero percent. The Workers' Compensation Advisory Council may consider adjustment or other further increases and make recommendations to the legislature.

Subd. 2. **Time of first adjustment.** For injuries occurring on or after October 1, 1981, the initial adjustment made pursuant to subdivision 1 is deferred until the first anniversary of the date of the injury. For injuries occurring on or after October 1, 1992, the initial adjustment under subdivision 1 is deferred until the second anniversary of the date of the injury. The adjustment made at that time shall be that of the last year only. For injuries occurring on or after October 1, 1995, the initial adjustment under subdivision 1 is deferred until the fourth anniversary of the date of injury. The adjustment at that time shall be that of the last year only. For injuries occurring on or after October 1, 2013, the initial adjustment under subdivision 1 is deferred until the third anniversary of the date of injury. The adjustment made at that time shall be that of the last year only.

History: *1975 c 359 s 20; 1977 c 342 s 23; 1981 c 346 s 137; 1992 c 510 art 1 s 12,13; 1995 c 231 art 1 s 28; 2013 c 70 art 2 s 10*

176.65 [Repealed, 1953 c 755 s 83]

176.651 SEVERABILITY.

In case for any reason any paragraph or any provision of this chapter shall be questioned in any court of last resort, and shall be held by such court to be unconstitutional or invalid, the same shall not be held to affect any other paragraph or provision thereof.

History: *1953 c 755 s 82*

176.66 OCCUPATIONAL DISEASES; HOW REGARDED.

Subdivision 1. **Disability, disablement.** The disablement of an employee resulting from an occupational disease shall be regarded as a personal injury within the meaning of the workers' compensation law.

Subd. 2. [Repealed, 1973 c 643 s 12]

Subd. 3. [Repealed, 1973 c 643 s 12]

Subd. 4. [Repealed, 1973 c 643 s 12]

Subd. 5. [Repealed, 1973 c 643 s 12]

Subd. 6. [Repealed, 1973 c 643 s 12]

Subd. 7. [Repealed, 1973 c 643 s 12]

Subd. 8. [Repealed, 1973 c 643 s 12]

Subd. 9. [Repealed, 1973 c 643 s 12]

Subd. 10. **Multiple employers or insurers; liability.** The employer liable for the compensation for a personal injury under this chapter is the employer in whose employment the employee was last exposed in a significant way to the hazard of the occupational disease. In the event that the employer who is liable for the compensation had multiple insurers during the employee's term of employment, the insurer who was on the risk during the employee's last significant exposure to the hazard of the occupational disease is the liable party. Where there is a dispute as to which employer is liable under this section, the employer in whose employment the employee is last exposed to the hazard of the occupational disease shall pay benefits pursuant to section 176.191, subdivision 1. If this last employer had coverage for workers' compensation liability from more than one insurer during the employment the insurer on the risk during the last period during which the employee was last exposed to the hazard of the occupational disease shall pay benefits as provided under section 176.191, subdivision 1, whether or not this insurer was on risk during the last significant exposure. The party making payments under this section shall be reimbursed by the party who is subsequently determined to be liable for the occupational disease, including interest at a rate of 12 percent a year. For purposes of this section, a self-insured employer shall be considered to be an insurer and an employer.

Subd. 11. **Amount of compensation.** The compensation for an occupational disease is 66-2/3 percent of the employee's weekly wage on the date of injury subject to a maximum compensation equal to the maximum compensation in effect on the date of last exposure.

History: *(4327) 1921 c 82 s 67; 1939 c 306; 1943 c 633 s 4; 1947 c 612 s 1; 1949 c 500 s 1-3; 1955 c 206 s 2; 1957 c 834 s 2; 1959 c 20 s 2; 1963 c 497 s 2; 1967 c 905 s 9; Ex1967 c 1 s 6; 1973 c 643 s 11; 1975 c 359 s 23; 1983 c 290 s 163,164; 1984 c 432 art 2 s 48,49; 1985 c 234 s 18; 1995 c 231 art 1 s 29*

176.661 [Repealed, 1973 c 643 s 12; 1976 c 2 s 164]

176.662 [Repealed, 1973 c 643 s 12; 1976 c 2 s 164]

176.663 [Repealed, 1973 c 643 s 12; 1976 c 2 s 164]

176.664 [Repealed, 1973 c 643 s 12; 1976 c 2 s 164]

176.665 [Repealed, 1973 c 643 s 12; 1976 c 2 s 164]

176.666 [Repealed, 1973 c 643 s 12; 1976 c 2 s 164]

176.667 [Repealed, 1973 c 643 s 12; 1976 c 2 s 164]

176.668 [Repealed, 1973 c 643 s 12; 1976 c 2 s 164]

176.669 [Repealed, 2008 c 250 s 18]

176.67 [Repealed, 1953 c 755 s 83]

176.68 [Repealed, 1953 c 755 s 83]

176.69 [Repealed, 1953 c 755 s 83]

176.70 [Repealed, 1953 c 755 s 83]

176.71 [Repealed, 1953 c 755 s 83]

176.72 [Repealed, 1953 c 755 s 83]

176.73 [Repealed, 1953 c 755 s 83]

176.74 [Repealed, 1953 c 755 s 83]

176.75 [Repealed, 1953 c 755 s 83]

176.76 [Repealed, 1953 c 755 s 83]

176.77 [Repealed, 1953 c 755 s 83]

176.78 [Repealed, 1953 c 755 s 83]

176.79 [Repealed, 1953 c 755 s 83]

176.80 [Obsolete]

176.81 [Repealed, 1953 c 755 s 83]

176.82 ACTION FOR CIVIL DAMAGES FOR OBSTRUCTING EMPLOYEE SEEKING BENEFITS.

Subdivision 1. **Retaliatory discharge.** Any person discharging or threatening to discharge an employee for seeking workers' compensation benefits or in any manner intentionally obstructing an employee seeking workers' compensation benefits is liable in a civil action for damages incurred by the employee including any diminution in workers' compensation benefits caused by a violation of this section including costs and reasonable attorney fees, and for punitive damages not to exceed three times the amount of any compensation benefit to which the employee is entitled. Damages awarded under this section shall not be offset by any workers' compensation benefits to which the employee is entitled.

Subd. 2. **Refusal to offer continued employment.** An employer who, without reasonable cause, refuses to offer continued employment to its employee when employment is available within the employee's physical limitations shall be liable in a civil action for one year's wages. The wages are payable from the date of the refusal to offer continued employment, and at the same time and at the same rate as the employee's preinjury wage, to continue during the period of the refusal up to a maximum of $15,000. These payments shall be in addition to any other payments provided by this chapter. In determining the availability of employment, the continuance in business of the employer shall be considered and written rules promulgated by the employer with respect to seniority or the provisions or any collective bargaining agreement shall govern. These payments shall not be covered by a contract of insurance. The employer shall be served directly and be a party to the claim. This subdivision shall not apply to employers who employ 15 or fewer full-time equivalent employees.

History: *1975 c 359 s 21,23; 1995 c 231 art 1 s 30*

RULES

176.83 RULES.

Subdivision 1. **Generally.** In addition to any other section under this chapter giving the commissioner the authority to adopt rules, the commissioner may adopt, amend, or repeal rules to implement the provisions of this chapter. The rules include but are not limited to the rules listed in this section.

Subd. 2. **Rehabilitation.** Rules necessary to implement and administer section 176.102, including the establishment of qualifications necessary to be a qualified rehabilitation consultant and the requirements to be an approved registered vendor of rehabilitation services.

The rules may also provide for penalties to be imposed by the commissioner against insurers or self-insured employers who fail to provide rehabilitation consultation to employees pursuant to section 176.102.

These rules may also establish criteria for determining "reasonable moving expenses" under section 176.102.

The rules shall also establish criteria, guidelines, methods, or procedures to be met by an employer or insurer in providing the initial rehabilitation consultation required under this chapter which would permit the initial consultation to be provided by an individual other than a qualified rehabilitation consultant. In the absence of rules regarding an initial consultation this consultation shall be conducted pursuant to section 176.102.

Subd. 3. **Clinical consequences.** Rules establishing standards for reviewing and evaluating the clinical consequences of services provided by qualified rehabilitation consultants, approved registered vendors of rehabilitation services, and services provided to an employee by health care providers.

Subd. 4. **Excessive charges for medical services.** Rules establishing standards and procedures for determining whether or not charges for health services or rehabilitation services rendered under this chapter are excessive. In this regard, the standards and procedures shall be structured to determine what is necessary to encourage providers of health services and rehabilitation services to develop and deliver services for the rehabilitation of injured employees.

The procedures shall include standards for evaluating hospital care, other health care and rehabilitation services to insure that quality hospital, other health care, and rehabilitation is available and is provided to injured employees.

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

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

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

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

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

(4) criteria for diagnostic imaging procedures;

(5) criteria for inpatient hospitalization;

(6) criteria for treatment of chronic pain;

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

(8) criteria for treatment of post-traumatic stress disorder. In developing such treatment criteria, the commissioner and the Medical Services Review Board shall consider the guidance set forth in the American Psychological Association's most recently adopted Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults. The commissioner shall adopt such rules using the expedited rulemaking process in section 14.389, including subdivision 5, to commence promptly upon May 20, 2018. Such rules shall apply to employees with all dates of injury who receive treatment after the commissioner adopts the rules. In consultation with the Medical Services Review Board, the commissioner shall review and update the rules governing criteria for treatment of post-traumatic stress disorder each time the American Psychological Association adopts a significant change to their Clinical Practice Guideline for the Treatment of PTSD in Adults, using the expedited rulemaking process in section 14.389, including subdivision 5.

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

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

Subd. 5a. **Reporting.** Rules requiring insurers, self-insurers, and group self-insurers to report medical and other data necessary to implement the procedures required by this chapter.

Subd. 6. **Certification of medical providers.** Rules establishing procedures and standards for the certification of physicians, chiropractors, podiatrists, and other health care providers in order to assure the coordination of treatment, rehabilitation, and other services and requirements of chapter 176 for carrying out the purposes and intent of this chapter.

Subd. 7. **Miscellaneous rules.** Rules necessary for implementing and administering the provisions of Minnesota Statutes 1990, section 176.131, Minnesota Statutes 1994, section 176.132, sections 176.238 and 176.239; sections 176.251 and 176.66, and rules regarding proper allocation of compensation under section 176.111. Under the rules adopted under section 176.111 a party may petition for a hearing before a compensation judge to determine the proper allocation. In this case the compensation judge may order a different allocation than prescribed by rule.

Subd. 8. **Change of provider.** Rules establishing standards or criteria under which a physician, podiatrist, or chiropractor is selected or under which a change of physician, podiatrist, or chiropractor is allowed under section 176.135, subdivision 2.

Subd. 9. **Intervention.** Rules to govern the procedure for intervention pursuant to section 176.361.

Subd. 10. **Joint rules.** Joint rules with either or both the Workers' Compensation Court of Appeals and the chief administrative law judge which may be necessary in order to provide for the orderly processing of claims or petitions made or filed pursuant to this chapter.

Subd. 11. **Independent contractors.** Rules establishing criteria to be used by the division, compensation judge, and court of appeals to determine "independent contractor."

Subd. 12. **Compensation judge procedures.** The chief administrative law judge shall adopt rules relating to procedures in matters pending before a compensation judge in the Office of Administrative Hearings.

Subd. 13. **Claims adjuster.** The commissioner may adopt rules regarding requirements which must be met by individuals who are employed by insurers or self-insurers or claims servicing or adjusting agencies and who work as claims adjusters in the field of workers' compensation insurance.

Subd. 14. [Deleted, 1995 c 233 art 2 s 56]

Subd. 15. **Forms.** The commissioner may prescribe forms and other reporting procedures to be used by an employer, insurer, medical provider, qualified rehabilitation consultant, approved vendor of rehabilitation services, attorney, employee, or other person subject to the provisions of this chapter.

History: *1983 c 290 s 165; 1984 c 432 art 2 s 50; 1984 c 640 s 32; 1986 c 461 s 36; 1987 c 332 s 110-112; 1987 c 384 art 2 s 44; art 3 s 4; 1992 c 510 art 4 s 21,22; 1995 c 231 art 2 s 99; 1996 c 305 art 1 s 48; 1997 c 7 art 5 s 17; 2008 c 250 s 16; 2013 c 70 art 2 s 11; 2018 c 185 art 5 s 6*

SPECIFICITY OF NOTICE

176.84 SPECIFICITY OF NOTICE OR STATEMENT.

Subdivision 1. **Specificity required.** Notices of discontinuance and denials of liability shall be sufficiently specific to convey clearly, without further inquiry, the basis upon which the party issuing the notice or statement is acting. If the commissioner or compensation judge determines that a notice or statement is not sufficiently specific to meet the standard under this section, the notice or statement may be rejected as unacceptable and the party issuing it shall be informed of this. The rejected notice or statement may be amended to meet the requirement of this section or a new one may be filed.

Subd. 2. **Penalty.** The commissioner or compensation judge may impose a penalty of $500 for each violation of subdivision 1. This penalty is payable to the commissioner for deposit in the assigned risk safety account.

Subd. 3. **Effective date.** This section shall not be effective until the commissioner adopts rules which specify what is required to be contained in the notice of discontinuance and the denial of liability.

History: *1983 c 290 s 166; 1987 c 332 s 113; 1995 c 231 art 2 s 100; 2002 c 262 s 22*

PENALTIES

176.85 PENALTIES; APPEALS.

Subdivision 1. **Appeal procedure.** If the commissioner has assessed a penalty against a party subject to this chapter and the party believes the penalty is not warranted, the party may request that a formal hearing

be held on the matter. The request must be filed within 30 days of the date that the penalty assessment is served on the party. Upon receipt of a timely request for a hearing the commissioner shall refer the matter to the chief administrative law judge for assignment to a compensation judge or administrative law judge.

The chief administrative law judge shall keep a record of the proceeding and provide a record pursuant to section 176.421.

The decision of the compensation judge or administrative law judge shall be final and shall be binding and enforceable. The decision may be appealed to the Workers' Compensation Court of Appeals.

Subd. 2. **Exception.** This section does not apply to penalties for which another appeal procedure is provided, including but not limited to penalties imposed pursuant to section 176.102 or 176.103.

Subd. 3. **Hearing costs.** For purposes of this section, a hearing before an administrative law judge shall be treated in the same manner as a hearing before a compensation judge and no costs may be charged to the commissioner for the hearing, regardless of who hears it.

History: *1983 c 290 s 167; 1984 c 432 art 2 s 51; 1984 c 640 s 32*

176.86 [Repealed, 1995 c 231 art 1 s 36]

DISCLOSURE

176.861 DISCLOSURE OF INFORMATION.

Subdivision 1. **Insurance information.** The commissioner may, in writing, require an insurance company to release to the commissioner any or all relevant information or evidence the commissioner deems important which the company may have in its possession relating to a workers' compensation claim including material relating to the investigation of the claim, statements of any person, and any other evidence relevant to the investigation. The writing from the commissioner requiring release of the information shall contain a statement that the commissioner has reason to believe a crime or civil fraud has been committed with respect to an insurance claim, payment, or application.

Subd. 2. **Information released to authorized persons.** If an insurance company has evidence that a claim may be fraudulent, the company shall, in writing, notify the commissioner and provide the commissioner with all relevant material related to the company's inquiry into the claim.

Subd. 3. **Good faith immunity.** An insurance company or its agent acting in its behalf and in good faith who releases oral or written information under subdivisions 1 and 2 is immune from civil or criminal liability that might otherwise be incurred or imposed.

Subd. 4. **Self-insurer; assigned risk plan.** For the purposes of this section "insurance company" includes a self-insurer and the assigned risk plan and their agents.

History: *1995 c 231 art 1 s 31*

176.862 DISCLOSURE TO LAW ENFORCEMENT.

The commissioner must disclose the current address of an employee collected or maintained under this chapter to law enforcement officers who provide the name of the employee and notify the commissioner

that the employee is a person required to register under section 243.166 and is not residing at the address at which the employee is registered under section 243.166.

History: *2000 c 311 art 6 s 3*

STATE EMPLOYEE CONTRACTING TUBERCULOSIS

176.87 EMPLOYEES CONTRACTING TUBERCULOSIS TO RECEIVE MEDICAL CARE AND COMPENSATION.

Any sanitarium, medical laboratories or institutional employee of the state or of any county or other subdivision of the state, or any duly licensed nurse employed by the state or by any county, city, nursing district or other subdivision of the state, whose duties in connection with such employment bring or have brought the employee or nurse in contact with patients or persons who are afflicted with tuberculosis, or with tuberculosis contaminated material, who contracts tuberculosis, shall be entitled to the medical care and compensation provided by sections 176.87 to 176.873. "Contracts tuberculosis" shall be construed to mean the development of demonstrable lesions of tuberculosis or the demonstration of the germs of tuberculosis in that person's secretions or excretions.

History: *1947 c 616 s 1; 1949 c 558 s 2; 1957 c 31 s 1; 1973 c 123 art 5 s 7; 1986 c 444; 2014 c 262 art 3 s 18; art 5 s 6; 2024 c 79 art 9 s 8; art 10 s 1; 2024 c 125 art 5 s 38; 2024 c 127 art 50 s 38*

176.871 REPORT OF ILLNESS OF EMPLOYEE, HEARING ON CLAIM.

Whenever the superintendent of any state, county or city sanitarium, medical laboratories or other institution, or the head of any department of the state or of any county, city, nursing district or other subdivision of the state employing licensed nurses, learns that any employee of the institution or department whose duties bring the employee in contact with patients or inmates or who works in and around any tuberculosis contaminated material, has contracted tuberculosis while employed in the institution or department, the superintendent or department head shall report the illness to the Workers' Compensation Division. Copies of the report shall be sent to the Direct Care and Treatment executive board if a state institution; to the head of the department if a department of the state; to the county board if a county institution or department; or to the governing body of the city or other subdivision of the state which employs the afflicted person. The commissioner of labor and industry, upon receiving the report, shall mail to the superintendent of the institution or the head of the department blank forms to be filled out by the employee claiming the medical and sanitarium treatment and compensation provided for in this chapter. The commissioner of labor and industry shall set the claim on for hearing and determination in the same manner as claims of other public employees under the workers' compensation law are heard and determined.

History: *1947 c 616 s 2; 1949 c 558 s 3; 1957 c 31 s 2; Ex1967 c 1 s 6; 1973 c 123 art 5 s 7; 1973 c 388 s 166; 1975 c 359 s 23; 1984 c 654 art 5 s 58; 1986 c 444; 2024 c 79 art 9 s 9; art 10 s 1; 2024 c 125 art 5 s 38; 2024 c 127 art 50 s 38*

176.872 FINDINGS, PAYMENT OF MEDICAL CARE AND COMPENSATION.

Subdivision 1. **Duty to seek treatment.** If upon the evidence mentioned in section 176.871, the workers' compensation division finds that an employee is suffering from tuberculosis contracted in the institution or department by contact with inmates or patients therein or by contact with tuberculosis contaminated material therein, it shall order the employee to seek the services of a physician, advanced practice registered nurse, physician assistant, or medical care facility.

Subd. 2. **Payment for medical care.** The physician, advanced practice registered nurse, physician assistant, or facility where the employee may be received must be paid the same fee for the maintenance and care of the person as is received by the institution for the maintenance and care of a nonresident patient. If the employee worked in a state hospital or nursing home, the Direct Care and Treatment executive board must pay for the care. If employed in any other institution or department the payment must be made from funds allocated or appropriated for the operation of the institution or department.

Subd. 3. **Payment of compensation.** If the employee dies from the effects of the disease of tuberculosis and if the tuberculosis was the primary infection and the authentic cause of death, the workers' compensation division shall order payment to dependents as provided for under the general provisions of the workers' compensation law.

Subd. 4. **Presumption of risk.** Whenever it appears that any employee subject to the provisions of sections 176.87 to 176.873 has come into contact with persons who are afflicted with tuberculosis or with tuberculosis contaminated material in connection with the employment and has subsequently contracted tuberculosis it shall be presumed that such employee contracted tuberculosis by such contact and while working within the scope of employment.

Subd. 5. **Date of contracting tuberculosis.** When an employee has contracted tuberculosis within the meaning of subdivision 1, the periods of time specified in section 176.141 shall be computed from the date that a confirmed diagnosis of tuberculosis is first communicated to the employee.

Subd. 6. **Payment for medical care of students and trainees.** (a) Any student nurse, medical student, or physician in training, who contracts tuberculosis as a result of direct contact with tuberculosis patients during the course of training, or internship in a public tax-supported hospital in this state, may be given care and treatment in a public tax-supported hospital operated and controlled by the county in which the public tax-supported hospital is located, and at the expense of the county in which the public hospital is located.

(b) Application for such care and treatment shall be made by such student nurse, medical student, or medical intern at any time during the course of training or internship, and after the termination thereof, application shall be made within 12 months after the termination of said training or internship.

History: *1947 c 569 s 1,2; 1947 c 616 s 3; 1949 c 558 s 4; 1957 c 31 s 3-5; 1957 c 287 s 3; Ex1967 c 1 s 6; 1973 c 123 art 5 s 7; 1973 c 388 s 167; 1975 c 359 s 23; 1976 c 2 s 88; 1980 c 357 s 18,20; 1984 c 654 art 5 s 58; 1986 c 444; 2014 c 262 art 3 s 18; art 5 s 6; 2020 c 115 art 4 s 96; 2022 c 58 s 118; 2024 c 79 art 9 s 10; art 10 s 1; 2024 c 125 art 5 s 38; 2024 c 127 art 50 s 38*

176.873 APPLICATION TO CERTAIN CASES.

Laws 1949, chapter 558, shall not be construed to apply in the case of employees known to have had tuberculosis as demonstrated by tuberculous lesions of the adult type or by demonstration of the germs of tuberculosis in such employee's secretions or excretions previous to or at the time of employment in said institutions. Laws 1949, chapter 558, shall apply in the case of employees known to have only an allergic reaction to tuberculin or only evidence of a healed primary infection if they contract tuberculosis while employed in said institutions. Laws 1949, chapter 558, shall apply to all employees of said institutions who sustain an accidental inoculation of the germs of tuberculosis through the skin and become disabled thereby.

History: *1949 c 558 s 5; 2024 c 79 art 10 s 1; 2024 c 125 art 5 s 38; 2024 c 127 art 50 s 38*

176.874 POLICE OFFICERS CONTRACTING TUBERCULOSIS.

Any police officer of the state or of any county or municipal subdivision of the state whose duties within the scope of employment as a police officer bring or did bring the officer in contact with persons afflicted with tuberculosis, which said police officer contracts or becomes ill from tuberculosis, shall be entitled to the medical care and compensation provided for by sections 176.874 to 176.876. "Contracts tuberculosis" shall be construed to mean the development of demonstrable tuberculosis in the police officer.

History: *1955 c 340 s 1; 1986 c 444; 2024 c 79 art 10 s 1,2; 2024 c 125 art 5 s 38; 2024 c 127 art 50 s 38*

176.875 REPORT OF ILLNESS.

Whenever the head of any state, county or city police department learns that any police officer employed by such department whose duties bring or did bring the employee in contact with any person suffering from tuberculosis while said police officer was in discharge of duties within the scope of employment, has contracted or become ill from tuberculosis while employed in such department, such head of the police department shall report such illness to the workers' compensation division. Copies of such report shall be sent to the commissioner of the Department of Human Services if a state police officer, to the county board if a county police officer, and to the governing body of the city if a municipal officer. The commissioner of the Department of Labor and Industry, upon receiving such report shall mail to the head of the department blank forms to be filled out by such employee claiming the medical and sanitarium treatment and compensation hereinafter provided for. The commissioner of the Department of Labor and Industry shall thereupon set the claim on for hearing and determination in the same manner as claims of other public employees under the workers' compensation law are heard and determined.

History: *1953 c 593 s 2; 1955 c 340 s 2; Ex1967 c 1 s 6; 1973 c 123 art 5 s 7; 1973 c 388 s 168; 1975 c 359 s 23; 1984 c 654 art 5 s 58; 1986 c 444; 2024 c 79 art 10 s 1; 2024 c 125 art 5 s 38; 2024 c 127 art 50 s 38*

176.876 OFFICERS ADMITTED TO HOSPITAL; PAYMENTS.

If upon the evidence mentioned in section 176.875, the Workers' Compensation Division finds that a police officer is suffering from tuberculosis contracted by contact with persons suffering from tuberculosis while the police officer was working within the scope of the officer's employment, it shall require the police officer to seek the services of a physician or a medical care facility. There shall be paid to the physician or facility where the employee may be received the same fee for the maintenance and care of the employee as is received by the facility for the maintenance and care of a nonresident patient, and the fees shall be paid by the state, county or city in whose employment the police officer was hired and working at the time the police officer contracted the tuberculosis. The police officer shall receive full hospital care and medical care without cost for the duration of the infection of tuberculosis or any recurrence thereof or any disability resulting therefrom. Further, the Workers' Compensation Division shall order payment to the police officer by the state, county or city concerned, of the compensation provided for under the general provisions of the workers' compensation law, including benefits to dependents as defined by the workers' compensation law, if the police officer dies from the effects of the disease of tuberculosis and if the tuberculosis was the primary infection and the authentic cause of death.

History: *1955 c 340 s 3; 1957 c 287 s 3; Ex1967 c 1 s 6; 1973 c 123 art 5 s 7; 1973 c 388 s 169; 1975 c 359 s 23; 1980 c 357 s 19; 2024 c 79 art 10 s 1,2; 2024 c 125 art 5 s 38; 2024 c 127 art 50 s 38*