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## **Workers' Compensation**

This information brief explains workers' compensation in Minnesota including its history, what is covered under the law, benefits available to an employee and an employee's dependents, and how disputes are resolved. A glossary at the end defines agencies and terms.

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### **What is Workers' Compensation?**

The workers' compensation system provides benefits to employees who suffer work-related injuries or disease. The first Minnesota Workers' Compensation Act was passed in 1913. The law has been amended many times since its passage, most recently in 1992 and 1995.

#### **The rationale for workers' compensation**

Before the advent of workers' compensation laws, claims for compensation from work-related injuries were resolved through the tort system, which involved considerable uncertainty and unpredictability for both employees and employers. Employees faced significant hurdles to recovery—for example, the employee had to prove that the employer was negligent; similarly, the employee could not recover if the employer showed that the employee was negligent, or “assumed the risk,” or that the injury was caused by a fellow employee. On the other hand, the employer could be liable for a large damage award if the employee prevailed.

The workers' compensation system was designed to address some of these problems. It operates under the following three major principles.

- First, the employee can recover **regardless of fault**, which allows the employee the security of having benefits available even if the employee cannot prove any wrongdoing by the employer.
- Second, the **benefits available to the employee are limited** and do not include some of what the employee might recover in court, such as pain and suffering.
- Finally, the workers' compensation system provides the **exclusive remedy** that the injured employee has against the employer.

When a work-related injury occurs under this system, the likelihood of receiving benefits increases, but the benefit amount that can be recovered decreases. Workers' compensation is meant to operate as a stabilizing force, giving moderate benefits to many employees rather than no benefits to many employees and large awards to a few others. In order to further this goal of stabilization and predictability and to lower the costs of administering benefits, mechanisms are in place to resolve workers' compensation claims in a simple, speedy fashion, preferably without resort to formal litigation.

In addition, workers' compensation matters are generally controlled by the law in effect on the date of injury. This means that the current state of the law as described in this guide may not be the law that applies to all injuries, particularly older injuries.

This reference guide presents an overview of the injuries covered by workers' compensation law, the benefits available to an injured worker, and the procedures that are used to resolve workers' compensation disputes. The guide does not examine the special compensation fund, the assigned risk pool, or insurance requirements under the law.

## **Injuries Covered under the Law**

### **Injuries arising out of and in the course of employment**

The workers' compensation system provides benefits to employees for injuries "arising out of and in the course of employment without regard to the question of negligence." Thus, to recover, the employee must establish a connection between employment and the injury. While in many cases this is a relatively simple issue, it can also be a complex one. Liability might be disputed on the grounds that the injury occurred off the work site, that the workplace activity did not cause the injury, or that the employee had a pre-existing condition that was the source of the injury. Fault, however, whether of the employer or of the employee, is generally not an issue.

Although often the employer will argue that the injury is *not* work-related, there are some instances in which the employer argues that the injury *is* work-related and therefore covered by the workers' compensation system. The reason for this is the exclusivity aspect of workers' compensation. If the injury is covered by the workers' compensation system, then the employee cannot sue the employer under other theories, such as negligence, which could make higher damages available.

## **Progressive injuries and disease**

In addition to the typical workplace injury, employers are liable for certain unusual types of injuries.

**Gillette injuries.** A particularly difficult type of injury to compensate is the so-called **Gillette injury** (named after the case in which the principle was established), which involves a slowly deteriorating condition that eventually breaks down and results in an inability to work. In these cases, a condition can develop over many years and often can involve multiple employers and insurers. Under the case law, the employer or insurer responsible for the employee at the time of the eventual breakdown in condition is liable for all benefits.

**Occupational diseases.** Benefits are payable to an employee with an occupational disease, defined as a disease that arises out of employment, that is peculiar to a particular occupation, and that results from causes beyond the ordinary hazards of employment. Examples of occupational diseases could include asbestosis or chemical bronchitis due to exposure to chemicals in the workplace. Some diseases are declared to be occupational by statute. For instance, a police officer or firefighter who suffers from certain medical conditions, including some forms of heart disease, is presumed to have a compensable occupational disease.

## **Excluded injuries**

**Self-inflicted or result of intoxication.** The statutes specifically provide that an employer is not liable for compensation if the employer can prove that the injury was self-inflicted or was the result of the intoxication of the employee.

**Mental injury without physical trauma.** Case law provides that purely mental injuries without any physical injury are not compensable under workers' compensation law. Either the mental injury must lead to a physical injury, or the mental injury must be caused or aggravated by a physical injury in order for the mental injury to be compensable.

## **Apportionment of Liability**

In some cases, the parties dispute which insurance company is liable for the claim, and to what extent, rather than whether any insurance company is liable. The issue typically arises when the

employee has worked for more than one employer, or when the same employer has had more than one insurer.

For many years, employers could ask a court for “equitable apportionment,” under which each employer would be held responsible for the part of the benefits proportional to the part of the disability caused while the employee worked for that employer. In 1995, however, equitable apportionment was largely abolished, except that it can sometimes be accomplished through settlement agreements or arbitration. This provision does not apply to occupational diseases, which are specially dealt with in another section of the law. That section states that whichever employer or insurer was responsible for the employee at the time the employee had his or her “last significant exposure” to the workplace hazard is liable for all of the benefits paid to the employee.

## **Benefits Available to the Injured Employee**

### **Temporary Total Disability (TTD) Benefits**

**Temporary total disability (TTD) benefits** are provided to an employee who cannot immediately return to work following a compensable injury. The benefits do not begin until after the employee has been disabled for three days, although those three days will be compensated if the employee is unable to work on any day more than ten days after the injury. So, for instance, if an employee is unable to work for eight days, the employee can be compensated for the last five days only. If unable to work for eleven days, however, the employee can be compensated for all eleven days.

**Amount of benefits.** The weekly benefit amount equals two-thirds of the employee’s gross weekly wage at the time of the injury. The maximum benefit is \$615, and the minimum is \$104 or the employee’s actual weekly wage, whichever is less. These levels are set by statute and do not change annually.

**Adjustment of benefits.** TTD benefits, like temporary partial and permanent total disability benefits, are adjusted annually to reflect increases in the average statewide weekly wage. Increases cannot exceed 4 percent per year for injuries prior to October 1, 1995, or 2 percent per year for injuries on or after October 1, 1995. For injuries on or after October 1, 1995, adjustment of benefit amounts does not occur until four years after the date of injury, and the adjustment at that time is only the adjustment for that one year.

**Termination of benefits.** There are four events that are the most common reasons for TTD benefits to terminate, although some other reasons for termination are listed in the statute. First, TTD terminates if the employee returns to work. Second, it terminates if the employee’s total disability ends and the employee fails to make a diligent effort to find work. Third, benefits terminate 90 days after the employee receives notice that he has reached “maximum medical

improvement,” meaning that it is reasonably medically certain that there will not be significant further improvement in the employee’s condition. Finally, it terminates after the employee has received 104 weeks of benefits.

Generally, if TTD ends because of a failure to look for work, it can recommence if the employee starts looking, but benefits are still subject to the maximum medical improvement and 104-week limitations. If TTD ends because the employee returns to work but the employee is then unable to continue in the job for medical reasons, then benefits can recommence, but are still subject to the 104-week maximum.

### **Temporary Partial Disability (TPD) Benefits**

Temporary partial disability (TPD) benefits are paid to an employee whose earnings are reduced by a disability. TPD benefits, like TTD benefits, are designed to provide wage replacement to the disabled employee. Because TPD deals with a partial loss of earning capacity rather than a total loss, it is calculated to compensate for part of the *difference* in the employee’s pre- and post-injury wage, rather than a part of the employee’s entire wage.

**Amount of benefits.** The weekly benefit amount is equal to two-thirds of the difference between the wage the employee was earning before the injury and the wage the employee is able to earn while disabled. The maximum, however, is the amount needed to raise the employee’s total income from work and TPD benefits to 500 percent of the statewide average weekly wage.

For example, if an employee earned \$450 per week before the injury and returned to work at a \$300 per week job because of the injury, the employee would be entitled to \$100 per week of TPD ( $450 - 300 = 150$ ;  $150 \times 2/3 = 100$ ).

**Termination of benefits.** TPD benefits terminate when the employee’s post-injury wage reaches his pre-injury wage. They will also terminate, however, after the employee has received 225 weeks of benefits, or 450 weeks after the injury, whichever is earlier.

### **Permanent Total Disability (PTD) Benefits**

Permanent total disability (PTD) benefits are paid when an injured worker is permanently unable to work.

**Permanent total disabilities.** The statute provides that the following injuries automatically constitute permanent total disability:

- permanent and total loss of sight in both eyes
- loss of both arms at the shoulder
- loss of both legs so close to the hips that no effective artificial member can be used
- complete and permanent paralysis

– total and permanent loss of mental facilities

Permanent total disabilities also include other disabilities that “cause the employee to be unable to secure anything more than sporadic employment resulting in an insubstantial income,” but in order to qualify for PTD under this part of the definition, the employee must meet a disability rating threshold that may be affected by the employee’s age at the time of injury as well as the employee’s education level. An employee younger than 50 must have a disability rating of the whole body of at least 17 percent, an employee 50 or older must have a rating of at least 15 percent, and an employee 55 or older who does not have a high school diploma or a GED must have a rating of at least 13 percent.

**Amount of benefits.** The weekly benefit amount is equal to two-thirds of the injured worker’s gross weekly wage, subject to the same statutory maximum as TTD (currently \$615 per week) and a minimum of 65 percent of the statewide average weekly wage.

**Relationship to other benefits.** Persons who are permanently totally disabled are often eligible for Social Security disability benefits as well as workers’ compensation. The relationship between workers’ compensation payments and Social Security benefits is complex, but generally, after a worker has received \$25,000 in weekly workers’ compensation benefits, additional weekly payments are reduced by the amount of Social Security disability payments received.

**Termination of benefits.** The weekly benefit is paid until the employee is 67, at which point the employee is presumed to be retired, unless the employee introduces evidence to the contrary.

## **Permanent Partial Disability (PPD) Benefits**

Permanent partial disability (PPD) benefits compensate injured employees for permanent damage to the body. The benefits are determined by the amount of impairment.

**Permanent partial disability schedule.** The schedule for PPD benefits is published by the Department of Labor and Industry (DLI). It lists different medical conditions and assigns each a percentage that represents the degree of impairment of the entire body. In publishing the schedule, DLI attempts to cover all conditions that affect a person’s ability to work.

The schedule is designed to eliminate subjective judgment by medical providers, reflecting the statutory requirement that ratings be based on objective medical evidence. Once the provider diagnoses the medical condition, the schedule provides a percentage of disability to the whole body. Generally, two doctors cannot assign different degrees of disability if they agree on the diagnosis of the medical condition, although doctors can increase ratings for severity in some cases. In addition, doctors can disagree about a diagnosis, as well as the rating for a combination of injuries. The percentage of disability is then used in a simple statutory formula to calculate the amount of PPD benefits.

The schedule used for injuries before 1984 assigns disability ratings based on the part of the body injured, as opposed to the degree of impairment of the entire body. Doctors at that time were also permitted to take into account subjective factors, such as pain. This system allowed medical providers more discretion in assigning disability ratings to medical conditions. Two doctors could assign different percentages of disability to the same medical condition.

**Prior Two-Tiered System.** For injuries occurring between 1984 and 1995, a two-tier system was in place for PPD payments. Employees who received offers of suitable employment within 90 days of reaching maximum medical improvement received impairment compensation, which was calculated according to one schedule. Other employees received economic recovery compensation, which was based on a higher schedule. The idea was to give employers an incentive to offer work to injured employees. In 1995, however, the two-tiered system was abolished, and all PPD benefits are now figured the same way.

**Method of payment.** Until 1995, PPD could be paid in a lump sum to the employee. Now, the statutes provide for payment in weekly installments at the same rate per week as TTD would have been available to the employee. In other words, PPD is not a periodic wage replacement, but a set total amount assigned for the loss of use of a body part. Nevertheless, it is paid out in installments that are the same size that the employee would receive as a wage replacement. As a result, an employee could receive benefits for a small or a large number of weeks, depending on the employee's wage and the total amount assigned to that employee's injury by the schedule.

## **Rehabilitation Benefits**

Rehabilitation benefits provide injured workers with vocational rehabilitation to assist them in returning to work.

The law mandates that the employer or insurer provide rehabilitation consultation through a qualified rehabilitation consultant (QRC) at the request of the employee or the employer or at the request of DLI. The employer or insurer may request a waiver of the consultation requirement if it appears that the employer will be able to rehire the employee without using rehabilitation services. Many employees, however, will at least be eligible for a consultation, which is intended to determine whether rehabilitation would be appropriate. Beyond that point, there is a screening process by which the eligibility of the employee for rehabilitation is determined.

If eligible, the employee is put on a rehabilitation plan, which is subject to a variety of statutory procedural and substantive requirements. Within the first 60 days after the plan is filed with the commissioner, the employee has the right to make one switch to a different QRC of his choice. After that point, if the employee wants to change his QRC, he must make a request and the department or a compensation judge will determine whether a change in QRC is in the "best interests of the parties." Failure to cooperate with the rehabilitation plan can cause the employee to lose benefits.

The most intensive type of vocational rehabilitation is retraining, which involves a formal course of education to prepare an injured worker for a new occupation. Retraining is limited to 156 weeks, and time spent in retraining is not counted toward the 225-week or 450-week limits on temporary partial compensation, or toward the 104-week limit on temporary total compensation. A request for retraining must be filed before 104 weeks of combined temporary total and temporary partial benefits have been paid to the employee.

The Rehabilitation Review Panel advises the commissioner concerning rehabilitation issues. The panel also has authority to discipline QRC's and rehabilitation vendors, subject to an appeal to the Workers' Compensation Court of Appeals.

## **Medical benefits**

**Reasonable and necessary services.** The workers' compensation system pays all reasonable and necessary medical expenses associated with a work-related injury. Medical benefits can continue even after an injured worker returns to work.

**Surgery.** Insurers are responsible for paying the cost of surgery that is "reasonably required to cure and relieve the effects of the personal injury or occupational disease." The employee or employer (for nonemergency surgery) may request a second opinion at the employer's expense. An employee cannot be forced to undergo surgery.

**Change of provider.** As a general matter, an employee may choose the health care provider. An employee can only have one primary health care provider at a time for an injury, and has the right to change providers once within the first 60 days after treatment begins. After that time, any further change in providers must be approved by either the insurer, the department, or a compensation judge. If the employer has a managed care plan certified by DLI, the employer may require the employee to see a provider in the certified network in order for the treatment to be covered.

**Fee schedule.** DLI maintains a "relative value fee schedule" that sets a maximum permissible fee for almost every medical procedure. The entire schedule can be adjusted upward or downward by changing just one figure—known as the "conversion factor"—rather than changing every individual fee annually. For example, assume that a particular procedure has a "relative value" of 0.5 and another has a relative value of 1, and the conversion factor is 50. The fee is figured by multiplying the two numbers, so the permissible fee for the procedures would be \$25 for the first and \$50 for the second. If the conversion factor is changed next year to be 60, then the allowable fee will be \$30 for the first procedure and \$60 for the second, without every single fee having to be individually adjusted. Providers may not bill injured workers for fees in excess of the fee set by the schedule.

**Medical Services Review Board.** The Medical Services Review Board, composed primarily of health care providers, advises the commissioner on aspects of workers' compensation medical care and services. Specifically, the board advises the commissioner concerning levels of PPD

and costs and effectiveness of medical services. The board also has authority to discipline health care providers, subject to an appeal to the Workers' Compensation Court of Appeals.

**Managed care.** An organization may apply to DLI to have a managed care plan certified to provide medical care to employees in workers' compensation cases. If an employer uses a certified managed care organization, then the employer can require that injured employees receive their medical care through the plan. In order for a plan to be certified, it must meet certain requirements for accessibility, availability of different types of treatment, case management, and availability of a dispute resolution mechanism.

## **Benefits Available to Dependents**

Benefits are paid to the spouse and certain dependents of an employee who dies because of a work-related injury.

### **Death related to a work-related injury**

Certain dependents of an employee are entitled to benefits if that employee dies as a result of a work-related injury. The amount of benefits depends on the number of dependents at the time of death, although limited to the maximum compensation rate at the time of death. The benefits are adjusted annually for inflation. Children under 18, and children under 25 if enrolled in school, are conclusively presumed to be dependent.

**Surviving spouse and no dependent children.** The spouse is paid 50 percent of the deceased's weekly wage at the time of injury.

**Surviving spouse and dependent children.** The amount of benefits depends on the number of dependent children, with a maximum of two-thirds of the deceased wage at the time of the injury (subject to the inflation adjustment).

**Orphan dependent.** Benefits equal 55 percent of the weekly wage for one dependent child and two-thirds of the weekly wage for two or more dependent children.

**No surviving spouse or children.** Benefits are paid to other close relatives who were actual dependents of the deceased.

**Survivor benefit offset.** If a dependent receives government survivor benefits, the total combined benefits cannot exceed 100 percent of the deceased's weekly wage at the time of injury.

**Termination of benefits.** If there is a surviving spouse and no children, payments continue for ten years. If there is a surviving spouse and there are dependent children, payments continue for

ten years after the last child ceases to be dependent. Otherwise, benefits continue until the marriage or death of any dependent.

**Burial expenses.** The insurer must pay burial expenses up to \$7,500.

## **Payments to the Special Compensation Fund**

When a death of an employee results from a work-related injury and no one is entitled to dependent benefits, the employer must pay the Special Compensation Fund \$25,000. In cases involving dependent benefits less than \$25,000, the employer must pay the fund the difference between the amounts actually paid in benefits and \$25,000.

## **Introduction to Dispute Resolution Procedures**

This section focuses on the ways disputes arise and the forums in which they may be resolved.

### **Where a dispute may be resolved**

Although the workers' compensation system provides for a variety of procedures depending on the nature of the dispute, most disputes follow a similar general pattern. DLI operates a workers' compensation telephone hotline to provide preliminary assistance in resolving disputes. If the dispute cannot be resolved, more formal action may follow. First, there is a more formal attempt to assist the parties in resolving the dispute on their own. This may take place during a **settlement conference** or **mediation**. Depending on the type of dispute, there may then be an informal procedure in which an administrative decision is made by an impartial decision-maker without resorting to a trial-type setting. This stage is usually called an **administrative conference**. Then, there will be the opportunity for a more formal hearing, similar to a trial, called an **administrative hearing**. Finally, there are two levels of **appeal** after this "trial" phase, first to the Workers' Compensation Court of Appeals and then the Minnesota Supreme Court.

In order to understand the dispute resolution procedures used in workers' compensation cases, it is helpful to be familiar with the different forums in which disputes are resolved. These forums include the Department of Labor and Industry, the Office of Administrative Hearings, the Workers' Compensation Court of Appeals, and the Minnesota Supreme Court.

### **Department of Labor and Industry (DLI)**

For issues that are not resolved through telephone intervention, the department holds informal conferences to consider rehabilitation disputes and medical disputes that involve less than \$1,500. These conferences are conducted by compensation specialists. These decisions can be appealed to the Office of Administrative Hearings, which holds an entirely new hearing (a

hearing *de novo*) in all cases. DLI customer assistance teams also conduct voluntary mediation sessions.

### **Office of Administrative Hearings (OAH)**

*Settlement division.* Judges in the newly created settlement division of OAH (formerly part of DLI) conduct informal settlement conferences and can also conduct administrative conferences on matters including discontinuances, larger medical claims, and medical and rehabilitation disputes too legally complex to be decided by compensation specialists at DLI.

*Compensation judges.* Judges that conduct more formal administrative hearings at OAH (who are not part of the settlement division) consider every type of workers' compensation dispute. They may hear discontinuance, rehabilitation, and medical claims when a party disputes the result of an administrative conference. OAH also hears cases involving penalties and disputes between insurers. Trial procedures at OAH are similar in formality to court proceedings, although the compensation judges are not bound by rules of evidence or procedure. Most cases involve a hearing before a compensation judge, although judges can now issue decisions on stipulated facts without a hearing. The decision of the judge must be issued within 60 days of the date that the case is submitted.

### **Workers' Compensation Court of Appeals**

Any decision of OAH may be appealed to the Workers' Compensation Court of Appeals (WCCA). This is a five-member executive branch appeals panel whose jurisdiction is limited to workers' compensation issues. The court reviews cases to determine whether there were errors of law and whether findings of fact are supported by substantial evidence. In any appeal of a judge's order relating to discontinuance of benefits, the court must complete arguments within 60 days of the day that the record is certified from OAH.

### **Minnesota Supreme Court**

Workers' Compensation Court of Appeals decisions may be appealed to the state Supreme Court, which has discretion whether to hear the case.

## **The Early Stages of a Claim**

A workers' compensation dispute may come in any one of a variety of forms, but cases generally have some things in common, particularly the first report of injury and the initial payment or denial.

## **First report of injury**

An employee who suffers a work-related injury must give the employer notice of the injury, unless the employer has actual notice of the injury. Notice must be provided within 14 days to assure eligibility for workers' compensation benefits, but may be given up to 180 days following the injury without loss of eligibility in certain limited circumstances.

The employer is then responsible for filing a "first report of injury." If the employee is **killed** or **seriously injured**, then the employer must report the injury to its insurer and to DLI within 48 hours. This notice can be by phone, telegraph, or personal notice, and must be followed within seven days of the injury by written notice.

Employers are responsible for reporting all work-related injuries to their insurers. If the injury is **not a serious injury** and does not result in death, but causes the employee to miss more than three days of work, then the employer must make a report to its insurer within ten days of the injury, and the insurer must inform the department within 14 days of the injury. Filing the first report of injury does not mean that the employer is accepting liability for the injury. For most work-related injuries, the insurer or employer pays the benefits claimed and there is no need for dispute resolution procedures. A variety of procedures are available when disputes do arise.

## **Initial payment or denial**

An insurance company must either begin paying benefits or deny liability within 14 days of the date that the employer receives notice or has actual knowledge of the injury.

If an insurer begins paying benefits and then determines that the injury was not compensable within 60 days of receiving notice of the injury, the insurer may terminate benefits to the employee without following the discontinuance procedures. After the 60 days are up, however, the insurer may terminate benefits only by filing a notice of intent to discontinue benefits (NOID) as described below.

The department rules require that the notice of denial provide the specific reasons for the denial and clearly state the facts forming the basis for the denial. A denial is not sufficiently specific, for example, if it states only that the injury did not arise out of and in the course of employment or that the injury was denied for lack of a medical report.

## **Dispute Resolution Procedures**

Often, the procedure followed in resolving a claim will depend on the type of claim and the stage at which it is disputed. This section discusses several kinds of cases, including disputes over initial liability and additional benefits, discontinuance disputes, and medical and rehabilitation disputes.

## **Disputes over initial liability or additional benefits**

If the employer or insurer denies liability for an injury, or if liability is admitted but the employee seeks additional wage loss or permanent partial disability benefits, the employee files a *claim petition*. The petition must be on a form prescribed by the commissioner, and is filed with DLI and served on the employer/insurer. It must contain basic information about the employee and the injury and must identify any witnesses the employee intends to call. The claim petition also must state whether the employee is requesting a prehearing or settlement conference, as well as the location where the employee is requesting that any hearing be held. The opposing party has 20 days after service of the petition to file an answer, which must admit or deny the allegations in the petition and identify potential witnesses.

When the petition is received at DLI, it must be transferred within ten days to the settlement division of the OAH, unless it is a rehabilitation dispute or medical dispute involving a claim of \$1,500 or less, in which case it can be handled within DLI by a compensation specialist. For petitions referred to OAH, a compensation judge will decide whether a settlement conference is appropriate, or whether the petition should be directly scheduled for an administrative hearing. Either way, the conference or hearing will be conducted by a compensation judge at OAH.

At a settlement conference, both parties are required to attend and to have authority to settle the claim. The compensation judge at the settlement conference can issue a decision, which will be binding unless one of the parties requests a formal hearing within 30 days. If that request is made, an OAH judge will conduct a formal administrative hearing to review the decision from the conference.

## **Discontinuance disputes**

**Beginning with a Notice of Intent to Discontinue (NOID).** If an employer or insurer has been paying benefits, but there has been no judicial or administrative decision regarding entitlement to benefits, then when the employer or insurer wishes to discontinue benefits, it must send the employee a NOID. This form must notify the employee of the proposed date of discontinuance and disclose what information is being relied on in discontinuing benefits. The employee and the employee's attorney must be served with the notice.

If the employee disputes discontinuance, the employee has two options. He or she can file a request for an administrative conference, which will be conducted at the settlement division of OAH. That informal conference will result in a decision that will be binding unless one of the parties appeals.

If the employee chooses not to ask for an administrative conference, the employee can move directly to the more formal step of filing an Objection to Discontinuance, which will lead to a formal administrative hearing. This hearing is the same procedure that will result if the employee or employer appeals the decision in the administrative conference. In other words, the employee

and employer end up at the same trial-type hearing whether they skip the administrative conference altogether or if they appeal the decision that results from it.

**Beginning with a Petition to Discontinue.** If the employer is paying benefits subject to a judicial or administrative decision, the employer cannot use a NOID, but must file a Petition to Discontinue. At that point, the claim will go directly to a formal administrative hearing, without going through an administrative conference. This “two-track” approach to discontinuance means that if an employer discontinues benefits that had been ordered in court or in an administrative proceeding, then the employer must go through a more formal process in order to stop paying.

## **Medical and rehabilitation disputes**

If an employee's employer has a certified managed care plan, then in the case of a medical dispute, the employee is required to begin by exhausting the dispute resolution process within the managed care plan. The employee cannot pursue DLI or OAH processes unless this requirement has been met.

When an employee disputes rehabilitation or medical benefits, the employee files a medical or rehabilitation request with DLI. DLI then contacts the parties to determine whether a dispute actually exists. If DLI certifies the dispute, the employer/insurer then has 20 days to answer and state its response or defenses.

Medical and rehabilitation disputes over small amounts of money are the only disputes over which DLI compensation specialists currently have the authority to make binding decisions. A specialist can conduct an administrative conference for a rehabilitation dispute or a medical dispute for less than \$1,500 if primary liability is admitted. If either party is dissatisfied with the outcome, that party can request a formal hearing at OAH.

For medical disputes over \$1,500, the claim is referred to the settlement division at OAH for a settlement conference or administrative conference, after which either party could request a formal administrative hearing.

## Glossary

<b>Administrative Conference</b>	A type of informal dispute resolution procedure conducted at the Office of Administrative Hearings to resolve discontinuance, medical, and rehabilitation disputes. Generally a decision of an administrative conference may be reviewed in a more formal hearing.
<b>Alternative Dispute Resolution</b>	An approach to resolving disputes informally and less adversarially, typically through intervention, arbitration, or mediation.
<b>Assigned Risk Plan</b>	An insurance plan administered by the Department of Commerce to provide workers' compensation insurance to employers who have been rejected by private insurance companies.
<b>Claim Petition</b>	A form that an employee may use to assert the right to any or all of the major types of benefits.
<b>Department of Labor and Industry (DLI)</b>	The state agency charged with administering the workers' compensation laws.
<b>Gillette Injuries</b>	Injuries involving the final breakdown of a slowly deteriorating condition, often developing over many years. Under the case law, the employer at the time that the injury causes a breakdown is liable for the entire claim.
<b>Lost-time Injury</b>	An injury that results in more than three days of disability.
<b>Maximum Medical Improvement (MMI)</b>	The point at which it is reasonably medically certain that there will be no further significant recovery or lasting improvement in the injured worker's medical condition. Sometimes referred to as the end of the healing period. May determine eligibility of temporary total disability.
<b>Medical Services Review Board</b>	The advisory board that assists the DLI commissioner with medical issues and disciplines health care providers.
<b>Notice of Primary Liability Determination</b>	A form filed by an employer or insurance company that accepts or denies liability for the injury. The notice must be filed when the insurer initially decides to pay benefits or deny liability for the claim. It is also filed if the insurer later decides to deny liability within 60 days of the employer's knowledge of the injury.
<b>Notice of Intent to Discontinue (NOID)</b>	The notice that must be filed by the insurer who wishes to terminate temporary benefits.
<b>Objection to Discontinuance</b>	The form filed by an employee seeking to prevent the termination of temporary total or temporary partial benefits. The objection is used to request a hearing at the Office of Administrative Hearings—either as an appeal of an adverse decision of a conference or as an alternative to the conference.
<b>Occupational Disease</b>	A disease arising out of employment that is peculiar to a particular occupation and that results from causes beyond the ordinary hazards of employment.
<b>Office of Administrative Hearings (OAH)</b>	The state agency that conducts settlement conferences, administrative conferences, and formal hearings on workers' compensation issues.
<b>Permanent Partial Disability (PPD) Benefits</b>	Benefits that compensate a worker for permanent loss of function or damage to a body part. PPD is paid in weekly amounts.

<b>Permanent Total Disability (PTD) Benefits</b>	Benefits that are paid when an injured worker is permanently unable to work. PTD is paid in weekly amounts.
<b>Petition to Discontinue</b>	The form filed to seek discontinuance of temporary total or temporary partial benefits. The form may be used either to seek a new hearing at OAH after an adverse decision from a discontinuance conference or to seek a hearing at OAH without having a discontinuance conference.
<b>Primary Liability</b>	The responsibility of an employer or insurance company for paying a workers' compensation claim. An employer or insurer who denies primary liability is asserting that it is not responsible for benefits. For example, the insurer may be claiming that the injury is not covered under the workers' compensation laws or that another employer or insurer is responsible for paying the claim.
<b>Qualified Rehabilitation Consultant (QRC)</b>	A licensed individual who, in appropriate cases, provides rehabilitation consultation and develops a rehabilitation plan designed to return the employee to work.
<b>Rehabilitation Review Panel</b>	The group that is responsible for regulating rehabilitation professionals.
<b>Second Injury Fund</b>	A fund administered by DLI to pay certain costs of the workers' compensation system, primarily the cost of administering the system, reimbursing second injuries, providing benefits to employees of uninsured employers, and paying supplementary benefits.
<b>Special Compensation Fund</b>	For certain injuries before July 1, 1992, the Special Compensation Fund reimbursed the insurer for most benefits to an injured employee whose injury was made substantially greater by a pre-existing injury that was registered with the fund. The fund could recover a proportional share from the first employer, where appropriate.
<b>Supplementary Benefits</b>	For injuries before October 1, 1995, an amount paid as an addition to permanent total disability benefits after the employee has received total benefits for four years. The supplementary benefit is the amount that raises the employee's workers' compensation benefits to 65 percent of the statewide average weekly wage.
<b>Temporary Partial Disability (TPD) Benefits</b>	Wage replacement benefits that partially compensate for a reduction in earnings, when an injured employee returns to a job paying less than the pre-injury job. Ends at the earlier of 225 weeks of benefits or 450 weeks after the injury. Available only to the extent the post-injury wage and TPD benefits do not exceed 500 percent of the statewide average weekly wage.
<b>Temporary Total Disability (TTD) Benefits</b>	Wage replacement benefits that compensate an employee who is temporarily unable to work, replacing a portion of wages lost due to a work-related injury. Ends after the earlier of 104 weeks or 90 days after maximum medical improvement.
<b>Workers' Compensation Court of Appeals</b>	A five-member executive branch panel that hears workers' compensation cases on appeal from OAH.
<b>Workers' Compensation Reinsurance Association</b>	A nonprofit association, created by statute, that provides reinsurance for expensive workers' compensation claims.