MINNESOTA SENATE

RESEARCH REPORT

SUMMARY OF

MINNESOTA'S WORKERS' COMPENSATION LAW

MINNESOTA STATUTES CHAPTER 176

Senate Counsel & Research

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December 1987

DEFINITIONS OF KEY TERMS

The following are brief definitions of key terms used in the workers' compensation law and/or this summary:

"Administrative conference" means a meeting conducted at the department of labor and industry by the commissioner or the commissioner's designee where parties to a workers' compensation dispute can discuss on an expedited basis and in an informal setting their viewpoints concerning disputed issues arising under the workers' compensation law. If the parties are unable to resolve the dispute, the commissioner or the commissioner's designee must issue an administrative decision which is binding on the parties, but is appealable.

"Assigned risk plan" means a plan of insurance administered by the department of commerce for the purpose of providing workers' compensation coverage to employers who have been rejected by a licensed insurance company. The plan is funded by premiums paid by plan participants and by assessments against all licensed insurers in this state.

"Commissioner" means the commissioner of the department of labor and industry, unless otherwise indicated.

"Compensation judge" means a judge at the office of administrative hearings who conducts formal hearings involving workers' compensation disputed issues.

"De novo hearing" means a new hearing where all issues in dispute are reheard without being bound by decisions or rulings on those issues in earlier proceedings on the matter.

"Department" means the department of labor and industry, unless otherwise indicated.

"Dependent allowance benefits" means compensation payable to surviving dependents in cases where the injured employee dies.

"Economic recovery compensation benefits" means compensation paid to an injured employee for bodily function loss as a result of permanent partial disability from a personal injury. Such compensation is paid in lieu of impairment compensation when the employer has not offered to or procured for the injured employee a suitable job within 90 days after the employee has reached maximum medical improvement. Economic recovery compensation must be at least 120 percent of the impairment compensation that would otherwise be payable.

"Health care provider" means a physician, podiatrist, chiropractor, dentist, optometrist, osteopath, psychologist, psychiatric social worker, and any other person who furnishes a medical or health service to an injured employee under the workers' compensation law, but does not include qualified rehabilitation consultants and approved rehabilitation vendors.

"Impairment compensation benefits" means compensation paid to an injured employee for bodily function loss as a result of permanent partial disability from a personal injury. Such compensation is paid to an injured employee who has had a suitable job offered or procured by the employer within 90 days after the employee has reached maximum medical improvement. Impairment compensation will always be at least 20 percent lower than economic recovery compensation.

"Light duty job" means a job which is consistent with an approved plan of rehabilitation, or if no rehabilitation plan has been approved, a job which is within the injured employee's physical limitations.

"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.

"Medical services review board" means a board composed of statutorily designated types of individuals whose primary functions include providing certain consultation, recommendations, and assistance to the commissioner of labor and industry, as well as responsibility for disciplining health care providers who violate provisions of the workers' compensation law.

"Monitoring period" means the number of weeks during which economic recovery compensation would have been paid if that compensation were payable.

"Monitoring period compensation" means compensation which is paid to an injured employee who accepts a suitable job but is subsequently unemployed at that job during the monitoring period because of economic conditions other than seasonal conditions.

"Occupational disease" means a disease arising out of and in the course of employment peculiar to the occupation in which the employee is engaged and due to causes in excess of the hazards ordinary of employment. An occupational disease arises out of the employment only if there is a direct causal connection between the conditions under which the work is performed and the disease follows as a natural incident of the work due to the exposure occasioned by the nature of the employment.

"Permanent partial disability benefits" means compensation paid to an injured employee for permanent bodily function loss as a result of the employee's personal injury. Such compensation is paid out as either impairment compensation or economic recovery compensation, whichever is applicable.

"Permanent total disability benefits" means compensation paid to an injured employee for wage replacement loss resulting from any injury which totally incapacitates the employee from working at an occupation which brings the employee an income. These benefits are also paid following certain statutorily set types of permanent bodily function loss injuries, whether or not employee is totally incapacitated from working at an income producing occupation.

"Personal injury" means an injury arising out of and in the course of employment and includes injuries caused by an occupational disease.

"Qualified rehabilitation consultant" means an individual who provides rehabilitation consultation and services to an injured employee.

"Rehabilitation review panel" means a panel composed of statutorily designated types of individuals whose primary functions include review and determinations with respect to appeals from orders of the commissioner of labor and industry regarding certification approval of qualified rehabilitation consultants and vendors, and discipline of those consultants and vendors for violations of the workers' compensation law and rules adopted pursuant thereto.

"Rehabilitation service provider" means a qualified rehabilitation consultant or other rehabilitation service vendor who provides rehabilitation services to an injured employee.

"Special compensation fund" means a fund established under the workers' compensation law for the purpose of administering specialized programs designed to increase the fairness and efficiency of that law, including subsequent injury fund and supplementary benefits reimbursements, as well as to cover the costs of administering the provisions of the workers' compensation law and verifying compliance with that law's insurance requirements.

"Subsequent injury fund" means a component of the special compensation fund designed to encourage employers to hire and retain workers with physical impairments that are permanent in nature and which are likely to be a hindrance or obstacle to finding and maintaining employment. This purpose is accomplished by reimbursing employers partially or totally for the cost of workers' compensation personal injury claims that were made more severe and expensive because of the original physical impairment, or were new injuries that would not have occurred if the physical impairment had not existed prior to the subsequent injury.

"Suitable job" means a job that is consistent with an injured employee's approved plan of rehabilitation or, if no plan has been approved, that the employee can do in his or her physical condition, and the job is one that produces an economic status as close as possible to that the employee would have enjoyed without the disability.

"Supplementary benefits" means compensation in addition to benefits received for a temporary total or permanent total disability, whichever is applicable, paid to an injured employee who has been totally disabled for a statutorily set number of weeks. Supplementary benefits are paid for the remainder of the period of total disablement.

"Temporary partial disability compensation" means compensation paid to an injured employee to provide supplemental wage loss replacement in cases where the injured employee goes back to work at a light duty job or suitable job which pays less than his or her pre-injury wage.

"Temporary total disability benefits" means compensation paid to an injured employee to provide wage loss replacement while the injured employee is out of work and recovering from his or her personal injury.

"Workers' compensation reinsurance association" means a nonprofit association created by statute providing excess of loss reinsurance coverage for Minnesota's workers' compensation claims. Membership in the WCRA is a condition of granting an insurer a license to write workers' compensation insurance in Minnesota and a self-insurer's authority to assume the risk of its own workers' compensation losses. Reinsurance premiums are determined as a percentage of each member's workers' compensation exposure in Minnesota.

INTENT OF THE LEGISLATURE

The legislature has specifically expressed its intent with regard to the workers' compensation law as follows:

> . . . 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 . . . 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 the rights and interests of the employer to be favored over those of the employee on the other hand.

SCOPE OF COVERAGE

(Employer Liability)

Every employer subject to the workers' compensation law is liable to pay workers' compensation benefits 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 employee has the burden of proving the existence of a personal injury.

In cases involving an occupational disease, the employer liable for workers' compensation benefits for that type of personal injury is the employer in whose employment the employee was last exposed in a significant way to the hazard of the occupational disease.

When compensation is payable under the workers' compensation law for the personal injury or death of an employee employed and paid jointly by two or more employers at the time of the injury or death, both employers are required to contribute to the payment of compensation in proportion to their wage liabilities to the employee.

(Excluded Employments; Election of Coverage)

Workers' compensation coverage and benefits do not apply to certain statutorily excluded employments. However, certain persons, partnerships, and corporations not otherwise covered under the workers' compensation law may elect to provide the insurance coverage required under that law, provided notice of the election of coverage is provided in writing to the insurer. In addition, an employer of workers on a farm operation or household workers not otherwise covered under the law may assume the liability for its uncovered employees. Such employer's procurement of a workers' compensation insurance policy constitutes an assumption of liability unless the employer elects in writing not to have those persons covered and the policy states that election.

(Application of WC Law to Out-of-State Injuries and Employments; Resolving Jurisdictional Conflicts)

The provisions of the workers' compensation law apply to injuries occurring out-of-state and also to individuals employed by out-of-state employers as follows:

(1) to an employee who regularly performs the primary duties of employment within Minnesota and who receives an injury while outside of this state while in the employ of the Minnesota employer;

(2) to an employee hired in this state by a Minnesota employer who receives an injury while temporarily employed outside of this state; and

(3) to an employee who regularly performs primary duties of employment outside of Minnesota or who was hired to perform the primary duties of employment outside of this state and who receives an injury within this state in the employ of the out-of-state employer, provided the injured employee chooses to forego any workers' compensation claim resulting from the injury that the employee may have a right to pursue in another state.

The commissioner of labor and industry is authorized to enter into agreements with the appropriate agencies of other states for the purpose of resolving conflicts of jurisdiction or disputes concerning workers' compensation coverage.

(Exclusive Liability Under WC Law; Exceptions)

The liability of an employer under the workers' compensation law is exclusive and in the place of any other liability to the injured employee or other person entitled to recover damages on account of the personal injury or death. There are, however, certain exceptions to this exclusive liability rule. These exceptions generally apply to situations where an employer fails to insure or self-insure as required under the workers' compensation law, and to situations where the personal injury or death occurs under circumstances which create a legal liability for damages on the part of a third party other than the employer. In such situations, the injured employee, legal representative, or, if applicable, any dependent may elect to claim compensation under the workers' compensation law or to maintain an action in the courts for damages on account of the personal injury or death. In addition, in one specified third party liability instance, the injured employee or legal representative may proceed both against the employer under the workers' compensation law and in an action at law against the third party. The employer or special compensation fund generally has a right of indemnity and subrogation in election of remedies or cumulative remedies cases.

COMPENSATION BENEFITS

(In General)

The purpose of Minnesota's "two-tier" system of workers' compensation benefits is to encourage the employer to return the injured employee to work as soon as possible and to provide incentives to the employee to do so likewise. The types of compensation benefits provided under the workers' compensation law are discussed below.

(Temporary Total Disability Benefits)

Temporary total disability benefits are designed to provide wage loss replacement while the injured worker is out of work and recovering from his or her personal injury. The benefits are paid at the intervals when the wage was payable or as nearly as close thereto. For an injury producing temporary total disability, the compensation benefit payable is 66-2/3 percent of the injured worker's weekly wage at the time of the injury, subject to a maximum and minimum amount.

The maximum weekly compensation payable is the statewide average weekly wage for the period ending December 31 of the preceding year; except that, in cases involving an occupational disease, the maximum compensation is equal to the maximum compensation in effect on the date of last exposure. The minimum weekly compensation payable is 50 percent of the statewide average weekly wage or the injured worker's actual weekly wage, whichever is less, but in no case can it be less than 20 percent of the statewide average weekly wage.

The injured employee's temporary total compensation must cease 90 days after the employee has reached maximum medical improvement or 90 days after the end of an improved retraining program, whichever is later. Temporary total compensation ceases prior to the end of the 90-period, however, if: the employee retires, the employer furnishes the employee with a light duty job or suitable job, or the employer provides or procures such employment with another employer; or the employee accepts a light duty or suitable job with another employer. Temporary total compensation does not actually cease until the job commences, however. Temporary total compensation also ends if and when the employee refuses to accept a light duty or suitable job offer.

Temporary total compensation is never paid concurrently with impairment compensation or economic recovery compensation, whichever is applicable.

(Temporary Partial Disability Benefits)

Temporary partial disability benefits are designed to provide supplemental wage loss replacement in cases where an injured employees goes back to work at a light duty job or suitable job which pays less than the preinjury wage. The compensation is paid at the intervals when the wage was payable or as nearly as close thereto. The compensation benefit for temporary partial disability is 66-2/3 percent of the difference between the injured worker's weekly wage at the time of the injury and the wage the employee is able to earn in his or her partially disabled condition. Temporary partial disability benefits are subject to the same minimum and maximum benefits described above for temporary total disability benefits.

The workers' compensation law is somewhat unclear as to when temporary partial disability benefits end. The Workers' Compensation Court of Appeals has held that an injured worker who returns to work after reaching maximum medical improvement (MMI) in a job which pays less than the preinjury wage is indefinitely entitled to temporary partial disability benefits. This decision seems to be clearly consistent with express statutory language. However, that same court has held, in a highly controversial decision, that temporary partial disability benefits are also payable in a case where the individual has reached MMI, has received no suitable job offer from the employer, and is unable to find a job on his or her own or, if one is found, to continue working at that job. In such cases, the court has interpreted the statute to provide for the payment of temporary partial disability benefits at the temporary total compensation rate. This controversial decision is clearly arguable, appears to argue from statutory silence, and may be an interpretation of the statute which is in violation of the legislative intent section of the workers' compensation law. The decision is presently on appeal before the Minnesota Supreme Court. It is clear in statute, however, that temporary partial disability benefits do come to an end, along with the ending of rehabilitation benefits as well, if the injured worker is offered and rejects a suitable job and the employee subsequently returns to another job which pays a wage less than the preinjury wage.

(Permanent Partial Disability Benefits)

Permanent partial disability benefits are designed to compensate the injured worker for any permanent bodily function loss as a result of his or her personal injury. The commissioner has established by rule a schedule of degrees of disability resulting from different kinds of injuries. The amount received for a particular injury is either impairment compensation or economic recovery compensation, but not both, and depends on whether the employer has offered to or procured for the injured employee a suitable job within 90 days after the injured worker has reached his or her maximum medical improvement (MMI) and whether or not the employee has accepted such position.

Generally, an employee who is offered a suitable job within the 90-day post-MMI period is entitled to receive the permanent partial disability benefit called impairment compensation in an amount based on the percent of bodily disability and equal to the proportion that the loss of function of the disabled part bears to the whole body multiplied by a statutory schedule amount which is aligned with that percent. For example, the statutory schedule amount for 46 to 50 percent disability is presently $100,000. Thus, if the injured worker suffered 48 percent disability, the impairment award would be equal to $48,000.

Generally, an employee who is not offered a suitable job within the 90-day post-MMI period is entitled to receive the greater permanent partial disability benefit called economic recovery compensation which is also an amount based on the percent of bodily disability. The actual amount is equal to 66-2/3 percent of the injured worker's weekly wage at the time of the injury, subject to a maximum amount equal to the statewide average weekly wage, and paid for a statutorily determined number of weeks. Specifically, the proportion that the loss of function of the disabled part bears to the whole body is multiplied by the number of statutory schedule weeks aligned with that percent. For example, the statutory number of weeks associated with 46 to 50 percent disability is 800 weeks. Thus, an injured worker who had a 48 percent disability would be eligible for 384 weeks of compensation at the above rate.

Whether permanent partial disability benefits are paid out as impairment compensation or economic recovery compensation, the maximum compensation payable to an injured employee is the maximum compensation payable for a 100 percent disability to the body as a whole. The injured employee is never entitled to receive more than that amount even if the employee sustains a disability to two or more body parts and the adding together of the disability schedule percentages for injuries to those body parts exceeds 100 percent.

Economic recovery compensation benefits will always be greater in total than the impairment compensation award for the same type of injury. The workers' compensation law provides that economic recovery compensation must be at least 120 percent of the impairment compensation that the employee would receive if that compensation were payable to the employee. Thus, in theory, under this so-called "two-tier" system of benefits, there is an economic incentive for the employer to offer or procure a suitable job to or for the injured employee after he or she has attained maximum medical improvement and thereby return that individual to work. Otherwise, the employer will be liable for the greater permanent partial disability award (i.e., economic recovery compensation). Likewise, there is an incentive for the employee to accept a light duty or suitable job offer and return to work because if he or she doesn't, impairment compensation benefits will be paid in installments instead of a lump sum, the individual will lose rehabilitation benefits, and temporary partial disability benefits which might otherwise have been payable if the individual later finds a job on his or her own will not be allowed. Applications of the two-tier system and the incentives involved are discussed below.

Job Offered/Accepted

To avoid having to pay the higher economic recovery compensation benefit, an employer must make a suitable job offer to the injured employee within 90 days after the employee has reached maximum medical improvement. Upon receipt of a written medical report indicating MMI, the 90-day period begins. The job itself, however, does not have to commence immediately but must commence within a reasonable period after the 90-day period.

The job offer must be in writing and must describe the nature of the job, the rate of pay, the physical requirements of the job, and any other information necessary to fully and completely inform the employee of the job duties and responsibilities. The employee has 14 days after receipt of the written job offer to accept or reject it. If accepted, the employee will receive impairment compensation paid in a lump sum 30 calendar days after the employee actually commences work, provided the employment has not been substantially interrupted by the injury for any part of the 30 days and the employee is still employed at the job at the end of that period.

Job Offered/Accepted/Subsequent Layoff

If the employee accepts a suitable job and is subsequently unemployed at that job during the monitoring period because of economic conditions other than seasonal conditions, the employee is entitled to receive monitoring period compensation, as well as rehabilitation consultation if the employee remains unemployed for 45 calendar days. This compensation is paid until either the monitoring period expires or the sum of the monitoring period compensation paid and impairment compensation paid or payable is equal to the amount of economic

recovery compensation that would have been paid if that compensation were payable, whichever occurs first, or until the employee returns to work.

Monitoring period compensation is payable at the same intervals and at the same rate as when temporary total compensation ceased, provided that the minimum rate for such compensation is 66-2/3 percent of the weekly wage for permanent partial disability, and subject to a statutorily determined maximum weekly wage.

If the employee accepts a suitable job offer and is subsequently laid off that job due to seasonal conditions, the employee is not entitled to monitoring period compensation. However, the employee will receive any unemployment compensation he or she is eligible for, and in addition and concurrently, the amount that the employee was receiving for temporary partial disability at the time of the layoff, if applicable.

Job Offered/Accepted/Medically Unable to Continue

If the employee has accepted and started a suitable job and is later medically unable to continue, he or she is again eligible to receive temporary total compensation and rehabilitation consultation.

Job Offered/Rejected

If the injured employee has been offered a suitable job and has refused the offer, two consequences occur. First, temporary total compensation ceases upon the employee's refusal to accept the job offer and no further additional temporary total compensation is payable for that injury. Second, the impairment compensation which would have been paid in a lump sum had the employee accepted the job offer is instead paid out in an amount and at the intervals that temporary total compensation was initially paid. The compensation is paid out until the statutorily set total schedule amount has been reached. If, however, the employee returns to work at another job procured on his or her own, the employee then receives the remaining impairment compensation due in a lump sum 30 days after the return to work if the employment has not been substantially interrupted by the injury for any part of that 30 days and the employee is still employed in the job at the end of that period.

No Job Offer Made

If the employer fails to make a suitable job offer to the injured employee within 90 days after the employee has reached maximum medical improvement, or 90 days after the end of an approved retraining plan, whichever is later, the employee is entitled to receive economic recovery compensation (ERC) which, as indicated above, must be at least 120 percent of the impairment compensation that the employee would have received if a suitable job offer was made. The economic recovery compensation is payable at the same intervals and the same amount as the injured employee's temporary total compensation was initially paid. However, if the employee returns to work on his or her own and the economic recovery compensation is still being paid, the remaining ERC due must be paid in a lump sum 30 days after the employee has returned to work if the employment has not been substantially interrupted by the injury for any part of the 30 days and the employee is still employed at that job at the end of the 30-day period.

Light Duty Job Offered/Accepted

As indicated above, if the employer offers to or procures for the injured employee a light duty job prior to his or her reaching maximum medical improvement (MMI), temporary total disability compensation ceases. If the employee accepts the light duty job offered, he or she is entitled to temporary partial disability benefits and, in addition, will receive impairment compensation for any permanent partial disability which is ascertainable at that time. However, instead of receiving the impairment compensation in a lump sum, that compensation will be paid out at the same rate that temporary total compensation was paid. Thereafter, when the employee reaches MMI, he or she will receive either impairment compensation or economic recovery compensation depending on whether a suitable job was offered and accepted as discussed above, and that compensation will be offset by the amount of impairment compensation already received.

If the employee rejects a light duty job offer, temporary total compensation payments cease.

(Permanent Total Disability Benefits)

Permanent total disability benefits are designed to provide wage loss replacement for any personal injuries which totally incapacitate the employee from working at an occupation which brings the employee an income. These benefits, however, are also paid to an injured employee who suffers certain types of permanent bodily function loss injuries whether or not the individual is able to go back to an income-producing job. These statutory types of permanent total disability include: the loss of 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; and total and permanent loss of mental faculties. Permanent total disability payments are paid during the period of total disability and are made at the intervals when the wage was payable or as nearly as close thereto as may be.

The rate of payment for permanent total disability benefits is 66-2/3 percent of the daily wage of the injured employee at the time of the personal injury, subject to the same maximum and minimum weekly compensation amount as that discussed above for temporary total disability benefits. After a total of $25,000 of such compensation has been paid, the amount of weekly permanent total disability benefits is reduced by the amount of any disability benefits being paid by any government disability benefit program if those benefits are occasioned by the same injury or injuries which gave rise to permanent total disability benefits under the workers' compensation law. This reduction also applies to any old age or survivor's insurance benefits.

An employee who is permanently totally disabled is also entitled to receive impairment compensation payable in addition to and concurrently with the permanent total disability compensation indicated above. In such cases, the impairment compensation is paid at the same intervals and amount as the permanent total compensation was originally paid and ceases when the amount due under the statutory schedule for impairment compensation is reached.

(Dependent Allowance Benefits)

In cases where the injured worker dies, dependent allowance benefits are payable to surviving dependents. The workers' compensation law sets forth certain persons who are conclusively presumed to be dependents. The amount and duration of such benefits for each type of dependent is also set forth under that law. Actual dependents are entitled to take compensation in a statutorily specified order during the period of dependency until 66-2/3 percent of the weekly wage of the deceased at the time of the injury is exhausted. However, the total weekly compensation to be paid to full actual dependents may not exceed in aggregate an amount equal to the maximum weekly compensation for a temporary total disability. Generally, compensation paid to any dependent ceases upon the death or marriage of that dependent.

Dependence allowance benefits must be coordinated with any governmental survival benefits in order that the total combined weekly government survivor benefits and workers' compensation death benefits do not exceed 100 percent of the weekly wage being earned by the deceased employee at the time of the injury causing death.

(Supplementary Benefits)

Supplementary benefits are paid to an injured employee who has been totally disabled as follows. An employee who suffered personal injury prior to October 1, 1983, and who has been totally disabled for more than 104 weeks, is eligible for supplementary benefits for the remainder of the total disablement. An employee who suffers personal injury after October 1, 1983, is also eligible to receive supplementary benefits but only after the employee has been receiving temporary total or permanent total disability benefits for 208 weeks. Notwithstanding the 104/208 week limitation on receipt of supplementary benefits, regardless of the number of weeks of total disability, an injured employee who is receiving temporary total compensation is eligible for supplementary benefits after four years have lapsed since the first date of the temporary total disability, provided that all periods of disability were caused by the same injury. In the case of an occupational disease, the employee is eligible for supplementary benefits notwithstanding the 104/208 week limitation after four years have elapsed since the date of last significant exposure to the hazard of the occupational disease, provided the employee's weekly compensation rate is less than the current supplementary benefit rate.

The amount of supplementary benefits payable is equal to the difference between the amount the employee receives for temporary total or permanent total disability compensation, whichever is applicable, and 65 percent of the statewide average weekly wage as computed annually. Supplementary benefits are adjusted each October 1 based upon the statewide average weekly wage for the preceding calendar year. If the eligible recipient is receiving simultaneous benefits from any governmental disability program, the amount of supplementary benefits payable is reduced by five percent, unless the individual does not receive the maximum benefits for which the individual is eligible under other government disability programs due to certain provisions in the United States Code.

(Adjustment of Benefits)

Temporary total, temporary partial, and permanent total disability benefits and dependent allowance benefits, for injuries occurring after October 1, 1975, are adjusted annually on the anniversary date of the employee's injury. Total

benefits due are adjusted by multiplying the benefits payable 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. However, no adjustment increase made on October 1, 1977, or thereafter may exceed six percent a year.

Economic recovery compensation, impairment compensation, and monitoring period compensation, as discussed above, are not eligible for adjustment.

MEDICAL BENEFITS AND RELATED MATTERS

(Liability for Treatment and Supplies)

The employer of an injured worker is required to furnish any medical treatment and supplies as may be reasonably required at the time of the personal injury and at any time thereafter to cure and relieve the effects of the injury. In the case of the employer's inability or refusal to do so in a timely manner, the employer is liable for the reasonable expenses incurred by or on behalf of the employee in providing reasonably required treatment or supplies, including the cost of copies of any existing medical records and reports and attorneys fees incurred by the employee to recover these expenses.

With respect to surgical treatment, the employer is required to furnish such treatment when the surgery is reasonably required to cure and relieve the effects of the personal injury or occupational disease. The employer is required to pay the reasonable value of the surgery unless the commissioner or a compensation judge determines that the surgery is not reasonably required. If the employee desires a second opinion on the necessity of the surgery, the employer is required to pay the cost of obtaining the second opinion. Except in cases of emergency surgery, the employer or insurer may also require the employee to obtain a second opinion on the necessity of surgery, at the expense of the employer, before the employee undergoes the surgery.

The commissioner or a compensation judge may determine the reasonable value of all medical treatment, services, or supplies required to be furnished and the liability of the employer is limited to the amount so determined.

(Payment)

Health care providers are required to submit to the insurer an itemized statement of medical charges along with copies of medical reports or records that substantiate the nature of the charge and its relationship to the work-related personal injury. As soon as reasonably possible, but no later than 30 calendar days after receiving the bill, the employer or insurer must pay any portion of the charge which is not denied, deny all or part of the charge on the basis of excessiveness or noncompensability, or specify the additional data needed with written notification to the employee and health care provider. The health care provider may not collect, attempt to collect, refer for collection, or commence an action for collection, against the employee, employer, or any other party until the information required above has been furnished.

(Certification of Providers, Change of Providers)

The commissioner is authorized to establish procedures and standards for certification of health care providers in order to ensure the coordination of medical treatment, rehabilitation, and other workers' compensation services. The commissioner is also required to adopt rules establishing standards and criteria to be used when a dispute arises over a change of health care provider in the case that either the employee or the employer desires a change.

(Medical Fee Review)

The commissioner is required to establish by rule procedures for determining whether or not the charge for a health service is excessive. A

statutory limit to allowable charges for medical treatment or services is also set forth. If the employer or insurer determines that the charge is excessive, no payment in excess of the reasonable charge for that treatment or service may be made, nor may the health care provider collect or attempt to collect from the injured employee or any insurer or government amounts in excess of the amount determined to be reasonable unless the commissioner, a compensation judge, or the workers' compensation court of appeals determines otherwise.

(Medical Health Care Review)

The commissioner is required to monitor the appropriateness, necessity, effectiveness, and cost of medical and surgical treatment provided to injured employees, services of other health care providers, and hospital utilization as it relates to the treatment of injured employees. Either as a result of this monitoring, or as a result of an investigation following receipt of a complaint, the commissioner may initiate a contested case proceeding if the commissioner believes that any health care provider has violated any provision of the workers' compensation law or rules adopted pursuant thereto. In such cases, upon receipt of a report by an administrative law judge, the medical service review board may upon finding a violation issue a penalty of $100 per violation, or disqualify or suspend a provider from receiving payment for treatment or services rendered. The board's decision is appealable to the workers' compensation court of appeals.

In consultation with the medical services review board, the commissioner has authority to adopt rules establishing standards and procedures for determining whether a health care provider is performing procedures or providing services at a level or with a frequency that is excessive, based upon accepted medical standards for quality health care. The provider may not be paid for the excessive procedure or service and, in addition, the provider may not be reimbursed or attempt to collect reimbursement for the excess from the injured employee or any other source unless the commissioner or a compensation judge determines at a administrative conference or hearing that the level, frequency, or cost was not excessive.

A health care provider who is determined by the medical services review board, after a 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 under the workers' compensation law.

(Medical Services Review Board)

The Medical Services Review Board is composed of the commissioner as an ex officio member, two persons representing chiropractic, one person representing hospital administrators, and six physicians representing different specialties which the commissioner determines are the most frequently utilized by injured employees. The board must also have one person representing employees, one person representing employers or insurers, and one person representing the general public.

The board's primary functions relate to providing certain consultation, recommendations, and assistance to the commissioner, as well as the responsibility for disciplining health care providers as indicated above in this section.

(Examinations)

An injured employee must submit to examination by the employer's physician, if requested by the employer, following an injury and at reasonable times thereafter. The employer, however, must pay the reasonable travel expenses and lost wages incurred by the employee in attending the examination. At the examination, the employee is entitled upon request to have a personal physician present. Any report or written statement made by the employer's physician as a result of the examination must be made available upon request without charge to the injured employee or representative of the employee.

If the injured employee refuses to comply with any reasonable request for examination, the right to compensation under the workers' compensation law may be suspended by order of the commissioner or a compensation judge, and no further compensation may be paid while the employee continues in the refusal.

In the case of a dispute as to the injury, the commissioner, a compensation judge, or the workers' compensation court of appeals, with respect to matters before them, may with or without the request of any interested party designate a neutral physician from a list of such physicians required to be developed by the commissioner to make an examination of the injured worker and report the findings. The signed certificate of a neutral physician is competent evidence of the facts stated therein, although either party may demand that the physician be produced at the hearing or administrative conference for purposes of cross examination. The expenses of the neutral examination must be paid as ordered by the commissioner, compensation judge, or workers' compensation court of appeals, as the case may be.

(Testimony of Health Care Providers)

Generally, all evidence related to health care to be used at a hearing or administrative conference must be submitted by written report as prescribed by the chief administrative law judge. A party wishing to cross examine an examining or treating physician or health care provider must do so by deposition. However, a physician or other health care provider may be required to testify as to any knowledge acquired in the course of treatment or examination relative to the injury or disability resulting therefrom in cases involving occupational diseases, cardiopulmonary injuries, cumulative trauma injuries, issues of apportionment of liability, and mental disorders, or in any other case upon an order of a compensation judge.

When the commissioner, a compensation judge, or the workers' compensation court of appeals, as the case may be, has reason to believe that a medical or other provider of treatment or services has submitted false testimony or a false report in any proceeding under the workers' compensation law, the matter must be referred to an appropriate licensing body or other professional certifying organization for review and recommendations. Based upon the recommendation, the medical services review board, after hearing, may bar the provider from making an appearance at the workers' compensation proceeding, and also disallow the admission into evidence any written reports of the provider in future proceedings for a period up to one year for the first violation, three years for the second violation, and permanently for the third or subsequent violations.

(Medical Data Access)

The release of written medical data relating to a current claim for workers' compensation benefits does not require the prior approval of any party to the claim. The data must be provided by the collector or possessor of the data within seven working days of receiving a request in writing. The commissioner may impose a penalty of up to $200 payable to the special compensation fund against a party who does not release the data in this timely manner. Upon release, the written data is treated as private data by the party who requests or receives it and any party who does not treat this data as private is guilty of a misdemeanor.

REHABILITATION BENEFITS AND RELATED MATTERS

(Purpose)

The statutorily stated purpose of rehabilitation is to restore the injured employee through physical and vocational rehabilitation so that the employee may return 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. Economic status is to be measured not only by opportunity for immediate income, but also by opportunity for future income.

(When Required)

An employer or insurer must provide rehabilitation consultation by a qualified rehabilitation consultant (QRC) to an injured employee within five days after the employee has 60 days of lost work time due to the personal injury other than a back injury, and within five days after the employee has 30 days of lost work time due to a back injury. "Lost work time" means only those days during which the employee would actually be working but for the injury, and the lost time in either case above may be intermittent. If the employer does not provide rehabilitation consultation within the above time limits, the commissioner or a compensation judge must notify the employer that if the employer fails to appoint a QRC within 15 days, the commissioner or compensation judge must appoint a QRC to provide the consultation at the expense of the employer.

If there is a dispute regarding medical causation or whether an injury arose out of and in the course and scope of employment, and the employee has been disabled for the requisite time as indicated above, prior to the determination of liability, the commissioner must refer the employee to the Department of Jobs and Training for rehabilitation consultation to determine whether rehabilitation is appropriate. If employer liability is subsequently determined, the employer is held responsible for the cost of rehabilitation already provided. Thereafter, the rehabilitation provisions summarized in this section apply.

(Change of Provider)

If the employee objects to the employer's selection of a qualified rehabilitation consultant, the employee must notify the employer and the commissioner in writing of the objection. The employee may choose a different QRC as follows: once during the first 60 days following the first in-person contact between the employee and the original QRC; once after this 60-day period; subsequent requests are determined by the commissioner or a compensation judge according to the best interests of the party.

(Rehabilitation Plan and Costs)

The employee and employer must enter into a rehabilitation program if one is prescribed in a rehabilitation plan developed by the QRC. In developing the plan, consideration must be given to the employee's qualifications including, but not limited to, age, education, previous work history, interests, transferable skills, and the present and future labor and market conditions. Retraining is a legitimate component of a rehabilitation plan, but is limited by

statute to 156 weeks. In cases of retraining, the commissioner may, upon petition by the injured employee, award additional compensation not to exceed 25 percent of the compensation otherwise payable under the workers' compensation law if warranted due to unusual or unique circumstances of the employee's retraining. Once developed, a copy of the plan, including the target date for return to work, must be submitted to the commissioner.

An employer is liable for the costs of the rehabilitation evaluation in preparation of the plan, costs of services and supplies necessary for implementation of the plan, and certain other costs associated with the plan.

(Rehabilitation Fee Review)

The commissioner is given authority to establish standards and procedures for determining whether or not charges for rehabilitation services are excessive and whether a rehabilitation service provider is providing services at a level or with a frequency that is excessive, based upon acceptable rehabilitation standards. If it is determined by the payer that the level, frequency, or cost of the rehabilitation services is excessive according to these established standards, the provider may not be paid for the excessive service unless the commissioner or a compensation judge determines at a hearing or an administrative conference that the level, frequency, or cost was not excessive.

(Functions of Commissioner and Compensation Judges With Respect to Rehabilitation Issues)

The commissioner or a compensation judge has authority to make determinations regarding eligibility for rehabilitation services and authority to review, approve, modify, or reject rehabilitation plans. Upon request by the employer, insurer, or employee, or upon the commissioner's own request, the commissioner or a compensation judge may suspend, terminate, or alter a rehabilitation plan upon a showing of good cause. The commissioner or a compensation judge also has authority to make determinations regarding rehabilitation issues not necessarily part of the plan including, but not limited to, whether an employee is eligible for further rehabilitation services and benefits.

The commissioner has authority to approve qualified rehabilitation consultants and vendors.

(Functions of Rehabilitation Review Panel)

The Rehabilitation Review Panel is composed of the commissioner or a designee who serves as an ex officio member; two members each from employers, insurers, rehabilitation, and medicine; one member representing chiropractors; and four members representing labor.

The panel has authority to review and make determinations with respect to appeals from orders of the commissioner regarding certification approval of qualified rehabilitation consultants and vendors. The hearing is de novo and is initiated by the panel under contested case procedures. The panel's decision is appealable to the worker's compensation court of appeals.

The panel also has authority to discipline qualified rehabilitation consultants and vendors for violations of the workers' compensation law or rules

adopted pursuant thereto. Complaints against registered consultants and vendors are made with the commissioner who investigates the complaint and, if appropriate, initiates a contested case proceeding. The panel makes the final decision following receipt of the report of the administrative law judge. It may impose a penalty of up to $1,000 per violation and may also suspend or revoke certification. In cases where the rehabilitation service provider is determined by the panel to be consistently performing procedures or providing services in excess of levels or costs, the panel may prohibit the provider from receiving any further reimbursement for services provided.

SPECIAL COMPENSATION FUND

(Purpose)

The special compensation fund is mandated under the workers' compensation law for the purpose of administering specialized programs designed to increase the fairness and efficiency of that law, as well as to cover the cost of administration of the law's mandatory provisions.

The five distinct functions of the fund, which are discussed below, are as follows: subsequent injury fund reimbursement; supplementary benefits reimbursement; special claims administration; insurance verification; and administration of the mandatory provisions of the workers' compensation law.

(Subsequent Injuries/the Second Injury Fund)

The subsequent injury fund, or so-called "second injury" fund, was created to encourage employers to hire and retain workers with physical impairments that are permanent in nature, whether congenital or due to injury, disease, or surgery, and which are likely to be a hindrance or obstacle to finding and maintaining employment. The workers' compensation law accomplishes this purpose by reimbursing employers partially or totally for the cost of workers' compensation personal injury claims that were made more severe and costly because of the original physical impairment, or new injuries that would not have occurred at all if the physical impairment had not existed prior to the subsequent injury. Physical impairment is limited under the workers' compensation law to certain specified types of conditions, including mental conditions, but also includes any other impairment resulting in a disability rating of at least ten percent of the whole body if the physical impairment were evaluated according to the standards used in workers' compensation proceedings, and any other physical impairments of a permanent nature which the commissioner by rule prescribes.

In order for the employer or insurer to receive partial or total reimbursement from the fund, the preexisting physical impairment must have been registered with the commissioner prior to the employee's subsequent personal injury and, in addition, the employer must be in compliance with the mandatory insurance requirements under the workers' compensation law. The registration must be accompanied by satisfactory evidence of the physical impairment, and registration is in effect as long as the impairment exists.

If the employee's personal injury results in disability or death, and if that disability or death would not have occurred except for the preexisting physical impairment registered with the commissioner, then the employer is required to pay all compensation provided under the workers' compensation law but is fully reimbursed from the special compensation fund for any amounts paid. (There are certain statutory exceptions to this rule.) If, however, the employee incurs personal injury that would have occurred irrespective of the preexisting physical impairment, but is made substantially greater because of that impairment, then the employer or insurer must pay all compensation provided under the workers' compensation law, but is entitled to a reimbursement from the special compensation fund for all amounts paid in excess of 52 weeks of monetary benefits and $2,000 in medical expenses. In such cases, however, the special compensation fund only reimburses for that portion of the compensation and

medical and rehabilitation expenses attributed to the subsequent injury after the above deductible has been met.

If the subsequent personal injury results in permanent partial disability and is not related or caused by preexisting physical impairment, the employer is not entitled to any reimbursement from the special compensation fund.

(Supplementary Benefits Reimbursement)

When supplementary benefits are due and payable, as discussed in the Compensation Benefits section of this summary, the employer or insurer paying such benefits has the right of full reimbursement from the special compensation fund for the amount of supplementary benefits paid.

(Special Claims Administration)

When any employee sustains a work-related personal injury, and the employer, other than the state or its political subdivisions, is not insured or self-insured as required under the workers' compensation law, the employee or the employee's dependents are nevertheless entitled to receive workers' compensation benefits from the special compensation fund. Likewise, when a self-insuring employer, other than the state or its political subdivisions, fails to pay benefits required under the workers' compensation law (usually due to insolvency), the employee or the employee's dependents will nevertheless receive the benefits from the special compensation fund.

(Insurance Verification)

The department attempts to ensure that employers have the mandatory workers' compensation coverage required by law. The insurance verification costs are charged against the special compensation fund.

(Administrative Expenses)

The costs of administering the mandatory provisions of the workers' compensation law are paid for from the special compensation fund.

(Sources of Funding)

The special compensation fund is funded from the following revenue sources:

1. Penalties assessed against insurers and self-insurers for violations of the provisions of the workers' compensation law;

2. Payments to the fund by insurers and self-insurers in cases involving a work-related personal injury where the employee dies. In such cases, the employer is required to pay into the fund between $5,000 and $25,000 depending on the number, if any, of dependents entitled to monetary benefits and the amounts actually paid for dependency benefits;

3. An appropriation from the general fund to pay special claims, including claims where the employer is uninsured or self-insured and unable to pay;

4. Recoveries from self-insurers, other than the state or its political subdivisions, who fail to pay workers' compensation benefits as required by the

law. The commissioner has a cause of actions against such self-insurers for reimbursement and, at the discretion of the court, a self-insurer who fails to pay may also be liable for punitive damages in an amount not to exceed 50 percent of the total of all benefits and other expenditures to be paid out by the special compensation fund;

5. Assessments against all insurers and self-insurers of workers' compensation liability doing business in this state based upon a percentage of the amount paid for temporary total, temporary partial, permanent total, and permanent partial disability benefits and dependent allowance benefits. The basic assessment rate is 20 percent, but that rate is adjusted annually by the commissioner based on the surplus or deficit in the special compensation fund. The adjustment may range from minus 10 percent to plus 12 percent based on the revenues received into the fund less expenditures for claims paid out of the fund for the preceding 12 months ending June 30 of each year. The assessment rate is applied to benefits paid during each calendar year. The assessment for benefits paid by an employer between January 1 and June 30 is due on August 15 of that year, and the assessment for benefits paid between July 1 and December 31 is due the following March 1. Payment is due within 45 days of the mailing of notice by the commissioner of the amount due. In addition, the commissioner may also impose a penalty of up to 15 percent of the amount due, but not less than $500, in the event payment is not made in the manner prescribed (i.e., the insurer or self-insurer fails to file the assessment report or make any payments by the due date). Any reimbursements due the insurer or self-insurer will not be made until delinquent reports and assessments are properly filed to the satisfaction of the commissioner.

CLAIMS PROCESS

(Notice of Injury to Employer)

No compensation payable under the workers' compensation law is due until notice of injury is first given by the injured employee or a dependent, or someone on behalf of either, to the employer unless the employer has actual knowledge of the occurrence of the injury. Generally, notice must be given within 14 days in order to receive full compensation benefits. If notice has not been given within 180 days, no compensation benefits are allowed at all. For notice given after 14 days but prior to 180 days, the law specifies that compensation is allowed but may be reduced by the sum which fairly represents any prejudice to the insurer or employer as a result of the delay in notice.

(Notice to Insurer and Commissioner)

In cases of death or serious personal injury to an employee, the employer must report by telephone, telegraph, or personal notice the injury or death to the commissioner and the insurer within 48 hours after its occurrence. The initial report must be followed up by a written report of the injury within seven days from its occurrence or within such time as the commissioner designates.

In cases not involving serious personal injury or death, the employer is required to report any injury which wholly or partly incapacitates the employee from performing labor or services for more than three calendar days to the insurer on a form prescribed by the commissioner within ten days from its occurrence. The insurer, or self-insured employer, in turn has 14 days from the occurrence of the injury to report it to the commissioner.

(Notice of Rights to Injured Employee)

Following receipt of notice of injury, the commissioner must mail a brochure to the employee explaining in readable and understandable language the rights and obligations of the employee, the assistance available, the operation of the workers' compensation law, and whatever other relevant information the commissioner deems necessary.

(Reports to the Commissioner)

The commissioner is required to keep fully informed of the nature and extent of all personal injuries compensable under the workers' compensation law, the resulting disabilities, and the rights of employees to compensation. The commissioner may do so, at least in part, by requesting certain reports from an employer, insurer, or health care provider with respect to a compensable injury. The workers' compensation law provides that a report filed with the commissioner is not available for public inspection, and any person who has access to such report who discloses the report or its context without authorization to another is guilty of a misdemeanor. Such reports, however, may be used in hearings held pursuant to the workers' compensation law, for the purpose of state investigations and statistical purposes, and by the workers' compensation reinsurance association in caring out its statutory responsibilities. In addition, the department, the office of administrative hearings, and the workers' compensation court of appeals may also permit the examination of a case file by the employer, insurer, employee, or dependent of a deceased employee, or

any person who furnishes written authorization to do so from the employer, insurer, employee, or dependent.

If an employer, insurer, or health care provider fails to file with the commissioner any required report in the manner and within the time limitations described under the workers' compensation law, the commissioner may impose a penalty, payable to the special compensation fund, of up to $200 for each failure. This penalty may be appealed to a compensation judge within 30 days of notice of the penalty.

(Commencement of Compensation)

In cases involving temporary total or temporary partial disability, no compensation except for medical benefits is allowed for the three calendar days after the disability occurred; except that, if the disability continues for ten calendar days or longer, the compensation is computed from the commencement of the disability.

Within 14 days of notice to or knowledge by the employer of a compensable personal injury or of a new period of temporary total disability which is caused by an old compensable personal injury, the payment of temporary total disability compensation must commence. With respect to a new period of disability, the employer or insurer may, however, file for a limited extension with the commissioner within this 14-day period. Commencement of payment by the employer or insurer does not waive any rights to any defense the employer may have on the claim or incident.

If the employer or insurer does not begin payment of compensation within the applicable time limits, the commissioner may assess a penalty against the insurer payable to the special compensation fund in an amount which ranges from 25 percent to 100 percent of the compensation due depending on the number of days late, subject to a statutory maximum amount. A penalized insurer may recover from the employer the portion of the penalty attributable to any action of the employer which resulted in the delay.

When late payments are finally made, they are with interest at a statutorily set interest rate.

The same penalties and interest rate provisions applicable to late payment of compensation benefits also apply for late payment of medical or rehabilitation benefits and late payment of permanent partial disability benefits (i.e., economic recovery compensation or impairment compensation).

(Additional Award as Penalty)

Upon reasonable notice and hearing or opportunity to be heard, the commissioner, a compensation judge, the workers' compensation court of appeals, or the supreme court, as the case may be, may award additional compensation up to 25 percent of the total amount of compensation otherwise payable under the workers' compensation law in situations where an employer or insurer has: instituted a proceeding or interposed a defense which does not present a real controversy but which is frivolous or for the purposes of delay; unreasonably or vexatiously delayed payments; neglected or refused to pay compensation; intentionally underpaid compensation; or unreasonably or vexatiously discontinued compensation in violation of the statutory provisions dealing with

discontinuance of payment. A lesser additional award of ten percent is made in the case of inexcusable delay in making payments. If any additional award sum is ordered by the department is not paid when due, and no appeal of the order is made, the sum bears interest at a rate of 12 percent per annum.

(Denial of Liability)

An employer or insurer may deny liability for compensation by giving the employee written notice of the denial of liability. The denial of liability must also be filed with the commissioner within 14 days after notice to or knowledge by the employer of a personal injury which is alleged to be compensable. The notice must state in detail specific reasons explaining, without the need for further inquiry, why the claimed injury or occupational disease was determined not to be within the scope and course of employment and must include the name and telephone number of the person making this determination. The commissioner may impose a penalty of $300 for each violation of the specificity requirement.

If the employer or insurer has already commenced payment but later determines that the disability is not the result of a work-related personal injury, payment of compensation may be terminated upon the filing of a notice of denial of liability within 30 days of notice to or knowledge by the employer that the injury is not compensable under the workers' compensation law. After this 30-day period, payment may be terminated only by filing a notice of discontinuance as provided in the Discontinuance of Payment section of this summary. Upon termination, payments may be recovered by the employer if the commissioner or a compensation judge finds that the employee's claim of work-related disability was not made in good faith.

(Payments Received in Good Faith)

No lump sum, weekly payment, or settlement which is voluntarily paid by an employer or insurer to an injured employee or the survivors of a deceased employee in apparent or seeming accordance with the provisions of the workers' compensation law or an order pursuant thereto and received in good faith may be refunded to the paying employer or insurer in the event that it is subsequently determined that the payment was made under a mistaken fact or law. However, a mistaken payment may be taken as a full credit against a future lump sum benefit awarded for the personal injury or death and is also a partial credit, not to exceed 20 percent, against future weekly compensation benefit amounts paid.

DISCONTINUANCE OF PAYMENT

(Discontinuances/In General)

Once the employer has commenced payment of workers' compensation benefits, the employer may not discontinue payment of compensation until the employer provides the employee, in writing, with a notice of discontinuance and files a copy of this notice with the department; or, the employer serves on the employee and files with the commissioner a petition to discontinue compensation.

(Notice of Discontinuance)

The notice of discontinuance must state the date of intended discontinuance and set forth a statement of facts clearly specifying, without the need for further inquiry, the reason for this action. The commissioner may impose a penalty of $300 for each violation of the specificity requirement.

If the stated reason is the employee's return to work, temporary total disability compensation may be discontinued effective the day the employee returned to work. In such cases, the written notice must be served on the employee and filed with the department within 14 days from the date the insurer or self-insured employer has notice that the employee has returned to work. If the discontinuance is for another stated reason, the liability of the employer to pay compensation continues until a copy of the notice and reports have been filed with the department. At that time, the duty of the employer to continue to pay compensation is suspended unless the injured employee requests an administrative conference because of disagreement with the discontinuance.

(Administrative Conferences/Discontinuances)

A request by the employee for an administrative conference to resolve discontinuance disputes may be made in writing, in-person, or by telephone to the commissioner. If benefits have been discontinued because of the employee's return to work, and the employee believes the benefits should be reinstated because of events occurring during the initial 14 calendar days following the return to work, the employee's request must be received by the commissioner within 30 calendar days after the return to work. If the benefits have been discontinued for another reason, the employee's request must be received by the commissioner within 30 calendar days after the notice of discontinuance is received by the commissioner. Following receipt of the request, the commissioner must schedule an administrative conference within ten calendar days. However, the commissioner may grant an unlimited number of continuances, not to exceed 14 calendar days each unless the parties agree to a longer period, upon a request for a continuance by an employer or employee and a showing of good cause. Generally, compensation is required to be continued pending the outcome of the administrative conference if the employee has not returned to work and also during the period of any any employer-granted continuance.

The commissioner must issue to all interested parties a written decision on whether the discontinuance of compensation payments is allowed. The decision must be: issued within five working days from the close of the conference; based upon information or reasons specified in the notice of discontinuance; and determined by a preponderance of the evidence. The commissioner's decision is binding on the parties pending a reversal on appeal. An employer appeals by filing with the commissioner a petition to discontinue compensation. An

employee appeals by serving on the employer and filing with the commissioner an objection to discontinuance.

(Petition to Discontinue)

As indicated above, a petition to discontinue compensation may be used when the employer disagrees with the commissioner's decision not to allow the discontinuance following an administrative conference. In addition, in lieu of filing a notice of discontinuance, and thereby bypassing an administrative conference, an employer may serve on the employee and file with the commissioner a petition to discontinue compensation and proceed directly to the dispute resolution process at the office of administrative hearings. Within ten calendar days after receipt of the petition, the commissioner must refer the matter to the OAH. Pending the outcome of the appeal, the employer must continue payment of compensation unless the discontinuance is permitted by commissioner's order following an administrative conference or if no administrative conference is requested.

(Objection to Discontinuance)

An employee may serve on the employer and file with the commissioner an objection to discontinuance if: the employee elects not to request an administrative conference to resolve any disputes relating to the discontinuance; the employee fails to timely proceed as required for an administrative conference; the discontinuance is not governed by the procedures for an administrative conference (i.e., the employer has bypassed such conference by filing a petition for discontinuance); or the employee disagrees with the commissioner's decision following an administrative conference. Within ten calendar days after receipt of the objection to discontinuance, the commissioner must refer the matter to the office of administrative hearings.

(Expedited Hearings at OAH)

A hearing at the office of administrative hearings involving discontinuance issues is de novo. Generally, the hearing before a compensation judge must be held within 30 calendar days after OAH receives the file from the commissioner. Other expedited procedures apply, including the following. Once the hearing date has been set, a continuance of that date will be granted only under certain narrow circumstances. Absent a clear showing of surprise at the hearing or the unexpected availability of a crucial witness, all evidence must be introduced at the hearing. The compensation judge must issue a decision within 30 days following the close of the hearing record. If the order confirms a discontinuance, the employer is relieved from further liability for compensation subject to an employee's right to appeal the order to the workers' compensation court of appeals. If appealed, the court must conclude any oral arguments by the parties within 60 days following certification of the record from OAH.

(Fines)

An employer who violates any requirements relating to discontinuance of benefits is subject to a fine, payable to the special compensation fund, of up to $500 for each violation.

DISPUTE RESOLUTION (OTHER THAN DISCONTINUANCES)

(In General)

The procedures for dispute resolution in cases of discontinuances were discussed in the Discontinuance of Payment section of this summary. Dispute resolution procedures in all other cases involves the option of either informal or formal proceedings.

A party may request an informal administrative conference to be held within the department to resolve outstanding disputes between the parties. The commissioner may, however, refuse to hold an administrative conference and refer the matter directly for a settlement or pretrial conference or may certify the matter directly to the office of administrative hearings for a full formal hearing before a compensation judge.

A party may also choose to proceed directly to the formal dispute resolution proceeding by the filing of a written claim petition.

(Administrative Conferences)

Following receipt of a request for an administrative conference, the commissioner must schedule such conference within 60 days. Notice of the conference must be served on all parties no later than 40 days prior to it being held. The commissioner must determine all issues and disputes based upon the written submissions available at the conference and based, with respect to issues of facts, upon a preponderance of the evidence. The commissioner must issue a decision within 30 days after the close of the conference or, if no conference was held, within 60 days after receipt of the request for a conference.

Any party aggrieved by the decision of the commissioner may request a formal hearing before the office of administrative hearings by filing such request with the commissioner no later than 30 days after the administrative conference decision. The commissioner must refer the request to OAH within five working days after the filing of the request. The hearing before a compensation judge is de novo and must be held on the first date that all parties are available but not later than 60 days after OAH has received the matter. Following a formal hearing, the compensation judge has 30 days to issue a decision.

(Formal Hearings Before OAH)

Generally, all proceedings for formal dispute resolution are initiated by the filing of a written, notarized petition with the commissioner stating the matter in dispute. The commissioner must schedule a settlement or pretrial conference, if appropirate, within 60 days after receiving the petition. In addition, a compensation judge may schedule a settlement or pretrial conference, whether or not a party requests such a conference. If appropriate, a written summary decision must be issued within ten days after the conference stating the issues and a determination of each of those issues.

Upon receipt of the matter from the commissioner, the chief administrative law judge must fix a time and a place for hearing the petition. The hearing is open to the public and must 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. Only the chief administrative law judge or his designee, upon a showing of good cause, may grant a continuance of the hearing.

Any person who has an interest in any matter before the commissioner, a compensation judge, or the workers' compensation court of appeals such that the person may either gain or lose by an order or decision issued pursuant to the hearing may intervene in the proceeding by filing an application in writing stating the facts which show the interest.

Absent a clear showing of surprise at the hearing or the unexpected availability of a crucial witness, all evidence must be submitted at the time of the hearing. However, upon a showing of good cause, a compensation judge may grant an extension not to exceed 30 days following the hearing date. The compensation judge is not bound by the formal rules of evidence, pleadings, or procedure. However, the hearing must be conducted in a manner to ascertain the substantial rights of the parties, and findings of fact must be based only on relevant and material evidence presented by competent witnesses. Issues of fact must be determined based upon a preponderance of the evidence.

The compensation judge must issue a decision that includes a determination of all contested issues of fact and law and awards or disallows compensation or other order as the pleadings, evidence, or provisions of the workers' compensation law or rules pursuant thereto require. The decision must be filed with the commissioner within 60 days after the matter is submitted to the judge unless sickness or casualty prevents a timely filing or the chief administrative law judge extends the time for good cause. No part of the salary of a compensation judge may be paid unless the chief administrative law judge determines that all decisions of that judge have been issued within the statutory time limits.

(Expedited Procedures for Cases Involving Significant Financial Hardship)

An injured employee may file a request for an expedited hearing at the office of administrative hearings which must be granted upon a showing of significant financial hardship. In such cases, the calendar judge must issue a prehearing order and notice of the date, time, and place for a prehearing conference to be set for no later than 45 days following the filing of the affidavit of certificate of significant financial hardship.

(Settlement of Claims)

An agreement between an employee or employee's dependent and the employer or insurer to settle any claim which is not upon appeal before the workers' compensation court of appeals is valid where it has been executed in writing and signed by the parties and intervenors in the matter. Where one or more of the parties is not represented by an attorney, the commissioner or a compensation judge must have approved the settlement and made an award thereon. If the matter is upon appeal before the workers' compensation court of appeals, or a district court, the court of appeals or district court is the approving body.

The parties to a settlement agreement have the burden of proving that it is reasonable, fair, and in conformity with the requirements of the workers' compensation law. An employer must be notified by the insurer 30 days after any final valid agreement is approved or otherwise made final. The notice must

include all terms of the settlement, including the total amount of money required to be reserved in order to pay the claim.

(Appeals)

Appeals from the decision of the commissioner or a compensation judge are made to the workers' compensation court of appeals. The grounds for appeal are limited to the following: the order does not conform with the requirements of the workers' compensation law; the compensation judge committed an error of law; the findings of fact and order were unsupported by substantial evidence in view of the entire record as submitted; or, the findings of fact and order were procured by fraud, coercion, or other improper conduct of a party in interest. An appeal must be made within 30 days after the original order was issued, except that the workers' compensation court of appeals may extend the time upon a showing of good cause for up to an additional 30 days.

Appeals of decisions by the workers' compensation court of appeals are made directly to the Minnesota Supreme Court. Review is by certiorari upon one of the following grounds: the order does not conform with the workers' compensation law; the workers' compensation court of appeals committed any other error of law; or, the findings of fact and order were unsupported by substantial evidence in view of the entire record submitted. An appeal to the supreme court must be made within 30 days from the date the party was served with notice of the order, except that the supreme court may for good cause extend the time for seeking review. The supreme court has original jurisdiction upon review and thus may reverse, affirm, or modify an order allowing or disallowing compensation and enter such judgment as it deems just and proper, or it may remand the cause to the workers' compensation court of appeals for a new hearing or further proceeding.

Generally, upon appeal, no costs may be awarded to any party. However, the workers' compensation court of appeals or the supreme court may award reasonable attorneys fees as an incitant to its review on appeal.

(Statute of Limitations)

The workers' compensation law sets out certain time limitations for bringing an action or proceeding under that law. Failure to institute the action or proceeding within the prescribed time limitation will bar recovery by the injured employee or employee's dependents.

ATTORNEYS FEES

(Allowable Fees)

Allowable attorney fees in workers' compensation cases must be based solely upon generally disputed portions of the claim, and fees for administrative conferences must be determined on an hourly basis. An attorney must file a statement of legal fees with the commissioner, a compensation judge, or the workers' compensation court of appeals, as the case may be, with respect to cases heard before those respective bodies. The statement of fees must be accompanied by a copy of the signed retainer agreement.

A fee for legal services of 25 percent of the first $4,000 of compensation awarded to the injured employee and 20 percent of the next $27,500 of compensation awarded is permissible without approval of the commissioner, a compensation judge, or any other party, unless a timely objection of the proposed fee is made as discussed below. An application for attorneys fees in excess of the amounts authorized without approval must be made to the commissioner, a compensation judge, or a district court, as the case may be, before whom the matter is being heard. Whether the excess amount is reasonable is determined on the basis of statutory standards.

(Objection to Fees)

An employee or insurer has ten calendar days to object to the attorneys fees requested. If no objection is made within this period, the amount requested is conclusively presumed reasonable provided the amount does not exceed the limitations stated above. If, however, a timely objection is filed, the commissioner, a compensation judge, or the workers' compensation court of appeals, as the case may be, must review the matter and make a determination based on statutory standards of reasonableness.

(Attorneys Fees Review by WCCA)

An employee who is dissatisfied with the attorneys fees charged may file an application for fee review by the workers' compensation court of appeals. In addition, that court has authority to raise the question of the issue of attorneys fees at any time upon its own motion and also has continuing jurisdiction over attorneys fees.

(Penalties)

An attorney who knowingly violates any provision of the workers' compensation law with respect to authorized fees for legal services is guilty of a misdemeanor. Also, in certain instances, the insurer or self-insured employer may be liable for additional compensation awards to pay for a portion of the employee's attorneys fees. Generally, an additional award equal to 25 percent of the portion of legal fees which is in excess of $250 must be added to the employee's benefit in the following situations: the employer or insurer denies liability, discontinues benefits, or fails to make timely payment of benefits, and the injured person employs an attorney who successfully procures such payment; a settlement offer has been made by the employee and is not accepted by the employer or insurer, and the judgment finally obtained by the employee is at least as favorable as the settlement offer; and the injured employee employs an attorney to obtain supplementary workers' compensation benefits.

INSURANCE REQUIREMENTS

(In General)

Every employer, except the state and its political subdivisions, who are subject to the workers' compensation law is required to insure payment of workers' compensation liability with some insurance carrier authorized to insure such liability in this state, or obtain a written order from the commissioner of commerce exempting the employer from the insurance requirement and permitting self-insurance. As a condition of granting permission to self-insure, the commissioner of commerce may require the employer to furnish security in an amount sufficient to ensure payment of all claims under the workers' compensation law.

(Penalties for Failure to Insure or Self-Insure)

Any employer who fails to insure or self-insure as required under the workers' compensation law is liable to pay a penalty, credited to the special compensation fund, of from $750 to up to $5,000, depending on the number of uninsured employees and whether or not the failure to insure or self-insure was willful and deliberate. In addition, any employer who willfully and intentionally fails to comply with the requirement to insure or self-insure as provided under the workers' compensation law is guilty of a gross misdemeanor.

Every state or local licensing agency must withhold the issuance for renewal of a license permit to operate a business in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement. The commissioner must assess a penalty against the employer of $1,000, payable to the special compensation fund, if the renewal information is not reported or if it is falsely reported. In addition, neither the state nor any political subdivision may 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.

Where an insurer, or its agent has been guilty of fraud, misrepresentation, or culpable, persistent, and unreasonable delay in making payments for settlements under the workers' compensation law, or has failed to comply with other provisions of that law, the commissioner of commerce must revoke, after notice and hearing, the license of the insurer to write workers' compensation insurance coverage in this state.

(Enforcement)

The commissioner is authorized to request satisfactory proof of workers' compensation insurance coverage or authority to self-insure workers' compensation liability. To obtain this proof, the commissioner is authorized to enter without delay and at reasonable times any place of employment to inspect any records pertaining to that employer's workers' compensation insurance policy and other documents which may be relevant to enforcement of the insurance requirements of the workers' compensation law. In addition, any employee representative may request an inspection by giving notice to the commissioner of the belief and grounds for the belief that the employer is uninsured against workers' compensation liability. If the commissioner determines that the reasonable grounds exist, an inspection may take place as indicated above.

The commissioner may obtain from the department of jobs and training and office of the secretary of state, or any other state agency, the names and lists of employers doing business in this state for the purpose of insurance verification. The commissioner may maintain insurance registration records.

Within ten days after issuance of a workers' compensation insurance policy, the insurer must file notice of coverage with the commissioner. Thereafter, the policy may not be cancelled by the insurer within the policy period nor terminated upon its expiration date, until notice in writing is delivered or mailed to the insured and filed with the commissioner, fixing the date on which it is proposed to cancel, or declaring that the insurer does not intend to renew the policy upon the expiration date. Cancellation or termination is not effective until 30 days after the written notice has been filed with the commissioner unless, prior to the expiration of the 30-day period, the employer obtains other insurance coverage or an exemption allowing self-insurance. Upon receipt of the notice, the commissioner must notify the insured that it is required to obtain coverage from some other licensed carrier and that, if it is unable to do so, it must request the commissioner of commerce to require the issuance of a policy under the assigned risk plan.

In the case of cancellation or termination by the insured, the insured must serve notice of such intent upon the insurer. Upon receipt of that notice, the insurer must notify the commissioner of the cancellation or termination. The commissioner must then ask the employer for the reasons for the cancellation or termination and notify the employer of the duty under the workers' compensation law to insure its employees.

(Prohibitions)

The workers' compensation law contains the following prohibitions with respect to insurance requirements:

1. No insurance policy may be issued unless it provides compensation for personal injury or death in accordance with the full benefits conferred by the workers' compensation law;

2. An agreement between an employee and employer under which the employee is to pay any part of the cost of insuring the employer's workers' compensation liability risk is prohibited and void. An employer who makes such charge or deduction is guilty of a misdemeanor and, in addition, is subject to a penalty of 200 percent of the amount withheld from or charged the employee. Fifty percent of this penalty is payable to the special compensation fund and 50 percent is payable to the employee.

3. An insurer or agent or employee of an insurer may not make or charge a rate which discriminates against the employment of a person who is partially handicapped through the loss or lost use of a body member whether due to accident or other cause. A person who violates this prohibition is guilty of a misdemeanor and such conviction is also sufficient cause for the commissioner of commerce to cancel the license of the insurer to write workers' compensation insurance in this state;

4. Insurers, self-insurers, group self-insurers, political subdivisions, and the administrator of state employee claims, are all prohibited from certain statutorily spelled out conduct generally relating to the failure to reply to

requests about claims, pay benefits or medical bills, deny liability, or obtain services of an attorney. Statutory penalties are set out for these specific violations and the penalties increase with successive violations. These penalties are in addition to any other penalties imposed under the workers' compensation law that might apply for the same violation. In addition to these statutorily prohibited conduct, the commissioner has authority to adopt rules specifying additional misleading, deceptive, or fraudulent practices or conduct which are subject to the statutory penalties.

(Disputes Between Two or More Employers or Insurers Regarding Liability)

Disputes may arise between two or more employers or two or more insurers regarding liability for workers' compensation benefits. The workers' compensation law sets forth certain rules for payment of the various workers' compensation benefits pending the resolution of the liability dispute. However, provisions for reimbursement to a party subsequently found not liable, but who paid benefits under these rules, are also provided for.

STATE AND POLITICAL SUBDIVISION CLAIMS

(Applicability of Workers' Compensation Law)

The provisions of the workers' compensation law also apply to employees of the state and its political subdivisions and school districts.

(Political Subdivision/School District Claims)

An award of compensation against a political subdivision or school district is a preferred claim against the subdivision or district. The award must be promptly 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.

(State Claims/Reporting/Investigations)

The administration and payment of workers' compensation claims with respect to state employees is handled by the commissioner of the department of employee relations. The head of the employing department must report each accident which occurs to an employee as and in the manner required under the workers' compensation law. The commissioner of employee relations must then make a preliminary investigation to determine the question of probable liability. Upon completion of the investigation, the commissioner must inform the claimant, head of the employing department, and the commissioner of finance in writing of the action to be taken.

The expenses of the commissioner of employee relations in administering workers' compensation claims with respect to state employees, and if applicable, defending against such claims, are paid for out of the state compensation revolving fund.

(Defending State Claims)

The commissioner of employee relations also has authority to defend against any claim for compensation. Thus, at any stage in a compensation proceeding, the attorney general may assume the duty of defending the state. Expenses of conducting the defense are charged to the department which employs the employee involved.

(Payment of State Claims/State Compensation Revolving Fund)

The department, 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. Thus, the procedure for determining the liability of the state for workers' compensation benefits is the same as that applicable in other cases. If liability is ultimately determined, the state treasurer must pay compensation to the employee or the employee's dependants from money appropriated for this purpose in the state compensation revolving fund.

Every department of the state, including the University of Minnesota, is required to reimburse the revolving fund for money paid for its claims, the costs of defending against those claims, and the costs of administering the fund at such times and in such amounts as the commissioner of labor and industry

certifies has been paid out of the fund for these purposes. The heads of the employing departments are required to anticipate these payments by including them in their annual departmental budgets.

In addition to maintaining an ongoing balance in the state compensation revolving fund sufficient to pay sums currently due for benefits and administrative costs, the commissioner of finance may, upon the request of the commissioner of labor and industry, transfer money from the general fund to the revolving fund. The amount necessary to make the transfer is appropriated from the general fund to the commissioner of finance, and the commissioner of labor and industry must make schedules to repay the transferred money to the general fund in a time period not to extend beyond five years.

(State Workers' Compensation Health Insurance)

The commissioner of employee relations is authorized to contract with group health insurance carriers and other health maintenance organizations to provide health care services and reimburse health care payments for injured state employees entitled to benefits under the workers' compensation law.