Labor/Business Workers' Compensation Agreement (4-10-13)

1. Repeal *Spaeth* decision.

2. Implementation of pain contracts.

3. Change the data collected on the prevailing charge from the current one year to two years.

4. Patient advocate two year pilot program for back fusions.

5. Increase maximum weekly benefit to 102% of the SAWW for all wage loss benefits.

6. COLA delay reduced to 3 years and COLA cap increased to 3% for all wage loss benefits.

7. Cover mental-mental cases for traumatic events. Use Chamber language with clarification that physical/mental injuries are also still compensable (current law).

8. Rehabilitation changes

   A. Job search/placement services

   - would be limited to 20 hours per month;
   - at 3 months of job search/placement there is a mandatory review. Job placement services would end **unless** parties agree to an additional 3 months of job placement services **OR** ordered by DLI or other options are chosen such as jobs skills enhancement, retraining, etc; and
   - at 6 months job search/placement services would end. An injured worker would have to do further job search on his/her own.

   B. DLI will hold any rehabilitation conference within 14 days of receipt of any Rehabilitation Request. Services to the injured worker would continue during the time the conference would be scheduled or heard.

   C. QRC's are not allowed to operate in the capacity of disability case manager.

9. A. Increase injured worker attorney fee cap to $26,000 – make it a straight cap of 20% and
   B. Injured worker attorneys waive subdivision 7 fees on Roraff/Heaton.

1. Repeal Spaeth decision.

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

. . . .

Subd. 3.**Insurer payment.**

If a dispute exists as to whether an employee's injury is compensable under this chapter and the employee is otherwise covered by an insurer or entity pursuant to chapters 62A, 62C, 62D, 62E, 62R, and 62T, that insurer or entity shall pay any medical costs incurred by the employee for the injury up to the limits of the applicable coverage and shall make any disability payments otherwise payable by that insurer or entity in the absence of or in addition to workers' compensation liability. If the injury is subsequently determined to be compensable pursuant to this chapter, the workers' compensation insurer shall be ordered to reimburse the insurer or entity that made the payments for all payments made under this subdivision by the insurer or entity, including interest at a rate of 12 percent a year. If the health care provider accepts payment for the services from the insurer or entity pursuant to chapters 62A, 62C, 62D, 62E, 62R, or 62T, the payment shall be deemed payment in full and the employer is not liable for additional payment under this chapter for the services. If a payment pursuant to this subdivision exceeds the reasonable value as permitted by sections 176.135 and 176.136, the provider shall reimburse the workers' compensation insurer for all the excess as provided by rules promulgated by the commissioner.

2. Implementation of pain contracts.

176.83. Rules

. . . .

Subd. 5.**Treatment standards for medical services.**

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

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

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

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

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

(4) criteria for diagnostic imaging procedures;

(5) criteria for inpatient hospitalization; ~~and~~

(6) criteria for treatment of chronic pain; and

(7) criteria for the long term use of opioids or other scheduled medications to alleviate intractable pain and improve function, including the use of written contracts between the injured worker and the health care provider who prescribes the medication.

(c) If it is determined by the payer that the level, frequency, or cost of a procedure or service of a provider is excessive, unnecessary, or inappropriate according to the standards established by the rules, the provider shall not be paid for the procedure, service, or cost by an insurer, self-insurer, or group self-insurer, and the provider shall not be reimbursed or attempt to collect reimbursement for the procedure, service, or cost from any other source, including the employee, another insurer, the special compensation fund, or any government program unless the commissioner or compensation judge determines at a hearing or administrative conference that the level, frequency, or cost was not excessive under the rules in which case the insurer, self-insurer, or group self-insurer shall make the payment deemed reasonable.

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

3. Change the data collected on the prevailing charge from the current one year to two years.

176.136. MEDICAL FEE REVIEW.

. . . .

Subd. 1b.**Limitation of liability.**

(a) The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a small hospital shall be the hospital's usual and customary charge, unless the charge is determined by the commissioner or a compensation judge to be unreasonably excessive. A "small hospital," for purposes of this paragraph, is a hospital which has 100 or fewer licensed beds.

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

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

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

*** Minn. R. 5221.0500, subp. 2. Limitation of payer liability.**

. . . . (2) A prevailing charge under Minnesota Statutes, section 176.136, subdivision 1b, paragraph (b), is the 75th percentile of the usual and customary charges as defined in subitem (1*) in the previous calendar year* for each service, article, or supply if the database for the service meets all of the following criteria:

(a)the database includes only Minnesota providers, with at least three different, identifiable providers of the same provider type, distinguished by whether the service is an inpatient hospital service, or an outpatient physician, pathology, laboratory, chiropractic, physical therapy or occupational therapy service, or provider of other similar service, article, or supply;

(b) there are at least 20 billings for the service, article, or supply; and

(c) the standard deviation is less than or equal to 50 percent of the mean of the billings for each service in the data base or the value of the 75th percentile is not greater than or equal to three times the value of the 25th percentile of the billings.

4. Patient advocate two year pilot program for back fusions (injuries?).

176.136, subd. 1c. PATIENT ADVOCATE PILOT PROGRAM

The commissioner shall implement a two year patient advocate program for employees with back injuries who are considering back fusion surgery. The purpose of the program is to ensure that injured workers understand their treatment options and receive treatment for their work injuries in accordance with accepted medical standards. The services provided by the patient advocate shall be paid for from the Special Compensation Fund.

5. Increase the maximum weekly benefit to 102% of the SAWW for all wage loss benefits.

176.101 COMPENSATION SCHEDULE.

Subdivision 1. **Temporary total disability.**

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

(b)(1) Commencing on October 1, ~~2008~~ 2013, and on each year thereafter, commencing on October 1, the maximum weekly compensation payable is ~~$850 per week~~ the statewide average weekly wage for the period ending December 31 of the preceding year.

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

(c) The minimum weekly compensation payable is $130 per week or the injured employee's actual weekly wage, whichever is less.

6. Reduce the COLA delay from 4 years to 3 and raise the annual COLA cap from 2% to 3% for all wage loss benefits.

176.645 ADJUSTMENT OF BENEFITS.

Subdivision 1.**Amount.**

For injuries occurring after October 1, 1975, for which benefits are payable under section 176.101, subdivisions 1, 2 and 4, and section 176.111, subdivision 5, the total benefits due the employee or any dependents shall be adjusted in accordance with this section. On October 1, 1981, and thereafter on the anniversary of the date of the employee's injury the total benefits due shall be adjusted by multiplying the total benefits due prior to each adjustment by a fraction, the denominator of which is the statewide average weekly wage for December 31, of the year two years previous to the adjustment and the numerator of which is the statewide average weekly wage for December 31, of the year previous to the adjustment. For injuries occurring after October 1, 1975, all adjustments provided for in this section shall be included in computing any benefit due under this section. Any limitations of amounts due for daily or weekly compensation under this chapter shall not apply to adjustments made under this section. No adjustment increase made on or after October 1, 1977, but prior to October 1, 1992, under this section shall exceed six percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be six percent. No adjustment increase made on or after October 1, 1992, under this section shall exceed four percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be four percent. For injuries occurring on and after October 1, 1995, no adjustment increase made on or after October 1, 1995 shall exceed two percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be two percent. <u>For injuries occurring on and after October 1, 2013 no adjustment increase shall exceed three percent a year; in those instances where the adjustment under the formula of this section would exceed this maximum, the increase shall be deemed to be three percent. No adjustment under this section shall be less than zero percent.</u> The Workers' Compensation Advisory Council may consider adjustment or other further increases and make recommendations to the legislature.

Subd. 2.**Time of first adjustment.**

For injuries occurring on or after October 1, 1981, the initial adjustment made pursuant to subdivision 1 is deferred until the first anniversary of the date of the injury. For injuries occurring on or after October 1, 1992, the initial adjustment under subdivision 1 is deferred until the second anniversary of the date of the injury. The adjustment made at that time shall be that of the last year only. For injuries occurring on or after October 1, 1995, the initial adjustment under subdivision 1 is deferred until the fourth anniversary of the date of injury. The adjustment at that time shall be that of the last year only. <u>For injuries occurring on or after October 1, 2013, the initial adjustment under subdivision 1 is deferred until the third anniversary of the date of injury. The adjustment made at that time shall be that of the last year only.</u>

7. Cover mental-mental cases for traumatic events. Use Chamber language with clarification that physical/mental injuries are also still compensable (current law).

176.011 DEFINITIONS.

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

. . . .

Subd. 15.**Occupational disease.**

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

. . . .

(d) Mental impairment is defined as a diagnosis of Post-traumatic Stress Disorder by a licensed physician or psychologist. Furthermore, "post- traumatic stress disorder" means that condition as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Subd. 16. **Personal injury.**

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

8A. Job search/placement services would be limited to 20 hours per month.
At 3 months of job search/placement there is a mandatory review. Job placement services would end unless parties agree to an additional 3 months of job placement services or ordered by DLI or other options are chosen such as jobs skills enhancement, retraining, etc. At 6 months job search/placement services would end. An injured worker would have to do further job search on his/her own.

176.102 REHABILITATION.

. . . .

Subd. 5.**On-the-job training; job placement and job development limitation.**

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

(b) For purposes of this paragraph, job placement includes job development services as defined in rules adopted by the commissioner. Unless the parties agree otherwise, job placement services provided by a qualified rehabilitation consultant firm or a registered rehabilitation vendor shall not exceed 20 hours per month or 24 consecutive or intermittent weeks. When 12 consecutive or intermittent weeks of job placement services have been provided, the qualified rehabilitation consultant must consult with the parties and either file a plan amendment reflecting an agreement by the parties to extend job placement services, or file a request for a rehabilitation conference under section 176.106. The commissioner or compensation judge may issue an order modifying the rehabilitation plan or make other determinations about the employee's rehabilitation, but may not order more than 24 total consecutive or intermittent weeks of job placement services.

8B. DLI will hold any rehabilitation conference within 14 days of receipt of any Rehabilitation Request. Services to the injured workers' would continue during the time the conference would be scheduled or heard.

176.106 ADMINISTRATIVE CONFERENCE.

Subdivision 1. **Scope.**

All determinations by the commissioner or compensation judge pursuant to section 176.102, 176.103, 176.135, or 176.136 shall be in accordance with the procedures contained in this section. For medical disputes under sections 176.135 and 176.136, the commissioner shall have jurisdiction to hold an administrative conference and issue decisions and orders under this section if the amount in dispute at the time the medical request is filed is $7,500 or less.

Subd. 2. **Request for conference.**

Any party may request an administrative conference by filing a request on a form prescribed by the commissioner.

Subd. 3.**Conference.**

The matter shall be scheduled for an administrative conference within 60 days after receipt of the request for a conference, except that an administrative conference on a rehabilitation issue under section 176.102 must be held within 14 days. If there is a rehabilitation plan in effect, the qualified rehabilitation consultant must continue to provide reasonable services under the plan until the date the conference was initially scheduled to be held. Notice of the conference shall be served on all parties no later than 14 days prior to the conference; unless the commissioner or compensation judge determines that a conference shall not be held. The commissioner or compensation judge may order an administrative conference before the commissioner's designee whether or not a request for conference is filed. The commissioner or compensation judge may refuse to hold an administrative conference and refer the matter for a settlement or pretrial conference or may certify the matter to the Office of Administrative Hearings for a full hearing before a compensation judge.

Implementation concerns about the proposal:

- DLI must give 14 days' notice of a conference. M.S. 176.081 requires DLI to "certify" that it has tried to resolve rehabilitation disputes before an attorney can collect fees for representing the employee. There is not enough time for DLI to try to resolve the dispute and send notice to the parties and have a conference in 14 days. (The notice of conference would have to go out the day we receive the rehabilitation request.)
- The 14 day requirement would also apply to OAH, because sometimes rehabilitation disputes are referred to OAH. DLI and OAH schedule conferences based on attorney availability from calendars they file with OAH. This proposal does not allow the agencies to consider attorney availability; in order to give the required 14 days' notice, the conference would have to be held *on* the 14th day after the dispute is received by DLI. It would be unusual for attorneys for both parties to be available for a conference on 14 days' notice.

Alternative proposal: The matter shall be scheduled for an administrative conference within 60 days after receipt of the request for a conference, except that an administrative conference on a rehabilitation issue under section 176.102 must be held within 28 days, unless the issue involves only fees for rehabilitation services that have already been provided or there is good cause for holding the conference later than 28 days. . . . .

8C. Proposal: QRCs are not allowed to operate in the capacity of disability case manager.

176.102. REHABILITATION.

. . . .

Subd. 10.**Rehabilitation; consultants and vendors.**

The commissioner shall approve rehabilitation consultants who may propose and implement plans if they satisfy rules adopted by the commissioner for rehabilitation consultants. A consultant may be an individual or public or private entity, and except for rehabilitation services, Department of Employment and Economic Development, a consultant may not be a vendor or the agent of a vendor of rehabilitation services. The commissioner shall also approve rehabilitation vendors if they satisfy rules adopted by the commissioner.

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

9 A. Increase injured worker attorney fee cap to $26,000 – make it a straight cap of 20%

176.081 LEGAL SERVICES OR DISBURSEMENTS; LIEN; REVIEW.

Subdivision 1.**Limitation of fees.**

(a) A fee for legal services of ~~25~~ 20 percent of the first ~~$4,000 of compensation awarded to the employee and 20 percent of the next $60,000~~ $130,000 of compensation awarded to the employee is the maximum permissible fee and does not require approval by the commissioner, compensation judge, or any other party. All fees, including fees for obtaining medical or rehabilitation benefits, must be calculated according to the formula under this subdivision, except as otherwise provided in clause (1) or (2).

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

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

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

(3) The fees for obtaining disputed medical or rehabilitation benefits are included in the $**~~13,000~~** **26,000** limit in paragraph (b). An attorney must concurrently file all outstanding disputed issues. An attorney is not entitled to attorney fees for representation in any issue which could reasonably have been addressed during the pendency of other issues for the same injury.

(b) All fees for legal services related to the same injury are cumulative and may not exceed $**~~13,000~~** **26,000**. If multiple injuries are the subject of a dispute, the commissioner, compensation judge, or court of appeals shall specify the attorney fee attributable to each injury.

. . . .

9 B. Injured worker attorneys waive subdivision 7 fees on Roraff/Heaton

176.081. LEGAL SERVICES OR DISBURSEMENTS; LIEN; REVIEW

. . . .

Subd. 7.**Award; additional amount.**

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