

Basic Adjusters' Training Guide

ANSWER KEY



MINNESOTA DEPARTMENT OF
LABOR & INDUSTRY

Workers' Compensation Division

September 2009

Waiting Period – Exercise 1A

1. An employee who works Monday through Friday was injured on February 5, 2007. The employee lost one hour from work on the date of injury and remained off work through February 13, 2007. The employee returned to work on February 14, 2007. What are the dates of the waiting period?

The waiting period is February 5th through February 7th.

2. An employee who works Monday through Friday was injured on March 2, 2007. The first day of disability was March 5, 2007 and the employee returned to work without disability on March 8, 2007. What are the dates of the waiting period? Are you required to report this claim to the department?

The waiting period is March 5th through March 7th. This does not need to be reported as the disability does not exceed the waiting period.

3. An employee who works Monday through Friday was injured on April 6, 2007, and lost one hour of work on that date. The employer paid the employee full wages for the date of the injury. The employee returned to work without disability on April 12, 2007. For which dates do you possibly owe compensation?

You would possibly owe for compensation for April 9th through April 11th as the waiting period is April 6th through April 8th.

4. An employee who works Monday through Thursday was injured on May 3, 2007. The first day of disability wasn't until May 14, 2007. The employee returned to work without disability on May 21, 2007. Disability began again on May 24, 2007 with a return to work without disability on May 28, 2007. All dates of disability were authorized by the treating doctor. What are the dates of the waiting period? Should the waiting period be paid?

The waiting period is May 14th through May 16th. Yes, as there is disability on or after the 10th calendar day (May 23rd).

5. An employee who works Monday through Friday was injured on April 13, 2007 and lost three hours of work on the date of injury. The employer paid full wages for the date of the injury. The employee returned to work without disability on April 23, 2007. All disability was authorized by the treating doctor. What are the dates of the waiting period? Should the waiting period be paid?

The waiting period is April 13th through April 15th. No, because the employee was paid his full wages on the date of injury and the other two days are non-scheduled work days. This question is also used to discuss the issue of the 10th day landing on a weekend with a return to work the next Monday.

Liability Determination – Exercise 1B

Part 1

See the FROI for Susan Jones. The employee normally works Monday through Friday. You have been unable to reach the employee. Upon contacting the employer, you are told that the injury was witnessed and the supervisor took the employee to a local hospital for immediate medical attention. The employer also states that the employee has not returned to work yet and according to medical information, should stay off work at least until the follow-up appointment on February 9th.

1. Should liability be accepted or denied? Why?

Inability to contact the employee, on its own, is not a basis to deny the claim. Based on the information you have from the FROI and employer, there is nothing to indicate that it is not a work related injury. You should get copies of the medical information from the employer and should contact the health care providers for further information as needed, but lack of receipt of this information shouldn't delay your liability determination.

2. What forms need to be filed?

FROI and NOPLD

3. What boxes need to be checked on the NOPLD?

As payment is being made for the lost time, you would check Box 1 and the box for TTD. Also complete the rest of the payment information in Box 1 and lost time and notice dates etc. on the top part of the form.

Part 2

See the FROI for Sam Smith. This claim has been assigned to you.

1. What steps do you need to take to determine if the claim is compensable?

Some of the steps may include contacting the employee, employer, and health care provider(s). Depending on the information you find out during your initial investigation, you may also need to request pre-existing medical information. You would also need to find out if the employee is able to return to work and if so, whether there are any restrictions.

2. What questions should you ask of the employer/employee?

You might want to ask about the employee's job duties and what part of those duties might be causing the problem, length of time working at that job, name of the current treating doctor, and any previous back problems, injuries, or treatment (including the doctors names) that might be related to the current problem. If the employee is able to return to work, you would want to know if the employer can accommodate any possible restrictions.

3. If the treating doctor said she had been treating the employee since he hurt his back three weeks ago lifting a refrigerator at home, would this affect your investigation and determination of liability?

Probably but you would need to find out from the doctor if the current problems are in any way related to the prior injury. Even if it is related, if the employee's work is a substantial contributing factor to the current problem and/or need for medical care, it still might be a work related injury.

4. Based on your determination, what box needs to be checked on the NOPLD?

Box 1 if you determine the claim is compensable and wage loss benefits are being paid.

Box 2 if you determine the claim is compensable but wage loss benefits are not being paid.

Box 3 if you have a specific factual and legal basis for denying the claim.

In all three situations remember to complete the lost time and notice dates etc. on the top part of the form.

Part 3

See the FROI for Andrew Anderson. You have tried on three occasions to reach the employee and left messages twice. The employee hasn't called you back. The employer tells you the employee was returning from a work-related training seminar when the vehicle accident occurred. The employee was taken from the scene of the accident by ambulance. You contact the treating doctor listed on the FROI. The treating doctor tells you the records have not been transcribed yet.

1. Should primary liability be accepted to denied? Why?

Inability to contact the employee, on its own, is not a basis to deny the claim. Neither is the inability to get the medical records. Based on the information you have from the FROI and employer, there is nothing to indicate that it is not a work related injury. Looking at a map you might want to confirm that the accident occurred on a route from the seminar back to work. You also need to find out if the employee is able to return to work and if so, whether there are any restrictions.

2. What boxes should be checked on the NOPLD?

Box 1 if you determine the claim is compensable and wage loss benefits are being paid.

Box 2 if you determine the claim is compensable but wage loss benefits are not being paid.

Box 3 if you have a specific factual and legal basis for denying the claim.

In all three situations remember to complete the lost time and notice dates etc. on the top part of the form.

3. After paying benefits for four weeks, the employee tells you he stopped at his parent's house on his way back from training. The police report verifies that the accident occurred two blocks from his parent's home. What should you do?

Assuming the stop at his parent's house was not related to work, it would appear that the employee was on a personal errand rather than coming directly back to work and you might now have a basis to deny liability for the claim. As it is within 60 days from the first day of disability or the date the employer was aware of disability, whichever is later, you may file an amended NOPLD, Box 3, to discontinue the benefits and deny primary liability.

Temporary Total Disability – Exercise 2A

1. a) Calculate the average weekly wage and TTD rate of an employee who is injured while working 12 hours per week at a fast food restaurant earning \$7.00 per hour.

Both the average weekly wage and TTD rate are \$84.00 per week.

- b) Calculate the average weekly wage and the TTD rate assuming the same employee has a full time job working 40 hours per week at \$16.50 per hour in addition to the part time job at the fast food restaurant.

The average weekly wage is \$744.00. The TTD rate is \$496.00.

2. a) Calculate the average weekly wage and TTD rate of an employee who has been an assembler for six years earning \$8.60 per hour, 40 hours per week. Assume that she worked overtime during two weeks in the past year prior to the injury, earning an additional \$80.00 in each of those weeks.

The average weekly wage is \$344.00. The TTD rate is \$229.33.

- b) Calculate the average weekly wage and TTD rate, assuming the same employee was promoted to supervisor three weeks before the injury. Assume that she now works 40 hours per week, but she earns \$10.00 per hour as a supervisor.

The average weekly wage is \$400.00. The TTD rate is \$266.67.
Remember the wage at the time of the injury determines the TTD rate.

3. An employee worked two jobs at the time of the injury. The first job is full-time Monday through Friday, earning \$8.00 per hour, 40 hours per week. The second job is part-time on Saturday and Sunday, working three hours each day at \$7.00 per hour, plus \$20.00 in declared tips each weekend. What is this employee's average weekly wage and TTD rate?

The average weekly wage at the first job is \$320.00. The average weekly wage at the second job is \$62.00. The overall average weekly wage is \$382.00. The TTD rate is \$254.67.

4. a) Calculate the TTD rate for an employee who quit her job as a chemical engineer earning \$45,000 per year to take a job as a naturalist at a camp earning \$80.00 per week at the time of the injury. She also gets room and board, estimated to be worth \$70.00 per week.

The average weekly wage is \$150.00. The TTD rate is \$130.00 (minimum rate applies as 2/3 of the average weekly wage is less than \$130.00.)

- b) Assume that the injury occurs the first week of camp. This is before the last check is received from the chemical company and before any checks are paid by the camp. Does this change the TTD rate? If so, how and why?

No, as the average weekly wage on the date of injury controls.

Temporary Partial Disability – Exercise 2B

For all of the exercises, assume no annual adjustments are due:

1. Calculate the TPD due for an employee who earned \$700.00 per week at the time of the injury and is currently earning \$500.00 per week. Assume no annual adjustments are due.

$$\$700.00 - \$500.00 = \$200.00 \times 2/3 = \$133.33$$

2. Calculate the TPD due for an employee who earned \$500.00 per week, when the injury occurred, and is currently earning \$200.00 per week.

$$\$500.00 - \$200.00 = \$300.00 \times 2/3 = \$200.00$$

3. Calculate the TPD due for an employee who earned \$500.00 per week at the time of the injury and earned \$550.00 the past week as a result of working overtime.

None, as the current weekly wage exceeds the average weekly wage at the time of the injury.

4. Calculate the TPD due for an employee who earned \$800.00 per week at the time of the injury and is currently unemployed, due to a layoff from his present employment. Assume the employee has been served with a medical report stating that he reached MMI more than 90 days ago.

None, as the TPD is not owed unless the employee is employed. Also, TTD is not owed as the employee is more than 90 days post MMI.

5. An employee has been collecting \$200.00 TPD per week for the past 20 weeks. Please answer the following questions:

- a) Should the employee be required to send you proof of earnings before you issue each TPD check?

No, as the employee's current weekly wages are consistent, wage documentation is not necessary to calculate the TPD owed.

- b) If the employee takes one week of unpaid vacation, how much TPD is due for that week?

\$200.00. The employee is not considered unemployed during vacations or holidays. Entitlement to TPD continues at the same rate.

Annual Adjustment of Benefits – Exercise 2C

For all of the exercises, use the charts on the following page.

1. An employee has a date of injury of January 1, 1986 and an average weekly wage of \$420.00. The maximum compensation rate on the date of injury is \$342.00.

- a) What is the TTD rate on the date of injury?

\$280.00

Next, find the adjusted TTD rate on May 10, 2006.

- b) How many adjustments are due?

20

- c) What is the multiplication factor?

2.25799

- d) What is the adjusted TTD rate?

\$632.24 ($\$280.00 \times 2.25799 = \632.24)

1. An employee has a date of injury of January 1, 1996 and an average weekly wage of \$950.00. The maximum compensation rate on the date of injury is \$615.00.

- a) What is the TTD rate on the date of injury?

\$615.00

Next, find the adjusted TTD rate on May 10, 2006.

- b) How many adjustments are due?

7

- c) What is the multiplication factor?

1.14868

- d) What is the adjusted TTD rate?

\$706.44 ($\$615.00 \times 1.14868 = \706.44)

Permanent Partial Disability – Exercise 2D

Refer to Minnesota Rules Part 5223.0510 Musculoskeletal Schedule; Knee and Lower Leg to complete the following exercise. Use a date of injury of October 1, 2000 when performing the calculations.

1. Calculate the PPD due (% and \$) for an undisplaced plateau fracture. (Hint: see Subp. 2)

$$2\% \times \$75,000 = \$1,500.00$$

Calculate the total PPD due (% and \$) for the fracture described above with additional ratings for a meniscectomy performed on each knee where less than 50% of the medial cartilage is removed in each knee. (Hint: see Subp. 3)

$$1 - [(1-A) \times (1-B) \times (1-C)]$$

$$1 - [(1-.02) \times (1-.02) \times (1-.02)]$$

$$1 - [(.98) \times (.98) \times (.98)]$$

$$1 - [.9412] = .0588$$

$$5.88\% \times \$80,000 = \$4,704.00$$

Refer to Minnesota Rules Part 5223.0390 Musculoskeletal Schedule; Lumbar Spine to complete the following exercise.

2. Determine the total PPD rating for the a back injury where subsequent to the injury there was radicular pain, objective radicular findings, an MRI scan showing evidence of spinal stenosis at one level that impinges on the nerve root and that correlate with the neurological finds, and where, at MMI after non-surgical treatment, the radicular pain is no longer present.

10%

In the above scenario, what would the rating be if there had been non-fusion surgical treatment at that one level?

15%

What would be the rating if at MMI there still was radicular pain despite that surgical treatment?

18%

Lastly what would be the rating be if later on a fusion was done at that one level which subsequently alleviates the ongoing radicular pain?

20%

Certified Managed Care Organizations – Exercise 3A

1. An employer is covered by a CMCO. What are the three ways that the employer must notify an employee of CMCO coverage?

- When the employer first enrolls in a CMCO all employees must be notified; all new employees must be given notice.
- When the employer receives notice of an injury, the employee must be informed of CMCO coverage.
- Notice of coverage must be posted at the work site.

All notices must include all information required by Minnesota Rules Part 5210.0250. The CMCO provides the employer with approved notices.

2. Three years ago, Ralph treated with a chiropractor, Dr. Jones, for several visits over a period of two months for a neck injury resulting from a motor vehicle accident. Ralph injured his low back at work and wants to treat with Dr. Jones. If Dr. Jones is not a participating provider, can Ralph see him? Why?

Minnesota Statutes §176.135, Subd. 1(f) allows an employer to require employees to treat with a CMCO. A non-participating provider may treat an employee under circumstances specified in Minnesota Rules Parts 5218.0250 and 5218.0500.

3. Dr. Jones recommends that Ralph have a CT scan. What must Dr. Jones do?

Dr. Jones should contact the CMCO because a provider in the network must provide any treatment. Also, the CMCO will determine whether a CT scan is medically necessary at this time.

4. The CT scan is denied. What course of action may be taken to resolve the issue?

Dr. Jones and Ralph may appeal the denial to the CMCO. The CMCO will review its decision in its internal dispute resolution program and issue its decision within 30 days. If Dr. Jones or Ralph are unsatisfied with the CMCO decision, or if there is no resolution within 30 days, they may file a Medical Request with the department.

Medical Fee Schedule – Exercise 3B

You will need to refer to the CPT Manual and Medical Fee Schedule Rules to complete this exercise.

For all the following examples, assume primary liability has been accepted and all treatments rendered are reasonable and necessary.

1. The bill for Richard Cunningham's claim is for a chiropractic appointment following a back injury.

- a) Determine the amount to be paid.

\$105.16

Formula is $RVU \times CF = \$\text{payment}$

Date of Service is 11/24/2006 --- CF is \$55.35

98941 Chiro manip 3-4 regions (spinal)	Status = A	RVU = .69	(Pay \$38.19)
97110 Ther exer	Status = A	RVU = .55	(Pay \$30.44)
97010 Hot/Cold pack	Status = B	RVU = 0	(Don't pay -- bundled)
97032 Electrical stim	Status = A	RVU = .32	[Pay \$13.28 (75%)]
97012 Mech traction	Status = A	RVU = .42	(Pay \$23.25)

- b) What modifier should be used on CPT code 97032?

-51 to indicate multiple modalities

2. The bill for Warren Weber's claim is for emergency room treatment following a forearm laceration.

- a) Is the hospital required to send a copy of the medical records with this bill?

No, hospitals are not required to send copies of records with their bills.

- b) What do you need to know in order to pay a hospital bill correctly?

- Whether treatment was inpatient or outpatient.
- Number of licensed beds at the hospital.
- If the bill contains physician charges, whether the physician is employed by the hospital and receives a base payment from the hospital, regardless of the number of patients seen (Minnesota Rules Part 5221.0700, Subp. 2(A)(3)).

- c) Assume it is a large hospital and the physician is an employee following the hospital. Determine the amount to be paid.

\$607.19

Formula is $RVU \times CF = \$\text{payment}$

Date of Service is 12/13/2006 ---CF is \$76.87.

A4570 Splint	Status = X	RVU = 0	(Pay @ 85% = 30.78)
A4550 Surgical trays	Status = A	RVU = .92	(Pay \$70.68)
A4322 Irrigation syringe	Status = P	RVU = 0	(Don't pay=incident to physician service)
A4649 Surgical supply	Status = P	RVU = .20	(Don't pay=incident to physician service)
A6405 Sterile elastic gauze	Status = P	RVU = .23	(Don't pay=incident to physician service)
12002 Pro Fee ER / MD repair superficial	Status = A	RVU = 2.49	(Pay \$191.41)
99282 ER visit level 2	Status = A	RVU = .88	(Pay 67.65)
12002 Facility fee			(Pay @ 85% = 163.37)
99282 Facility fee			(Pay @ 85% = 83.30)

- d) What if the hospital had 78 licensed beds?

Pay 100% of usual and customary for both hospital and physician services provided the physician meets the requirements of a salaried employee of the hospital under Minnesota Rules Part 5221.0700, Subp. 2(A)(3).

3. The bill for Ralph Malph's claim is for treatment of a hand injury.

- a) Why might you want the medical record?

To substantiate the nature and necessity of the service or charge submitted by the health care provider (i.e. whether the criteria for a level 3 E&M service were met and documented).

- b) What would you do if the medical record was not included with the bill?

Within 30 days of receiving the bill, request a copy of the appropriate record in writing from the health care provider. A payer may deny payment of the bill until the appropriate record is provided. The payer must notify the provider and the employee in writing of the reason for the denial.

- c) How long does the provider have to supply the medical record if it was not included with the bill?

7 working days after receipt of request

- d) What is the maximum amount the provider can be reimbursed for copying and sending the medical record if it is two pages?

\$1.50 + tax + postage

- e) Determine the amount to be paid.

\$90.18

Formula is $R\text{VU} \times \text{CF} = \payment

Date of Service is 12/13/2006 ---CF is \$76.87.

99213 Office outpatient Level 3 E/M	Status = A	RVU = 1.04	(Pay \$60.00 as U&C is less than the fee schedule amount of \$79.94)
90471 Tetanus shot	Not in fee schedule		(Pay @ 85% of U&C = \$15.73)
90718 Tetanus and Diphtheria toxoids	Status = E	RVU = .0	(Pay @ 85% of U&C = \$14.45)

Penalties – Exercise 5A

Review the FROI, found on the next page of this training guide. Answer the following questions:

1. Did the employer submit the FROI to the insurance company on time?

No. The first day of lost time and employer notice were both May 7, 2007, therefore the FROI was due to the insurance company by May 17, 2007.

2. Did the insurance company submit the FROI to the department on time?

No. The employer filed the FROI so late that the insurance company had no ability to file it timely.

3. In order for the FROI to be considered filed timely, by what dates did the insurance company and the department need to receive the FROI?

The insurance company needed to receive the FROI by May 17, 2007. The department needed to receive the FROI by May 21, 2007.

Review the NOPLD, found after the FROI in this training guide. Answer the following questions:

1. By what date is was the first payment or denial due?

May 21, 2007.

2. Was the payment made timely?

No. Due to late filing of FROI by the employer, the insurance company had no chance to make a timely first payment or denial.

Section 8

Case Study

The Beginning of the Story – Liability Determination

Pat Williams is a 56 year old church secretary. On March 21, 2007 Pat had a low back injury at work and immediately notified the supervisor. Pat lost two hours on the date of injury to go to the emergency room. The doctor prescribed painkillers and authorized time off from work through March 23rd. Pat returned to work on March 26th. On March 27th, Pat felt that the pain was getting worse instead of better and sought additional medical treatment from Dr. Crunch, D.C. half way through the work day. Pat was taken off work for one week as of that date and notified the employer of this on the same day. Pat normally works Monday through Friday, eight hours per day at \$15.00 per hour, with an average weekly wage on the date of injury of \$600.

You have been assigned this claim.

1. What are the dates of the waiting period?

March 21, 2007 through March 23, 2007

2. By what date is the FROI required to be filed with the department?

April 10, 2007

3. On what date is either payment or denial due?

April 10, 2007

4. As of March 27th, when Pat starts losing time again, would the waiting period be payable? If so, why? If not, when would it become payable?

No. If there was any lost time on or after March 30, 2007 (the 10th calendar day).

5. You have determined that the injury and lost time are compensable. Fill out the NOPLD (leave the payment information, except for the date of payment, blank for now).

Notice of Insurer's Primary Liability Determination

See instructions on reverse side.
 PRINT IN INK or TYPE
 Enter dates in MM/DD/YYYY format.



DO NOT USE THIS SPACE

Amended

WID or SSN	DATE OF INJURY	DATE OF DEATH (if applicable)
EMPLOYEE		
EMPLOYER		
INSURER/SELF-INSURER/TPA		
INSURER CLAIM NUMBER		

First date of lost time	Date employer notified of this lost time	Initial date of return to work	Average weekly wage at date of injury
If the initial return to work was followed by a new period of lost time, complete the following information: First date of new period of lost time: _____ Date employer notified of this lost time: _____			

1. Your claim is ACCEPTED and wage loss benefits will be paid.

Benefit type: <input type="checkbox"/> Temporary Total (TTD) <input type="checkbox"/> Temporary Partial (TPD) <input type="checkbox"/> Permanent Total (PTD) <input type="checkbox"/> Dependency (DEP)			
Date of payment	Amount of payment	Time period covered with this payment Date from _____ Date through _____	Compensation rate
Any ongoing payments will be made on _____ (day of week) at _____ (weekly, biweekly, etc.) intervals.			

Check all that apply	<input type="checkbox"/> Full wage continuation by the employer under M.S. § 176.221, subd. 9. <input type="checkbox"/> TPD payment made according to the wage loss verification received by the insurer on _____ (date). <input type="checkbox"/> Fatality with dependents. Payment is being made according to dependent information, which must be ATTACHED . <input type="checkbox"/> Fatality with no dependents. Payment is being made to the estate or the Special Compensation Fund.
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2. Your claim is ACCEPTED. However, wage loss benefits will not be paid at this time for the following reason:

Check only one	<input type="checkbox"/> A. Injury did not cause lost time from work beyond the three calendar day waiting period. If employee's work schedule is not Monday through Friday, explain: _____ <input type="checkbox"/> B. Verification of reduced wages for TPD has not been received from the employee or employer. <input type="checkbox"/> C. Other reason (include legal and factual basis): <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>
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3. Primary liability is DENIED for the claimed work related injury and/or death. (Check one or both)

Reason for denial (include legal and factual basis):
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NAME OF THE PERSON MAKING THIS DETERMINATION (print)	PHONE NUMBER	EXTENSION	DATE SERVED (must be completed)
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INSTRUCTIONS TO EMPLOYEE/HEIRS AND DEPENDENTS

PLEASE KEEP A COPY OF THIS NOTICE FOR YOUR RECORDS

General Information

This liability determination is the opinion of the insurer. If the claim has been denied, this opinion may not be final. If you have questions about any of the information on this form, you should first contact the person making this determination (see name and phone number on the front side of this form). If you still have questions, contact the Department of Labor and Industry (DLI), Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you (listed below). For the hearing impaired, please call our Telecommunication Device for the Deaf (TDD) at (651) 297-4198. If there are problems with your claim, there are several options available to resolve them informally.

Minnesota Department of Labor and Industry

5 North Third Avenue West, Suite 400
Duluth, MN 55802-1614
Telephone: (218) 733-7810
1-800-342-5354

443 Lafayette Road North
St. Paul, MN 55155-4301
Telephone: (651) 284-5030
1-800-342-5354

Mailing Address
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221

Time Limitations

If the injury claim has been denied, you may lose your right to benefits if you do not commence legal proceedings within three years after your employer/insurer filed a written report of your claimed injury with DLI, not to exceed six years after the date of the claimed injury. If you have an occupational disease, you have three years to begin legal proceedings from the date you learned that the cause of the disease might be work related and the disease first caused disability.

If the death claim has been denied, you may lose your right to benefits if you do not commence legal proceedings within three years after the employer/insurer filed the written notice of death with DLI, except that:

- 1) For claims where the employer/insurer did not pay benefits for the injury, commencement of legal proceedings cannot exceed six years from the **date of injury** resulting in the death.
- 2) For claims where the employer/insurer did pay benefits for the injury, commencement of legal proceedings cannot exceed six years from the **date of death**.

In very rare circumstances, there may be exceptions to the time limits noted above.

Vocational Rehabilitation

If the insurer is denying primary liability for your claim and you disagree, cannot return to your former employment, and would like vocational rehabilitation assistance, contact DLI, Vocational Rehabilitation Unit at (651) 284-5038.

Instructions to Insurer/Claims Administrator

1. If the claim is a fatality with dependents and payment is being made, attach dependent information.
2. The reason for a denial must be clear and specific, and state a legal and factual basis in language which is easily understood. If the reason for a denial is based on medical information, attach medical reports or summary of any health care provider contacts that support your reason for denial.
3. This form may be filed more than once if your liability determination changes. (Examples: when you initially deny primary liability, but later accept liability; when you initially accept a claim and pay wage loss benefits, but later deny primary liability within 60 days pursuant to M.S. § 176.221, subd 1; when you accept liability, but are unable to pay TPD benefits until verification of wage loss is received, but later issue the first TPD check.)
4. If you file this form more than once, check the Amended box in the upper left-hand corner for each subsequent filing.
5. Do not use this form to reinstate benefits. Use the Notice of Benefit Reinstatement (NOBR) form.
6. If you indicate that the employer paid "full wage," you must also file a Notice of Intention to Discontinue (NOID) at the appropriate time showing the date of return to work or other reason for discontinuance and the payment data on the back of the form as required by M.S. § 176.221, subd. 9.
7. The date served must be completed each time you file this form.
8. The boxes (in the upper left-hand corner on the front of the form) containing claim identifying information must be fully completed each time you file the form. The boxes containing the dates of lost time, notice, and initial return to work, and the average weekly wage must also be completed, if applicable, each time you file the form, regardless of your liability determination.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

The Beginning of the Story – Medical Communication

Remember Pat Williams, the 56 year old church secretary? You have already made your initial determination regarding primary liability and need to obtain written medical information to substantiate the disability. You find out during the course of your investigation that Pat has treated with Dr. Crunch prior to the work injury.

Answer the following questions:

1. Can Pat Williams choose to treat with Dr. Crunch? Why or why not?

Yes, an employee has the right to choose a treating doctor except in the following circumstances:

- The employee is covered by a managed care organization certified by the department.
- The employer is part of a collective bargaining agreement recognized by the department.

2. What form should Dr. Crunch be providing to his patient?

Report of Work Ability

3. How do you request prior medical records and what are the requirements under the workers compensation statutes or rules?

- In writing, identifying yourself as the WC insurer.
- Specify the records being requested.
- Enclose an authorization (that meets HIPPA standards) signed by the employee.
- Send employee and his/her attorney a copy of the request.

4. Dr. Crunch sends an itemized, coded bill for services along with copies of his office notes to your office. How many days do you have to pay or deny the bill?

30 days to pay all or part of the charges; deny the charges and provide the basis of denial citing the rule; or request additional information. You must send your notice of denial to the employee and provider.

The Middle of the Story – Indemnity Benefits

Remember Pat Williams? Pat had a low back injury at work on March 21, 2007 and lost two hours on the date of injury to go to the emergency room. Pat initially returned to work on March 26th, but on March 27th Pat returned to the doctor half way through the work day and has been off work as of that date. Pat normally works Monday through Friday, eight hours per day at \$15.00 per hour, with an average weekly wage of \$600 on the date of injury.

The doctor has released Pat to return to work light duty four hours per day on April 9, 2007. The employer can accommodate the light duty work and Pat goes back to work on April 9th, at light duty four hours per day.

1. What is the TTD rate? Fill in the payment information you left blank on the NOPLD you started in “The Beginning of the Story – Liability Determination”.

\$400.00

2. What benefits are owed through the return to work on April 9th?

TPD 3/21/2007 .2 wks = \$20.00

TTD 3/22 - 3/23/2007 .4 wks = \$160.00

TPD 3/27/2007 .2 wks = \$40.00

TTD 3/28 - 4/8/2007 1.6 wks = \$640.00

3. Fill out the NOID.

The return to work is again unsuccessful as symptoms continue to worsen. Pat returns to Dr. Crunch and is taken off work again as of April 13, 2007.

4. Fill out the NOBR.

Notice of Insurer's Primary Liability Determination

See instructions on reverse side.
 PRINT IN INK or TYPE
 Enter dates in MM/DD/YYYY format.



DO NOT USE THIS SPACE

Amended

WID or SSN	DATE OF INJURY	DATE OF DEATH (if applicable)
EMPLOYEE		
EMPLOYER		
INSURER/SELF-INSURER/TPA		
INSURER CLAIM NUMBER		

First date of lost time	Date employer notified of this lost time	Initial date of return to work	Average weekly wage at date of injury
If the initial return to work was followed by a new period of lost time, complete the following information:			
First date of new period of lost time: _____		Date employer notified of this lost time: _____	

1. Your claim is ACCEPTED and wage loss benefits will be paid.

Benefit type: <input type="checkbox"/> Temporary Total (TTD) <input type="checkbox"/> Temporary Partial (TPD) <input type="checkbox"/> Permanent Total (PTD) <input type="checkbox"/> Dependency (DEP)			
Date of payment	Amount of payment	Time period covered with this payment Date from _____ Date through _____	Compensation rate
Any ongoing payments will be made on _____ (day of week) at _____ (weekly, biweekly, etc.) intervals.			

Check all that apply	<input type="checkbox"/> Full wage continuation by the employer under M.S. § 176.221, subd. 9. <input type="checkbox"/> TPD payment made according to the wage loss verification received by the insurer on _____ (date). <input type="checkbox"/> Fatality with dependents. Payment is being made according to dependent information, which must be ATTACHED . <input type="checkbox"/> Fatality with no dependents. Payment is being made to the estate or the Special Compensation Fund.
----------------------	---

2. Your claim is ACCEPTED. However, wage loss benefits will not be paid at this time for the following reason:

Check only one	<input type="checkbox"/> A. Injury did not cause lost time from work beyond the three calendar day waiting period. If employee's work schedule is not Monday through Friday, explain: _____ <input type="checkbox"/> B. Verification of reduced wages for TPD has not been received from the employee or employer. <input type="checkbox"/> C. Other reason (include legal and factual basis): <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>
----------------	---

3. Primary liability is DENIED for the claimed work related injury and/or death. (Check one or both)

Reason for denial (include legal and factual basis):
--

NAME OF THE PERSON MAKING THIS DETERMINATION (print)	PHONE NUMBER	EXTENSION	DATE SERVED (must be completed)
--	--------------	-----------	---------------------------------

INSTRUCTIONS TO EMPLOYEE/HEIRS AND DEPENDENTS

PLEASE KEEP A COPY OF THIS NOTICE FOR YOUR RECORDS

General Information

This liability determination is the opinion of the insurer. If the claim has been denied, this opinion may not be final. If you have questions about any of the information on this form, you should first contact the person making this determination (see name and phone number on the front side of this form). If you still have questions, contact the Department of Labor and Industry (DLI), Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you (listed below). For the hearing impaired, please call our Telecommunication Device for the Deaf (TDD) at (651) 297-4198. If there are problems with your claim, there are several options available to resolve them informally.

Minnesota Department of Labor and Industry

5 North Third Avenue West, Suite 400
Duluth, MN 55802-1614
Telephone: (218) 733-7810
1-800-342-5354

443 Lafayette Road North
St. Paul, MN 55155-4301
Telephone: (651) 284-5030
1-800-342-5354

Mailing Address
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221

Time Limitations

If the injury claim has been denied, you may lose your right to benefits if you do not commence legal proceedings within three years after your employer/insurer filed a written report of your claimed injury with DLI, not to exceed six years after the date of the claimed injury. If you have an occupational disease, you have three years to begin legal proceedings from the date you learned that the cause of the disease might be work related and the disease first caused disability.

If the death claim has been denied, you may lose your right to benefits if you do not commence legal proceedings within three years after the employer/insurer filed the written notice of death with DLI, except that:

- 1) For claims where the employer/insurer did not pay benefits for the injury, commencement of legal proceedings cannot exceed six years from the **date of injury** resulting in the death.
- 2) For claims where the employer/insurer did pay benefits for the injury, commencement of legal proceedings cannot exceed six years from the **date of death**.

In very rare circumstances, there may be exceptions to the time limits noted above.

Vocational Rehabilitation

If the insurer is denying primary liability for your claim and you disagree, cannot return to your former employment, and would like vocational rehabilitation assistance, contact DLI, Vocational Rehabilitation Unit at (651) 284-5038.

Instructions to Insurer/Claims Administrator

1. If the claim is a fatality with dependents and payment is being made, attach dependent information.
2. The reason for a denial must be clear and specific, and state a legal and factual basis in language which is easily understood. If the reason for a denial is based on medical information, attach medical reports or summary of any health care provider contacts that support your reason for denial.
3. This form may be filed more than once if your liability determination changes. (Examples: when you initially deny primary liability, but later accept liability; when you initially accept a claim and pay wage loss benefits, but later deny primary liability within 60 days pursuant to M.S. § 176.221, subd 1; when you accept liability, but are unable to pay TPD benefits until verification of wage loss is received, but later issue the first TPD check.)
4. If you file this form more than once, check the Amended box in the upper left-hand corner for each subsequent filing.
5. Do not use this form to reinstate benefits. Use the Notice of Benefit Reinstatement (NOBR) form.
6. If you indicate that the employer paid "full wage," you must also file a Notice of Intention to Discontinue (NOID) at the appropriate time showing the date of return to work or other reason for discontinuance and the payment data on the back of the form as required by M.S. § 176.221, subd. 9.
7. The date served must be completed each time you file this form.
8. The boxes (in the upper left-hand corner on the front of the form) containing claim identifying information must be fully completed each time you file the form. The boxes containing the dates of lost time, notice, and initial return to work, and the average weekly wage must also be completed, if applicable, each time you file the form, regardless of your liability determination.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Notice of Intention to Discontinue Workers' Compensation Benefits



DO NOT USE THIS SPACE

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY
EMPLOYEE	EMPLOYER
EMPLOYEE ADDRESS	
CITY	STATE
ZIP CODE	
INSURER CLAIM NUMBER	

Your benefits for (check one) TEMPORARY TOTAL TEMPORARY PARTIAL PERMANENT TOTAL disability are being discontinued for one of the following reasons:

1. You have returned to work on _____ (date) at full wage.
2. You have returned to work on _____ (date) at reduced hours or wages.
 Temporary partial will will not be paid. Temporary partial is usually based on the difference between your wage of \$ _____ at the time of the injury and your current weekly wage.
3. Reasons other than return to work. Payment will be made through _____ (date)
 Give reasons and facts below. (Appropriate medical reports must be attached).

Reasonable medical expenses and any permanent partial disability due will still be paid, unless your claim has been denied.

INSTRUCTIONS TO EMPLOYEE – THIS REQUIRES YOUR IMMEDIATE ATTENTION

You are responsible for reviewing this form to make sure that you have been properly paid the benefits due you.
YOU DO NOT NEED TO TAKE ANY ACTION IF YOU BELIEVE THAT YOU HAVE RECEIVED ALL BENEFITS DUE OR THAT THE REDUCTION OF BENEFITS IS PROPER.

If Box 1 or 2 is checked above and you believe that your benefits should be reinstated due to an occurrence during the initial 14 calendar days after your return to work, you may request a conference. Your request must be received by the Workers' Compensation Division within 30 calendar days after the date that you returned to work.

If Box 3 is checked above and you think the reason for stopping your benefits is incorrect, or you disagree with the proposed discontinuance, you may request a conference. Your request must be received within 12 calendar days after this notice is received by the Workers' Compensation Division.

TO REQUEST A CONFERENCE, YOU MUST MAIL OR DELIVER THE ATTACHED FORM TO THE WORKERS' COMPENSATION DIVISION SO THAT IT IS RECEIVED WITHIN THE ABOVE TIME LIMITS. TELEPHONE REQUESTS WILL ALSO BE ACCEPTED AT (651) 361-7912 OR 1-800-342-5354.

The conference will be scheduled within 10 calendar days of the date your request is received by the Division. You, your employer, and the insurer will be invited to attend. You are not required to bring an attorney, but may bring one if you wish. You should bring to the conference any current reports and return-to-work restrictions, if available.

You may instead file an Objection to Discontinuance with the Division. This is a formal procedure before a compensation judge which takes longer than the administrative conference process and usually requires an attorney. If you do this, your benefits will stop on the date stated in this notice and will not be paid during the time you wait for the hearing.

If the insurer is denying primary liability for your claim and you disagree with the denial, cannot return to your former employment and would like vocational rehabilitation assistance, contact the Department of Labor and Industry, Vocational Rehabilitation Unit at (651) 284-5038.

If you have questions about your benefits, you should first contact the claim representative whose telephone number is at the bottom of the page. Be sure to provide that person with any additional information you have to support your claim. If you still have questions, contact the Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you.

Minnesota Department of Labor and Industry

5 North Third Avenue West, Suite 400
 Duluth, MN 55802-1614
 Telephone: (218) 733-7810
 1-800-342-5354

443 Lafayette Road North
 St. Paul, MN 55155-4301
 Telephone: (651) 284-5030
 1-800-342-5354

Mailing Address
 Workers' Compensation Division
 PO Box 64221
 St. Paul, MN 55164-0221

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
<input type="checkbox"/> Temporary Total Disability or					
<input type="checkbox"/> Permanent Total Disability					
<div style="border: 1px solid black; height: 40px; width: 100%;"></div>					
<input type="checkbox"/> Benefit Addendum Attached					
Temporary Partial Disability					
Retraining Benefits					
Permanent Partial Disability _____%					
<input type="checkbox"/> Injuries on or after 10/01/95					
<input type="checkbox"/> Impairment Compensation (injuries 01/01/1984 - 09/30/1995)					
<input type="checkbox"/> Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995)					
<input type="checkbox"/> _____ [part of body] (injuries before 01/01/1984)					
Attorney Fees/Expenses		Benefit Totals			
M.S. 176.081, subd. 1 & 3 Paid			*Lump sum Payment Under Award or Order		
M.S. 176.081, subd. 1 & 3 Still Withheld			Attorney Fees Reimbursed to Employee (M.S. 176.081, subd. 7)		
Heaton Fees Paid			Interest Paid		
Roraff Fees Paid			*TOTAL COMPENSATION PAID		
M.S. 176.191 Paid			*Total Supplementary Benefits		
Other Fees Paid			Total Medical Expenses Paid to Date		
Costs & Disbursements Paid					
INSURER/SELF-INSURER/TPA		CLAIM REPRESENTATIVE NAME			
ADDRESS		PHONE NUMBER (include area code)			
CITY	STATE	ZIP CODE	DATE SERVED ON EMPLOYEE	DATE SERVED ON ATTORNEY	

*Include attorney fees in these totals.

Employee's Request for Administrative Conference

Minn. Stat. § 176.239, subd. 2



DO NOT USE THIS SPACE

PRINT IN INK or TYPE.
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY
EMPLOYEE	EMPLOYER
EMPLOYEE ADDRESS	
CITY	STATE ZIP CODE
INSURER CLAIM NUMBER	INSURER/SELF-INSURER/TPA
<p>ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.</p>	
<p><i>This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.</i></p>	

THIS REQUIRES YOUR IMMEDIATE ATTENTION

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation re-insurance association.

INSTRUCTIONS TO EMPLOYEE

DO NOT COMPLETE THIS FORM IF YOU AGREE THAT YOUR WEEKLY WORKERS' COMPENSATION BENEFITS MAY BE STOPPED OR CHANGED.

HOWEVER, IF YOU DISAGREE THAT YOUR BENEFITS MAY BE STOPPED OR CHANGED, YOU MAY BE ENTITLED TO AN ADMINISTRATIVE CONFERENCE. At the conference, a decision can be made about your right to further weekly benefits.

TO REQUEST A CONFERENCE, MAIL OR DELIVER THIS COMPLETED FORM TO:

DEPARTMENT OF LABOR AND INDUSTRY
WORKERS' COMPENSATION DIVISION
PO BOX 64218
ST PAUL, MN 55164-0218

Requests will also be accepted by telephone. Call (651) 361-7912 or 1-800-342-5354

TIME LIMIT TO REQUEST A CONFERENCE

IF BOX 1 OR 2 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received by the Workers' Compensation Division **WITHIN 30 DAYS AFTER YOU RETURNED TO WORK.**

IF BOX 3 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received **WITHIN 12 DAYS AFTER A COPY OF THE NOTICE OF INTENTION TO DISCONTINUE WORKERS' COMPENSATION BENEFITS IS RECEIVED BY THE WORKERS' COMPENSATION DIVISION.**

EMPLOYEE'S REQUEST FOR ADMINISTRATIVE CONFERENCE			
1. BOX (check one)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits.
2. My weekly benefits should not be changed/stopped because: _____			
(attach separate sheet if more room is needed)			
EMPLOYEE SIGNATURE	EMPLOYEE PHONE # (include area code)	DATE	
ATTORNEY (if you have one)	ATTORNEY #	ATTORNEY PHONE # (include area code)	QRC (if you have one)

Notice of Benefit Reinstatement



PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY	DATE OF DEATH (if applicable)
EMPLOYEE		
EMPLOYER		
INSURER/SELF-INSURER-TPA		
INSURER CLAIM NUMBER		

THIS IS NOTIFICATION THAT WORKERS' COMPENSATION BENEFITS HAVE BEEN REINSTATED.

Date of new payment	Amount of payment	Type of benefit	Time period covered with this payment Date from - Date through	Compensation rate
		<input type="checkbox"/> TTD <input type="checkbox"/> TPD <input type="checkbox"/> PTD <input type="checkbox"/> DEP		

Insurer: Check appropriate box and enter data information:

<input type="checkbox"/>	1. Payment resumed voluntarily. First date of new period of time lost: _____ Date of notice to employer of new period of time lost: _____
<input type="checkbox"/>	2. Payment resumed pursuant to order served and filed on _____ <input type="checkbox"/> M.S. § 176.239 decision OR <input type="checkbox"/> Other decision (OAH, WCCA, or Supreme Court)
<input type="checkbox"/>	3. TPD changed to TTD effective _____
<input type="checkbox"/>	4. Full wage continuation changed to TTD effective _____

Please provide the following pre-injury wage information ONLY if it differs from prior submissions:

Average Weekly Wage	Weekly value of:	Meals	Lodging	2nd income

Straight time:

Rate per hour	Hours per day	Days per week	26 week earnings	Total days worked in last 26 weeks	Total weeks worked in last 26 weeks

IF OVERTIME IS PAID OR IF EMPLOYEE IS IRREGULARLY SCHEDULED, ATTACH A 26 WEEK WAGE STATEMENT.

CLAIM REPRESENTATIVE NAME	PHONE # (include area code)	DATE

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

The Middle of the Story – Rehabilitation Benefits

Remember Pat Williams? S/he has tried to return to work but is unsuccessful. Dr. Crunch has authorized disability again as of April 13, 2007.

1. When is the DSR due to be filed?
 - 1) Within 14 calendar days of knowledge that employee's temporary total disability will extend beyond 13 cumulative weeks.
 - 2) Within 90 calendar days when the employee has not returned to work after the injury.
 - 3) Within 14 calendar days after receiving a request for rehabilitation consultation.
 - 4) Within 14 calendar days of expiration of waiver.
2. What information is required to be provided when requesting a waiver of rehabilitation services?

Documents to prove employee will return to work with date of injury employer within 90 calendar days after request for the waiver is filed. (Job offer + RWA)

3. When are you required to assign Pat for a rehabilitation consultation?

If the employee requests consultation, if the employer requests a consultation, if commissioner orders a consultation, or if a rehabilitation waiver is not granted.

4. It is now May 31, 2007. Pat is still off work and it doesn't appear that Pat will be able to return to work in the near future. Should you file a DSR? If so, complete the DSR.

Yes as it now appears that the employee's TTD is likely to exceed 13 cumulative weeks.

Disability Status Report

Filed as required by Minn. Rules 5220.0110, subp. 7



PRINT IN INK or TYPE
 Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

1. WID or SSN	2. DATE OF INJURY		
3. EMPLOYEE NAME			
4. EMPLOYEE ADDRESS			
CITY	STATE	ZIP CODE	5. EMPLOYEE PHONE #
6. EMPLOYER		7. EMPLOYER CONTACT PERSON	8. PHONE #
9. INSURER/SELF-INSURER/TPA		12. TITLE OF JOB AT DATE OF INJURY	
10. INSURER ADDRESS		13. AVERAGE WEEKLY WAGE AT DATE OF INJURY	14. JOB AT DATE OF INJURY <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME
CITY	STATE	ZIP CODE	15. NUMBER OF DAYS OF DISABILITY
11. INSURER CLAIM NUMBER		16. IS THE EMPLOYEE CURRENTLY WORKING? <input type="checkbox"/> YES <input type="checkbox"/> NO	
11. INSURER CLAIM NUMBER		17. WILL THE DISABILITY LIKELY EXTEND BEYOND 13 WEEKS? (see instructions on back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
18. REASON FOR FILING THE DISABILITY STATUS REPORT: (Check A or B)			
Was a consultation requested? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, consultation requested by:			
<input type="checkbox"/> Insurer <input type="checkbox"/> Employer <input type="checkbox"/> Employee on _____ (date of request)			
<input type="checkbox"/> A. The employee is being referred for a rehabilitation consultation. (Insurer must send a copy of this Disability Status Report, the First Report of Injury, and the treating physician's Report of Work Ability to the QRC before the rehabilitation consultation.)			
Name of QRC _____			
<input type="checkbox"/> B. A waiver of the rehabilitation consultation is being requested. (An offer of suitable gainful employment signed by the date-of-injury employer and the Report of Work Ability must be attached.)			
Projected return to work date _____			

Name of insurer representative completing form	Phone number	Extension	Date served on employee
--	--------------	-----------	-------------------------

Instructions to Insurer

The Disability Status Report (DSR) is used to notify parties that you are either referring the injured worker for a rehabilitation consultation or requesting a waiver of the consultation. The DSR, with a Report of Work Ability (RWA), must be mailed to the injured worker and filed with the Department of Labor and Industry:

- Within 14 calendar days of knowledge that the employee's temporary total disability is likely to exceed 13 cumulative weeks; or
- Within 90 calendar days of the date of injury when the employee has not returned to work following a work injury; or
- Within 14 calendar days after receiving a request for a rehabilitation consultation, whichever is earlier; or
- Within 14 calendar days of expiration of an approved waiver of rehabilitation services.

To Refer for a Rehabilitation Consultation:

If you are referring the injured worker for a rehabilitation consultation, check Box 18A. Send a copy of the DSR form, the First Report of Injury and the treating physician's Report of Work Ability to the QRC prior to the consultation. Fill in the name of the QRC on the form and indicate which party requested the consultation. If the employee requested the consultation, fill in the date of the request.

To Request a Waiver of a Rehabilitation Consultation:

M.S. § 176.102, subd. 4 and Minn. Rules 5220.0110 and 5220.0120 provide that the commissioner may grant a waiver of a rehabilitation consultation to an otherwise qualified employee if there is documentation that the employee will return to suitable gainful employment with the date-of-injury employer within 90 calendar days after the request for waiver is filed. A waiver will not be granted unless documentation is submitted that a suitable job offer within the treating doctor's restrictions has been made.

If you are requesting a waiver, check Box 18B and attach the following documentation:

- Report of Work Ability or other medical report with the same information from the treating doctor which indicates that the employee will be released to return to work within 90 calendar days after the request for waiver is filed and specifying the employee's work restrictions in functional terms.
- Written offer of suitable gainful employment signed by the employer that is within the treating doctor's restrictions to which the employee will return within the timeframe indicated above. Include one of the following:
 - If the employer is offering the employee his/her date-of-injury job, any modifications of the job to accommodate the employee's restrictions must be noted.
 - If the written offer of suitable gainful employment (which does not include temporary, light-duty) is for a different job with the date-of-injury employer, the offer must include the job title, job environment, work tasks, weekly wage, physical, mental and educational demands of the job, and/or employer modifications of the job to accommodate the employee's restrictions.

Instructions to Employee

If you do not agree with the insurer's recommendation for a rehabilitation consultation or a waiver of rehabilitation consultation, you may file a Rehabilitation Request with the Department of Labor and Industry. If you have questions call the Benefit Management and Resolution Unit at 1-800-342-5354 or 651-284-5032.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

The Middle of the Story – Medical Benefits

As you recall, Pat Williams has back pain related to the work injury. Pat has been receiving passive chiropractic care from Dr. Crunch since March 27th.

1. Dr. Crunch must evaluate whether Pat is making progressive improvement with the treatment plan. What are the criteria for progressive improvement?

- Decrease in pain symptoms described by employee.
- Improvement in objectively measured signs documented by HCP.
- Improvement in functional/vocational status.

2. Pat has had eight weeks of passive chiropractic care. If Pat continues to demonstrate progressive improvement, how many more weeks of passive care is allowed under the rules without prior notification?

Pat is eligible to receive four more weeks of regularly scheduled passive care followed by 12 additional visits over the next 12 months provided all of the requirements of the 12 + 12 rule are satisfied.

3. If Pat is having pain and is unable to work after eight weeks of treatment, what treatment should be considered?

Surgical evaluation. If the employee refuses surgery or is not a candidate for surgery, chronic management phase begins.

4. If Dr. Crunch requests a departure from the treatment parameters, how many days do you have to respond to this request? What happens if you fail to respond?

- You must respond within seven working days to the HCP and employee.
- You must approve, deny, request additional information, request a second opinion, or request an IME.
- If the insurer fails to respond within seven working days, authorization is deemed to have been given.

The End of the Story?

After additional conservative treatment, Pat Williams has back surgery on July 16, 2007 for a herniated disc (you know that the minimum PPD rating for this is 11%). After recovering from the surgery, Pat is released to return to light duty work and returns to work four hours a day on August 27, 2007.

1. What forms need to be filed? Fill them out.

NOID – add

TPD 4/9 - 4/12/2007 .8 wks = \$160.00

TTD 4/13 - 8/26/2007 19.2 wks = \$7,680.00

NOBP – PPD 11% X \$85,000 = \$9,350.00 ÷ 400 = 23.38 weeks starting on 8/27/2007

add on back of form PPD 2 wks = \$800.00

add on benefit addendum TPD 2 wks = \$400.00

2. Pat continues to work four hours a day until February 18, 2008 when Pat starts working six hours a day. Between September 10th and February 18th have you filed any additional forms with the department? If yes, fill them out.

NOBP on 2/11/2008 showing the discontinuance of PPD. Show all benefits paid to date including TPD paid through 2/10/2008.

3. Do you need to file a form to reduce the TPD being paid?

No.

4. On February 22, 2008, you receive a health care provider report form from the treating doctor stating that MMI was reached on January 24, 2008 and giving a final PPD rating of 11%. What should you do with this medical report? Why?

Serve it on the employee and attorney, with a copy to the department. It establishes an end date to entitlement of TTD (90 days post service of MMI).

5. Since MMI has been reached, what affect does that have on future medical treatment?

None.

6. It is now February 11, 2009 and Pat Williams is still working six hours per day and still receiving TPD benefits. Do you need to file any forms with the department? If so, fill them out.

ISR – add TPD 2/11/2008 - 2/8/2009 52 wks = \$5300.00.

7. On March 9, 2009, Pat Williams is able to return to work full time without a wage loss. What form needs to be filed? Fill it out.

NOID #1 – add TPD 2/9/2009 - 3/8/2009 4 wks = \$400.00.

Notice of Intention to Discontinue Workers' Compensation Benefits



DO NOT USE THIS SPACE

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY
EMPLOYEE	EMPLOYER
EMPLOYEE ADDRESS	
CITY	STATE
ZIP CODE	
INSURER CLAIM NUMBER	

Your benefits for (check one) TEMPORARY TOTAL TEMPORARY PARTIAL PERMANENT TOTAL disability are being discontinued for one of the following reasons:

1. You have returned to work on _____ (date) at full wage.
2. You have returned to work on _____ (date) at reduced hours or wages.

 Temporary partial will will not be paid. Temporary partial is usually based on the difference between your wage of \$ _____ at the time of the injury and your current weekly wage.
3. Reasons other than return to work. Payment will be made through _____ (date)
 Give reasons and facts below. (Appropriate medical reports must be attached).

Reasonable medical expenses and any permanent partial disability due will still be paid, unless your claim has been denied.

INSTRUCTIONS TO EMPLOYEE – THIS REQUIRES YOUR IMMEDIATE ATTENTION

You are responsible for reviewing this form to make sure that you have been properly paid the benefits due you.
YOU DO NOT NEED TO TAKE ANY ACTION IF YOU BELIEVE THAT YOU HAVE RECEIVED ALL BENEFITS DUE OR THAT THE REDUCTION OF BENEFITS IS PROPER.

If Box 1 or 2 is checked above and you believe that your benefits should be reinstated due to an occurrence during the initial 14 calendar days after your return to work, you may request a conference. Your request must be received by the Workers' Compensation Division within 30 calendar days after the date that you returned to work.

If Box 3 is checked above and you think the reason for stopping your benefits is incorrect, or you disagree with the proposed discontinuance, you may request a conference. Your request must be received within 12 calendar days after this notice is received by the Workers' Compensation Division.

TO REQUEST A CONFERENCE, YOU MUST MAIL OR DELIVER THE ATTACHED FORM TO THE WORKERS' COMPENSATION DIVISION SO THAT IT IS RECEIVED WITHIN THE ABOVE TIME LIMITS. TELEPHONE REQUESTS WILL ALSO BE ACCEPTED AT (651) 361-7912 OR 1-800-342-5354.

The conference will be scheduled within 10 calendar days of the date your request is received by the Division. You, your employer, and the insurer will be invited to attend. You are not required to bring an attorney, but may bring one if you wish. You should bring to the conference any current reports and return-to-work restrictions, if available.

You may instead file an Objection to Discontinuance with the Division. This is a formal procedure before a compensation judge which takes longer than the administrative conference process and usually requires an attorney. If you do this, your benefits will stop on the date stated in this notice and will not be paid during the time you wait for the hearing.

If the insurer is denying primary liability for your claim and you disagree with the denial, cannot return to your former employment and would like vocational rehabilitation assistance, contact the Department of Labor and Industry, Vocational Rehabilitation Unit at (651) 284-5038.

If you have questions about your benefits, you should first contact the claim representative whose telephone number is at the bottom of the page. Be sure to provide that person with any additional information you have to support your claim. If you still have questions, contact the Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you.

Minnesota Department of Labor and Industry

5 North Third Avenue West, Suite 400
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 Telephone: (218) 733-7810
 1-800-342-5354

443 Lafayette Road North
 St. Paul, MN 55155-4301
 Telephone: (651) 284-5030
 1-800-342-5354

Mailing Address
 Workers' Compensation Division
 PO Box 64221
 St. Paul, MN 55164-0221

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
<input type="checkbox"/> Temporary Total Disability or					
<input type="checkbox"/> Permanent Total Disability					
<div style="border: 1px solid black; height: 40px; width: 100%;"></div>					
<input type="checkbox"/> Benefit Addendum Attached					
Temporary Partial Disability					
Retraining Benefits					
Permanent Partial Disability _____%					
<input type="checkbox"/> Injuries on or after 10/01/95					
<input type="checkbox"/> Impairment Compensation (injuries 01/01/1984 - 09/30/1995)					
<input type="checkbox"/> Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995)					
<input type="checkbox"/> _____ [part of body] (injuries before 01/01/1984)					
Attorney Fees/Expenses		Benefit Totals			
M.S. 176.081, subd. 1 & 3 Paid			*Lump sum Payment Under Award or Order		
M.S. 176.081, subd. 1 & 3 Still Withheld			Attorney Fees Reimbursed to Employee (M.S. 176.081, subd. 7)		
Heaton Fees Paid			Interest Paid		
Roraff Fees Paid			*TOTAL COMPENSATION PAID		
M.S. 176.191 Paid			*Total Supplementary Benefits		
Other Fees Paid			Total Medical Expenses Paid to Date		
Costs & Disbursements Paid					
INSURER/SELF-INSURER/TPA		CLAIM REPRESENTATIVE NAME			
ADDRESS		PHONE NUMBER (include area code)			
CITY	STATE	ZIP CODE	DATE SERVED ON EMPLOYEE	DATE SERVED ON ATTORNEY	

*Include attorney fees in these totals.

Employee's Request for Administrative Conference

Minn. Stat. § 176.239, subd. 2



DO NOT USE THIS SPACE

PRINT IN INK or TYPE.
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY
EMPLOYEE	EMPLOYER
EMPLOYEE ADDRESS	
CITY	STATE ZIP CODE
INSURER CLAIM NUMBER	INSURER/SELF-INSURER/TPA
<p>ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.</p>	
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THIS REQUIRES YOUR IMMEDIATE ATTENTION

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation re-insurance association.

INSTRUCTIONS TO EMPLOYEE

DO NOT COMPLETE THIS FORM IF YOU AGREE THAT YOUR WEEKLY WORKERS' COMPENSATION BENEFITS MAY BE STOPPED OR CHANGED.

HOWEVER, IF YOU DISAGREE THAT YOUR BENEFITS MAY BE STOPPED OR CHANGED, YOU MAY BE ENTITLED TO AN ADMINISTRATIVE CONFERENCE. At the conference, a decision can be made about your right to further weekly benefits.

TO REQUEST A CONFERENCE, MAIL OR DELIVER THIS COMPLETED FORM TO:

DEPARTMENT OF LABOR AND INDUSTRY
WORKERS' COMPENSATION DIVISION
PO BOX 64218
ST PAUL, MN 55164-0218

Requests will also be accepted by telephone. Call (651) 361-7912 or 1-800-342-5354

TIME LIMIT TO REQUEST A CONFERENCE

IF BOX 1 OR 2 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received by the Workers' Compensation Division **WITHIN 30 DAYS AFTER YOU RETURNED TO WORK.**

IF BOX 3 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received **WITHIN 12 DAYS AFTER A COPY OF THE NOTICE OF INTENTION TO DISCONTINUE WORKERS' COMPENSATION BENEFITS IS RECEIVED BY THE WORKERS' COMPENSATION DIVISION.**

EMPLOYEE'S REQUEST FOR ADMINISTRATIVE CONFERENCE			
1. BOX (check one)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits.
2. My weekly benefits should not be changed/stopped because: _____			
(attach separate sheet if more room is needed)			
_____ EMPLOYEE SIGNATURE	_____ EMPLOYEE PHONE # (include area code)	_____ DATE	
_____ ATTORNEY (if you have one)	_____ ATTORNEY #	_____ ATTORNEY PHONE # (include area code)	_____ QRC (if you have one)

Notice of Benefit Payment



PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY	
EMPLOYEE	EMPLOYER	
EMPLOYEE ADDRESS		
CITY	STATE	ZIP CODE
INSURER CLAIM NUMBER		

THE FOLLOWING PERMANENT PARTIAL DISABILITY BENEFIT WILL BE PAID TO YOU:

_____ % of whole body according to Minnesota Workers' Compensation Permanent Partial Disability Schedule
number(s) _____
The rating is based on the attached medical report of Dr. _____ dated _____

This payment is based on the preliminary rating. If your final disability rating is higher, further payments will be made.

For injuries on or after 10/01/1995 payment will be made at \$ _____ per week beginning on
(date) _____ for a total of _____ weeks and a total amount of \$ _____

For injuries on or after 10/01/2000 a total lump sum payment of \$ _____, rather than weekly payments
will be made as requested by the employee.

For injuries between 01/01/1984 and 09/30/1995 payment will be made as follows:

- \$ _____ **Impairment compensation** will be paid in a lump sum on _____ (date).
(if you are laid off from your job for economic reasons within _____ weeks of the day your returned to work,
you may be entitled to monitoring period compensation, in addition to Impairment Compensation.)
- Periodic impairment compensation** or **Periodic economic recovery compensation**
of \$ _____ per week beginning on _____ (date) will be paid for up to _____ weeks. If you
return to work before this number of weeks, you will receive the balance due in a lump sum after working 30 days.
- 26 weeks economic recovery compensation** (M.S. § 176.101, subd. 3t) of \$ _____
per week will be paid beginning on _____ (date).

YOUR FINAL PAYMENT OF \$ _____ FOR _____
BENEFITS WAS WILL BE ISSUED ON _____ (DATE) ACCORDING TO:

- A. An award on agreement of the parties dated _____
- B. A prior Notice of Benefit Payment for periodic payment of permanent partial disability dated _____
- C. An administrative decision under M.S. § 176.239 dated _____
- D. A judge's decision and order dated _____

INSTRUCTIONS TO EMPLOYEE

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If you have questions about your benefits, you should first contact the claim representative whose telephone number is at the bottom of the page. Be sure to provide that person with any additional information you have to support your claim. If you still have questions, contact the Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you.

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THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
<input type="checkbox"/> Temporary Total Disability or					
<input type="checkbox"/> Permanent Total Disability					
<div style="border: 1px solid black; height: 40px; width: 100%;"></div>					
<input type="checkbox"/> Benefit Addendum Attached					
Temporary Partial Disability					
Retraining Benefits					
Permanent Partial Disability _____%					
<input type="checkbox"/> Injuries on or after 10/01/95					
<input type="checkbox"/> Impairment Compensation (injuries 01/01/1984 - 09/30/1995)					
<input type="checkbox"/> Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995)					
<input type="checkbox"/> _____ [part of body] (injuries before 01/01/1984)					
Attorney Fees/Expenses		Benefit Totals			
M.S. 176.081, subd. 1 & 3 Paid				*Lump sum Payment Under Award or Order	
M.S. 176.081, subd. 1 & 3 Still Withheld				Attorney Fees Reimbursed to Employee (M.S. 176.081, subd. 7)	
Heaton Fees Paid				Interest Paid	
Roraff Fees Paid				*TOTAL COMPENSATION PAID	
M.S. 176.191 Paid				*Total Supplementary Benefits	
Other Fees Paid				Total Medical Expenses Paid to Date	
Costs & Disbursements Paid					
INSURER/SELF-INSURER/TPA	CLAIM REPRESENTATIVE NAME				
ADDRESS	PHONE NUMBER (include area code)				
CITY	STATE	ZIP CODE	DATE SERVED ON EMPLOYEE	DATE SERVED ON ATTORNEY	

*Include attorney fees in these totals.

Notice of Benefit Payment



PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY	
EMPLOYEE	EMPLOYER	
EMPLOYEE ADDRESS		
CITY	STATE	ZIP CODE
INSURER CLAIM NUMBER		

THE FOLLOWING PERMANENT PARTIAL DISABILITY BENEFIT WILL BE PAID TO YOU:

_____ % of whole body according to Minnesota Workers' Compensation Permanent Partial Disability Schedule number(s) _____
The rating is based on the attached medical report of Dr. _____ dated _____
 This payment is based on the preliminary rating. If your final disability rating is higher, further payments will be made.

For injuries on or after 10/01/1995 payment will be made at \$ _____ per week beginning on (date) _____ for a total of _____ weeks and a total amount of \$ _____

For injuries on or after 10/01/2000 a total lump sum payment of \$ _____, rather than weekly payments will be made as requested by the employee.

For injuries between 01/01/1984 and 09/30/1995 payment will be made as follows:

\$ _____ **Impairment compensation** will be paid in a lump sum on _____ (date).
(if you are laid off from your job for economic reasons within _____ weeks of the day your returned to work, you may be entitled to monitoring period compensation, in addition to Impairment Compensation.)

Periodic impairment compensation or **Periodic economic recovery compensation** of \$ _____ per week beginning on _____ (date) will be paid for up to _____ weeks. If you return to work before this number of weeks, you will receive the balance due in a lump sum after working 30 days.

26 weeks economic recovery compensation (M.S. § 176.101, subd. 3t) of \$ _____ per week will be paid beginning on _____ (date).

YOUR FINAL PAYMENT OF \$ _____ FOR _____ BENEFITS WAS WILL BE ISSUED ON _____ (DATE) ACCORDING TO:

- A. An award on agreement of the parties dated _____
- B. A prior Notice of Benefit Payment for periodic payment of permanent partial disability dated _____
- C. An administrative decision under M.S. § 176.239 dated _____
- D. A judge's decision and order dated _____

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THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
<input type="checkbox"/> Temporary Total Disability or					
<input type="checkbox"/> Permanent Total Disability					
<div style="border: 1px solid black; height: 40px; width: 100%;"></div>					
<input type="checkbox"/> Benefit Addendum Attached					
Temporary Partial Disability					
Retraining Benefits					
Permanent Partial Disability _____%					
<input type="checkbox"/> Injuries on or after 10/01/95					
<input type="checkbox"/> Impairment Compensation (injuries 01/01/1984 - 09/30/1995)					
<input type="checkbox"/> Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995)					
<input type="checkbox"/> _____ [part of body] (injuries before 01/01/1984)					
Attorney Fees/Expenses		Benefit Totals			
M.S. 176.081, subd. 1 & 3 Paid				*Lump sum Payment Under Award or Order	
M.S. 176.081, subd. 1 & 3 Still Withheld				Attorney Fees Reimbursed to Employee (M.S. 176.081, subd. 7)	
Heaton Fees Paid				Interest Paid	
Roraff Fees Paid				*TOTAL COMPENSATION PAID	
M.S. 176.191 Paid				*Total Supplementary Benefits	
Other Fees Paid				Total Medical Expenses Paid to Date	
Costs & Disbursements Paid					
INSURER/SELF-INSURER/TPA	CLAIM REPRESENTATIVE NAME				
ADDRESS	PHONE NUMBER (include area code)				
CITY	STATE	ZIP CODE	DATE SERVED ON EMPLOYEE	DATE SERVED ON ATTORNEY	

*Include attorney fees in these totals.

Interim Status Report



PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY		
EMPLOYEE	EMPLOYER		
EMPLOYEE ADDRESS			
CITY	STATE	ZIP CODE	
INSURER CLAIM NUMBER			

THE FORM MUST BE SUBMITTED ANNUALLY ON ALL CLAIMS OF CONTINUING DISABILITY, SUPPLEMENTARY OR DEPENDENCY BENEFITS. Please provide additional information on the Benefit Addendum (BA01).

	FROM	THROUGH	WEEKS	RATE	*TOTAL
<input type="checkbox"/> Temporary Total* <input type="checkbox"/> Permanent Total* <div style="text-align: right;">Balance Carried Forward</div>					
TOTAL:					
Temporary Partial <div style="text-align: right;">Balance Carried Forward</div>					
TOTAL:					
Permanent Partial Permanent Partial Disability _____% <input type="checkbox"/> Injuries on or after 10/01/95 <input type="checkbox"/> Impairment Compensation (injuries 01/01/1984 - 09/30/1995) <input type="checkbox"/> Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995) <input type="checkbox"/> _____ [part of body] (injuries before 01/01/1984)					
TOTAL:					

*These areas need not be completed if this form is being attached to and filed with the **Annual Claim for Reimbursement of Supplementary Benefits.**

	FROM	THROUGH	WEEKS	RATE	TOTAL
Retraining Benefits Balance Carried Forward					

TOTAL:

Dependency Benefits Balance Carried Forward					

TOTAL:

Supplementary Benefits* Balance Carried Forward					

TOTAL:

Social Security Benefits or Other Government Benefits* Retirement Disability

Name of Program: _____

FROM	THROUGH	PER WEEK

*These areas need not be completed if this form is being attached to and filed with the **Annual Claim for Reimbursement of Supplementary Benefits.**

Attorney Fees Paid		Interest Paid	
Attorney Fees Still Withheld		Lump Sum Payment Under Award or Order	
Attorney Fees Reimbursed to Employee M.S. 176.081, subd. 7		Total Compensation Paid to Employee	
		Total Dependency Benefits Paid (Please attached copy of worksheet)	
INSURER/SELF-INSURER/TPA		CLAIM REPRESENTATIVE NAME	
ADDRESS		PHONE NUMBER (include area code)	
CITY	STATE	ZIP CODE	DATE SERVED

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Notice of Intention to Discontinue Workers' Compensation Benefits



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PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY
EMPLOYEE	EMPLOYER
EMPLOYEE ADDRESS	
CITY	STATE
ZIP CODE	
INSURER CLAIM NUMBER	

Your benefits for (check one) TEMPORARY TOTAL TEMPORARY PARTIAL PERMANENT TOTAL disability are being discontinued for one of the following reasons:

1. You have returned to work on _____ (date) at full wage.
2. You have returned to work on _____ (date) at reduced hours or wages.
 Temporary partial will will not be paid. Temporary partial is usually based on the difference between your wage of \$ _____ at the time of the injury and your current weekly wage.
3. Reasons other than return to work. Payment will be made through _____ (date)
 Give reasons and facts below. (Appropriate medical reports must be attached).

Reasonable medical expenses and any permanent partial disability due will still be paid, unless your claim has been denied.

INSTRUCTIONS TO EMPLOYEE – THIS REQUIRES YOUR IMMEDIATE ATTENTION

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YOU DO NOT NEED TO TAKE ANY ACTION IF YOU BELIEVE THAT YOU HAVE RECEIVED ALL BENEFITS DUE OR THAT THE REDUCTION OF BENEFITS IS PROPER.

If Box 1 or 2 is checked above and you believe that your benefits should be reinstated due to an occurrence during the initial 14 calendar days after your return to work, you may request a conference. Your request must be received by the Workers' Compensation Division within 30 calendar days after the date that you returned to work.

If Box 3 is checked above and you think the reason for stopping your benefits is incorrect, or you disagree with the proposed discontinuance, you may request a conference. Your request must be received within 12 calendar days after this notice is received by the Workers' Compensation Division.

TO REQUEST A CONFERENCE, YOU MUST MAIL OR DELIVER THE ATTACHED FORM TO THE WORKERS' COMPENSATION DIVISION SO THAT IT IS RECEIVED WITHIN THE ABOVE TIME LIMITS. TELEPHONE REQUESTS WILL ALSO BE ACCEPTED AT (651) 361-7912 OR 1-800-342-5354.

The conference will be scheduled within 10 calendar days of the date your request is received by the Division. You, your employer, and the insurer will be invited to attend. You are not required to bring an attorney, but may bring one if you wish. You should bring to the conference any current reports and return-to-work restrictions, if available.

You may instead file an Objection to Discontinuance with the Division. This is a formal procedure before a compensation judge which takes longer than the administrative conference process and usually requires an attorney. If you do this, your benefits will stop on the date stated in this notice and will not be paid during the time you wait for the hearing.

If the insurer is denying primary liability for your claim and you disagree with the denial, cannot return to your former employment and would like vocational rehabilitation assistance, contact the Department of Labor and Industry, Vocational Rehabilitation Unit at (651) 284-5038.

If you have questions about your benefits, you should first contact the claim representative whose telephone number is at the bottom of the page. Be sure to provide that person with any additional information you have to support your claim. If you still have questions, contact the Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you.

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THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
<input type="checkbox"/> Temporary Total Disability or					
<input type="checkbox"/> Permanent Total Disability					
<div style="border: 1px solid black; height: 40px; width: 100%;"></div>					
<input type="checkbox"/> Benefit Addendum Attached					
Temporary Partial Disability					
Retraining Benefits					
Permanent Partial Disability _____%					
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M.S. 176.191 Paid				*Total Supplementary Benefits	
Other Fees Paid				Total Medical Expenses Paid to Date	
Costs & Disbursements Paid					
INSURER/SELF-INSURER/TPA		CLAIM REPRESENTATIVE NAME			
ADDRESS		PHONE NUMBER (include area code)			
CITY	STATE	ZIP CODE	DATE SERVED ON EMPLOYEE	DATE SERVED ON ATTORNEY	

*Include attorney fees in these totals.

Employee's Request for Administrative Conference

Minn. Stat. § 176.239, subd. 2



DO NOT USE THIS SPACE

PRINT IN INK or TYPE.
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY
EMPLOYEE	EMPLOYER
EMPLOYEE ADDRESS	
CITY	STATE ZIP CODE
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<p><i>This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.</i></p>	

THIS REQUIRES YOUR IMMEDIATE ATTENTION

Private or confidential data you supply on this form, and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation re-insurance association.

INSTRUCTIONS TO EMPLOYEE

DO NOT COMPLETE THIS FORM IF YOU AGREE THAT YOUR WEEKLY WORKERS' COMPENSATION BENEFITS MAY BE STOPPED OR CHANGED.

HOWEVER, IF YOU DISAGREE THAT YOUR BENEFITS MAY BE STOPPED OR CHANGED, YOU MAY BE ENTITLED TO AN ADMINISTRATIVE CONFERENCE. At the conference, a decision can be made about your right to further weekly benefits.

TO REQUEST A CONFERENCE, MAIL OR DELIVER THIS COMPLETED FORM TO:

DEPARTMENT OF LABOR AND INDUSTRY
WORKERS' COMPENSATION DIVISION
PO BOX 64218
ST PAUL, MN 55164-0218

Requests will also be accepted by telephone. Call (651) 361-7912 or 1-800-342-5354

TIME LIMIT TO REQUEST A CONFERENCE

IF BOX 1 OR 2 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received by the Workers' Compensation Division **WITHIN 30 DAYS AFTER YOU RETURNED TO WORK.**

IF BOX 3 is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits, your request for a conference must be received **WITHIN 12 DAYS AFTER A COPY OF THE NOTICE OF INTENTION TO DISCONTINUE WORKERS' COMPENSATION BENEFITS IS RECEIVED BY THE WORKERS' COMPENSATION DIVISION.**

EMPLOYEE'S REQUEST FOR ADMINISTRATIVE CONFERENCE			
1. BOX (check one)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/> is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits.
2. My weekly benefits should not be changed/stopped because: _____			
(attach separate sheet if more room is needed)			
EMPLOYEE SIGNATURE	EMPLOYEE PHONE # (include area code)	DATE	
ATTORNEY (if you have one)	ATTORNEY #	ATTORNEY PHONE # (include area code)	QRC (if you have one)



DO NOT USE THIS SPACE

Notice of File Closing

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY
EMPLOYEE	
EMPLOYER	
INSURER CLAIM NUMBER	

THIS IS TO NOTIFY YOUR OFFICE THAT ALL PAYMENTS AND OTHER ACTIVITIES HAVE BEEN COMPLETED ON THIS FILE. AS A RESULT, WE ARE NOW CLOSING IT ON OUR SYSTEM.

CLAIM REPRESENTATIVE NAME	DATE
ADDRESS	INSURER/SELF-INSURER/TPA
CITY STATE ZIP CODE	PHONE NUMBER (include area code)

Send completed form to: Minnesota Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221

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