

Major workers' compensation legislation enacted

During the last few days of the 2018 legislative session, both houses unanimously approved H.F. 3878, containing the recommendations of the Workers' Compensation Advisory Council. Governor Mark Dayton signed the measure into law as soon as he could, on May 20.

The bill was the most comprehensive workers' compensation legislation in two decades. More importantly, it will benefit injured workers, employers and health care providers directly, as well as improve the system's administrative processes.

See 2018 Minnesota Sessions Laws, Chapter 185 – H.F. No. 3873 final engrossment. Chapter 185 is online at www.revisor.mn.gov/laws/?id=185&year=2018&type=0.

Article 1 adjusts the salaries of the judges of the Workers' Compensation Court of Appeals (WCCA); permits the WCCA chief judge to use a retired workers' compensation or WCCA judge to hear a case when there is an insufficient number of WCCA judges to constitute a quorum; appropriates funds to the WCCA; allows the Department of Labor and Industry (DLI) to provide the worker identification (WID) number to specified persons; and coordinates the Office of Administrative Hearing's (OAH's) case management system and the workers' compensation system.

Article 2 establishes a workers' compensation hospital outpatient fee schedule, using Medicare's Outpatient Prospective Payment System as a framework.

Article 3 establishes billing, payment and dispute-resolution requirements for the services provided by a hospital under Article 2 and by an ambulatory surgical center under Article 4.

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

Article 5 provides a rebuttable presumption that an employee in one of the specified occupations, who is diagnosed with post-traumatic stress disorder (PTSD), has an occupational disease due to the nature of employment; requires the DLI commissioner to adopt treatment parameters for PTSD; increases the maximum number of weeks of temporary partial disability benefits to 275 weeks; increases permanent partial disability benefits; and deletes the retirement presumption at age 67 and, instead, provides that permanent total disability benefits cease at age 72. Employees who are injured after age 67 receive permanent total disability benefits for five years.

A detailed summary of this new workers' compensation law, including effective dates, begins on page 10 of this edition of *COMPACT*.



Notice to attorneys and other interested parties

New legislation coordinating OAH case management, DLI imaging systems – effective June 1, 2018

Under new legislation (Minnesota Statutes § 176.2611), the following must be filed with the Department of Labor and Industry (DLI): Medical Request forms; Rehabilitation Request forms; Claim Petition forms containing only medical or vocational rehabilitation issues; requests for medical and rehabilitation dispute certification; motions to intervene in administrative conferences pending at DLI; documents related to an administrative conference pending at DLI; and objections to penalties assessed by DLI.

Do not file Medical Request forms, Rehabilitation Request forms or Claim Petition forms containing only medical or vocational rehabilitation issues with the Office of Administrative Hearings (OAH).

Dispute certification

Attorneys are advised to file an Attorney Request for Certification of Dispute form or a letter requesting certification before filing a Medical Request form, Rehabilitation Request form or Claim Petition form containing only medical or rehabilitation issues.

Attorney Request for Certification of Dispute forms, Medical Request forms and Rehabilitation Request forms can be accessed and submitted online at <https://secure.doli.state.mn.us/adrlogin/Login.aspx>. Fillable PDF versions of these forms are available at www.dli.mn.gov/WC/Wcforms.asp.

Scheduling administrative conferences

DLI will use attorneys' state of Minnesota Outlook calendars, the imaging database and the OAH case management system to determine when attorneys' are unavailable.

Attorneys currently without access to state Outlook calendars are advised to register for these calendars as soon as possible. To establish a free account, contact Angel Severson at angel.severson@state.mn.us or (651) 284-5241.

From the *State Register*: Provider participation list available

Minnesota Statutes § 256B.0644 and Minnesota Rules parts 5221.0500, subp. 1, and 9505.5200 to 9505.5240, also known as the Department of Human Services (DHS) "Rule 101," require health care providers that provide medical services to an injured worker under the workers' compensation law to participate in the Medical Assistance Program, the General Assistance Medical Care Program and the MinnesotaCare Program.



Notice is hereby given that the Minnesota Health Care Programs provider participation list for April 2018 is now available. The provider participation list is a compilation of health care providers that are in compliance with DHS Rule 101. If a provider's name is not on the list, DHS considers the provider noncompliant.

The list of providers is separated by provider types, each section is in alphabetical order by provider name and there is no additional information on the list other than the provider's name. This list is distributed on a quarterly basis to Minnesota Management and Budget, the Department of Labor and Industry, and the Department of Commerce.

To obtain the list, call the DHS Provider Call Center at (651) 431-2700 or 1-800-366-5411. Requests may also be faxed to (651) 431-7462 or mailed to the Department of Human Services, P.O. Box 64987, St. Paul, MN 55164-0987.

Annual Workers' Compensation System Report released:

Long-term downward trends continue in number of claims and system cost

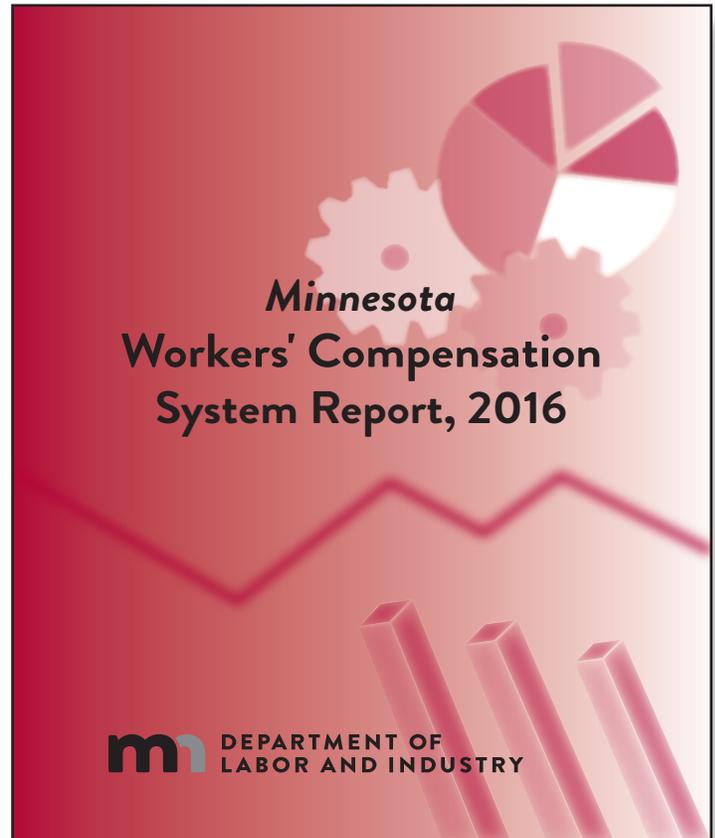
By David Berry, Research and Statistics

The number of paid workers' compensation claims fell 54 percent relative to the number of full-time-equivalent (FTE) employees from 1996 to 2016, according to the *2016 Minnesota Workers' Compensation System Report*, released in April 2018 by the Department of Labor and Industry.

Among the report's findings are the following.

- The number of paid claims fell from 8.8 per 100 FTE employees in 1996 to 4.0 in 2016.
- The cost of the workers' compensation system for 2016 amounted to \$1.24 per \$100 of payroll. In Minnesota and elsewhere, this cost follows a multi-year pricing cycle. However, comparable points in the cycle for Minnesota indicate a long-term downward trend.
- Adjusted for average wage growth, average medical benefits per claim were 74 percent higher in 2015 than in 1996; indemnity benefits per claim were 36 percent higher. Medical benefits per claim have been stable (relative to average wages) since 2008 and indemnity benefits since 2003.
- Despite higher benefits per claim, costs are down relative to payroll because of the falling claim rate. Compared to 1996, indemnity benefits per \$100 of payroll were 40 percent lower in 2016 and medical benefits were 30 percent lower.
- In 2016, on a current-payment basis, medical benefits accounted for an estimated 35 percent of total system cost, followed by insurer expenses at 31 percent and indemnity benefits other than vocational rehabilitation at 29 percent.
- The percentage of indemnity benefit claimants receiving vocational rehabilitation services rose from 15 percent in 1997 to 25 percent in 2016.
- The percentage of indemnity claims with a dispute of any type rose from 16 percent in 1996 to 21 percent in 2008 but has been stable since then.

This report, part of an annual series, presents data from 1996 through 2016 about Minnesota's workers' compensation system. The purpose of the report is to describe the current status and direction of the system and to offer explanations, where possible, for recent developments. It is available on the Department of Labor and Industry website at www.dli.mn.gov/RS/WcSystemReport.asp.



Review of a recent study:

The Impact of Opioid Prescriptions on Duration of Temporary Disability

By David Berry, Research and Statistics

As in general medicine, the widespread use of opioids in workers' compensation has been of major concern. Opioid use in workers' compensation has been documented by several researchers including at the Workers' Compensation Research Institute (WCRI). In an earlier WCRI study of injured workers off the job for more than seven days, more than half of those without surgery and with pain medications received opioid prescriptions, many of these on a longer-term basis.¹

But there is little solid evidence about the effects of opioid prescriptions on workers' compensation outcomes. Some studies have found positive correlations between opioid prescribing and the duration of disability. But these correlations do not necessarily indicate that opioid prescribing affects disability duration. For example, more severe injuries may lead to both longer disability and more opioid use, or doctors more prone to prescribe opioids may also be more prone to specify extensive work restrictions. The problem is not solved with statistical controls for observable factors such as worker demographics or injury diagnosis.



Dealing with this problem is the central challenge of any effort to gauge the effects of opioids on disability duration. Since randomized trials are generally not feasible in workers' compensation, other approaches must be employed.

An example of another approach is the recently released WCRI study, *The Impact of Opioid Prescriptions on Duration of Temporary Disability*.² Using individual claim data from 28 states (including Minnesota) for 2008 to 2013, the study estimates the effect of opioid prescribing (measured in different ways) on the duration of temporary disability for workers with low-back injuries and more than seven days of disability. The study employs a wide array of statistical controls for worker, employer and injury characteristics, and local economic conditions. In addition, it uses the large variation across geographic areas in opioid prescribing patterns to derive a correlation between opioid prescribing and disability duration that represents a causal effect of opioid prescribing.

In a preliminary analysis, the study finds that local prescribing patterns have a strong effect on opioid prescriptions for individual workers, after extensively controlling for worker, employer and injury characteristics, and local economic conditions. Building on this result, the authors also find that individual opioid prescribing affects disability duration at the claim level.

This finding holds for long-term but not short-term opioid prescribing. The authors estimate that workers with longer-term opioid prescriptions (measured in different ways) had substantially longer disability durations than similar workers with similar low-back injuries and no opioid prescriptions.

¹Workers' Compensation Research Institute, June 2017, "Interstate Variations in Use of Opioids, 4th ed."

²WCRI, March 2018.

SAVE THE DATE:

Fall conference for qualified rehabilitation consultants and vendors

Rehabilitation Update **LESSONS LEARNED**

mi DEPARTMENT OF
LABOR AND INDUSTRY

Sept. 18, 2018 • Conference and simulcast event



Minnesota Work Comp Forum happening Friday, Sept. 21

Workers' compensation professionals are invited to attend the free, one-day Minnesota Work Comp Forum for educational workshops and information about various available workers' compensation resources. Attendees will learn from industry professionals, meet other local and regional professionals and expand their knowledge and networks.

The event, Friday, Sept. 21, in Bloomington, Minnesota, is being hosted by the Workers' Compensation Reinsurance Association (WCRA) and the Minnesota Workers' Compensation Insurers Association (MWCIA), with support from its partners, the Minnesota Department of Commerce and the Minnesota Department of Labor and Industry.

Complete information and registration is online at www.mnworkcompforum.com.



Two annual Workers' Compensation Division reports updated, online

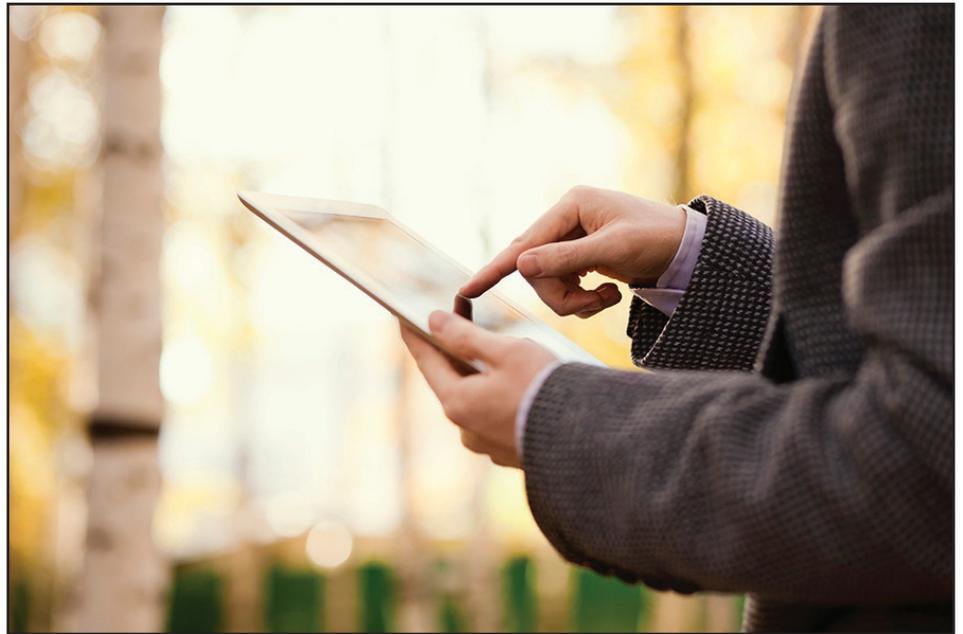
Collection and Assessment of Fines and Penalties

Minnesota Statutes § 176.222 directs the commissioner of the Department of Labor and Industry (DLI) to publish an annual report about the assessment and collection of fines and penalties under the workers' compensation law. Some of the results of the current report include the following findings.

Failure-to-insure penalties and the amount collected have stabilized as greater emphasis has been placed on partnering with other state, county and city agencies to ensure workers' compensation insurance is in place at the time those agencies issue licenses to employers. Continuing efforts to reach all new business owners to inform them of their responsibility to obtain workers' compensation insurance appear to have been successful.

Claim-related penalties have remained relatively stable.

Penalties issued for late filing of the first report of injury increased in fiscal-year 2014 through 2016, likely due to increasing filings from system auto-triggers related to mandatory electronic reporting. Although the overall number of prohibited practice penalties issued has decreased, the number of penalties with a dollar amount assessed increased in fiscal-year 2016.



Prompt First Action Report on Workers' Compensation Claims

Minnesota Statutes § 176.223 directs the Department of Labor and Industry commissioner to publish an annual report providing data about the promptness of all insurers and self-insurers in making first payments or denials on a claim for injury.

The department evaluates data submitted on the First Report of Injury and Notice of Insurer's Primary Liability Determination forms to determine whether the first payment or denial of benefits is timely. In fiscal-year 2017, 90.5 percent of the 23,049 lost-time claims had a timely first action. This percentage is slightly higher than fiscal-year 2016, where 90.1 percent of the 23,407 lost-time claims had a timely first action.

The department's Workers' Compensation Division anticipates increased use of technology, electronic data exchange and early intervention will maintain or improve the overall first action timeliness percentage.

Access the reports

Both reports are available on the DLI website at www.dli.mn.gov/WC/ReportsPubs.asp.

CompFact:

Payments at minimum, maximum TTD benefit levels

By Brian Zaidman, Research and Statistics

Temporary total disability (TTD) is the most common type of indemnity benefit. According to the *Minnesota Workers' Compensation System Report, 2016*, 82 percent of the workers with paid indemnity claims for injuries in 2016 received TTD benefits (see Figure 3.2 in the report, www.dli.mn.gov/RS/WcSystemReport.asp). While most workers are paid TTD benefits at the rate of two-thirds of their weekly wage, minimum and maximum weekly benefit levels affect payments at the lowest and highest wages.

The minimum TTD benefit level has remained at \$130 since Oct. 1, 2000 (not to exceed the worker's actual wage). As shown in Figure 1, the percentage of workers receiving the minimum TTD benefit decreased from 4.8 percent of all workers with TTD benefits in 2005 to 2.9 percent in 2017. (The years in Figure 1 begin on Oct. 1 of the preceding year and results for 2017 are preliminary.) This trend accelerated after 2014; the timing suggests this may have resulted from increases in the minimum wage beginning in August 2014.

The maximum TTD benefit level has been changed by statute twice since 2005. After being set at \$750 weekly beginning Oct. 1, 2000, it increased to \$850 weekly beginning Oct. 1, 2008 (the year 2009 in Figure 1) and then to 102 percent of the statewide average weekly wage (SAWW) beginning Oct. 1, 2013 (the year 2014 in Figure 1).

These statutory changes dramatically affected the percentage of workers with TTD benefits who received the maximum benefit. Among TTD beneficiaries injured in 2008, 11.7 percent received the maximum benefit, but that fell to 7.5 percent among workers injured in 2009. The percentage at the maximum level increased annually from 2009 to 2013, as wages increased and the maximum rate remained at \$850, peaking at 10.1 percent of workers in 2013. Under the current maximum benefit statute, the annual increases have kept the percentage of workers receiving the maximum TTD benefit at less than 7 percent.

Percentage of injured workers paid temporary total disability benefits at the minimum and maximum benefit levels



WCRI report compares Minnesota with 17 other states

By Brian Zaidman, Research and Statistics

The Workers' Compensation Research Institute's (WCRI's) most recent report for Minnesota, *CompScope Benchmarks for Minnesota, 18th Edition*, was released in April. This report uses insurer claim files to compare Minnesota's medical payments, indemnity benefits and insurer expenses with those of 17 other states, including Iowa and Wisconsin, for the 2011-to-2016 period. The report is available for purchase from WCRI at www.wcrintet.org. Here are some of the major findings.

- Average costs for all paid claims, measured at an average of 36 months after the injury (2014 claims measured in 2017), were 19 percent lower in Minnesota than the 18-state median.
- Average payments for Minnesota claims have showed little to moderate growth from 2011 to 2016. Analysis of claims with more than seven days of lost time, measured an average of 12 months after the injury, shows the total of medical costs, indemnity benefits, vocational rehabilitation and claims expenses increased at an average annual rate of 3.1 percent. Claim costs measured an average of 36 months after the injury grew at an annual rate of 1.2 percent.
- Medical payments for Minnesota claims with more than seven days of lost time, at an average of 12 months after the injury, grew at a rate of 1.1 percent from 2011 to 2016, similar to the median annual growth of 1.3 percent among the 18 states in the study.
- Minnesota had slightly fewer claims with any permanent partial disability (PPD) or lump-sum payment, at an average of 36 months after the injury, than the median state; however, the average PPD/lump-sum payment for these claims was 25 percent higher than the median.
- Benefit delivery expenses (for claims with these expenses) were 15 percent lower than the median state value for Minnesota claims with more than seven days of lost time at an average of 36 months after the injury. Benefit delivery expenses include medical cost containment expenses, defense attorney fees and independent medical examination costs.



Two sessions of free recordkeeping training offered

The Department of Labor and Industry (DLI) offers free introductory-level training seminars about OSHA recordkeeping requirements and the OSHA electronic reporting requirements.

Date, times

- June 21, 1 to 3:30 p.m.
- June 29, 9 to 11:30 a.m.

Learn more, register for a recordkeeping seminar

Learn more about OSHA recordkeeping requirements and register for one of the seminars at www.dli.mn.gov/OSHA/Recordkeeping.asp.

If you have questions, call DLI Research and Statistics at (651) 284-5025.



Workers' compensation events calendar

June

- June 13** **Workers' Compensation Advisory Council**
www.dli.mn.gov/Wcac.asp
- June 21** **OSHA recordkeeping basics seminar**
www.dli.mn.gov/OSHA/Recordkeeping.asp
- June 29** **OSHA recordkeeping basics seminar**
www.dli.mn.gov/OSHA/Recordkeeping.asp

July

- July 12** **Rehabilitation Review Panel**
www.dli.mn.gov/Rrp.asp
- July 19** **Medical Services Review Board**
www.dli.mn.gov/Msrb.asp

August

- Aug. 8** **Workers' Compensation Advisory Council**
www.dli.mn.gov/Wcac.asp
- Aug. 23** **Orientation training session**
www.dli.mn.gov/WC/TrainingRp.asp

September

- Sept. 18** **Rehabilitation provider update conference**
www.dli.mn.gov/WC/TrainingRp.asp
- Sept. 19** **Workers' Compensation Insurers' Task Force**
www.dli.mn.gov/Wcitf.asp

Workers' Compensation Advisory Council legislation summary

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

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

Article 1: General

Section 1

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

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

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

Section 2

- Minn. Stat. § 175A.05, Quorum

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

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

Section 3

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

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

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

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

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

Section 4

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

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

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

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

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

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

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

- all requests for a medical or rehabilitation administrative conference under Minn. Stat. § 176.106, regardless of the amount in dispute;
- a motion to intervene in an administrative conference pending at DLI;
- any other document related to an administrative conference pending at DLI;
- an objection to a penalty assessed by the commissioner or DLI;
- requests for medical and rehabilitation dispute certification under section 176.081, subdivision 1, paragraph (c), including related documents; and
- any other document required to be filed with the commissioner, except as provided in subdivision 3 or subdivision 4.

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 6, Data privacy –

Paragraph (a) – All dispute resolution documents filed with or issued by DLI or OAH under the workers' compensation law are private data on individuals and nonpublic data under chapter 13, except that the documents are available to the specified agencies and persons in clauses (1) to (10) (parties to the claim and their attorneys; an intervenor in a dispute; a person who has written authorization from a party to the workers' compensation claim; DLI, OAH and any other person, agency or entity allowed access by law).

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

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

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

Section 5

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

Article 2: Hospital outpatient fee schedule

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

Section 1

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

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

Subd. 2, Applicability –

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

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

Subd. 3, Hospital outpatient fee schedule –

Paragraph (a) – The commissioner must establish the HOFS amounts for services with a J1 or J2 status indicator in Addendum B of Medicare's OPPS and the comprehensive observation services Ambulatory Payment Classification 8011 in Addendum A. The commissioner must publish a link to the HOFS in the *State Register* before Oct. 1, 2018, and place the HOFS on DLI's website.

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

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

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

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

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

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

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

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

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

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

Payment for each service with a J2 status indicator is the amount listed in the HOFS, regardless of the amount charged.

- Payment for services without a Healthcare Common Procedure Coding System (HCPCS) code that are billed with a service with a J2 status indicator is packaged into the payment for the J2 service.
- Payment for drugs with a HCPCS code delivered by injection or infusion is packaged into payment for the injection or infusion service. Payment for drugs not delivered by injection or infusion is the Medicare Average Sales Price (ASP) of the drug when dispensed. The commissioner must publish on DLI's website a link to the ASP most recently available as of the preceding July 1.
- If a bill includes eight or more units of service with HCPCS code G0378 (observation services, per hour) and there is a physician's or dentist's order for observation, payment is the amount listed in the HOFS for Ambulatory Payment Classifications 8011, regardless of the amount charged. All other services billed by the hospital are packaged into the payment amount for code G0378.
- For other services on the same bill as the service with the J2 status indicator, payment is the amount allowed by the relative value fee schedule or, if not covered by the RVFS, 85 percent of the hospital's usual and customary charge.

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

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

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

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

Article 3: Outpatient billing, payment and dispute resolution

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

Section 1

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

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

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

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

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

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

Section 2

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

Subdivision 1, Scope – Section 2 applies to billing, payment and dispute resolution for services provided by an ASC under Article 4 (Minn. Stat. § 176.1363) and by a hospital under Article 2 (Minn. Stat. § 176.1364).

"Insurer" includes a self-insured employer and "services" is as defined in section 176.1364.

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

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

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

Paragraph (c) –

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

Paragraph (d) – ASC or hospital bills must be submitted as required by Minn. Stat. § 176.135, subs. 7 and 7a, and within the time period required by Minn. Stat. § 62Q.75, subd. 3. Insurers must respond to the initial bill

as provided in Minn. Stat. § 176.135, subds. 6 and 7a. Copies of records or reports related to charges are separately payable as provided in section 176.135, subd. 7 (a).

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

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

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

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

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

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

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

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

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

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

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

Article 4: Ambulatory surgical centers

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

Section 1

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

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

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

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

- the ASC's usual and customary charge for all services, supplies and implantable devices; or
- the Medicare ASCPS payment times a multiplier of 320 percent.
 - The 320 percent must be adjusted on July 1 of every year if the conversion factor (dollar multiplier) for the service is less than 98 percent of the conversion factor in effect on the previous July 1, according to a specific formula.
 - The amount payable includes payment for all implantable devices.
 - The 320 percent is annually adjusted; starting July 1, 2019, the conversion factor is less than 98 percent of the conversion factor in effect on the previous July 1.

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

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

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

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

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

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

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

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

Article 5: Workers' compensation benefits

Section 1

- Minnesota Statutes § 176.011, subdivision 15, Occupational disease

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

- a licensed police officer;
- a firefighter;
- a paramedic;
- an emergency medical technician;
- a licensed nurse employed to provide emergency medical services outside of a medical facility;
- a public safety dispatcher;
- an officer employed by the state or a political subdivision at a corrections, detention or secure treatment facility;
- a sheriff or full-time deputy sheriff of any county; or
- a member of the Minnesota State Patrol.

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

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

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

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

Section 2

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

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

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

Section 3

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

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

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

Section 4

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

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

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

Section 5

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

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

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

Section 6

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

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

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

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

Section 7

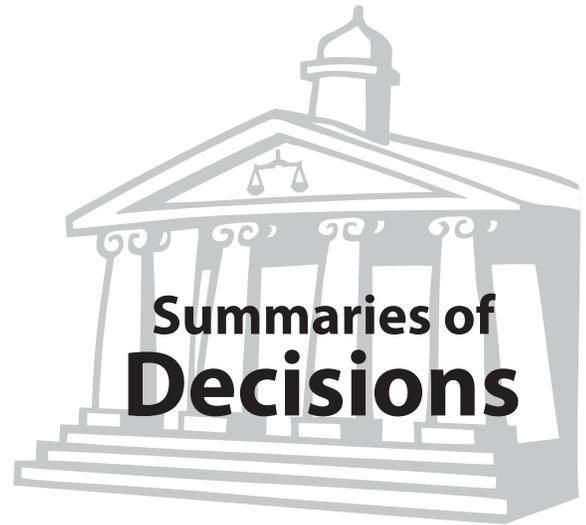
Effective date: Unless otherwise specified, Article 5 is effective for employees with dates of injury on or after Oct. 1, 2018.

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

Workers' Compensation Court of Appeals

January through March 2018

Case summaries published are
those prepared by the WCCA



Kenneth Hinkle v. Ruan Transportation, Inc., Jan. 5, 2018

Jurisdiction – Out-of-state Injury Statute Construed – Minnesota Statutes § 176.041

Where an over-the-road truck driver had a home terminal in Otsego, Minnesota, received routes from a dispatcher in Minnesota, made 19 trips to and from Minnesota in the 10 months before a work-related injury, and picked up and delivered in Minnesota several times, jurisdiction existed in Minnesota for a work-related injury sustained by the employee in Georgia.

Affirmed.

John Devos v. Rhino Contracting, Inc., Jan. 8, 2018

Practice and Procedure

Where material facts remain at issue and there was no stipulated facts by the parties, the compensation judge erred by determining the employee had been recalled in 2012, hired in North Dakota, and by a North Dakota employer, without an evidentiary hearing and by dismissing the employee's claim pursuant to Minnesota Statutes section 176.041, subdivision 5b.

Vacated and remanded.

Pamela J. Beguhl v. Supportive Living Solutions, Jan. 11, 2018

Evidence – Credibility Substantial Evidence

The assessment of credibility is the unique function of the compensation judge and the Workers' Compensation Court of Appeals will not disturb the credibility findings and reasonable inferences taken from those findings on appeal.

Evidence – Expert Medical Opinion

Where the treating physician had enough facts to form a reasonable opinion, and that opinion does not appear to be based upon speculation or conjecture, that opinion was adequately founded and could be relied upon by the compensation judge.

Rehabilitation – Fees and Expenses

Where the qualified rehabilitation consultant (QRC) testified to the actual time spent on providing rehabilitation services, substantial evidence supports the compensation judge's award against unsupported assertions of what time is reasonable.

Rehabilitation – Fees and Expenses

Where the QRC provides medical management to the qualified employee, there is no deduction for those services directed toward medical care for nonwork injuries.

Affirmed, as modified.

Teresa C. Santelli v. Walmart, Jan. 24, 2018

Causation – Substantial Evidence Medical Treatment and Expense Rehabilitation

Substantial evidence, including adequately founded medical opinion, supports the compensation judge's finding that the employee's work injuries of Oct. 11, 2012, and Oct. 12, 2014, were substantial contributing factors of the employee's restrictions, need for treatment and rehabilitation services.

Medical Treatment and Expense – Treatment Parameters Rules Construed – Minnesota Rules 5221.6020, subp. 2

The medical treatment parameters do not apply to treatment related to a work injury after an insurer has denied liability for the injury or has denied medical causation for subsequent symptoms or conditions.

Temporary Total Disability Job Search

Where the employee had been terminated from her employment, was planning to undergo shoulder replacement surgery and vocational rehabilitation services had been discontinued, the compensation judge could reasonably conclude that any job search was effectively rendered futile.

Affirmed.

Wayne A. Armstrong v. Clyde Machines, Inc., Jan. 30, 2018

Settlements – Interpretation

The compensation judge properly concluded that the referral to a pain clinic did not constitute treatment closed out under the language of the settlement agreement.

Affirmed.

Marilyn C. Azuz v. Vescio's, Feb. 1, 2018

Causation – Substantial Evidence

Substantial evidence, including expert opinion and medical records, supports the compensation judge's decision that the employee's 2013 work injury was not a substantial contributing cause of her need for a five-level fusion surgery and to certain claimed disability benefits.

Permanent Partial Disability

An error in identifying a treating physician's permanency rating does not require further proceedings where the compensation judge found that the work injury was temporary and resolved and the medical records support a reasonable inference that any continuing pain arose from the employee's pre-existing degenerative back condition.

Affirmed, vacated in part.

Steven R. Weber v. Jake Bauerly, Feb. 8, 2018

Permanent Partial Disability – Substantial Evidence

Substantial evidence, including adequately founded expert medical opinion, supports the compensation judge's determinations of the employee's permanent partial disability ratings.

Affirmed.

Sheila S. Grabosky v. I.S.D. 720, Feb. 9, 2018

Causation – Temporary Aggravation – Substantial Evidence

Substantial evidence, in the form of expert medical opinion, medical records and lay testimony, supported the compensation judge's finding that the employee's Feb. 9, 2016, work injury was a temporary aggravation of her pre-existing condition and that it resolved by March 1, 2016.

Affirmed.

Charlotte M. Wilson v. Twin Town Logistics, Feb. 9, 2018

Attorney Fees – Roraff Fees – Excess Fees

Where the compensation judge properly applied the factors set out in Irwin v. Surdyk's Liquor, 599 N.W.2d 132, 59 W.C.D. 319 (Minn. 1999), and did not abuse her discretion, her determination of excess fees is affirmed.

Affirmed.

Yusuf M. Ahmed v. Loop Parking Co., Feb. 13, 2018

Causation – Substantial Evidence

Substantial evidence in the record, including medical records and well-founded expert opinion, supports the compensation judge's denial of the employee's claims for payment of medical expenses and a repeat MRI scan.

Affirmed.

Sharquita Guyton v. Hennepin County Medical Center and Hennepin County, Feb. 13, 2018

Evidence – Admission

The compensation judge did not abuse his discretion by excluding the employee's proposed post-hearing exhibits as untimely.

Wages – Calculation

Due to the employee's consistent working of overtime, calculation of the employee's average weekly wage by averaging the employee's actual earnings over the 26 weeks prior to the work injury was appropriate.

Affirmed.

Peter Dahl v. Rice County, March 5, 2018

Rehabilitation – Retraining

Substantial evidence in the record, including testimony of the employee, records, reports and testimony of the qualified rehabilitation consultant, and the report and testimony of a vocational expert, supports the compensation judge's conclusion that the employee is a candidate for retraining and that the proposed retraining plan is reasonable.

**Evidence – Admission
Practice and Procedure**

The compensation judge's decision to admit previously undisclosed vocational records, and to continue the hearing so as to allow review and rebuttal of said records and the submission of deposition testimony of later witnesses, was not an abuse of discretion.

Affirmed.

Corey C. Miller vs. Valley Paving, Inc., March 6, 2018

Causation – Permanent Injury

Substantial evidence, including expert medical opinion, medical records and lay testimony, supported the finding that the employee's work injury was permanent in nature.

Affirmed.

Maija M. Karkanen v. University of Minnesota, March 14, 2018

Vacation of Award – Substantial Change in Condition

Where the employee failed to provide any evidence to demonstrate the existence of a causal relationship between the work injury and her present condition, we conclude the employee has failed to show cause sufficient to vacate the award on stipulation on the grounds of substantial change in condition.

Denied.

Judith A. Weiss v. St. Mary's Medical Center, March 15, 2018

Causation – Gillette Injury

Substantial evidence, including expert medical testimony, medical records and lay testimony, supported the compensation judge's Gillette injury findings.

Temporary Partial Disability – Substantial Evidence

Substantial evidence, including the employee's testimony and medical records, supported the compensation judge's finding that the employee was eligible for temporary partial disability compensation.

Wages

Practice and Procedure – Matters at Issue

Where the issue of whether to include the employee's wages from her second job at Walmart in her weekly wage was not raised at the hearing, the compensation judge did not err in leaving that question open for future determination.

Affirmed.

Lynn M. Mellgren v. Minnesota Department of Corrections, March 21, 2018

**Causation – Temporary Aggravation
Substantial Evidence**

Substantial evidence, including adequately founded expert medical opinion, supports the compensation judge's finding that the employee's January 2016 work injury was not a substantial contributing factor to her current right knee condition or need for treatment.

Affirmed.

Thomas E. Colton v. Bloomington Plating, March 26, 2018

Rules Construed – Minnesota Rules 5221.4070

Under Minnesota Rules 5221.4070, subp. 5, where a workers' compensation payer contracts with a network of pharmacies and the contract provides for a different reimbursement amount, the maximum allowed fee provisions of Minn. R. 5221.4070, subps. 3 and 4, do not apply.

Affirmed.

Maria Perez v. Swift Pork Co./JBS USA LLC, March 26, 2018

Causation – Substantial Evidence

Where the employee did not raise the issue of misinterpretation of material testimony by the court-appointed interpreter at the hearing, the employee was able to adequately describe her work activities to the judge and medical evidence indicates the employee's work injury was temporary, substantial evidence supports the compensation judge's denial of benefits.

Affirmed.

Donald Cornelius v. Woods Landscaping, Inc., March 28, 2018

Temporary Partial Disability Compensation – Substantial Evidence

Substantial evidence, including expert medical opinion, medical records and lay testimony, supported the compensation judge's denial of temporary partial disability compensation for the periods requested.

Temporary Total Disability Compensation – Substantial Evidence

Substantial evidence, including expert medical opinion, medical records and lay testimony, supported the compensation judge's denial of temporary total disability compensation for the periods requested.

Affirmed.

Daniel Loos v. White Bear Lake Superstore, Inc., March 28, 2018

Evidence – Credibility

The assessment of credibility is the unique function of the compensation judge, and any claim that the employee's past conduct renders the employee's testimony not credible is to be resolved by the compensation judge.

Job Offer – Refusal

An employee's refusal of a job offer does not support denial of temporary total disability benefits where the performance of necessary job duties are outside of the employee's medical restrictions.

Affirmed.

Gillette Injury – Substantial Evidence

Substantial evidence, including adequately founded expert medical opinion, supports the compensation judge's finding that the employee sustained a cervical spine Gillette injury.

Affirmed.