Minnesota Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221
St. Paul, MN 55164-0221

An employee's guide to the Minnesota workers' compensation system

Update: Online claims portal available

The Department of Labor and Industry (DLI) now has an online workers' compensation claims portal, Work Comp Campus, to make your claim information accessible to you on computers, tablets and smartphones – 24 hours a day, seven days a week.

Employees who choose to use Campus
You are not required to use Campus, but can create an account with a simple login at www.campus.dli.mn.gov.

For information about Campus, visit www.dli.mn.gov/business/workers-compensation/work-comp-campus.

Get help
For help with Campus or your claim, contact the Workers' Compensation Division Help Desk at:

- 651-284-5005 (press 3);
- 800-342-5354 (press 3); or
- helpdesk.dli@state.mn.us.

DEPARTMENT OF LABOR AND INDUSTRY

Workers' Compensation Division
P.O. Box 64221, St. Paul, MN 55164-0221
651-284-5005 • 800-342-5354
www.dli.mn.gov

In this guide

This guide briefly explains how current Minnesota laws apply to work-related injuries or illnesses occurring on or after Oct. 1, 1995. *This is not a full description of the workers' compensation system*. Please refer to the text of the law or call the Alternative Dispute Resolution (ADR) unit at the Department of Labor and Industry (DLI) for detailed information. Telephone numbers and addresses for ADR are listed on page 14 of this booklet.

Helpful hints for injured workers

- Save copies of all claim-related documents, letters, forms, benefit checks and medical bills, especially the ***First Report of Injury*** form.
- Keep track of your mileage and parking fees for medical visits, vocational rehabilitation services and job-search visits.
- Save notes of phone conversations.
- Put your name, Social Security number or worker identification (WID) number, date of injury, employer and insurance company on all papers and forms you send to DLI's Workers' Compensation Division.
- Keep your employer informed about your recovery and plans to return to work.
- Call DLI's ADR unit if you have any questions, at 651-284-5032 or 800-342-5354.

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Office of Administrative Hearings; the Workers' Compensation Court of Appeals; the Department of Health; the Department of Revenue; and the Workers' Compensation Reinsurance Association.

Workers' compensation claim files closed in 1993 or after are available for review. To review your file or have copies made, call at 651-284-5200. There is a fee for copies and prepayment is required.

Fraud

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 Minnesota Statutes §609.52, subdivision 3.

Contact the Minnesota Department of Commerce's Fraud Prevention unit about possible workers' compensation fraud at 888-372-8366.

Who can answer my questions?

Your employer or your employer's insurance company can answer most questions about your claim. If you need more help or if you feel you do not understand something about the workers' compensation process, call DLI's ADR unit between 8 a.m. and 4:30 p.m., Monday through Friday. More information is on the DLI website at www.dli.mn.gov.

Twin Cities area and southern Minnesota
Minnesota Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221, St. Paul, MN 55164-0221
651-284-5032 or 800-342-5354

Duluth and northern Minnesota
Minnesota Department of Labor and Industry
Workers' Compensation Division
525 Lake Ave. S., Suite 330, Duluth, MN 55802
218-733-7810 or 800-342-5354

– simple or complex – can be resolved to the satisfaction of all concerned parties. For further information, call ADR or visit the DLI website (see page 14 for contact information).

If your medical benefits are provided through a certified managed care plan, you must first use the managed care plan's dispute-resolution process to resolve disagreements about medical care. The managed care plan must respond to you within 30 days after you notify them, in writing, of a problem.

Some unions and employers, especially in the construction industry, have specific procedures that must be followed when resolving disputes. Contact your union representative for further information.

Records privacy

State claim files

Besides state agency staff members, the contents of your workers' compensation file can be examined only by: you (the employee); your employer at the time of injury; your employer's insurer; an agent of the employer or insurer; the dependents of an employee who has died; or anyone else with written permission from the employee or dependents.

To further protect your identity, the Department of Labor and Industry assigns a unique two- to eight-digit number to claims, the worker identification – or WID – number. DLI will only use the WID number on outgoing correspondence. You will not have to know your WID number to ask DLI questions about your claim, but the department wants you to be aware of WID number use.

If you contact DLI about your workers' compensation claim, you may be asked to provide private or confidential data to better assist you. You may refuse to provide the data, but then DLI may not be able to assist you with your question or problem. Any private or confidential data you provide will be used by department staff members who have authorized access to the data; it may also be used for state investigations and statistics. The data may be made part of the department's file for your claim; therefore, it 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

Important information for your claim

Use this page to keep important names and telephone numbers.

Date of injury _____

Your insurance claim number _____

Your WID number* (when assigned) _____

Insurance company name _____

Claim adjuster's name _____

_____

Claim adjuster's phone number _____

Managed care plan (if applicable) _____

Doctor's name _____

Doctor's phone number _____

Qualified rehabilitation consultant (QRC) name _____

_____

QRC's phone number _____

Other names and phone numbers _____

_____

_____

_____

_____

*DLI recommends you use your WID number when contacting DLI about your claim. DLI avoids the use of your Social Security number whenever possible in identifying your claim.

What is workers' compensation?

Minnesota workers' compensation law states all employers are required to purchase workers' compensation insurance or become self-insured. The workers' compensation system provides benefits if you become injured or ill from your job. Workers' compensation covers injuries or illnesses caused or made worse by work or the workplace. Workers' compensation benefits are paid regardless of any fault of either the employer or employee. Your employer pays the cost of the insurance.

Workers' compensation pays for:

- medical care related to the injury, as long as it is reasonable and necessary;
- wage-loss benefits for part of your income loss;
- benefits for permanent damage to a body function;
- benefits to your dependents if you die of a work injury;
- vocational rehabilitation services if you cannot return to your job or to the employer you had before your injury; and
- travel mileage to obtain medical treatment and/or for certain vocational rehabilitation activities.

How are workers' compensation benefits paid?

Benefits are paid by your employer's insurance company or by your employer (if self-insured). State law sets the benefit levels. Employers must display the "Employee Rights and Responsibilities" poster, which includes the name of the employer's workers' compensation insurer. If you cannot find the poster at your workplace or if the insurer's name is not on it, ask your employer.

The DLI website offers a search tool for verifying workers' compensation insurance coverage at www.inslookup.doli.state.mn.us. If you cannot find an employer by using the search tool, contact Insurance Verification at 651-284-5170 or at dli.scf@state.mn.us to request insurance coverage verification about any employer in the state.

Retraining

- Your rehabilitation plan may include retraining. Retraining is a formal course of study designed to assist an injured worker's return to suitable gainful employment.
- For dates of injury from Oct. 1, 1995, through Sept. 30, 2000, you must file a request for retraining with the department before you receive 104 weeks of any combination of temporary total disability and temporary partial disability benefits.
- For dates of injury between Oct. 1, 2000, and Sept. 30, 2008, you must file a request for retraining with the department before 156 weeks of any combination of temporary total disability and temporary partial disability benefits are paid.
- For dates of injury on or after Oct. 1, 2008, you must file a request for retraining with the department before 208 weeks of any combination of temporary total disability and temporary partial disability benefits are paid.
- Retraining benefits are limited to 156 weeks. Your QRC is responsible for preparing your retraining plan. It must be approved by the insurer and by the Department of Labor and Industry.

Problems with your claim

Most workers' compensation claims are paid without any problems. If you have questions or if you feel you are not receiving the correct benefits, follow these steps.

1. Call the insurance claims adjuster. Write down the date, time and adjuster's name for your records. Explain the problem and try to work it out. Many problems can be fixed with a telephone call.

2. Discuss your problem with an Alternative Dispute Resolution specialist at the Department of Labor and Industry (see page 14 for contact information). The Alternative Dispute Resolution specialist will try to help resolve your problem. If your problem has not been resolved, the specialist can explain the dispute-resolution process and provide information to help you decide the best way to resolve your problem.

The Department of Labor and Industry offers mediation services for resolving disputes about workers' compensation claims. Mediation is a free, informal process where trained, experienced workers' compensation mediators offer the parties a quick, cost-effective means by which any issue

The QRC will work with you, your employer and the insurer to plan the services you need to return to suitable gainful employment.

If you disagree about your eligibility for rehabilitation services or if you disagree about the rehabilitation plan, you may call DLI's ADR unit; if they cannot resolve your problem, they will instruct you about how to file a ***Rehabilitation Request*** form to seek assistance.

Disability case management; vocational rehabilitation services

If an insurer has been granted a waiver for vocational rehabilitation services or if you are not qualified for statutory rehabilitation services, your employer or insurer may assign a disability case manager (DCM) – sometimes just referred to as a case manager – to work with you instead of a QRC. The employer or insurer might ask the DCM to communicate with you, your health care provider(s), your employer and the insurer to help you successfully return to work and/or to coordinate medical treatment.

A DCM is not a rehabilitation provider, as defined by rule, and is not necessarily bound by all of the statutes and rules pertaining to QRCs. To avoid confusion and understand the role of the individual you are working with, clarify whether you are working with a QRC or a DCM. Although there is no law that requires you to work with a DCM, a DCM can be a helpful resource in coordinating medical treatment or assisting your return to work. As noted in the previous section, you may ask for a vocational rehabilitation consultation with a QRC at any time, even if you are working with a DCM. A person who worked with you as a DCM may not be your QRC. If you disagree about your eligibility for rehabilitation services or have questions about a DCM, call DLI's ADR unit for additional information.

Choosing a qualified rehabilitation consultant

Find a list of QRCs in your area at www.dli.mn.gov.

For a rehabilitation consultation, the insurer may refer you to a QRC or you may choose your own. If you do not choose the QRC for your consultation, you have up to 60 days after a rehabilitation plan is filed to request a different QRC. You may be entitled to change QRCs at other times as well. Call DLI's ADR unit if you would like more information.

What happens when I am injured on the job?

- Don't wait. Report your injury to your supervisor as soon as possible You may lose the right to workers' compensation benefits if you do not report the injury within time frames set by law.
- Your employer must complete the ***First Report of Injury*** form.
- The employer has 10 days from its knowledge of a lost-time claim to report it to the employer's insurance company.
- If your disability lasts for more than three days, the insurer must file the *First Report of Injury* form with the Department of Labor and Industry. See page 7 for an explanation of disability.
- Your employer or its insurer must provide you with a copy of the *First Report of Injury*. A copy of the *First Report of Injury* in a lost-time claim must also be sent to your union, if there is one.
- The employer must give you the ***Minnesota Workers' Compensation System Employee Information Sheet*** at the time you are given a copy of the *First Report of Injury* form.
- After you have reported the injury, the insurer will investigate your claim to verify it was work-related.
- You should keep your employer informed of your medical condition and any work restrictions.
- **You must notify the insurer of changes in your employment status and keep your employer and the insurer informed of your ability to work.**

If the insurer accepts your claim for benefits the following happens.

- The insurer must send you a copy of the ***Notice of Insurer's Primary Liability Determination*** form stating your claim is accepted.
- The insurer must start paying wage-loss benefits within 14 days of the day your employer was informed about your work injury and lost wages. The insurer must pay benefits at the same intervals you were paid wages.
- For injuries between Oct. 1, 2000, and Sept. 30, 2008, after you have been paid 52 weeks of temporary total disability benefits, the insurer must notify you in writing of the 104-week limitation on payment of this benefit.
- For injuries on or after Oct. 1, 2008, after you have been paid 52 weeks of temporary total disability benefits, the insurer must notify you in writing of the 130-week limitation on payment of this benefit.
- Before 80 weeks of wage-loss benefits have been paid, the insurer must notify you of the time limit for you to request retraining (see page 12 for the time limits).

If the insurer denies your claim for benefits the following happens.

- The insurer must send you a copy of the ***Notice of Insurer's Primary Liability Determination*** form stating denial of primary liability for your claim. The form must clearly explain the facts and reasons the insurer is using to deny your claim.
- If you disagree with the denial, you should talk with the insurance claims adjuster who is handling your claim. Read "Problems with your claim" on page 12 for information about how to resolve disputes.
- If you need help returning to work but your claim has been denied, call the department's Vocational Rehabilitation unit at 651-284-5038 or 888-772-5500 and ask for a rehabilitation consultation.

What health care benefits are available?

- If your claim is accepted, payment will be made for the cost of all reasonable and necessary health care treatment related to your work injury.
- Treatment by certain unlicensed complementary and alternative health care providers is not paid.
- Prescriptions and reimbursement for mileage to medical appointments are also payable.
- The insurer may designate a pharmacy or pharmacies that you must use to obtain medicine for your injury, if the pharmacy is within 15 miles of your home.
- You may choose your own health care provider under most circumstances. See "What is a certified managed care plan?" on page 6 for exceptions.
- Make sure your health care provider sends all bills and supporting information to the insurer. The supporting information must explain how the treatments and charges relate to your work injury.
- Your health care provider must notify the insurer before you have any surgery or hospitalizations, except in an emergency. You or the insurer may ask for a second opinion for any surgery that is not an emergency. The insurer must pay for the second opinion. You cannot be forced to have surgery if you do not want it.
- Your health care provider cannot bill you for treatment unless the insurer determines the treatment was not related to an accepted work injury.

Workers with injuries occurring on or after Oct. 1, 2013, are eligible for annual cost-of-living adjustments starting three years after the injury date, with the maximum annual adjustment limited to three percent.

Vocational rehabilitation services

You may be eligible for vocational services if:
- you need help returning to work because of your injury; and
- your employer is unable to offer you suitable gainful employment within your work restrictions.

Vocational rehabilitation services are planned by you, the employer/insurer and a qualified rehabilitation consultant (QRC). These services are:
- modifying job duties to fit abilities;
- finding work with a different employer if yours does not have suitable work available; and
- training for a new job.

How do I ask for vocational rehabilitation?

You may ask for vocational rehabilitation at any time. If you think vocational rehabilitation services will be helpful, write to the insurer to request a rehabilitation consultation with a QRC.

Insurers must file a ***Disability Status Report*** form with the department:
- when rehabilitation services are requested by you, your employer or the insurer;
- when it becomes known you will be unable to return to work for at least 13 weeks; or
- when 90 days have passed since your injury and you have not returned to work.

On the ***Disability Status Report*** form, the insurer must either refer you for a rehabilitation consultation or request that the department waive vocational rehabilitation services.

A QRC conducts a vocational rehabilitation consultation to determine whether you are eligible for rehabilitation services. If you are eligible, the QRC will write a rehabilitation plan and coordinate rehabilitation services.

If you object to the proposed discontinuance, you may talk to the insurer, contact ADR, request a conference (this must be done within 12 days) or start an objection procedure. Benefits usually must be paid through the date of the conference. (See page 14 for contact information.)

Permanent total disability (PTD) benefits

- If a work injury or illness prevents you from ever returning to a steady job and earning a living from work, you may be eligible for PTD benefits.
- You need a certain level of permanent disability, depending on your age and education, to be considered for PTD benefits.
- The PTD benefit amount is two-thirds of the gross weekly wage you were earning at the time you were injured.
- The amount of these benefits is determined by the law in effect on the date of injury.

Permanent partial disability (PPD) benefits

- PPD benefits compensate for permanent loss-of-use of a body part.
- These benefits are paid after temporary total disability ends, at approximately the same rate and intervals.
- You may request payment of PPD in a lump sum. The lump sum can be discounted to present value with up to a five percent discount factor.

Death/dependency benefits

- The spouse, children and/or other dependents of a worker who dies because of a work-related accident or occupational illness are eligible for dependency benefits.
- Workers' compensation insurance also pays burial expenses. For dates of injury on or after April 28, 2000, the maximum amount is $15,000.
- For injuries on or after April 28, 2000, payment is made to the estate, if the deceased has no dependents.

Cost-of-living adjustments

Cost-of-living adjustments for wage-loss benefits are determined by the law in effect on the date of the injury. Workers with injuries occurring on or after Oct. 1, 1995, are eligible for annual cost-of-living adjustments starting four years after the injury date, with the maximum annual adjustment limited to two percent.

What is a certified managed care plan?

Some employers participate in a workers' compensation certified managed care plan. A certified managed care plan is an organization that has been certified by the state to manage health care for injured workers. Your employer must tell you if you are covered by a certified managed care plan. Some employers or insurers have contracted with a managed care plan or network of doctors who are not certified by the department. You are not required to receive treatment from a doctor in a plan or network that is not certified.

If you are covered by a workers' compensation certified managed care plan:

- your employer must post a notice that shows how to get treatment using the managed care plan and provide the name and phone number of a contact person;
- you may ask the employer, the insurer or the certified managed care plan staff for a list of providers in the plan; and
- a medical case-manager might be assigned to coordinate the delivery of health care for your injury.

You must go to a provider in the certified managed care plan *unless*:

- you need emergency medical care;
- you want to receive care from another health care provider who is able to treat your injury and has treated you at least twice in the past two years or who has a documented history of treating you; or
- you live or work too far from a health care provider in the plan. (There is a 30-mile limit in the seven-county Twin Cities area and a 50-mile limit in all other areas.)

What are independent medical examinations?

The insurer may ask you to be examined by a health care provider of its choice. The examination is often called an independent medical examination (IME). The insurer may suspend your benefits if you refuse to be examined by that doctor. The insurer must reimburse you for mileage and other costs for attending the examination.

What monetary benefits are available?

Disability begins on the first calendar-day or fraction of a calendar-day that you are unable to work. By law, no wage-loss benefits are paid for the first three calendar-days after the disability begins. If the disability continues, even if intermittently, for 10 calendar-days or longer, the compensation is owed from the first day you were unable to work.

Temporary total disability (TTD) benefits

- TTD benefits are paid if you are unable to work due to your work injury.
- TTD benefits are equal to two-thirds of your gross weekly wage at the time of injury (with maximum and minimum limits).
- The maximum and minimum amounts payable are determined by the law on the date of the injury.

- TTD benefits are paid a maximum number of weeks depending on the date of injury. For injuries from Oct. 1, 1995, through Sept. 30, 2008, 104 weeks; for injuries on or after Oct. 1, 2008, 130 weeks. They may be paid longer if you are in an approved retraining program.
- These benefits are paid at the same intervals as your wages were paid before the injury.

For dates of injury from Oct. 1, 1995, through Sept. 30, 2000

Maximum weekly rate	$615
Minimum weekly rate	$104 (or the actual weekly wage, whichever is less)
Maximum number of weeks	104

For dates of injury from Oct. 1, 2000, through Sept. 30, 2008

Maximum weekly rate	$750
Minimum weekly rate	$130 (or the actual weekly wage, whichever is less)
Maximum number of weeks	104

For dates of injury on or after Oct. 1, 2008, through Sept. 30, 2013

Maximum weekly rate	$850
Minimum weekly rate	$130 (or the actual weekly wage, whichever is less)
Maximum number of weeks	130

For dates of injury on or after Oct. 1, 2013

Maximum weekly rate	102 percent of statewide average weekly wage for the period ending Dec. 31 of the preceding year
Minimum weekly rate	$130 (or the actual wage, whichever is less)
Maximum number of weeks	130

TTD benefits generally end when:

- the maximum number of weeks of TTD benefits have been paid and you are not in an approved retraining program;

- you have returned to appropriate work;
- 90 days have passed since you were notified that you have reached maximum medical improvement;
- 90 days have passed since the completion of an approved retraining plan;
- you do not cooperate with an approved rehabilitation plan;
- you are able to work, but refuse gainful work within your physical restrictions;
- you are able to work with restrictions, but fail to diligently search for appropriate work;
- you are able to work, but withdraw from the labor market;
- your health care provider releases you to work without any physical restrictions caused by the work injury; or
- you retire for reasons other than your injury.

You have an obligation to inform the insurer if you return to any sort of work. The insurer may propose to discontinue your TTD benefits if you fail to diligently search for appropriate work within your physical restrictions.

Temporary partial disability (TPD) benefits

- TPD benefits are paid if your work injury results in a lower weekly wage than you earned at the time of injury.
- Payment is two-thirds of the difference between your average gross weekly wage at the time of the injury and your current gross weekly earnings.
- The maximum amount payable is determined by the law that is in effect on the day of the injury.
- For injuries on or after Oct. 1, 1992, you cannot be paid more than 225 weeks of TPD benefits or receive such benefits after 450 weeks beyond the date of injury. For injuries on or after Oct. 1, 2018, you cannot be paid more than 275 weeks of TPD benefits or receive such benefits after 450 weeks beyond the date of injury. However, if you are in an approved training program and are working at a wage loss during retraining, the TPD paid does not count against the 225-, 275- or 450-week limit.

Procedure for discontinuing wage-replacement benefits

Your employer or insurer must provide you with a written notice of its intention to suspend or discontinue benefits and file a copy of the notice with the department. The notice must indicate the proposed date of discontinuance and clearly indicate the reason, with all documentation of supporting facts attached.