MAJ 2023 Proposed Legislative Changes

JUSTICE

MINNESOTA ASSOCIATION FOR JUSTICE

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DLI Legislative Proposal

We agree to the Department's legislative proposal to amend 176.081, except that the insurance company reimburses any cost associated with the request for additional information. This addition would be included in line 28-29.

Proposal #1: Improve Efficiency

Problem: The current process does not provide quick and efficient treatment to injured workers.

Solution:
Amend MN. Stat 176.081; MN. Stat 176.135; MN. Stat 176.155.

We agree to the Department's legislative proposal to amend 176.081, except that the insurance company reimburses any cost associated with the request for additional information. This addition would be included in line 28-29.

176.135 TREATMENT; APPLIANCES; SUPPLIES.
…
Subd. 1a. Nonemergency surgery; second surgical opinion. The employer is required to furnish surgical treatment pursuant to subdivision 1 when the surgery is reasonably required to cure and relieve the effects of the personal injury or occupational disease. An employee may not be compelled to undergo surgery. If an employee desires a second opinion on the necessity of the surgery, the employer shall pay the costs of obtaining the second opinion. Except in cases of emergency surgery, the employer or insurer may require the employee to obtain a second opinion on the necessity of the surgery, at the expense of the employer, before the employee undergoes surgery. Failure to obtain a second surgical opinion shall not be reason for nonpayment of the charges for the surgery. The employer is required to pay the reasonable value of the surgery unless the commissioner or compensation judge determines that the surgery is not reasonably required. If the insurer requests an Employer Physician Examination, the insurer must:

(i)notify the employee of the examination within 5 working days of the request for surgery;

(ii) conduct the second opinion examination within 45 days of the determination to conduct the examination, and;

(iii) serve the report of the examination upon the employee, and the employee's attorney if any, within 14 days of the examination. An extension up to 30 days may be allowed for good cause only if the request for an extension is made prior to expiration of the original 14 day period.

…
176.155 EXAMINATIONS.

Subdivision 1. Employer's physician. The injured employee must submit to examination by the employer's physician, if requested by the employer, and at reasonable times thereafter upon the employer's request. Examinations shall not be conducted in hotel or motel facilities. The examination must be scheduled at a location within 150 miles of the employee's residence unless the employer can show cause to the department to order an examination at a location further from the employee's residence. The employee is entitled upon request to have a personal physician or witness present at any such examination. Each party shall defray the cost of that party's physician. Any report or written statement made by the employer's physician as a result of an examination of the employee, regardless of whether the examination preceded the injury or was made subsequent to the injury, shall be made available, upon request and without charge, to the injured employee or representative of the employee. Any report or written statement made by the employer's physician must be served upon the employee and the employee's attorney within 14 days of the issuance of the report, and no later than 60 days following the date of the examination. All reports generated as a result of an examination by the employer's physician shall be served upon the employee and the employee's attorney. The employer shall pay reasonable travel expenses incurred by the employee in attending the examination including mileage, parking, and, if necessary, lodging and meals. The employer shall also pay the employee for any lost wages resulting from attendance at the examination. A self-insured employer or insurer who is served with a claim petition pursuant to section 176.271, subdivision 1, or 176.291, shall schedule any necessary examinations of the employee, if an examination by the employer's physician or health care provider is necessary to evaluate benefits claimed. The examination shall be completed and the report of the examination shall be served on the employee and filed with the commissioner within 120 days of service of the claim petition.

No evidence relating to the examination or report shall be received or considered by the commissioner, a compensation judge, or the court of appeals in determining any issues unless the report has been served and filed as required by this section, unless a written extension has been granted by the commissioner or compensation judge. The commissioner or a compensation judge shall extend the time for completing the adverse examination and filing the report upon good cause shown. The extension must not be for the purpose of delay and the insurer must make a good faith effort to comply with this subdivision. Any request for extension must be presented within the 120 day period. Good cause shall include but is not limited to:

(1) that the extension is necessary because of the limited number of physicians or health care providers available with expertise in the particular injury or disease, or that the extension is necessary due to the complexity of the medical issues, or

(2) that the extension is necessary to gather additional information which was not included on the petition as required by section 176.291.

Good cause does not include, and is not limited to:

(1) Failure to take a good faith effort to solicit an employer physician prior to the 120 days following the filing of a claim petition.

(2) Failure to solicit an employer physician because the employee's claims are allegedly unknown.

(3) Failure to solicit an employer physician because the physician is not available within the 120 days, while other physicians of equal expertise are available. Proof is necessary to show that other physicians are not available.

Rationale

With the requested statutory changes, our main objective is to allow the quick and efficient delivery of medical benefits to injured workers.[1] The statute, as written, is causing significant delay and harm to injured workers trying to obtain necessary medical treatment. Unfortunately, the statutes fail to adequately provide timelines for when certain actions need to be accomplished to approve medical treatment. As a result, injured workers are suffering permanent damage as they have been unable to obtain treatment in a reasonable time. This also creates early involvement of attorneys and inconsistent decisions regarding the Certification of Disputes with DOLI. We want to prevent this.

Example

The typical example is the injured worker with an admitted injury who gets a recommendation for surgery. Assume that this example it is for outpatient surgery. We understand there can be delays in getting the order to the insurance company, but for this example, assume the order is provided immediately to the insurer. **How long should the injured worker wait for a response?** Again, for this example, assume the injured worker waited two weeks. The injured worker calls/emails the adjuster with no response. The adjuster has not communicated with the injured worker regarding the status of the surgery request. The injured worker is in pain and is being told that if they do not get the surgery, there could be permanent damage. Private health insurance will not approve the surgery as there is no "denial" from workers' compensation.

[1] MN § 176.001, "It is the intent of the legislature that chapter 176 be interpreted so as to assure the quick and efficient delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter."

Eventually, the injured worker reaches out to an attorney.[2] The attorney hesitates to help as there is not yet a clear "dispute" or "denial" for which an attorney fee can be claimed and costs recovered. Regardless, the injured worker retains the attorney. A week later, the attorney confirmed the surgery order has been provided to the insurance company. The attorney requests the surgery order and files a Request for Certification[3] with the Minnesota Dept. of Labor and Industry. Another week goes by, and DOLI responds with the following:

> This notice acknowledges receipt of your request for assistance in resolving a workers' compensation dispute.
>
> You requested the employer/insurer provide prior authorization of and payment for a total shoulder replacement recommended by Dr. [redacted].
>
> **A dispute is not certified. The insurer has elected to have an IME to address this issue, and is in the process of scheduling the IME. Therefore, certification of dispute is premature. If a dispute exists after receipt of the IME report, a new Request for Certification may be filed.**

Unfortunately, the insurer fails to provide a date for an AME[4] or when one will be scheduled. **Again, how long does an insurer have to schedule an AME and complete it?** Several weeks go by with no response. Eventually, a letter arrives indicating that the insurer has scheduled an AME, but it is scheduled for 3 months out. From this example, more than 5 months will have passed before an IME occurs. **Once again, how long does the AME doctor have to get the report done? When can the matter finally be certified? When can a Medical Request be filed and a conference held? When will the injured worker get approval or denial to schedule the surgery?**

As you can see, the statute and the rules leave many unanswered questions, leaving injured workers uncertain about when things will be accomplished. These situations not only cause physical, emotional, and financial harm to injured workers, but it also causes harm to the system. Due to delayed medical treatment and recovery periods, insurers are forced to pay for additional medical treatment, wage loss, and rehabilitation benefits, which could have been avoided with timely approval or denial of medical treatment. Overall, the system is negatively affected.

Minn. Stat 176

While Minnesota Statute 176 requires that the employer and insurer pay for all reasonable, necessary, and causally related medical treatment, it fails to lay out how an injured worker

[2] Injured worker could reach out to an Ombudsman at DOLI, but they too have no legal authority to require the insurer take action. https://www.dli.mn.gov/business/workers-compensation/work-comp-ombudsman.
[3] https://www.dli.mn.gov/workers/workers-compensation/work-comp-alternative-dispute-resolution-services
[4] AME is an "adverse medical examination." The statute does not refer to AME or IME (Independent medical examination) but instead "Employer's Physician." MN DOLI and other stakeholders typically refer to it as an IME although it is not independent and both sides do not agree on the chosen physician. Under the statute, there are "Neutral Physicans" but those selected by all parties.

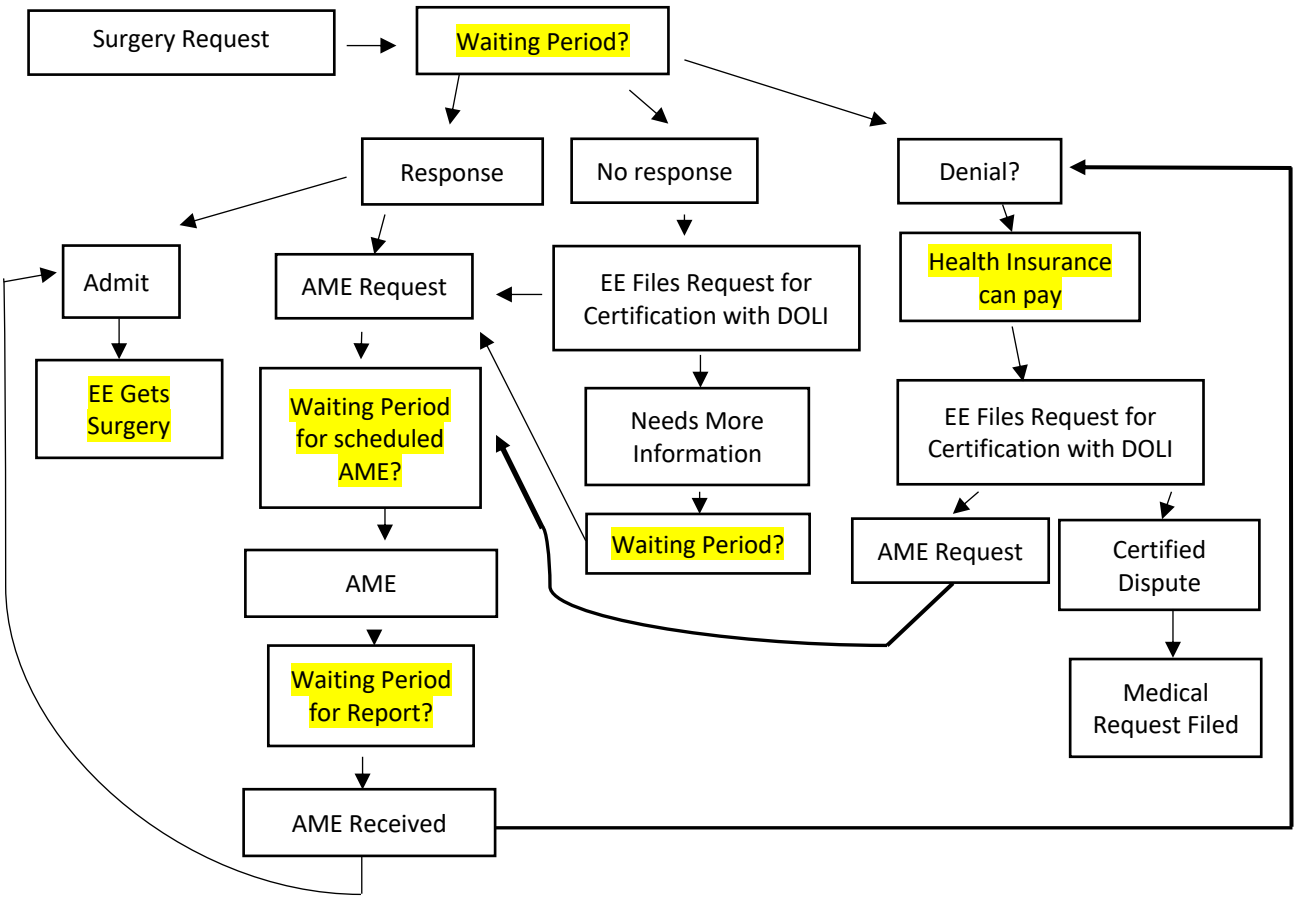
goes about getting approval and payment of that treatment. For example, under 176.135 the subdivision discusses nonemergency surgery and second surgical opinions, but provides very little, if any, guidance as to how a healthcare provider or an injured worker goes about getting approval for treatment. Additionally, it does not place any deadlines or timeframes on an employer and insurer to respond to a request for treatment or to even obtain an AME. Instead, guidance is left to DOLI's rule making process.

There must also be accompanied changes to Minn. Rule 5221.6050, Subp 9.

Public Policy and Improvements to the System

We have learned that some may question whether this problem needs to be corrected. Presumably, this is because those questioning would only be involved after DOLI has decided to certify the dispute. As with the example above, DOLI does not certify the matter until after an IME has been completed. Again, this can be months from the time of the treatment recommendation. Also, a defense attorney would most likely not get involved until after a Medical Request has been filed, which can be months from the original order. See the example below. Sadly, this is a problem, and it is problem that can be solved.

Example 1:



that the delay and unknowns can cause a tremendous amount of emotional stress on an injured worker. As the example above illustrates, an injured worker is left with ambiguity for every surgical request. To make matters more confounding, no one, including DOLI employees, can tell an injured worker when they will receive a denial or an agreement to pay for surgery when a surgery order is submitted. We find this unacceptable.

A 2013 MN DOLI study, *Workers' Perspectives on Settlements and Hearing*, revealed that most of those surveyed were concerned with the length of the process and workers' need for more information. One of the other startling comments was about the "fairness of the system" where insurers can achieve their goals by putting pressure on injured workers.[5] Injured workers are concerned regarding the timelines of when benefits are being approved. Without timelines, injured workers are left to dangle on the proverbial "hook" with no deadline in sight.

The Minnesota Workers' Compensation Court of Appeals has even commented on the negative effects of delaying surgery:

> [T]he legislature's express intent to "assure the quick and efficient delivery of ... medical benefits to injured workers" would be undermined. Minn. Stat. § 176.001. Moreover, unnecessary postponement of appropriate medical treatment would in many cases unnecessarily delay return to work and other vocational rehabilitation efforts, again inconsistent with the intent of the workers' compensation act. Id., see also Minn. R. 5220.0100, subps. 22 and 34.[6]

History of the Workers' Compensation System

When the workers' compensation act was enacted in 1913, the legislature recognized the devastating effect of the current system and sought to create a statutory system that insured **prompt payment** of workers' compensation benefits to, or on behalf of, the employee from the employer/insurer regardless of fault.[7] This was in exchange for a trade-off on the employer and insurer's liability by placing caps and limits on what can be recovered.

Workers' compensation is social legislation, providing a measure of security to workers injured on the job, with the burden of that expense considered a proportionate part of the expense of production[8]:

> [T]he entire compensation system has been set up and paid for, not by the parties, but by the public. The public has ultimately borne the costs of compensation protection in the price of the product, and it has done so for the specific purpose of avoiding having the disabled victims of industry thrown on private charity or public

[5] 2013 MN DOLI Study, *Workers' Perspectives on Settlements and Hearings.*
[6] Fahey v R & L Shared Services LLC, WCCA 8/28/09.
[7] See MINN. STAT. § 176.001 (2022).
[8] Quoting Franke v. Fabcon, Inc., 509 N.W.2d373, 376 (Minn. 1993)

relief. To this end, the public has enacted into law a scale of benefits that will forestall such destitution.[9]

The goal should be to enforce the quick and efficient delivery of medical benefits.

Cost Savings to the System

The medical literature indicates that delays in treatment will result in permanent damage and prolonged disability. For example:

- **Flexor Tendon Surgery** – complications may be avoided if surgery is done within three to seven days. [10]
- **Low Back Fusion Surgery** –Patients with shorter symptom duration reported consistent improvement in legs and back.[11][12]
- **Lumbar Discectomy** – leg pain lasting more than 8 months correlates with unfavorable postoperative outcome as well as high risk of not returning to work.[13]
- **Cervical Decompression Surgery** - early surgery include the clinical advantages of a decreased length of hospitalization and its associated complications and a decreased time to rehabilitation and mobilization.[14] Early surgery may improve neurologic recovery.[15]
- **Hip Arthroscopy** – study shows delay in surgery or length of symptoms adversely affects outcome and disability.[16]
- **Peripheral Nerve Repair** – Prolonged delay affects functional recovery. Regeneration becomes poor after 3 months.[17]

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[9] *Arthur Larson & Lex K. Larson, Larson=s Workers' Compensation Law' 132.04(1) (2003)*

[10] *The Effect of Delay to Surgery on Major Complications after Primary Flexor Tendon Repair*, J. Hand Surg. Asian Pac Vol 2019 Vol. 2019 Jun;24(2) 161-168

[11] *Does Preoperative Symptom Duration Impact Clinical Outcomes After Minimally Invasive Transforaminal Lumbar Interbody Fusion in the Ambulatory Setting?* JW Nie, TJ Hartman, KR MacGregor, OO Oyetayo… - World Neurosurgery, 2022 - Elsevier

[12] Nie, James W., et al. "*Impact of preoperative symptom duration in patients undergoing lateral lumbar interbody fusion*." *Acta neurochirurgica*.

[13] *Duration of leg pain as a predictor of outcome after surgery for lumbar disc herniation: a prospective cohort study with 1-year follow up*, Nygaard, R Kloster, T Solberg - Journal of Neurosurgery: Spine, 2000 - thejns.org

[14] Rosenfeld, J. F., Vaccaro, A. R., Albert, T. J., Klein, G. R., & Cotler, J. M. (1998). The benefits of early decompression in cervical spinal cord injury. *American Journal of Orthopedics (Belle Mead, NJ)*, *27*(1), 23-28.

[15] Mirza, S. K., Krengel III, W. F., Chapman, J. R., Anderson, P. A., Bailey, J. C., Grady, M. S., & Yuan, H. A. (1999). Early versus delayed surgery for acute cervical spinal cord injury. *Clinical Orthopaedics and Related Research®*, *359*, 104-114.

[16] *Does duration of symptoms affect clinical outcome after hip arthroscopy for labral tears? Analysis of prospectively collected outcomes with minimum 2-year follow-up. J Hip Preserv Surg*. 2017;4(4):308-317. Dierckman BD, Ni J, Hohn EA, Domb BG.

[17] Jonsson, S., Wiberg, R., McGrath, A. M., Novikov, L. N., Wiberg, M., Novikova, L. N., & Kingham, P. J. (2013). *Effect of delayed peripheral nerve repair on nerve regeneration, Schwann cell function and target muscle recovery*. *PloS one*, *8*(2), e56484.

- **Brachial Plexus Repair** – functional recovery was shown to improve with early intervention of surgery.[18] Optimal time to surgery is shorter than 6 months.[19]
- **Ruptured Pectoral Muscle Repair** – Better outcomes were reported with surgery within 8 weeks of tear.[20][21]
- **Carpal Tunnel Surgery** - improvement was better in patients who underwent early surgery compared with patients who underwent delayed surgery. In addition, return to daily activities was complete and better in patients who underwent early surgery.[22]
- **ACL Repair Surgery** - delayed ACL surgery significantly resulted in a higher risk of meniscus tear and cartilage injury. Earlier surgical intervention results in better clinical outcomes.[23][24]

This delay in surgery results in prolonged and protracted recovery which in turn is **more costly to the system**. This includes:

- More medical treatment including physical therapy, medications.
- More wage loss due to time off from work and possible need for permanent restrictions due to permanent damage.
- More permanent partial disability due to damage done from delay in surgery; and
- More vocational rehabilitation as more time and effort will be needed to assist the injured worker back to work.

Per the MN DOLI Workers' Compensation System Report, workers' compensation denials rose to 17% in 2020 - a 2% increase from 2020. Medical benefits accounted for 33% of the total system cost which is down from previous years. However, in 2020 indemnity benefits increased to 31.5% of the total workers compensation system. Compared to 2000, the average amount of time an injured worker received TTD was 14% longer in 2019 and 18% longer in 2020.[25] It is unclear as to the exact cause for this increase, but one can assume

[18] Jivan S, Kumar N, Wiberg M, Kay S: *The influence of pre-surgical delay on functional outcome after reconstruction of brachial plexus injuries.* J Plast reconstr Aesthet Surg 2008;May 15 (Epub ahead of print)
[19] Martin, E., Senders, J. T., DiRisio, A. *C., Smith, T. R., & Broekman, M. L. (2018).* Timing of surgery in traumatic brachial plexus injury: a systematic review. *Journal of neurosurgery*, *130*(4), 1333-1345.
[20] Bak, K., Cameron, E. A., & Henderson, I. J. P. (2000). Rupture of the pectoralis major: a meta-analysis of 112 cases. *Knee Surgery, Sports Traumatology, Arthroscopy*, *8*(2), 113-119.
[21] Äärimaa, Ville, Jussi Rantanen, Jouni Heikkilä, Ilmo Helttula, and Sakari Orava. "Rupture of the pectoralis major muscle." *The American Journal of Sports Medicine* 32, no. 5 (2004): 1256-1262.
[22] Chandra, P. Sarat, Pankaj Kumar Singh, Vinay Goyal, Avnish Kumar Chauhan, Nirmal Thakkur, and Manjari Tripathi. "Early versus delayed endoscopic surgery for carpal tunnel syndrome: prospective randomized study." *World Neurosurgery* 79, no. 5-6 (2013): 767-772.
[23] Kim, Seong Hwan, Sang-Jin Han, Yong-Beom Park, Dong-Hyun Kim, Han-Jun Lee, and Nicolas Pujol. "A systematic review comparing the results of early vs delayed ligament surgeries in single anterior cruciate ligament and multiligament knee injuries." *Knee Surgery & Related Research* 33, no. 1 (2021): 1-19.
[24] Chhadia AM, , Inacio MC, , Maletis GB, , Csintalan RP, , Davis BR, , Funahashi TT. and Are meniscus and cartilage injuries related to time to anterior cruciate ligament reconstruction? Am J Sports Med. 2011; 39: 1894– 1899.
[25] MN DOLI, Workers' Compensation System Report, November 2022, page 18.

further delays and denials in medical treatment have increased payment of indemnity. Indemnity payments cost the system $49,140,000 in 2020.

Moreover, the employee's ability to prosecute their claims is taking longer. When a medical request can be filed (this requires a Request for Certification), the median time was 72 days in 2021.[26] This means many injured workers were waiting longer, most likely around 120 days, for a Medical Conference. In conjunction with the delay in getting approval or denial so that a matter can be certified, this has created a significant problem for injured workers.

Solution

We see our requested changes as a potential solution to the above problem. We firmly believe that deadlines should be in place to ensure the "quick and efficient" delivery of medical benefits.

Getting Medical Bills Paid Timely

Similarly, to getting approval for the treatment, we see a widespread issue with injured workers' getting medical bills paid in a timely fashion. These delays cause significant stress to injured workers and their families. Often, injured workers are contacted by collection agencies or debt collectors who care very little about the workers' compensation system. These individuals threaten legal action and have a negative impact on an injured worker's credit report. As we know, this is not something easily corrected. Unfortunately, the statute and rules fail to provide significant guidance for an injured worker, adjuster, or DOLI. We want to correct this.

MN Stat 176.135
MN Stat 176.135 only relates to the payment of medical bills. However, it is silent as to whether an insurer can request an IME/AME to delay payment of those bills. Unfortunately, the statute, as written, creates significant litigation and expense. It fails to set forth the insurer's obligation and deadline for when an IME/AME can be requested. Thus, leaving an injured worker in financial straits and uncertain when the bill will be paid. Most private health insurers require a bill to be submitted within 180 days. This could cause issues for an injured worker if the insurer delays action on medical bills promptly. This is why we need the requested changes.

MN Stat 176.155
Our requested change to this section is primarily to place requirements that the AME report is done promptly. All too often, the injured worker must wait months for a report. This is unacceptable. Most reports from the same physician are "cookie cutter" to one another. We believe getting the report should not take months but weeks to days at best. We believe they should be served and filed immediately, not "sandpapered" by the adjuster or defense.

[26] MN DOLI, Workers' Compensation System Report, November 2022, page 67.

We believe there should be accompanying changes to MN Rule 5221.0600.

Solution

We see our requested changes as a potential solution to the above problem. We firmly believe that deadlines should be in place to ensure the "quick and efficient" payment of medical benefits.

Proposal # 2: Reducing Medical Record Costs

Problem: The costs to obtain medical records are excessive and are barriers to speedy resolutions of claims.

Solution:
Legislative Changes: MN. Stat 176.136

Subd. 3. Medical Records Costs

(a) A provider or its representative may not charge more than a $10 retrieval fee, and must not charge a per page fee to provide copies of records requested by a patient or the patient's authorized representative or the employer and insurer or employer and insurer's authorized representative if the request for copies of records is for purposes of procuring workers' compensation benefits or defending a workers' compensation claim under this Act. A provider or its representative must provide the said records in electronic format without additional cost.

Rationale

Medical record requests to prosecute and defend claims are increasingly becoming more expensive for employees and employers, and insurers.

Under the current rule, Minn. Rule 5219.0300, medical providers have been allowed since the 1990s to charge a $10 retrieval fee and 75 cents per page. This has created a situation where it is becoming more challenging to represent injured workers on simple and routine disputes due to the increased number of records generated by the facilities.

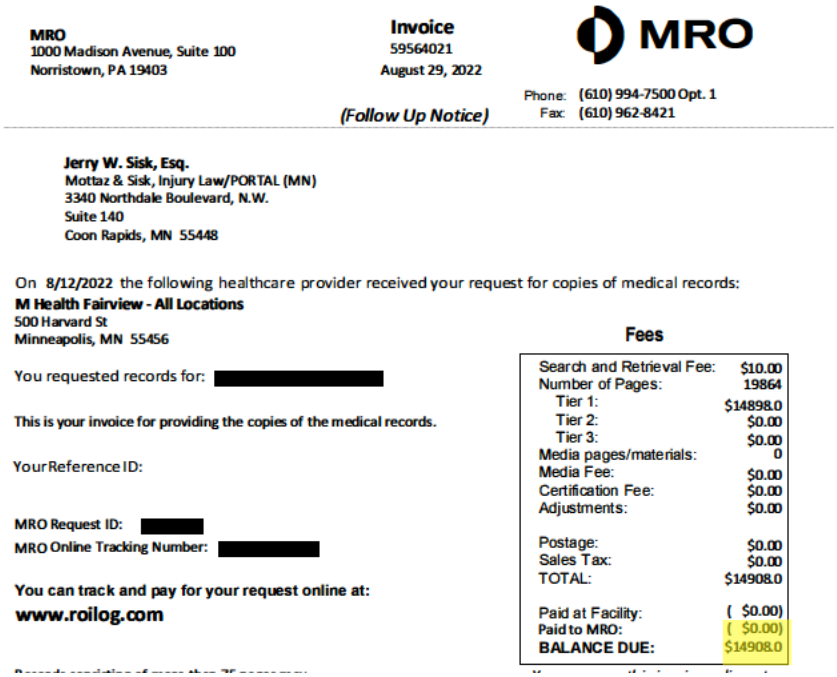
We propose the repeal of Minn. Rule 5219.0300 and amend MN Stat. 176.136. The cost of requesting medical records has become a deterrent to representing injured workers. While reasonable expenses can be recouped if a claimant's attorney is successful, the exorbitant costs can add up over the life of a claim. These costs, if lost, could be recovered against the injured worker. Thus, creating a significant financial hardship for the injured and even a deterrent to pursuing legal action. Moreover, companies like Ciox and MRO frequently

charge more than allowed and even charge additional fees such as "e-delivery fees," which are not covered under the current rule. These costs can be a roadblock for injured workers in obtaining representation.

The Current Rule is Outdated

Minn. Rule 5219.0300 was established in 1990 and has not changed. See 15 SR 800. At that time, computers were rarely used. Medical records were kept on paper. Flash forward 30 years, and no longer are the days of drudging through records by hand. Instead, records are now electronic and easily accessible.

In the 1990s, records were significantly smaller when compared to today's records. A complete record set could be requested, and one piece of paper could contain multiple dates of service. One service date can take 20 to 30 pages with only relevant information on 1 to 2 pages. In the 1990s, a complete record set would cost $20-$30. Now, we see records costing hundreds if not thousands of dollars. When the petitioner's attorney is trying to get a $300 medical bill paid but must pay $2,000+ in medical records and another $3,000 for a narrative report to get it paid, the economics of that doesn't make a lot of sense. My office just recently had a request for medical records of $14,908. Why would someone spend $14,000 on records to recover $2,000 in fees? Also, think this would be paid 3 times – Insurance company, defense lawyer and injured workers' attorney. **The facility would make $44,724 to provide medical records.**



MRO
1000 Madison Avenue, Suite 100
Norristown, PA 19403

Invoice
59564021
August 29, 2022

(Follow Up Notice)

MRO
Phone: (610) 994-7500 Opt. 1
Fax: (610) 962-8421

Jerry W. Sisk, Esq.
Mottaz & Sisk, Injury Law/PORTAL (MN)
3340 Northdale Boulevard, N.W.
Suite 140
Coon Rapids, MN 55448

On **8/12/2022** the following healthcare provider received your request for copies of medical records:

M Health Fairview - All Locations
500 Harvard St
Minneapolis, MN 55456

You requested records for: [redacted]

This is your invoice for providing the copies of the medical records.

Your Reference ID:

MRO Request ID: [redacted]
MRO Online Tracking Number: [redacted]

You can track and pay for your request online at:
www.roilog.com

Fees

Search and Retrieval Fee:	$10.00
Number of Pages:	19864
Tier 1:	$14898.0
Tier 2:	$0.00
Tier 3:	$0.00
Media pages/materials:	0
Media Fee:	$0.00
Certification Fee:	$0.00
Adjustments:	$0.00
Postage:	$0.00
Sales Tax:	$0.00
TOTAL:	$14908.0
Paid at Facility:	($0.00)
Paid to MRO:	($0.00)
BALANCE DUE:	$14908.0

More Denials. More Litigation. More Expenses

Attorneys are needed more now than before due to the increasing denial of worker's compensation benefits. As noted above, denials have increased significantly over the years.

The Minnesota Department of Labor and Industry Workers Compensation System Report of 2018 provides that claimant attorney involvement has increased substantially since 1998. The percentage of paid indemnity claims with a claimant attorney has risen from 16.8% in 1998 to 24.1%. Furthermore, the rate of denied indemnity claims was 14.6% in 2018 and increased by 12.2% to 12.25% from 2007 through 2011.

The cost of records is a deterrent for injured workers from accessing good counsel.

Cost Saving to the System

This change would dramatically affect the overall cost of the system. For example, per the Workers' Compensation System Report, November 2022, **29.9% of the $1.56 billion dollar system costs are related to insurer expenses which include litigation and defense costs.** Presumably, a good portion included medical records. Moreover, if a case settles or if the injured worker wins at a conference or hearing, the insurer is required to pay for the employee's costs which include medical records. This means the insurer could pay for **three separate sets of medical records**.

Solution

We see our requested changes as a potential solution to the above problem. We firmly believe that reducing the cost of medical records will reduce the system's overall costs and improve the injured workers' ability to retain an attorney.

Support for Labor's Proposal: Increasing the Permanent Partial Disability Payments

Legislative Changes: MN Stat. 176.101, Subd. 2a

Rationale

MN DOLI Reports

On February 10, 2021, and October 13, 2021, the Minnesota Department of Labor and Industry presented to the Workers' Compensation Advisory Council the results of its extensive analysis of the effective monetary compensation provided to injured workers for permanent partial disability benefits (compensation for impairment or loss of function to a body part) from 1984 to 2021.[27]

The Department concluded that this benefit, largely fixed between 1984 and 2021, contributed to a 9.6% **decrease in** the overall workers' compensation cost per $100 of payroll. The Department indicated that if the PPD benefit had been indexed to the statewide average weekly wage since 1984, the index schedule **would have neutralized** the Workers' Compensation System per $100 of payroll over those years.[28] **(The effect of a failure to index this benefit over these years resulted in a monetary reduction in compensation for PPD in real dollar figures between 50 and 70%.)[29]**

	In the dollars of the time (unadjusted) [1]			In constant 1983 dollars [2]			In constant 2022 dollars [2]		
Impairment rating	1983 benefit	2022 benefit	Change	1983 benefit	2022 benefit	Change	1983 benefit	2022 benefit	Change
5%	$3,750	$3,940	+5.1%	$3,750	$1,490	-60.3%	$9,920	$3,940	-60.3%
10%	$7,500	$8,400	+12.0%	$7,500	$3,170	-57.7%	$19,850	$8,400	-57.7%
20%	$15,000	$19,960	+33.1%	$15,000	$7,540	-49.7%	$39,690	$19,960	-49.7%
40%	$36,000	$50,400	+40.0%	$36,000	$19,050	-47.1%	$95,260	$50,400	-47.1%

1. These benefits were calculated using the formula in effect at the time, assuming no change in 2022.
2. The benefit amounts in 1983 and 2022 constant dollars were calculated using the Consumer Price Index for Urban Consumers (CPI-U) (Twin Cities), which will have increased by a projected 165% between 1983 and 2022.

The Department concluded that restoring PPD benefits to where they would be if indexed for wages since 1983[30] would raise cost, but that this would occur by means of ending (or reducing) previous annual cost savings relative to payroll that accrued since 1984 as a

[27] **The non-indexing of PPD benefits and alternatives for raising them**, WCAC 10/13/21, David Berry Research and Statistics.
[28] Id. At page 15.
[29] Id. At page 7.
[30] Id At page 6. As shown on slide 6, on 10/1/22 as opposed to 10/1/84, the SAWW was 405% as high and the PPD benefit schedule was 120% as high, so the PPD schedule would have to increase by 405%/120% - 100% = 238% on 10/1/22 to be where it would if it had been indexed to the SAWW since 10/1/83.

result of non-indexing. Stated another way, the 9.6% savings which occurred would be offset by the one-time 10.6% increase in correcting the failure to index. After the first year, however, the continued indexing of the permanent partial disability schedule by utilization of the statewide average weekly wage increases would be cost-neutral as a percentage of cost per $100 of payroll.[31]

History of PPD

Before 1974, PPD was paid to compensate for wage loss that would occur in the future due to the injury. After 1974, PPD is compensation for "functional loss of use or impairment of function" A dollar amount is paid based on the date of injury, body parts, and percentage given to the body part or whole body. Before 1984, Minnesota did not have a guideline for rating PPD. A doctor was able to assign any rating. The amount of permanent partial disability was calculated by multiplying the percentage of permanent partial disability by the number of weeks given to the Injured Body part or "member" and then multiplying that product by 2/3 of the injured worker is the average weekly wage at the time of the injury.

Example:
Injured Worker: 15%
Weeks: 15% x 350 = 52.5 weeks
Amount (Max CR):
1981 @ $267 = $14,017.50
1982 @ $290 = $15,225
1983 @ $313 = $16,432.50
If no change to the system in 1984, a 15% PPD with today's Max Compensation Rate would be:
2022 @ $1,256.64 = $65,973.60
Instead, the same disability would result in a 10.65% of the whole body (conversion under MN Rule 5223.0250).
2022 = $9,510.45 (10.65% x $89,300)
Under New Proposal
2023 = $22,587.26 (10.65% x $212,087)

1983
In 1983, the legislature enacted 176.105, directing the Commissioner of Labor and Industry to establish a schedule of degrees of disability.
The legislature declared its intent that the schedule be determined on" sound actuarial evaluation." The PPD guidelines have been used since 1984.

1984-1995
From 1984 to 1995, Minnesota workers' compensation used a two-tier system – introduced Impairment Compensation (IC) and Economic Recovery Compensation (ERC)

[31] Id. At page 6 and 15.

- IC – payable if the employee returns to work. PPD was calculated by multiplying the % PPD by the corresponding dollar amount.
- ERC – payable if the employee did not receive a suitable job offer. PPD % x Weeks of Compensation x 2/3rds of AWW.

1995 to Present

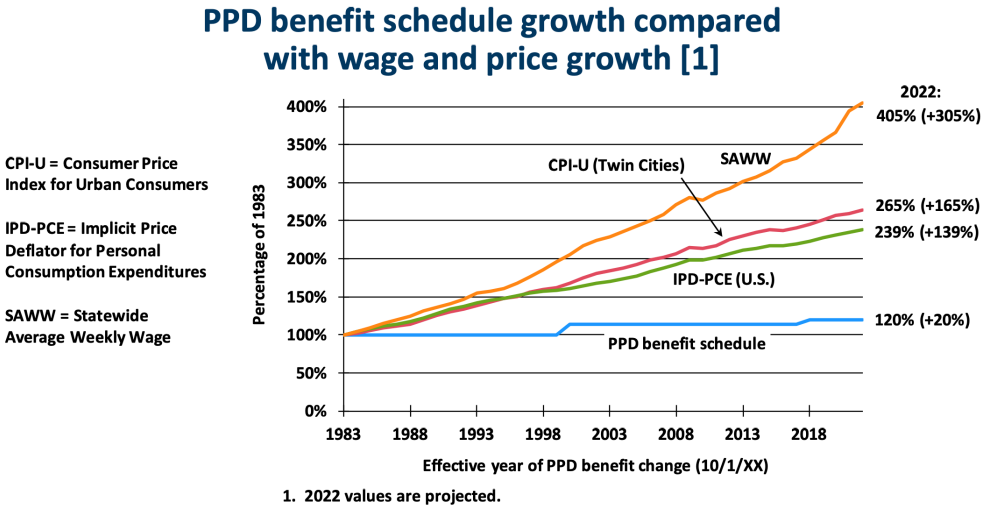
In 1995, the legislature removed the two tiers and left IC or PPD. Essentially, removing any cost-of-living adjustment to the PPD. Thus, ignoring the legislative intent of 176.095.

From 1995 to the present, PPD was calculated by multiplying the % PPD by the corresponding dollar amount. These amounts stayed the same from 1995 to 2000. In 2000 they slightly increased overall by 14.1%. They did not change again until 18 years later in 2108 when a slight increase of 5% was given. No changes have been made since that time.

Legislative Intent

Furthermore, the legislature has provided under Minnesota Statute 176.095 that "it is the legislature's policy that **any change** in the benefits schedule for total disability **be accompanied by an appropriate change** in the benefits schedule for partial disability." This provision was enacted in 1969 and amended in 1975. Total disability is based on the average weekly wage, adjusted yearly based on 176.645. This adjustment, as required, has not occurred. Benefits must be adjusted appropriately to the level they should've been from the beginning. Otherwise, the legislative intent is not being followed.

If adjusted as required under 176.095, we would see an increase as follows:



Other Workers' Compensation Benefits are Adjusted Yearly

Other than attorney fees, all other benefits including wage loss, vocational rehabilitation and medical are adjusted yearly to reflect current trends. PPD sadly does not.

Solution

We see our requested changes a potential solution to the above problem. Our position and request are in line with the Minnesota Department of Labor and Industry. We firmly believe that PPD should be adjusted, as intended by the legislature, to reflect today's dollar and should be indexed with a cost-of-living adjustment yearly like all other workers' compensation benefits.

Support for Labor's Proposal: Including Employer Contributions to the Average Weekly Wage

Legislative Changes: MN Stat. 176.011, Subd. 8a

We support employer contributions, including, but not limited to, health insurance, retirement plans, and disability, as part of an injured worker's earnings.

Support for Labor's Proposal: Removing the "Presumed" Cap on Attorney Fees

Legislative Changes: MN Stat. 176.081

Rationale

The Minnesota Association for Justice supports the removal of the "presumed" cap on attorney fees.

Contingency fees are one of the two dominant means of attorney compensation in the United States. Every state in the country has accepted the contingency fee as a practical and essential way for an attorney to provide specific legal services in certain instances. Petitioners' lawyers for workers' compensation in Minnesota are retained on a contingent basis. "No fee until you win" is a common slogan for petitioner attorneys. In other words, no attorney fees are due unless the client or petitioner prevails in obtaining benefits. If the benefits are not "disputed," the attorney recovers nothing. The contingent fee is thus predicated on an element of risk, and payment will only accrue on the happening of a future event – this future event is not readily predictable. This risk is accepted by the attorney when taking on these cases.

In certain circumstances, such as in our office, we also take on the risk of assuming the petitioners' costs. These include narrative reports, medical records, division file records, employment files, expert reports, etc. Unfortunately, this process is becoming increasingly expensive and vital to a successful case resolution. This places another significant risk of loss on an injured worker's lawyer. A "presumed cap" fails to account for the significant risk associated with these contingent cases.

Uncertainty in Litigation

Risk and uncertainty are part of every worker's compensation case. For both the lawyer and the client, recovery or no recovery is only one part of the uncertainty inherent in litigation. The other risks faced by the lawyer (and the client) include:

- Uncertainty about the amount that will be recovered (and hence the fee the lawyer will receive).
- Uncertainty if the client will continue to pursue the case.

- Uncertainty about what it will cost, in both effort and actual expenses, to obtain the recovery.
- Uncertainty about how much time will pass before the recovery is obtained; and
- Uncertainty about ultimate judicial award, if necessary, on costs and fees even with a successful resolution.

In fact, for most cases the real contingencies are not whether you will win but these other areas of uncertainty and risk.

Benefits of a Contingent Model

There are many benefits to the contingent model. The contingency fee has proven particularly well-suited to an individual who has been injured and desires to sue based on the injury but cannot afford representation. It allows those who are indigent access to an attorney. It also affords the following benefits:

- **Freedom to contract**. It allows the injured worker to contract away part of their recovery (not have to put money down as a retainer) when they could not afford it.
- **It links the interest of the injured worker to the attorney**. The more the attorney can recover for the injured worker, the more for the attorney—incentivizing risk vs. high reward.
- **Promotes positive change to the law**. Without contingent fees, if litigation appears to risky to injured workers, the case would not be pursued as it would be paid on an hourly basis. Additionally, the threat of a lawsuit for employers and insurers provides a deterrent to bad and harmful practices. Significant progress has been made through litigation which would not have occurred but for the contingent fee.

20% Contingent Fee

The Minnesota Legislature as determined that a contingency fee of 20% is reasonable for every date of injury. Presumably, it is because it is an acceptable percentage in dealing with these types of cases. However, higher percentages have been utilized in other areas of law, including:

- Social Security representation is at the rate of 25%.
- Personal injury representation ranges from 33% to 40%.
- Medical malpractice/product liability representation is up to 50%.
- In other injury representations, usually, the client assumes the risks pertaining to the advancement of costs. In other words, that amount will be deducted from their recovery.

Statutory Presumed Reasonable Attorney Fee or Cap of $26,000 Per Date of Injury

As of October 1, 2013, lawyers representing injured workers can charge 20 percent of the first $130,000 as long as those fees are calculated on genuinely disputed or portions of claims. All fees for legal services related to the same injury, including fees for recovery of disputed medical or rehabilitation benefits and fees paid for by the employer or insurer, **are cumulative** and may not exceed $26,000. MINN. STAT. § 176.081, SUBD. 1(a)(3) & 1(b). This means a "presumed cap" is $26,000 for the claimant's life. It has not been increased despite the obvious cost of doing business, inflation, and similar considerations. Other workers' compensation benefits, including medical, rehabilitation, wage loss, and AME/IME charges, are increased annually. In the past 10 years, the COLA adjustments have increased, cumulating 33.02%. While inflation has gone up 27.47% since 2013.

Following the 2013 change, some have attempted to assert that $26,000 was an absolute cap. However, in Irwin v. Surdyk's Liquor, 59 W.C.D. 319, 599 N.W.2d 132 (Minn.1999), the Minnesota Supreme Court held that limitations on attorney fees were **unconstitutional** in that the limitations impinged upon the Court's inherent power to oversee attorneys and attorney fees, depriving the Court of a final, independent review of attorney fees in violation of the Separation of Powers Clause of the Minnesota Constitution. The court determined that a compensation judge can determine a fee above the "cap" but must use these factors: (1) the amount involved;(2) the time and expense necessary to prepare for trial; (3) the responsibility assumed by counsel; (4) the expertise of counsel; (5) the difficulty of the issues; (6) the nature of the proof involved; and (7) the results obtained. These are often referred to as the seven Irwin factors. Unfortunately, this process has resulted in numerous challenges to fees claimed more than $26,000, but rarely by employees. Most disputes are raised by insurers – either in an attempt to avoid Subd. 7 reimbursements, or to discourage representation of injured workers. Additionally, it disregards the contractional agreement between the Employee and his/her attorney. The employee's attorney is discouraged further because he/she must prepare and litigate the claimed attorney fee at a separate hearing, with no additional charge.

It is understood that the statutory scheme or "two pillars" governing attorney fees in workers' compensation cases was designed to first protect compensation claimants from excessive legal charges which might otherwise severely deplete funds badly needed by the employee and his or her dependents and, second, to ensure that attorneys who represent compensation claimants will receive reasonable compensation for their efforts and is in furtherance of public policy that injured employees have access to representation by competent counsel knowledgeable in intricacies of workers' compensation law. Kahn v. State, University of Minnesota, 1982, 327 N.W.2d 21 (Minn. 1980). This presumed cap, unfortunately, does not further these two pillars.

Petitioners Attorneys Have to Assess Risk

A contingency fee practitioner seeks to choose cases that offer a high probability of providing at least an acceptable return and hopes to find some fraction of cases that present the opportunity to generate a significant fee. Lawyers evaluate potential cases

regarding the risks involved and the potential returns associated with those risks. An attorney will reject cases not satisfying the attorney's risk-to-return criteria. Thus, contingency fee lawyers resemble portfolio managers, choosing to "invest" (their time) in cases hoping to obtain adequate or better returns.

Lawyers will most likely decline cases for the following reasons:

- Questions about liability.
- Low damages or benefits.
- Inability to recover reasonable attorney fees.
- A combination of questionable liability and low damages.
- Outside of the lawyer's area of practice.

There is no doubt that, on occasion, lawyers handling cases on a contingency fee basis obtain fees beyond their strict hourly time and, on occasion, they lose. In the typical case, the contingency fee lawyer does not do better than the median hourly rate if billed out. For example, one attorney's recovered fees for a year only equals 1/3 of what they billed for a year. In other words, two-thirds of their time was lost and not recovered. One must recognize the day-to-day reality of contingency fees and limiting attorney fee recoveries.

The problem of excessive and unreasonable fees exists for plaintiffs and defendants alike. The real problem lies not inherently within either system. Instead, the problem of excessive fees stems from unscrupulous attorneys on both sides of the Bar who act in their own self-interests when setting and collecting fees. Just as some plaintiffs' attorneys overestimate the risk involved in a case when settling a contingency fee, some defense counsels are guilty of padding client bills by logging excessive hours. Regardless, a cap should not be implemented for this sole reason as it deters "good lawyering," deters keeping benefits open for injured workers, deters helping those injured workers who have already met the attorney fee cap, and deters maximizes settlements.

A "Presumed Cap" has become a Detriment to the Two Pillars of Protecting Injured Workers and Access to Justice

A "presumed cap" is problematic in today's world as it limits an attorney's recovery and harms the overall system. 20% is already the lowest versus any other contingent fee for injury legal work in Minnesota. Furthermore, according to the 2022 WCRI report, most other states have provisions for 20-25% of benefits for attorney fees, but with no cap.[32] In other words, we would appear to be the only state limiting attorneys' recoveries. Where costs are growing and often not recovered if the claim is lost, the "cost of doing business" is becoming ever more expensive. The bootstrapping of attorney fees and ever-increasing costs and risk erodes away access to attorneys. Removing the cap will help keep in line the two pillars of protecting injured workers and access to justice.

Under the Statute, $26,000 in attorney fees is the limit per injury regardless of whether the fee is taken from the injured workers' recovery or paid by the Employer and Insurer as

[32] WCRI, January 1, 2022, Workers' Compensation Laws as of January 1, 2022, page 105-110

a Roraff/Irwin or Heaton fee. This can be problematic if the injured worker has a lifelong claim with multiple disputes. For example, if the injured worker is represented by an attorney who recovers $26,000 in fees, any attorney that represents this injured worker afterward is now limited to a "reasonable fee" analysis under Irwin. The defense council and the compensation judges often fight, reduce, or slash these attorney fee claims. This creates further litigation and costs to the system, along with additional expenses to the attorney. This limitation discourages representing injured workers if their cap has been met.

Additionally, once the presumed cap has been met, there is no longer a contract between the injured worker and the attorney of 20%. Again, this disincentives attorneys from taking on these cases where the cap has been met because even if they are successful, which is not guaranteed, they will have to put in the non-recoverable time to get paid with the risk they will not get paid a "reasonable fee." This comes with significant risk to the attorney, as not only do they bear the risk of lost costs and fees, the fee is no longer determined on the 20% basis under the contract but instead on Irwin factors. Most compensation judges, although contrary to the law, place a tremendous amount of weight on time, which in of itself creates a cap. Additionally, an attorney must spend considerable non-recoverable time pursuing collection by filing a statement of attorney fees, attending a settlement conference on the fees, and attending a hearing. Again, there is no guarantee that the attorney will recover the requested fee. This gives little incentive for an attorney to assist in the recovery of smaller ticket items such as medical bills or out of pockets. Moreover, if a lump sum is payable, the attorney is strictly limited to an Irwin analysis, which may disrupt the attorney/ client relationship if the client disputes the fee.

In turn, attorneys are less likely to take on these cases. In turn, injured workers are required to turn to the ombudsman program through the Minnesota Department of Labor and Industry. Currently, there is only one staffed ombudsman in the Department. While the ombudsman program is helpful for injured workers, it does not provide them "access to justice," as attorneys have no efficient way of getting reasonably compensated.

Another reason the cap should be removed is that it incentivizes attorneys to settle earlier than they should and only up to $130,000. Under Minnesota law, lump-sum payments of workers' compensation serve the same purpose as periodic payments. They should be favored in that they avoid litigation delays and expedite relief granting. However, workers' compensation benefits can remain open for life. But, if an attorney knows that their fees are limited and it will be a struggle to recover fees, there is no incentive for the attorney to work harder than necessary to obtain the maximum fee recovery. Alternatively, as mentioned above, once the $26,000 has been met, the attorney may also no longer wish to represent the injured worker due to the difficulties associated with getting paid and obtaining a reasonable fee.

Conclusion

We do not dispute that the 20% contingent fees are reasonable, but the rationale that a fee of $26,000 per date of injury over the life of a claimant, with no escalations, is not reasonable and should be removed.

Support for Labor's Proposal: Current penalties are not a sufficient deterrent to prevent Employers and Insurers from acting negligently regarding claims handling.

Legislative Changes: Amend MN Stat. 176.225 & 176.194

Rationale

The current statute penalizes delayed payments or neglect in making a timely payment. Based on the amount of weekly benefits, the penalty is only a few hundred dollars. The penalty amount does not justify pursuing a claim, and many circumstances of delayed payment go undetected by the department or a compensation judge. These small penalty amounts, which are often not assessed, are not a deterrent to the insurer.

Amendment to 176.221, subd. 1. When benefits are awarded, payment must be made within 14 days under 176.221, subd. 8. Failure to pay timely should be an automatic penalty of 25%. That is currently available, however, insurers make excuses for the delay. These deter the pursuit of the penalty. Failure to pay within the 14-day period following an award is unreasonable and should be listed as grounds for assessing a penalty.

Amendment to 176.221, subd. 5 Similarly, failure to make payment within 14 days of an order for payment should be deemed an inexcusable delay. This should be clarified that it is any order for payment of benefits. The current statute indicates that a failure to make timely payment of an order is subject to 12 percent interest; however, if a payment is made 30 days late, that adds only 1% of the amount ordered. That does not act as a deterrent nor create a sense of urgency to pay an award promptly.

In circumstances of an award of benefits, the injured worker has often gone months without income. The timeliness of payment of the award is critical to the injured worker who has already suffered financially. There should be greater importance placed on ensuring the benefits are paid timely.

Amendment to 176.194, Subd. 3 Inverting paragraphs 5 and 6 addresses the importance of the penalty attached to each. Beginning with paragraph 6, a penalty is issued on the first offense. By moving the old paragraph 5 up to 6 and starting the penalty on the first offense of the new paragraph 6 impresses the importance of making timely payments.

The new paragraph 6 addresses payment of weekly benefits once benefits have commenced. The penalty applies to delay in making those payments. Injured workers rely upon receiving those payments regularly. Under the current statute, if an insurer fails to make a payment within 3 days after it was due, it is not a violation unless it happens 4 times in a 12-month period. Even then, they will not face a penalty unless this occurs 6 times. Under the proposed amendment, a penalty will be assessed if this occurs twice in a 12-month period in any one case or on any occasion that a payment is made more than a week after it was due.

Even under our proposal, the insurer can still make payments consistently two days late without any penalty.

Injured workers receiving weekly benefits rely upon the consistent payment of benefits. If a payment is delayed this causes stress, worry and often includes financial hardship. The revision is intended to make it a serious offense to consistently delay those payments by more than 2 days.

Paragraph 7 is amended to also enforce a timely payment of an award of benefits. Payment is supposed to be made within 14 days, however no penalty should be issued if the insurer uses the 30 days to contemplate an appeal. If the order is not appealed within the 30 days, they should not have an extra 15 days to make payment without penalty. The penalty should be assessed upon failure to make the payment on the 30th day. That payment is already 16 days after payment was due.

Adding paragraph 12 addresses an issue of misleading statements being made by insurance adjusters. When an old claim has been inactive, an insurance company will often close the active file. When injured workers return to seek benefits, they are told that the file is closed. The injured worker interprets this as there are no further benefits available. They will occasionally seek the advice of an attorney to see if there is any recourse, only to find out that the benefits are not closed. It is unknown how many injured workers will not pursue this further. The statements are intentionally misleading and should be a prohibited practice. Assessing a penalty for this type of misleading statement will deter these statements from being made.

Amendment to 176.194, Subd. 4 As noted above, paragraph 5 is being moved so that failure to make timely payment of weekly benefits will incur a penalty after the second offense.

Penalties for these prohibited actions are paid to the State. We are proposing an additional penalty under this section to address the hardships facing the injured workers with these violations. This penalty is not mandatory, but it will act as a deterrent. Under circumstances where timeliness of payment is completely disregarded, or timeliness to responding to request for medical treatment are disregarded, a penalty can be assessed and paid to the injured workers. In addition the ability for the injured worker to hire an attorney to pursue the correction of these actions. Often the amount of the penalty or the amount of time it takes to straighten out a situation where payment is not timely is not financially viable for an attorney. If an injured worker has to hire an attorney to get involved to obtain relief for the injured worker, the cost of the attorney should be borne by the insurer and the attorney should be able to be paid a reasonable fee for their services. This provides the injured worker with access to justice which would otherwise be denied due to the dollar values involved.