

Section 1

176.101 COMPENSATION SCHEDULE.

Subd. 2a. Permanent partial disability.

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

(b) The percentage determined pursuant to the rules adopted under section 176.105 must be multiplied by the corresponding amount in the following table ~~at the time permanent partial disability is payable according to paragraph (c):~~

Impairment Rating...

EFFECTIVE DATE. This section is effective the day following final enactment.

Section 2

176.104 REHABILITATION PRIOR TO DETERMINATION OF LIABILITY.

Subdivision 1. Dispute.

If there exists a dispute regarding medical causation or whether an injury arose out of and in the course and scope of employment and an employee is otherwise eligible for rehabilitation services under section 176.102 prior to determination of liability, the employee shall be referred by the commissioner to the department's Vocational Rehabilitation Unit which shall provide rehabilitation consultation if appropriate. If the sole dispute is regarding discontinuance of compensation, an employee eligible for rehabilitation services may be referred to the Vocational Rehabilitation Unit only after the employee or employer has filed an objection under section 176.238, subd. 6, to the administrative decision on discontinuance.

The services provided by the department's Vocational Rehabilitation Unit and the scope and term of the rehabilitation are governed by section 176.102 and rules adopted pursuant to that section. Rehabilitation costs and services under this subdivision shall be monitored by the commissioner.

EFFECTIVE DATE. This section is effective August 1, 2024.

Section 3

176.129 CREATION OF SPECIAL COMPENSATION FUND.

Subd. 10. **Penalty.**

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

EFFECTIVE DATE. This section is effective for due dates on or after the day following final enactment.

Section 4

176.135 TREATMENT; APPLIANCES; SUPPLIES.

Subd. 7. **Medical bills and records.**

(a) Health care providers shall submit to the insurer an itemized statement of charges in the standard electronic transaction format when required by section 62J.536 or, if there is no prescribed standard electronic transaction format, on a billing form prescribed by the commissioner. Health care providers shall also submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury. Pursuant to Minnesota Rules, part 5219.0300, health care providers may charge for copies of any records or reports that are in existence and directly relate to the items for which payment is sought under this chapter. The commissioner shall adopt, by rule, a schedule of reasonable charges by rule that will apply to charges not covered by paragraphs (d) and (e).

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

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

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

use the General Equivalence Mappings established by the Centers for Medicare and Medicaid Services to replace the ICD-9 diagnostic codes with ICD-10 codes in the rules.

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

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

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

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

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

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

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

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

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

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

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

(5) \$500 for any request.

(f) The commissioner may assess a penalty assessed against a health care provider for each violation of this section by the health care provider or their agent shall be of \$1,000, payable to the assigned risk safety account.

EFFECTIVE DATE. This section is effective August 1, 2024.

Section 5

176.231 REPORT OF DEATH OR INJURY TO COMMISSIONER OF DEPARTMENT OF LABOR AND INDUSTRY.

Subd. 9a. Access to division file without an authorization; attorney access.

(c) If the attorney's access is not limited by an authorization, notice of representation, or the represented person or entity's access under paragraph (a), the attorney's access continues until one of the following occurs in Campus, whichever is later:

(1) one year after an authorization is filed;

(2) ~~five~~ three years after the date a retainer agreement or notice of representation was filed where no dispute has been initiated; or

(3) five years after the date ~~the attorney filed a document initiating, responding to, or intervening in a workers' compensation dispute under this chapter a retainer agreement or notice of representation was filed where a dispute has been initiated by filing a document specified in section 176.2611, subd. 4.~~

~~(4) five years after the date an award on stipulation was served and filed if the award was related to a dispute in which the attorney represented a party in paragraph (a); or~~

~~(5) five years after the date a final order or final penalty assessment was issued as defined in subdivision 9c, paragraph (a), clause (3), if the final order or penalty assessment was related to a dispute in which the attorney represented a party listed in paragraph (a).~~

Notwithstanding the time frames in clauses (1) to (~~5~~ 3), an attorney no longer has access to the division file as of the date the attorney files a notice of withdrawal from the case, or the date the department receives written notice that the authorization is withdrawn or that the attorney no longer represents the person. However, if a dispute over an attorney's fees is pending at the office, the attorney has continued access to the division file until a final order or award on stipulation resolving the attorney fee dispute is received by the commissioner.

EFFECTIVE DATE. This section is effective August 1, 2024.

Section 6

176.238 NOTICE OF DISCONTINUANCE OF COMPENSATION.

Subdivision 1. Necessity for notice and showing; contents.

Except as provided in section 176.221, subdivision 1, once the employer or insurer has commenced payment of benefits, the employer or insurer may not discontinue payment of compensation until it provides the employee with notice in writing of intention to do so. A copy of the notice shall be filed with the division by the employer or insurer. The notice to the employee and the copy to the division shall state the date of intended discontinuance and set

forth a statement of facts clearly indicating the reason for the action. Copies of whatever medical reports or other written reports in the employer's or insurer's possession which are relied on for the discontinuance shall be attached to the notice.

Subd. 2. **Employer's liability for compensation; discontinuance.**

(a) If the reason for discontinuance is that the employee has returned to work, temporary total compensation may be discontinued effective the day the employee returned to work. Written notice shall be served on the employee and filed with the division within 14 days of the date the ~~insurer or self-insured~~ employer or insurer has notice that the employee has returned to work.

(b) If the reason for the discontinuance is for other than that the employee has returned to work, the liability of the employer or insurer to make payments of compensation continues until the copy of the notice and reports have been filed with the division. When the division has received a copy of the notice of discontinuance, the statement of facts and available medical reports, the duty of the employer or insurer to pay compensation is suspended, except as provided in the following subdivisions and in section 176.239.

Subd. 3. **Interim administrative decision.**

An employee may request the commissioner to schedule an administrative discontinuance conference to obtain an expedited interim decision concerning the discontinuance of compensation. Procedures relating to discontinuance conferences are set forth in section 176.239.

Subd. 4. **Objection to discontinuance.**

An employee may serve on the employer and insurer and file with the commissioner an objection to discontinuance if:

- (1) the employee elects not to request an administrative conference under section 176.239;
- (2) if the employee fails to timely proceed under that section;
- (3) if the discontinuance is not governed by that section; or
- (4) if the employee disagrees with the interim administrative decision issued under that section. Within ten calendar days after receipt of an objection to discontinuance, the commissioner shall refer the matter to the office for a de novo hearing before a compensation judge to determine the right of the employee to further compensation.

Subd. 5. **Petition to discontinue.**

Instead of filing a notice of discontinuance, an employer or insurer may serve on the employee and file with the commissioner a petition to discontinue compensation. A petition to discontinue compensation may also be used when the employer or insurer disagrees with the interim administrative decision under section 176.239. Within ten calendar days after receipt of a petition to discontinue, the commissioner shall refer the matter to the office for a de novo hearing before a compensation judge to determine the right of the employer or insurer to discontinue compensation.

The petition shall include copies of medical reports or other written reports or evidence in the possession of the employer or insurer bearing on the physical condition or other present status of the employee which relate to the proposed discontinuance. The employer or insurer shall continue payment of compensation until the filing of the decision of the compensation judge and thereafter as the compensation judge, court of appeals, or the supreme court directs, unless, during the interim, occurrences arise justifying the filing of a notice under subdivision 1 or 2 and the discontinuance is permitted by the commissioner's order or no conference under section 176.239 is requested.

Subd. 6. Expedited hearing before compensation judge.

(a) A hearing before a compensation judge shall be held within 60 calendar days after the ~~office receives the file from the commissioner~~ filing of the objection to discontinuance or petition to discontinue if:

(1) an objection to discontinuance has been filed under subdivision 4 within 60 calendar days after the notice of discontinuance was filed and where no administrative conference has been held;

(2) an objection to discontinuance has been filed under subdivision 4 within 60 calendar days after an interim administrative decision under this section has been issued;

(3) a petition to discontinue has been filed by the employer or insurer in lieu of filing a notice of discontinuance; or

(4) a petition to discontinue has been filed within 60 calendar days after the interim administrative decision under this section has been issued.

(b) If the petition or objection is filed later than the deadlines listed above, the expedited procedures in this section apply only where the employee is unemployed at the time of filing the objection and shows, to the satisfaction of the chief administrative judge, by sworn affidavit, that the failure to file the objection within the deadlines was due to some infirmity or incapacity of the employee or to circumstances beyond the employee's control. The hearing shall be limited to the issues raised by the notice or petition unless all parties agree to expanding the issues. If the issues are expanded, the time limits for hearing and issuance of a decision by the compensation judge under this subdivision shall not apply.

(c) Once a hearing date has been set, a continuance of the hearing date will be granted only under the following circumstances:

(1) the employer or insurer has agreed, in writing, to a continuation of the payment of benefits pending the outcome of the hearing; or

(2) the employee has agreed, in a document signed by the employee, that benefits may be discontinued pending the outcome of the hearing.

(d) Absent a clear showing of surprise at the hearing or the unexpected unavailability of a crucial witness, all evidence must be introduced at the hearing. If it is necessary to accept additional evidence or testimony after the scheduled hearing date, it must be submitted no later than 14 days following the hearing, unless the compensation judge, for good cause, determines otherwise.

(e) When a compensation judge issued the interim administrative decision, the de novo hearing under paragraph (a), clauses (2) and (4), must be held before a compensation judge other than the compensation judge who presided over the administrative conference. The compensation judge shall issue a decision pursuant to this subdivision within 30 days following the close of the hearing record.

Subd. 7. Order of compensation judge.

If the order of the compensation judge confirms a discontinuance of compensation, the service and filing of the order relieves the employer and insurer from further liability for compensation subject to the right of review provided by this chapter, and to the right of the compensation judge to set aside the order at any time prior to the review and to grant a new hearing pursuant to this chapter. Once an appeal to the Workers' Compensation Court of Appeals is filed, a compensation judge may not set aside the order. In any appeal from the compensation judge's decision under this section, the court of appeals shall conclude any oral arguments by the parties within 60 days following certification of the record from the office.

Subd. 8. Notice forms.

Notices under this section shall be on forms prescribed by the commissioner.

Subd. 9. Service on attorney.

If the employee has been presently represented by an attorney for the same injury, all notices required by this section shall also be served on the last attorney of record.

Subd. 10. Fines; violation.

An employer or insurer who violates requirements set forth in this section or section 176.239 is subject to a fine of up to ~~\$1,000~~ \$5,000 for each violation payable to the commissioner for deposit in the assigned risk safety account.

EFFECTIVE DATE. This section is effective August 1, 2024.

Section 7

176.275 FILING OF PAPERS; PROOF OF SERVICE.

Subdivision 1. Filing.

If a document is required to be filed by this chapter or any rules adopted pursuant to authority granted by this chapter, the filing shall be completed upon acceptance of the document by the agency. Any document that lacks information required by statute or rule, or is not filed in the manner and format required by this chapter, may be rejected. A document rejected for any of these reasons is not considered filed. An agency is not required to maintain, and may destroy, a duplicate of a document that has already been filed. If a workers' compensation identification number has been assigned by the department, it must be substituted for the Social Security

262 number on a document. The commissioner may request additional proof of an injured worker's
263 identity before assigning an identification number.

264 A notice or other document required to be served or filed at either the department, the office, or
265 the court of appeals which is inadvertently served or filed at the wrong one of these agencies by
266 an unrepresented employee shall be deemed to have been served or filed with the proper agency.
267 The receiving agency shall note the date of receipt of a document and shall forward the
268 documents to the proper agency no later than two working days following receipt.

269 **EFFECTIVE DATE.** This section is effective the day following final enactment.