DEPARTMENT OF LABOR AND INDUSTRY

# Workers' Compensation Advisory Council legislation summary

## 2018 Minnesota Session Laws, Chapter 185 – H.F. No. 3873 final engrossment; governor approval: May 20, 2018

**This provides only an overview of the 2018 workers' compensation legislation. The actual language of Chapter 185 is at www.revisor.mn.gov/laws/?id=185&year=2018&type=0.**

## Article 1: General

### Section 1

- Minn. Stat. § 15A.083, subd. 7, Workers' Compensation Court of Appeals and compensation judges

Subdivision 7 is amended to adjust the salaries of the judges of the Workers' Compensation Court of Appeals (WCCA) to provide parity with increases provided in 2017 for workers' compensation judges at the Office of Administrative Hearings (OAH). The amendments provide that the salaries of the WCCA judges are 105 percent of the OAH judges and the salary of the chief judge of the WCCA is 107 percent of the salaries of the OAH judges.

Effective date: This section 1 is effective June 1, 2018.

### Section 2

- Minn. Stat. § 175A.05, Quorum

The proposed amendment adds a new subdivision 3, which permits the chief judge of the WCCA to assign a retired workers' compensation judge or WCCA judge (with the retired judge's permission) to hear any case at the WCCA when there is an insufficient number of WCCA judges to constitute a quorum (there are five WCCA judges, so there must be at least three judges assigned to hear each case). The retired judge shall receive pay and expenses in the amount and manner provided by law for judges serving on the court, less the retirement pay the judge is receiving under chapter 352 or 490.

Effective date: This section 2 is effective June 1, 2018.

### Section 3

- Minn. Stat. § 176.231, subd. 9, Uses that may be made of reports

The existing subdivision 9 governs who has access, with and without an authorization, to workers' compensation reports filed with the commissioner of the Department of Labor and Industry (DLI).

Paragraph (b) – This amendment changes "written" authorization to "signed" authorization. This change reflects the increasing use of electronic signatures permitted by Minnesota Statutes, sections 176.285, subd. 2 (b) and 325.02. Under these sections, a "signature" may be an electronic signature.

Paragraph (c) – The Department of Labor and Industry creates a worker identification (WID) number when a first report of injury is filed. Parties are encouraged to use the WID number when filing documents in the workers' compensation system to minimize the use of the injured workers' Social Security number. This amendment allows DLI to provide the WID number without the signed authorization of a party to the workers' compensation claim (the employee, employer and insurer) to: the attorney for a party; an attorney for an intervenor or potential intervenor in a dispute; an intervenor; or the employee's assigned qualified rehabilitation consultant (QRC).

Effective date: This section 3 is effective June 1, 2018.

## Section 4

- [To be codified as Minn. Stat. § 176.2611], Coordination of the Office of Administrative Hearings' case management system and the workers' compensation imaging system

**Subdivision 1, Definitions** – Terms used in section 4 are defined.

- *Commissioner* means the commissioner of the Department of Labor and Industry.
- *Department* means the Department of Labor and Industry.
- *Document* includes all electronic or paper data filed with or issued by the office or department that is related to a claim-specific dispute resolution proceeding under this section.
- *Office* means the Office of Administrative Hearings.

**Subd. 2, Applicability** – Section 4 governs: filing requirements pending completion of the Workers' Compensation Modernization Program; and access to documents and data in the OAH case management system, the workers' compensation imaging system and the system that will be developed as a result of the Workers' Compensation Modernization Program. This section prevails over contrary provisions in the workers' compensation law and rules.

**Subd. 3, Documents that must be filed with the office** – Except as provided in subdivision 4 and section 176.421 (appeals to the WCCA), all documents related to a workers' compensation dispute that require action by OAH must be filed with OAH as provided by the chief administrative law judge. Filing a document that initiates or is filed in preparation for a proceeding at OAH satisfies any requirement in Minn. Stat. chapter 176 that the document must be filed with the commissioner of DLI.

**Subd. 4, Documents that must be filed with the commissioner** –

Paragraph (a), clauses (1) to (6) – The types of workers' compensation dispute resolution documents that must be filed with the commissioner include:

- all requests for a medical or rehabilitation administrative conference under Minn. Stat. § 176.106, regardless of the amount in dispute;
- a motion to intervene in an administrative conference pending at DLI;
- any other document related to an administrative conference pending at DLI;

- an objection to a penalty assessed by the commissioner or DLI;
- requests for medical and rehabilitation dispute certification under section 176.081, subdivision 1, paragraph (c), including related documents; and
- any other document required to be filed with the commissioner, except as provided in subdivision 3 or subdivision 4.

Paragraph (b) – The requirement in paragraph (a), that medical and rehabilitation requests for an administrative conference must be filed with the commissioner, does not change existing jurisdictional provisions in section 176.106; and a claim petition that contains only medical or rehabilitation issues is considered to be a request for an administrative conference unless primary liability is disputed.

Paragraph (c) – The commissioner must refer to OAH, within 60 days, a timely unresolved objection to a penalty assessed by the commissioner or DLI.

**Subd. 5, Form revision and access to documents and data** –

Paragraph (a) – The commissioner must revise dispute resolution forms, in consultation with the chief administrative law judge, to reflect the filing requirements in this section.

Paragraph (b) – "Complete, read-only, electronic access" is defined for purposes of this subdivision and excludes: confidential mediation statements; work product of a compensation judge, mediator or commissioner; the Vocational Rehabilitation unit of DLI's case management system data; the Special Compensation Fund's case management system data; and audit trail information.

Paragraph (c) – OAH must be provided with continued complete, read-only electronic access to DLI's imaging system.

Paragraph (d) – DLI must be provided with read-only electronic access to OAH's case management system, including the ability to view all data but excluding access into filed documents.

Paragraph (e) – OAH must send DLI all documents that are accepted for filing or issued by OAH within two business days.

Paragraph (f) – DLI must place documents sent by OAH in the appropriate imaged file for the employee.

Paragraph (g) – DLI must send OAH the following documents within two business days: notices of discontinuance; decisions issued by DLI; and mediated agreements.

Paragraph (h) – When OAH's case management system is integrated with the new DLI technology system that will result from the Workers' Compensation Modernization Program, both DLI and OAH will be provided with complete, read-only, electronic access to the other agency's system.

Paragraph (i) – Each agency's responsible authority for the purposes of data practices is responsible for his or her own employees' use and dissemination of the data and documents in DLI's and OAH's technology systems.

**Subd. 6, Data privacy** –

Paragraph (a) – All dispute resolution documents filed with or issued by DLI or OAH under the workers' compensation law are private data on individuals and nonpublic data under chapter 13, except that the documents are available to the specified agencies and persons in clauses (1) to (10) (parties to the claim and

their attorneys; an intervenor in a dispute; a person who has written authorization from a party to the workers' compensation claim; DLI, OAH and any other person, agency or entity allowed access by law).

Paragraph (b) – OAH and DLI may post notice of scheduled proceedings on the agencies' websites and principal places of business in any manner that protects the employee's identifying information.

**Subd. 7, Workers' Compensation Court of Appeals** – WCCA is given authority to amend its rules of procedure to reflect electronic filing with OAH under this section for purposes of section 176.421, subdivision 5 (transmission of the record on appeal), and to allow electronic filing with the court as allowed by section 176.285. The court may amend its rules using the procedures in section 14.389.

Effective date: This section 4 is effective June 1, 2018.

### Section 5

- Laws 2017, chapter 94, article 1, section 6, is amended to appropriate funds to WCCA from the workers' compensation fund

## Article 2: Hospital outpatient fee schedule

Article 2 establishes a workers' compensation hospital outpatient fee schedule (HOFS) for payment of workers' compensation hospital outpatient surgical, emergency room and clinic services, using Medicare's Outpatient Prospective Payment System (OPPS) as a framework.

### Section 1

- [To be codified as Minn. Stat. § 176.1364], Workers' Compensation Hospital Outpatient Fee Schedule

**Subdivision 1, Definitions** – Paragraphs (a) to (h) define terms used in the proposal, including Medicare OPPS tables, called Addenda A and B, which are used to determine the workers' compensation HOFS amounts. Addenda A and B include a list of hospital service codes and descriptions and the Medicare relative weight for each service.

**Subd. 2, Applicability** –

Paragraph (a) – This section only applies to payment of hospital outpatient charges if they are listed in the hospital outpatient fee schedule (HOFS) established by the commissioner. If a hospital's charges do not include a service in the HOFS, it is paid according to the relative value fee schedule. If it is not covered by the relative value fee schedule, it is paid at 85 percent of the hospital's usual and customary charge.

Paragraph (b) – The HOFS does not apply to Medicare-certified critical access hospitals, which are paid as provided in Minn. Stat. § 176.136, subd. 1b (a): 100 percent of the critical access hospital's usual and customary charge, unless the commissioner or compensation judge determines the charge is unreasonably excessive.

**Subd. 3, Hospital outpatient fee schedule** –

Paragraph (a) – The commissioner must establish the HOFS amounts for services with a J1 or J2 status indicator in Addendum B of Medicare's OPPS and the comprehensive observation services Ambulatory Payment

Classification 8011 in Addendum A. The commissioner must publish a link to the HOFS in the *State Register* before Oct. 1, 2018, and place the HOFS on DLI's website.

Paragraphs (b) and (c) – These paragraphs establish the formula for calculating the payment amounts for services in the HOFS.

- The relative weights for the services with a J1 and J2 status indicator in Addenda A and B are multiplied by separate dollar conversion factors for: non-critical access hospitals of 100 or fewer licensed beds; and hospitals with more than 100 licensed beds.
- The commissioner must establish the conversion factors, in consultation with insurers and hospitals, using the process described in paragraph (b), so that the overall payment under the HOFS for the two hospital categories is the same as under the law in effect before the HOFS becomes effective.

Paragraph (d) – This paragraph describes how the HOFS conversion factors are adjusted annually, based on the market basket index published on Medicare's website.

Paragraph (e) – This paragraph describes the process for updating the HOFS in 2021 and at least every three years thereafter.

Paragraph (f) – This paragraph specifies how the commissioner must provide, by each Oct. 1, notice in the *State Register* of adjustments to the conversion factors and HOFS amounts in paragraphs (d) and (e). The notice must include a link to the updated HOFS published on DLI's website.

**Subd. 4, Payment under the hospital outpatient fee schedule** –

Paragraph (a) – This paragraph describes the scope of payment under the HOFS according to paragraphs (b) and (c).

Paragraph (b) – This paragraph describes the comprehensive payment when a bill includes one or more services with a J1 status indicator.

- If the bill includes charges for one service with a J1 status indicator, payment is the amount listed in the HOFS for that service, regardless of the amount charged.
- If the bill includes charges for more than one service with a J1 status indicator, payment for the service with the highest listed fee is 100 percent of the listed fee; each additional service in the HOFS is paid at 50 percent of the listed fee.
- No separate payment is made for charges for additional services on the bill, except for implantable devices paid as provided in subdivision 5.

Paragraph (c) – This paragraph describes payment for a bill with one or more services with a J2 status indicator, and no J1 service.

- Payment for each service with a J2 status indicator is the amount listed in the HOFS, regardless of the amount charged.
- Payment for services without a Healthcare Common Procedure Coding System (HCPCS) code that are billed with a service with a J2 status indicator is packaged into the payment for the J2 service.
- Payment for drugs with a HCPCS code delivered by injection or infusion is packaged into payment for the injection or infusion service. Payment for drugs not delivered by injection or infusion is the Medicare

Average Sales Price (ASP) of the drug when dispensed. The commissioner must publish on DLI's website a link to the ASP most recently available as of the preceding July 1.

- If a bill includes eight or more units of service with HCPCS code G0378 (observation services, per hour) and there is a physician's or dentist's order for observation, payment is the amount listed in the HOFS for Ambulatory Payment Classifications 8011, regardless of the amount charged. All other services billed by the hospital are packaged into the payment amount for code G0378.
- For other services on the same bill as the service with the J2 status indicator, payment is the amount allowed by the relative value fee schedule or, if not covered by the RVFS, 85 percent of the hospital's usual and customary charge.

**Subd. 5, Implantable devices** – Payment for implantable devices is included in the maximum fee for services in the HOFS, except that an implantable device with a H status indicator in Addendum B that is billed with a J1 service is paid at 85 percent of the hospital's usual and customary charge. The HOFS must be updated each year to include any HCPCS codes payable under this section.

**Subd. 6, Study** – The commissioner must conduct a study of the HOFS and report to the Workers' Compensation Advisory Council by Jan. 15, 2021. Based on the results of the study, WCAC must consider if there is a minimum 80 percent compliance with timeliness and accuracy of payments, and additional statutory amendments, including a maximum 10 percent reduction in payments under the HOFS and an increase in indemnity benefits to injured workers.

**Subd. 7, Rulemaking** – The commissioner has rulemaking authority under section 14.386 if needed to implement the law.

Effective date: This section 1 is effective for hospital outpatient services provided on or after Oct. 1, 2018.

## Article 3: Outpatient billing, payment and dispute resolution

Article 3 establishes billing, payment and dispute-resolution requirements for the hospital outpatient fee schedule (in Article 2) and ambulatory surgical center (ASC) payment provisions (in Article 4).

### Section 1

- Minn. Stat. § 176.136, subd. 1b, Limitation of Liability

Paragraph (a) – This eliminates payment at 100 percent of the hospital's usual and customary charge for outpatient services provided by non-critical access hospitals of 100 or fewer licensed beds.

Paragraph (b) – All non-critical access hospitals are paid 85 percent of the hospital's usual and customary charge if the outpatient charges are not covered by 176.1363 (the ASC fee schedule in Article 4) or 176.1364 (the HOFS in Article 2).

Paragraph (e) – The prevailing charge as a basis to reduce a payment to an ASC under section 176.1363 or a hospital as defined in section 176.1364 is repealed.

Paragraph (f) – "Inpatient" is defined as a patient admitted to a hospital by order of a physician or dentist for purposes of chapter 176 (the workers' compensation law). The hospital must provide documentation of the order if requested by the employer.

Effective date: This section 1 is effective for hospital outpatient services provided on or after Oct. 1, 2018.

## Section 2

- [To be codified as Minn. Stat. § 176.1365], Outpatient Billing, Payment, and Dispute Resolution

**Subdivision 1, Scope** – Section 2 applies to billing, payment and dispute resolution for services provided by an ASC under Article 4 (Minn. Stat. § 176.1363) and by a hospital under Article 2 (Minn. Stat. § 176.1364). "Insurer" includes a self-insured employer and "services" is as defined in section 176.1364.

**Subd. 2, Outpatient billing, coding and prior notification** –

Paragraph (a) – For services governed by Articles 2 and 4, hospitals and ASCs must bill insurers using the same codes, formats and details required for billing Medicare.

Paragraph (b) – All charges for ASC or HOFS services must be submitted on the appropriate electronic transaction required by the workers' compensation law. ASCs must submit charges on the electronic 837P form. ASCs must not bill for services and items that are included in the facility fee under federal ASC regulations; Minn. R. 5221.4033, subp. 1a, governing facility fees, does not apply to ASCs.

Paragraph (c) –

- ASCs, hospitals and insurers must comply with existing workers' compensation rules governing prior notice to the insurer, and the insurer's response. Prior notice may be provided by the hospital, ASC or surgeon.
- For purposes of the rule that requires notice to insurers of a non-emergency inpatient hospitalization, "inpatient" has the meaning as provided in section 176.136, subd. 1b (d) (which requires an order from a physician or dentist).

Paragraph (d) – ASC or hospital bills must be submitted as required by Minn. Stat. § 176.135, subds. 7 and 7a, and within the time period required by Minn. Stat. § 62Q.75, subd. 3. Insurers must respond to the initial bill as provided in Minn. Stat. § 176.135, subds. 6 and 7a. Copies of records or reports related to charges are separately payable as provided in section 176.135, subd. 7 (a).

**Subd. 3, ASC or hospital request for reconsideration; insurer response; time frames** –

Paragraph (a) – An ASC or hospital's request for reconsideration of an insurer's payment denial or reduction must be submitted to the insurer in writing within one year of the EOR or EOB.

Paragraph (b) – The insurer must respond in writing to the reconsideration request within 30 days and must respond to the issues raised by the ASC or hospital in its request.

**Subd. 4, Insurer request for reimbursement of overpayment; time frame** – A payer that determines it has overpaid an ASC or hospital must request reimbursement in writing to the ASC or hospital within one year of the date of the payment.

**Subd. 5, Medical request for administrative conference; time frame to file** –

Paragraph (a) – An ASC or hospital must notify the payer of intent to file a medical request for an administrative conference at least 20 days before filing and a payer must notify an ASC or hospital of its intent to file a medical request at least 20 days before filing.

If the medical request is permitted by section 176.136, subdivision 2 (which allows health care providers to file a medical request with DLI only for disputes about whether the charge was excessive or treatment was reasonable and necessary), the ASC, hospital or insurer must file the medical request with DLI within one year after the:

- initial EOR or EOB if the ASC or hospital does not request reconsideration;
- date of the insurer's response to the ASC or hospital's request for reconsideration; or
- insurer's request for reimbursement of an overpayment under subdivision 4.

Paragraph (b) – Paragraph (a) does not prohibit an employee from filing a medical request for assistance or claim petition for payment denied or reduced by the insurer. The ASC or hospital may not bill the employee for the denied or reduced payment when prohibited by the workers' compensation law.

**Subd. 6, Interest** – Paragraphs (a) and (b) state interest at an annual rate of 4 percent is payable to an ASC, hospital or insurer for amounts that are underpaid or overpaid.

Effective date: This section 2 is effective for services provided on or after Oct. 1, 2018.

# Article 4: Ambulatory surgical centers

Article 4 establishes payment provisions for workers' compensation treatment provided by ambulatory surgical centers (ASCs).

## Section 1

- [To be codified as Minn. Stat. § 176.1363], Ambulatory Surgical Center Payment

**Subdivision 1, Definitions** – Provides definitions of terms used in the proposal, including ASC, conversion factor and Medicare Ambulatory Surgical Center Payment System (ASCPS). The definition of ASCPS also describes the Medicare ASCPS Addenda (AA, BB and DD1), which provide the payment rate and weight for specific services, and payment provisions in the Medicare ASCPS.

**Subd. 2, Payment for covered surgical procedures and ancillary services based on the ASCPS** –

Paragraph (a) – Payment to an ASC shall be the lesser of:

- the ASC's usual and customary charge for all services, supplies and implantable devices; or
- the Medicare ASCPS payment times a multiplier of 320 percent.
  - The 320 percent must be adjusted on July 1 of every year if the conversion factor (dollar multiplier) for the service is less than 98 percent of the conversion factor in effect on the previous July 1, according to a specific formula.
  - The amount payable includes payment for all implantable devices.

- The 320 percent is annually adjusted; starting July 1, 2019, the conversion factor is less than 98 percent of the conversion factor in effect on the previous July 1.

Paragraph (b) – Payment is effective for surgical procedures from Oct. 1, 2018, through Sept. 30, 2019, and must be updated each Oct. 1 based on the ASCPS addenda AA, BB and DD1 most recently available from Medicare's website as of the previous July 1 and the corresponding Medicare claims processing manual. If Medicare has not updated the ASCPS addenda, the addenda identified in the notice most recently published by the commissioner in the *State Register* shall remain in effect.

Paragraph (c) – The commissioner must annually, and no later than Oct. 1, give notice in the *State Register* of any adjustment to the multiplier under paragraph (a) and of the applicable Medicare addenda. The notice must identify and link to the applicable addenda.

**Subd. 3, Payment for compensable surgical services not covered under ASCPS** –

Paragraph (a) – If a compensable surgical procedure is not listed in the ASCPS addenda, payment is 75 percent of the ASC's usual and customary charge for the procedure with the highest charge. Subsequent unlisted procedures are paid at 50 percent of the ASC's usual and customary charge.

Paragraph (b) – If the service is listed in the ASCPS addenda, but a payment amount is not listed, or the payment indicator provides it is paid at reasonable cost or is contractor priced, payment is 75 percent of the ASC's usual and customary charge.

**Subd. 4, Study** – The commissioner must conduct a study analyzing the impact of the reforms, including timeliness and accuracy of payments, and recommend further changes if needed. The results must be reported to the WCAC and legislative leaders with jurisdiction over workers' compensation matters by Jan. 15, 2021.

**Subd. 5, Rulemaking** – The commissioner may adopt or amend rules to implement this section and the Medicare ASCPS for workers' compensation using the process in section 14.386, paragraph (a).

Effective date: This section 1 is effective for procedures and services provided by an ASC on or after Oct. 1, 2018, except subdivision 5 is effective the day following final enactment.

# Article 5: Workers' compensation benefits

## Section 1

- Minnesota Statutes § 176.011, subdivision 15, Occupational disease

Paragraph (e) – This paragraph creates a post-traumatic stress disorder (PTSD) presumption for an employee who was employed on active duty as:

- a licensed police officer;
- a firefighter;
- a paramedic;
- an emergency medical technician;
- a licensed nurse employed to provide emergency medical services outside of a medical facility;
- a public safety dispatcher;

- an officer employed by the state or a political subdivision at a corrections, detention or secure treatment facility;
- a sheriff or full-time deputy sheriff of any county; or
- a member of the Minnesota State Patrol.

If an employee in one of the listed occupations is diagnosed with a mental impairment under paragraph (d) (PTSD according to DSM-V) and has not been diagnosed with PTSD previously, then the PTSD is presumptively an occupational disease that is presumed to have been due to the nature of employment.

The presumption may be rebutted by substantial factors brought by the employer and insurer.

- Substantial factors known to the employer or insurer at the time of the denial of liability must be communicated to the employee on the denial of liability.
- PTSD is not considered an occupational disease if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement or similar action taken in good faith by the employer.

Effective date: This section 1 is effective for employees with dates of injury on or after Jan. 1, 2019.

### Section 2

- Minnesota Statutes § 176.101, subdivision 2, Temporary partial disability

The maximum number of weeks that an employee is entitled to temporary partial workers' compensation benefits is increased from 225 to 275.

Effective date: This section 2 is effective for employees with dates of injury on or after Oct. 1, 2018.

### Section 3

- Minnesota Statutes § 176.101, subdivision 2a, Permanent partial disability

The table of dollar amounts used to calculate permanent partial disability benefits are increased.

Effective date: This section 3 is effective for employees with dates of injury on or after Oct. 1, 2018.

### Section 4

- Minnesota Statutes § 176.101, subdivision 4, Permanent total disability

Permanent total disability benefits currently cease at age 67 because the employee is presumed retired from the labor market. This section deletes the retirement presumption at age 67 and, instead, provides that permanent total disability benefits cease at age 72. There is an exception provided for employees who are injured after age 67, whose permanent total disability benefits cease after five years.

Effective date: This section 4 is effective for employees with dates of injury on or after Oct. 1, 2018.

### Section 5

- Minnesota Statutes § 176.101, subdivision 11, Retraining; compensation

The existing reference to “225” weeks of temporary partial disability benefits is changed “275” to reflect the same change as in section 3.

Effective date: This section 5 is effective for employees with dates of injury on or after Oct. 1, 2018.

## Section 6

- Minnesota Statutes § 176.83, subdivision 5, Treatment standards for medical services

Clause (8), which is added to paragraph (b), directs the commissioner, in consultation with the Medical Services Review Board, to adopt rules for the treatment of PTSD using the expedited process in Minn. Stat. § 14.389.

- In developing the treatment criteria, the guidance found in the American Psychological Association’s most recently adopted Clinical Practice Guideline for the Treatment of PTSD in Adults must be considered.
- The rules must be promptly adopted and updated each time the APA adopts a significant change to its clinical practice guideline.
- The rules apply to employees with all dates of injury who receive treatment for PTSD after the rules are adopted.

Effective date: This section 6 is effective June 1, 2018.

## Section 7

Effective date: Unless otherwise specified, Article 5 is effective for employees with dates of injury on or after Oct. 1, 2018.