DEPARTMENT OF LABOR AND INDUSTRY

Workers' Compensation Division

Basic Adjusters' Training Guide

ANSWER KEY

March 2018

Waiting Period – Exercise 1A

1. An employee who works Monday through Friday was injured on February 10, 2014. The employee lost one hour from work on the date of injury and remained off work through February 18, 2014. The employee returned to work on February 19, 2014. What are the dates of the waiting period?

   The waiting period is February 10th through February 12th.

2. An employee who works Monday through Friday was injured on March 7, 2014. The first day of disability was March 10, 2014 and the employee returned to work without disability on March 13, 2014. What are the dates of the waiting period? Are you required to report this claim to the department?

   The waiting period is March 10th through March 12th. This does not need to be reported as the disability does not exceed the waiting period.

3. An employee who works Monday through Friday was injured on April 11, 2014, and lost one hour of work on that date. The employer paid the employee full wages for the date of the injury. The employee returned to work without disability on April 17, 2014. For which dates do you possibly owe compensation?

   You would possibly owe for compensation for April 14th through April 16th as the waiting period is April 11th through April 13th.

4. An employee who works Monday through Thursday was injured on May 1, 2014. The first day of disability wasn't until May 12, 2014. The employee returned to work without disability on May 19, 2014. Disability began again on May 22, 2014 with a return to work without disability on May 26, 2014. All dates of disability were authorized by the treating doctor. What are the dates of the waiting period? Should the waiting period be paid?

   The waiting period is May 12th through May 14th. Yes, as there is disability on or after the 10th calendar day (May 21st).

5. An employee who works Monday through Friday was injured on April 18, 2014 and lost three hours of work on the date of injury. The employer paid full wages for the date of the injury. The employee returned to work without disability on April 28, 2014. All disability was authorized by the treating doctor. What are the dates of the waiting period? Should the waiting period be paid?

   The waiting period is April 18th through April 20th. No, because the employee was paid his full wages on the date of injury and the other two days are non-scheduled work days. This question is also used to discuss the issue of the 10th day landing on a weekend with a return to work the next Monday.

Liability Determination – Exercise 1B

Part 1

See the FROI for Susan Jones. The employee normally works Monday through Friday. You have been unable to reach the employee. Upon contacting the employer, you are told that the injury was witnessed and the supervisor took the employee to a local hospital for immediate medical attention. The employer also states that the employee has not returned to work yet and according to medical information, should stay off work at least until the follow-up appointment on February 14th.

1. Should liability be accepted or denied? Why?

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

2. What forms need to be filed?

   FROI and NOPLD

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

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

Part 2

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

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

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

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

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

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

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

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

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

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

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

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

Part 3

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

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

2. What boxes should be checked on the NOPLD?

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

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

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

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

3. After paying benefits for four weeks, the employee tells you he stopped at his parent's house on his way back from training. The police report verifies that the accident occurred two blocks from his parent's home. What should you do?
   Assuming the stop at his parent's house was not related to work, it would appear that the employee was on a personal errand rather than coming directly back to work and you might now have a basis to deny liability for the claim. As it is within 90 days from the first day of disability or the date the employer was aware of disability, whichever is later, you may file an amended NOPLD, Box 3, to discontinue the benefits and deny primary liability.

Temporary Total Disability – Exercise 2A

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Temporary Partial Disability – Exercise 2B

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

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

   $700.00 – $500.00 = $200.00 X 2/3 = $133.33

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

   $500.00 - $200.00 = $300.00 X 2/3 = $200.00

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

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

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

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

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

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

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

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

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

Annual Adjustment of Benefits – Exercise 2C

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

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

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

   $280.00

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

   b) How many adjustments are due?

   20

   c) What is the multiplication factor?

   2.25799

   d) What is the adjusted TTD rate?

   $632.24 ($280.00 x 2.25799 = $632.24)

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

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

   $615.00

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

   b) How many adjustments are due?

   7

   c) What is the multiplication factor?

   1.14868

   d) What is the adjusted TTD rate?

   $706.44 ($615.00 x 1.14868 = $706.44)

Permanent Partial Disability – Exercise 2D

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

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

   2% x $75,000 = $1,500.00

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

   1 - [(1-A) x (1-B) x (1-C)]

   1 - [(1-.02) x (1-.02) x (1-.02)]

   1 - [(.98) x (.98) x (.98)]

   1 - [.9412] = .0588

   5.88% x $80,000 = $4,704.00

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

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

   10%

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

   15%

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

   18%

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

   20%

Certified Managed Care Organizations – Exercise 3A

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

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

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

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

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

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

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

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

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

Medical Fee Schedule – Exercise 3B

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

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

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

   a) Determine the amount to be paid.

   $124.77

   Formula is RVU x CF = $payment
   Date of Service is 11/24/2010 --- CF is $53.48

   98941 Status = A
   Work RVU .65 x Work GPCI 1.0 = .65
   Trans Non Fac RVU .28 x PE GPCI .983 = .27524
   MP RVU .01 x MP GPCI .245 = .00245

   Total RVU = .65 + .27524 + .00245 = .92769 x CF $53.48 = $49.61 ($45.00 charged amount)

   97110 Status = A
   Work RVU .45 x Work GPCI 1.0 = .45
   Trans Non Fac RVU .31 x PE GPCI .983 = .30473
   MP RVU .02 x MP GPCI .245 = .0049

   Total RVU = .45 + .30473 + .0049 = .75963 x CF $53.48 = $40.63

   97010 Status = B
   Pay $0.00

   97032 Status = A
   Work RVU .25 x Work GPCI 1.0 = .25
   Trans Non Fac RVU .19 x PE GPCI .983 = .18677
   MP RVU .01 x MP GPCI .245 = .00245

   Total RVU = .25 + .18677 + .00245 = .43922 x CF $53.48 = $23.49

   97012 Status = A
   Work RVU .25 x Work GPCI 1.0 = .25
   Trans Non Fac RVU .14 x PE GPCI .983 = .13762
   MP RVU .01 x MP GPCI .245 = .00245

   Total RVU = .25 + .13762 + .00245 = .39007 x CF $53.48 = $20.86 x .75 = $15.65

b) What modifier should be used on CPT code 97012?

-51 to indicate multiple modalities

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

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

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

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

- Whether treatment was inpatient or outpatient.
- Number of licensed beds at the hospital.

c) Assume it is a large hospital of 100 beds or more. Determine the amount to be paid.

$497.32
$585.08 x 85%

d) What if the hospital had 78 licensed beds?

Pay 100% of usual and customary of the hospital services. $585.08

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

a) Why might you want the medical record?

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

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

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

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

7 working days after receipt of request

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

$1.50 + tax + postage

e) Determine the amount to be paid.

$183.94

Formula is RVU x CF = $payment
Date of Service is 1/17/2011 --- CF is $67.23

99213 Status = A
Work RVU .92 x Work GPCI 1.0 = .92
Trans Non Fac RVU .75 x PE GPCI .983 = .73725
MP RVU .03 x MP GPCI .245 = .00735

Total RVU = .92 + .73725 + .00735 = 1.6646 x CF $67.23 = $111.91

90471 Status = A
Work RVU .17 x Work GPCI 1.0 = .17
Trans Non Fac RVU .40 x PE GPCI .983 = .3932
MP RVU .01 x MP GPCI .245 = .00245

Total RVU = .17 + .3932 + .00245 = .56565 x CF $67.23 = $38.03

90718 Status = E
85% of U&C = $34.00

Penalties – Exercise 5A

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

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

   No. The first day of lost time and employer notice were both March 10, 2014, therefore the FROI was due to the insurance company by March 20, 2014.

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

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

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

   The insurance company needed to receive the FROI by March 20, 2014. The department needed to receive the FROI by March 24, 2014.

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

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

   March 24, 2014.

2. Was the payment made timely?

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

Case Study

The Beginning of the Story – Liability Determination

Pat Williams is a 56 year old church secretary. On September 4, 2013 Pat had a low back injury at work and immediately notified the supervisor. Pat lost two hours on the date of injury to go to the emergency room. The doctor prescribed painkillers and authorized time off from work through September 6th. Pat returned to work on September 9th. On September 10th, Pat felt that the pain was getting worse instead of better and sought additional medical treatment from Dr. Crunch, D.C. half way through the work day. Pat was taken off work for one week as of that date and notified the employer of this on the same day. Pat normally works Monday through Friday, eight hours per day at $15.00 per hour, with an average weekly wage on the date of injury of $600.00.

You have been assigned this claim.

1. What are the dates of the waiting period?

   September 4, 2013 through September 6, 2013

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

   September 24, 2013

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

   September 24, 2013

4. As of September 10th, when Pat starts losing time again, would the waiting period be payable? If so, why? If not, when would it become payable?

   No. If there was any lost time on or after September 13, 2013 (the 10th calendar day).

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

Notice of Insurer's Primary Liability Determination

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

N L01
DO NOT USE THIS SPACE

☐ **Amended**

WID or SSN	DATE OF INJURY	DATE OF DEATH (if applicable)
999-99-9999	09/04/2013	

EMPLOYEE (last, first, mi): WILLIAMS, PAT

EMPLOYER: COMPANY ABC

INSURER/SELF-INSURER/TPA: INSURANCE MUTUAL

INSURER CLAIM NUMBER: WC 0001-0404

First date of lost time	Date employer notified of this lost time	Initial date of return to work	Average weekly wage at date of injury
09/04/2013	09/04/2013	09/09/2013	$600.00

If the initial return to work was followed by a new period of lost time, complete the following information:

First date of new period of lost time: 09/10/2013

Date employer notified of this lost time: 09/10/2013

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

Benefit type: ☐ Temporary Total (TTD) ☐ Temporary Partial (TPD) ☐ Permanent Total (PTD) ☐ Dependency (DEP)

Date of payment	Amount of payment	Time period covered with this payment Date from	Date through	Compensation rate
09/24/2013				

Any ongoing payments will be made on _____ (day of week) at _____ (weekly, biweekly, etc.) intervals.

Check all that apply

- ☐ Full wage continuation by the employer under M.S. § 176.221, subd. 9.
- ☐ TPD payment made according to the wage loss verification received by the insurer on _____ (date).
- ☐ Fatality with dependents. Payment is being made according to dependent information, which must be **ATTACHED**.
- ☐ Fatality with no dependents. Payment is being made to the estate or the Special Compensation Fund.

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

Check only one

- ☐ A. Injury did not cause lost time from work beyond the three calendar day waiting period. If employee's work schedule is not Monday through Friday, explain: _____
- ☐ B. Verification of reduced wages for TPD has not been received from the employee or employer.
- ☐ C. Other reason (include legal and factual basis):

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

Reason for denial (include legal and factual basis):

NAME OF THE PERSON MAKING THIS DETERMINATION (print)	PHONE NUMBER (area code)	EXTENSION	DATE SERVED (must be completed)
PAULA PETERSON	(612) 111-1111	325	09/24/2013

INSTRUCTIONS TO EMPLOYEE/HEIRS AND DEPENDENTS

PLEASE KEEP A COPY OF THIS NOTICE FOR YOUR RECORDS

General Information

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

Minnesota Department of Labor and Industry

525 Lake Avenue South, Suite 330
Duluth, MN 55802-2368
Telephone: (218) 733-7810
1-800-342-5354

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

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

Time Limitations

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

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

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

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

Vocational Rehabilitation

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

Instructions to Insurer/Claims Administrator

1. If the claim is a fatality with dependents and payment is being made, attach dependent information.
2. The reason for a denial must be clear and specific, and state a legal and factual basis in language which is easily understood. If the reason for a denial is based on medical information, attach medical reports or summary of any health care provider contacts that support your reason for denial.
3. This form may be filed more than once if your liability determination changes. (Examples: when you initially deny primary liability, but later accept liability; when you initially accept a claim and pay wage loss benefits, but later deny primary liability within 90 days pursuant to M.S. § 176.221, subd 1; when you accept liability, but are unable to pay TPD benefits until verification of wage loss is received, but later issue the first TPD check.)
4. If you file this form more than once, check the Amended box in the upper left-hand corner for each subsequent filing.
5. Do not use this form to reinstate benefits. Use the Notice of Benefit Reinstatement (NOBR) form.
6. If you indicate that the employer paid "full wage," you must also file a Notice of Intention to Discontinue (NOID) at the appropriate time showing the date of return to work or other reason for discontinuance and the payment data on the back of the form as required by M.S. § 176.221, subd. 9.
7. The date served must be completed each time you file this form.
8. The boxes (in the upper left-hand corner on the front of the form) containing claim identifying information must be fully completed each time you file the form. The boxes containing the dates of lost time, notice, and initial return to work, and the average weekly wage must also be completed, if applicable, each time you file the form, regardless of your liability determination.

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

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

The Beginning of the Story – Medical Communication

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

Answer the following questions:

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

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

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

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

   Report of Work Ability

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

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

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

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

The Middle of the Story – Indemnity Benefits

Pat had a low back injury at work on September 4, 2013 and lost two hours on the date of injury to go to the emergency room. Pat initially returned to work on September 9th, but on September 10th Pat returned to the doctor half way through the work day and has been off work as of that date. Pat normally works Monday through Friday, eight hours per day at $15.00 per hour, with an average weekly wage of $600 on the date of injury.

The doctor has released Pat to return to work light duty four hours per day on September 23, 2013. The employer can accommodate the light duty work and Pat goes back to work on September 23rd, at light duty four hours per day.

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

   $400.00

2. What benefits are owed through the return to work on September 23, 2013?

   TPD 09/04/2013 .2 wks = $20.00
   TTD 09/05 – 09/06/2013.4 wks = $160.00
   TPD 09/10/2013 .2 wks = $40.00
   TTD 09/11 – 09/22/2013 1.6 wks = $640.00

3. Fill out the NOID.

The return to work is again unsuccessful as symptoms continue to worsen. Pat returns to Dr. Crunch and is taken off work again as of September 27, 2013.

4. Fill out the NOBR.

Notice of Insurer's Primary Liability Determination

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

N L01
DO NOT USE THIS SPACE

☐ **Amended**

WID or SSN	DATE OF INJURY	DATE OF DEATH (if applicable)
999-99-9999	09/04/2013	

EMPLOYEE (last, first, mi): WILLIAMS, PAT

EMPLOYER: COMPANY ABC

INSURER/SELF-INSURER/TPA: INSURANCE MUTUAL

INSURER CLAIM NUMBER: WC 0001-0404

09/04/2013 and 09/10/2013 TPD
09/05/2013 - 09/06/2013 and
09/11/2013 - 09/22/2013 TTD

First date of lost time	Date employer notified of this lost time	Initial date of return to work	Average weekly wage at date of injury
09/04/2013	09/04/2013	09/09/2013	$600.00

If the initial return to work was followed by a new period of lost time, complete the following information:

First date of new period of lost time: 09/10/2013

Date employer notified of this lost time: 09/10/2013

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

Benefit type: ☑ Temporary Total (TTD) ☑ Temporary Partial (TPD) ☐ Permanent Total (PTD) ☐ Dependency (DEP)

Date of payment	Amount of payment	Time period covered with this payment Date from	Date through	Compensation rate
09/24/2013	$860.00	09/04/2013	09/22/2013	$400.00

Any ongoing payments will be made on Monday (day of week) at Biweekly (weekly, biweekly, etc.) intervals.

Check all that apply

- ☐ Full wage continuation by the employer under M.S. § 176.221, subd. 9.
- ☐ TPD payment made according to the wage loss verification received by the insurer on _____ (date).
- ☐ Fatality with dependents. Payment is being made according to dependent information, which must be **ATTACHED**.
- ☐ Fatality with no dependents. Payment is being made to the estate or the Special Compensation Fund.

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

Check only one

- ☐ A. Injury did not cause lost time from work beyond the three calendar day waiting period. If employee's work schedule is not Monday through Friday, explain: _____
- ☐ B. Verification of reduced wages for TPD has not been received from the employee or employer.
- ☐ C. Other reason (include legal and factual basis):

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

Reason for denial (include legal and factual basis):

NAME OF THE PERSON MAKING THIS DETERMINATION (print)	PHONE NUMBER (area code)	EXTENSION	DATE SERVED (must be completed)
PAULA PETERSON	(612) 111-1111	325	09/24/2013

INSTRUCTIONS TO EMPLOYEE/HEIRS AND DEPENDENTS

PLEASE KEEP A COPY OF THIS NOTICE FOR YOUR RECORDS

General Information

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

Minnesota Department of Labor and Industry

525 Lake Avenue South, Suite 330
Duluth, MN 55802-2368
Telephone: (218) 733-7810
1-800-342-5354

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

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

Time Limitations

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

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

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

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

Vocational Rehabilitation

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

Instructions to Insurer/Claims Administrator

1. If the claim is a fatality with dependents and payment is being made, attach dependent information.
2. The reason for a denial must be clear and specific, and state a legal and factual basis in language which is easily understood. If the reason for a denial is based on medical information, attach medical reports or summary of any health care provider contacts that support your reason for denial.
3. This form may be filed more than once if your liability determination changes. (Examples: when you initially deny primary liability, but later accept liability; when you initially accept a claim and pay wage loss benefits, but later deny primary liability within 90 days pursuant to M.S. § 176.221, subd 1; when you accept liability, but are unable to pay TPD benefits until verification of wage loss is received, but later issue the first TPD check.)
4. If you file this form more than once, check the Amended box in the upper left-hand corner for each subsequent filing.
5. Do not use this form to reinstate benefits. Use the Notice of Benefit Reinstatement (NOBR) form.
6. If you indicate that the employer paid "full wage," you must also file a Notice of Intention to Discontinue (NOID) at the appropriate time showing the date of return to work or other reason for discontinuance and the payment data on the back of the form as required by M.S. § 176.221, subd. 9.
7. The date served must be completed each time you file this form.
8. The boxes (in the upper left-hand corner on the front of the form) containing claim identifying information must be fully completed each time you file the form. The boxes containing the dates of lost time, notice, and initial return to work, and the average weekly wage must also be completed, if applicable, each time you file the form, regardless of your liability determination.

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

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

Mail or fax to:
Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

Notice of Intention to Discontinue Workers' Compensation Benefits

Print in ink or type
Enter dates in MM/DD/YYYY format

ND01

DO NOT USE THIS SPACE

WID number or SSN	Date of injury	
12345	09/04/2013	
Employee (last, first, middle initial)	Employer	
WILLIAMS, PAT	COMPANY ABC	
Employee address		
441 MAIN STREET		
City	State	ZIP code
PEACEFUL VALLEY	MN	55800
Insurer claim number		
WC 0001-0404		

Notes

Your benefits for (check one) ☐ temporary total disability ☐ temporary partial disability ☐ permanent total disability are being discontinued or reduced for the following reason(s):

☐ 1. You returned to work at full wage on _____ (date).

☑ 2. You returned to work at reduced hours or wage on 09/23/2013 (date).

Temporary partial disability benefits ☑ will be paid or ☐ will not be paid. Temporary partial disability benefits are usually two-thirds of the difference between your average weekly wage at the time of the injury and your current weekly wage.

☐ 3. For reasons other than return to work as stated below. (Relevant medical reports or other documents must be attached.) Payment will be made through _____ (date).

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

INSTRUCTIONS TO EMPLOYEE – THIS REQUIRES YOUR IMMEDIATE ATTENTION

Review this form to make sure your benefits have been properly paid.

You do not need to take any action if you agree the discontinuance or the reduction of benefits is proper.

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

If box 3 above is checked, you may request a conference if you think the reason for stopping your benefits is incorrect or you disagree with the proposed discontinuance. Your request must be received within 12 calendar days after this Notice of Intention to Discontinue Workers' Compensation Benefits form is received by the Workers' Compensation Division.

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

To request a conference, you must mail or deliver the attached form to the Workers' Compensation Division so it is received within these time limits. You may also request a conference by calling (651) 361-7901 (Court of Administrative Hearings) or 1-800-342-5354 (Department of Labor and Industry).

The conference will be scheduled within 10 calendar days after your request is received. You, your employer and the insurer will be invited to attend. You are not required to have an attorney for this conference. If you have an attorney, the attorney will also be invited. Bring any reports and return-to-work restrictions that show why your benefits should not be discontinued.

Instead of requesting a conference, you or your attorney may request a formal hearing by filing an Objection to Discontinuance form with the Workers' Compensation Division. A formal hearing process takes longer than the conference process. You may want to talk with an attorney.

If you have questions about your benefits, contact the claim representative whose telephone number is at the bottom of the page. If you still have questions after talking to the claim representative, contact the Workers' Compensation Division office:

525 Lake Ave. S., Suite 330
Duluth, MN 55802
(218) 733-7810
1-800-342-5354

443 Lafayette Road N.
St. Paul, MN 55155
(651) 284-5030
1-800-342-5354

Average weekly wage at DOI $ 600.00	Include contingent attorney fees in benefit totals				
The following benefits have been paid	**From**	**Through**	**Weeks**	**Rate**	**Total**
☑ Temporary total disability or	09/05/2013	09/06/2013	.4	$400.00	$160.00
☐ Permanent total disability	09/11/2013	09/22/2013	1.6	$400.00	$640.00
Notes					
☑ Benefit addendum attached					
Temporary partial disability	09/04/2013	09/04/2013	.2		$20.00
Retraining benefits					
Permanent partial disability ____ %					
☐ Injuries on or after 10/01/1995					
☐ Impairment compensation (injuries 01/01/1984 through 09/30/1995)					
☐ Economic recovery compensation (injuries 01/01/1984 through 09/30/1995)					
☐ Part of body ____ (injuries before 01/01/1984)					

Attorney fees/expenses		**Benefit totals**	
M.S. § 176.081, subd. 1, contingent fees paid		Lump-sum payment under award or order (include contingent attorney fees)	
M.S. § 176.081, subd. 1, contingent fees still withheld		Attorney fees reimbursed to employee (M.S. § 176.081, subd. 7)	
Heaton fees paid		Interest paid	
Roraff fees paid		**Total compensation paid** (include contingent attorney fees)	$860.00
M.S. § 176.191 fees paid		Total supplementary benefits (include contingent attorney fees)	
Other fees paid		Total medical expenses paid to date	
Costs and disbursements paid			

Insurer/self-insurer/TPA			Claim representative name	
INSURANCE MUTUAL			PAULA PETERSON	
Address			Phone number (include area code)	Extension
PO BOX 007			(612) 111-1111	325
City	State	ZIP code	Date served on employee	Date served on employee's attorney
MINNEAPOLIS	MN	55400	09/24/2013	

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

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.

Send to: Workers' Compensation Division, employee and the employee's attorney (if any).

Minnesota Department of Labor and Industry
Workers' Compensation Division
www.dli.mn.gov/wc/wcforms.asp

Benefit Addendum

Enter dates in MM/DD/YYYY format.

PRINT IN INK or TYPE

WID or SSN	DATE OF INJURY
12345	09/04/2013
EMPLOYEE	
WILLIAMS, PAT	
INSURER CLAIM NUMBER	DATE SERVED ON EMPLOYEE
WC 0001-0404	09/24/2013

This addendum must be attached to one of the following benefit forms: (check one)
Use this page ONLY if you have paid more benefits than recorded on the benefit form.

- ☐ NB01
- ☑ ND01
- ☐ IS03
- ☐ BD02

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
TEMPORARY PARTIAL	09/10/2013	09/10/2013	.2		$40.00

*Include attorney fees in these totals.

Distribution: Workers' Compensation Division, Employer, Employee, Insurer

Employee's Request for Administrative Conference on Discontinuance of Workers' Compensation Benefits

EQ05

DO NOT USE THIS SPACE

Print in ink or type
Enter dates in MM/DD/YYYY format

WID number or SSN 12345	Date of injury 09/04/2013	
Employee WILLIAMS, PAT	Employer COMPANY ABC	
Employee address 411 MAIN ST		
City PEACEFUL VALLEY	State MN	ZIP code 55800
Insurer claim number WC 0001-0404	Insurer/self-insurer/TPA INSURANCE MUTUAL	

Private or confidential data you supply on this form and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by Department of Labor and Industry staff members who have authorized access to the data and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse, your claim may be delayed or denied or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the Court of Administrative Hearings; the Workers' Compensation Court of Appeals; the Department of Revenue; the Department of Health; and the Workers' Compensation Reinsurance Association.

THIS REQUIRES YOUR IMMEDIATE ATTENTION

Do not complete this form if you agree that your weekly workers' compensation benefits may be stopped or changed.

If you disagree that your benefits may be stopped or changed, you may request an administrative conference. A decision can be made at the conference about your weekly benefits.

- **If box 1 or 2** is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form, your request for a conference must be received by the Workers' Compensation Division **within 30 days after you returned to work.**
- **If box 3** is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form, your request for a conference must be received **within 12 days after a copy of the Notice of Intention to Discontinue Workers' Compensation Benefits form is received by the Workers' Compensation Division.**

Complete this section to request a conference by mail, by fax or in person
(You do not need to complete this section to request a conference by phone)

Box (check one) 1 ☐ 2 ☐ 3 ☐ is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form.

My weekly benefits should not be stopped or changed because

(Attach a separate sheet if needed)

If an interpreter is needed for conference, specify the language/dialect

Employee signature	Employee phone number (include area code)	Date
Attorney (if you have one)	Attorney phone number (include area code)	

To request a conference, take one of the following actions:

Call
(651) 361-7901; or
1-800-342-5354, press number 3

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

Fax this form
(651) 284-5731

Deliver this form
Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road N.
St. Paul, MN 55155

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

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.

Mail or fax to:
Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221

St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

Notice of Benefit Reinstatement

Print in ink or type

Enter dates in MM/DD/YYYY format

NC01

Do not use this space

WID number or SSN	Date of injury (DOI)	Date of death (if applicable)
12345	09/04/2013	
Employee (last, first, MI) WILLIAMS, PAT		
Employer COMPANY ABC		
Insurer/self-insurer/TPA INSURANCE MUTUAL		
Insurer claim number WC 0001-0404		

This is notification that workers' compensation benefits have been reinstated or changed.

Date of new payment	Amount of payment	Type of benefit	Time period covered with this payment		Compensation rate
			Date from	Date through	
10/04/2013	$400.00	☑ TTD ☐ TPD ☐ PTD ☐ DEP	09/27/2013	10/03/2013	$400.00

Insurer: Check the appropriate box(es) and enter date(s).

☐ 1. Payment resumed voluntarily. First date of new period of time lost _____

Date of notice to employer of new period of time lost _____

☐ 2. Payment resumed pursuant to order served and filed on _____

☐ M.S. § 176.239 decision OR ☐ Other decision (CAH, WCCA or Supreme Court)

☑ 3. TPD changed to TTD effective 09/27/2013

☐ 4. Full wage continuation changed to TTD effective _____

Provide the following pre-injury wage information *only* if it differs from prior submissions.

Average weekly wage at DOI	Weekly value of:	Meals	Lodging	Second income

Explain below the reason for the change and attach a 26-week wage statement.

Claim representative name	Phone number (include area code)	Date
PAULA PETERSON	(612) 111-1111	10/04/2013

The Middle of the Story – Medical Benefits

As you recall, Pat Williams has back pain related to the work injury. Pat has been receiving passive chiropractic care from Dr. Crunch since September 10th.

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

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

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

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

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

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

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

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

The Middle of the Story – Rehabilitation Benefits

Pat has tried to return to work but is unsuccessful. Dr. Crunch has authorized disability again as of September 27, 2013.

1. When is the DSR due to be filed?

   - Within 14 calendar days of knowledge that employee's temporary total disability will extend beyond 13 cumulative weeks.
   - Within 90 calendar days when the employee has not returned to work after the injury.
   - Within 14 calendar days after receiving a request for rehabilitation consultation.
   - Within 14 calendar days of expiration of waiver.

2. What information is required to be provided when requesting a waiver of rehabilitation services?

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

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

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

4. It is now November 26, 2013. Pat is still off work and it doesn't appear that Pat will be able to return to work in the near future. Should you file a DSR? If so, complete the DSR.

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

Mail or fax to:
MN Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

Disability Status Report

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

PRINT IN INK or TYPE
ENTER DATES IN MM/DD/YYYY FORMAT

DS01

DO NOT USE THIS SPACE

1. WID or SSN	2. DATE OF INJURY
12345	09/04/2013

3. EMPLOYEE NAME: WILLIAMS, PAT

4. EMPLOYEE ADDRESS: 411 MAIN ST

CITY	STATE	ZIP CODE	5. EMPLOYEE PHONE #
PEACEFUL VALLEY	MN	55800	

6. EMPLOYER	7. EMPLOYER CONTACT PERSON	8. PHONE #
COMPANY ABC		

9. INSURER/SELF-INSURER/TPA	12. TITLE OF JOB AT DATE OF INJURY	
INSURANCE MUTUAL	SECRETARY	
10. INSURER ADDRESS: PO BOX 007	13. AVERAGE WEEKLY WAGE AT DATE OF INJURY: $600.00	14. JOB AT DATE OF INJURY: ☐ PART TIME ☑ FULL TIME
CITY: MINNEAPOLIS; STATE: MN; ZIP CODE: 55400	15. NUMBER OF DAYS OF DISABILITY	16. IS THE EMPLOYEE CURRENTLY WORKING? ☐ YES ☑ NO
11. INSURER CLAIM NUMBER: WC 0001-0404	17. WILL THE DISABILITY LIKELY EXTEND BEYOND 13 WEEKS? (see instructions on back) ☑ YES ☐ NO	

18. REASON FOR FILING THE DISABILITY STATUS REPORT: **(Check A or B)**

Was a consultation requested? ☑ NO ☐ YES If yes, consultation requested by:

☐ Insurer ☐ Employer ☐ Employee on _____ (date of request)

☑ A. The employee is being referred for a rehabilitation consultation. (Insurer must send a copy of this Disability Status Report, the First Report of Injury, and the treating physician's work ability report to the QRC before the rehabilitation consultation.)

Name of QRC RITA RULE

☐ B. A waiver of the rehabilitation consultation is being requested. An offer of suitable gainful employment signed by the date-of-injury employer and the treating physician's work ability report are attached. (NOTE: A waiver will not be granted if a consultation has been requested pursuant to Minn. Stat. § 176.102, subd. 4(a).)

Projected return to work date _____

Name of insurer representative completing form	Phone number	Extension	Date served on employee
PAULA PETERSON	(612) 111-1111	325	11/26/2013

(over)

INSTRUCTIONS TO INSURER

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

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

If you are referring the injured worker for a rehabilitation consultation, check Box 18A. Send a copy of the DSR form, the First Report of Injury and the treating physician's work ability report to the QRC prior to the consultation pursuant to Minn. Rule 5220.0130, subp. 3(A). Fill in the name of the QRC on the form and indicate which party requested the consultation. If the employee requested the consultation, fill in the date of the request.

To Request a Waiver of a Rehabilitation Consultation:

M.S. § 176.102, subd. 4 and Minn. Rules 5220.0110 and 5220.0120 provide that the commissioner may grant a waiver of a rehabilitation consultation to an otherwise qualified employee if there is documentation that the employee will return to suitable gainful employment with the date-of-injury employer within 90 calendar days after the request for waiver is filed. A waiver will be denied if no documentation is submitted showing that a suitable job offer within the treating doctor's restrictions has been made. A waiver will also be denied if a consultation has been requested.

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

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

INSTRUCTIONS TO EMPLOYEE

If you have a question about this form or rehabilitation services, call the Workers' Compensation Division at 1-800-342-5354 or 651-284-5032.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198.

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

Minnesota Department of Labor and Industry
Workers' Compensation Division
www.dli.mn.gov/WC/Wcforms.asp

Report of Work Ability

See Instructions of Reverse Side

RW 01

DO NOT USE THIS SPACE

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.
This form must be provided to the employee.
(Minn. Rules 5221.0410,l subd. 6)

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

WID or SSN	DATE OF INJURY
12345	09/04/2013
EMPLOYEE: WILLIAMS, PAT	
EMPLOYER: COMPANY ABC	
INSURER/SELF-INSURER-TPA: INSURANCE MUTUAL	
INSURER CLAIM NUMBER: WC0001-0404	

Date of most recent examination by this office 11/18/2013

Select the appropriate option(s) below and fill in the applicable dates.

1. ☐ Employee is able to work without restrictions as of _____ (date)

2. ☐ Employee is able to work with restrictions, from _____ (date) to _____ (date)

The restrictions are:

3. ☑ Employee is unable to work from 11/19/2013 (date) to 12/03/2013 (date)

The next scheduled visit is: ☑ as needed OR _____

NAME (Type or Print)	SIGNATURE	DEGREE
DR. CRUNCH		DC

ADDRESS	STATE	LICENSE #/REGISTRATION #
444 OTHER STREET	MN	99999

CITY	STATE	ZIP CODE	PHONE # (include area code)	DATE SIGNED
PEACEFUL VALLEY	MN	55800	(218) 888-8888	11/19/2013

INSTRUCTIONS FOR COMPLETING REPORT OF WORK ABILITY

Each health care provider directing the course of treatment for an employee who alleges to have incurred an injury on the job must complete a Report of Work Ability within 10 days of a request for a Report of Work Ability from the insurer, or at the applicable interval (Minn. Rules 5221.0410, subp. 6):

1. every visit if visits are less frequent that one every two weeks;

2. every 2 weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; and

3. upon expiration of the ending or review date of the restrictions specified in a previous Report of Work Ability.

The Report of Work Ability must either be on this form or in a report that contains the same information. The Report of Work Ability must:

- Identify the employee by name, WID or social security number, and date of injury.
- Identify the employer at the time of the employee's claimed work injury.
- If known, identify the workers' compensation insurer at the time of the claimed injury, or the workers' compensation third-party administrator. Also indicate this workers' compensation payer's claim number.
- Indicate the date of the most recent examination by this office. The Report of Work Ability should be completed based on this evaluation.
- Identify the appropriate option which best describes the employee's current ability to work by checking box 1, 2, or 3.
    1. If the employee is able to work without restrictions, fill in the beginning date.
    2. If the employee is able to work with restrictions, fill in the date any restriction of work activity is to begin and the anticipated ending or review date. Describe any restrictions in functional terms (e.g., employee can lift up to 20 pounds, 15 times per hour; should have 10 minute break every hour).
    3. If the employee is unable to work at all, fill in the date the restriction of work activity is to begin and the anticipated ending or review date.
- Indicate the date of the next scheduled visit or indicate that additional visits will be scheduled as needed.
- Identify the health care provider completing the report by name, professional degree, license or registration number, address and phone number.
- Include the signature of the health care provider and date of the report.

The health care provider must provide the Report of Work Ability to the employee and place a copy in the medical record.

If you have questions, please call the claim representative or the Department of Labor and Industry, Workers' Compensation Division at (651) 284-5030 or 1-800-342-5354.

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

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

The End of the Story?

After additional conservative treatment, Pat Williams has back surgery on December 30, 2013 for a herniated disc (you know that the minimum PPD rating for this is 11%). After recovering from the surgery, Pat is released to return to light duty work and returns to work four hours a day on February 10, 2014.

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

   NOID # 2 – add
   TPD 09/23 – 09/26/2013 .8 wks = $160.00
   TTD 09/27/2013 – 02/09/2014 19.2 wks = $7,680.00
   NOBP – PPD 11% X $85,000 = $9,350.00 ÷ 400 = 23.38 weeks starting on 02/10/2014
   add on back of form PPD 2 wks = $800.00
   add on benefit addendum TPD 2 wks = $400.00

2. Pat continues to work four hours a day until August 4, 2014 when Pat starts working six hours a day. Between February 24th and August 4th have you filed any additional forms with the department? If yes, fill them out.

   NOBP on July 28, 2014 showing the discontinuance of PPD. Show all benefits paid to date including TPD paid through July 27, 2014.

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

   No.

4. On August 5, 2014, you receive a HCPR form from the treating doctor stating that MMI was reached on July 8, 2014 and giving a final PPD rating of 11%. What should you do with this medical report? Why?

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

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

   None.

6. It is now July 28, 2015 and Pat Williams is still working six hours per day and still receiving TPD benefits. Do you need to file any forms with the department? If so, fill them out.

   ISR – add TPD 07/28/2014 – 07/26/2015 52 wks = $5300.00

7. On August 17, 2015, Pat Williams is able to return to work full time without a wage loss. What form needs to be filed? Fill it out.

   NOID #1 – add TPD 07/27/2015 – 08/16/2015 3 wks = $300.00

Mail or fax to:
Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

Notice of Intention to Discontinue Workers' Compensation Benefits

Print in ink or type
Enter dates in MM/DD/YYYY format

ND01

DO NOT USE THIS SPACE

WID number or SSN	Date of injury		
12345	09/04/2013		
Employee (last, first, middle initial)	Employer		
WILLIAMS, PAT	COMPANY ABC		
Employee address			
441 MAIN STREET			
City	State	ZIP code	
PEACEFUL VALLEY	MN	55800	
Insurer claim number			
WC 0001-0404			

Notes

Your benefits for (check one) ☑ temporary total disability ☐ temporary partial disability ☐ permanent total disability are being discontinued or reduced for the following reason(s):

☐ 1. You returned to work at full wage on _____ (date).

☑ 2. You returned to work at reduced hours or wage on 02/10/2014 (date).

Temporary partial disability benefits ☑ will be paid or ☐ will not be paid. Temporary partial disability benefits are usually two-thirds of the difference between your average weekly wage at the time of the injury and your current weekly wage.

☐ 3. For reasons other than return to work as stated below. (Relevant medical reports or other documents must be attached.) Payment will be made through _____ (date).

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

INSTRUCTIONS TO EMPLOYEE – THIS REQUIRES YOUR IMMEDIATE ATTENTION

Review this form to make sure your benefits have been properly paid.

You do not need to take any action if you agree the discontinuance or the reduction of benefits is proper.

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

If box 3 above is checked, you may request a conference if you think the reason for stopping your benefits is incorrect or you disagree with the proposed discontinuance. Your request must be received within 12 calendar days after this Notice of Intention to Discontinue Workers' Compensation Benefits form is received by the Workers' Compensation Division.

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

To request a conference, you must mail or deliver the attached form to the Workers' Compensation Division so it is received within these time limits. You may also request a conference by calling (651) 361-7901 (Office of Administrative Hearings) or 1-800-342-5354 (Department of Labor and Industry).

The conference will be scheduled within 10 calendar days after your request is received. You, your employer and the insurer will be invited to attend. You are not required to have an attorney for this conference. If you have an attorney, the attorney will also be invited. Bring any reports and return-to-work restrictions that show why your benefits should not be discontinued.

Instead of requesting a conference, you or your attorney may request a formal hearing by filing an Objection to Discontinuance form with the Workers' Compensation Division. A formal hearing process takes longer than the conference process. You may want to talk with an attorney.

If you have questions about your benefits, contact the claim representative whose telephone number is at the bottom of the page. If you still have questions after talking to the claim representative, contact the Workers' Compensation Division office:

525 Lake Ave. S., Suite 330
Duluth, MN 55802
(218) 733-7810
1-800-342-5354

443 Lafayette Road N.
St. Paul, MN 55155
(651) 284-5030
1-800-342-5354

Average weekly wage at DOI $ 600.00	Include contingent attorney fees in benefit totals				
The following benefits have been paid	**From**	**Through**	**Weeks**	**Rate**	**Total**
☑ Temporary total disability or	09/05/2013	09/06/2013	.4	$400.00	$160.00
☐ Permanent total disability	09/11/2013	09/22/2013	1.6	$400.00	$640.00
Notes	09/27/2013	02/09/2014	19.2	$400.00	$7,680.00
☑ Benefit addendum attached					
Temporary partial disability					
Retraining benefits					
Permanent partial disability ____ % ☐ Injuries on or after 10/01/1995 ☐ Impairment compensation (injuries 01/01/1984 through 09/30/1995) ☐ Economic recovery compensation (injuries 01/01/1984 through 09/30/1995) ☐ Part of body ____ (injuries before 01/01/1984)					

Attorney fees/expenses		**Benefit totals**	
M.S. § 176.081, subd. 1, contingent fees paid		Lump-sum payment under award or order (include contingent attorney fees)	
M.S. § 176.081, subd. 1, contingent fees still withheld		Attorney fees reimbursed to employee (M.S. § 176.081, subd. 7)	
Heaton fees paid		Interest paid	
Roraff fees paid		**Total compensation paid** (include contingent attorney fees)	$8,700.00
M.S. § 176.191 fees paid		Total supplementary benefits (include contingent attorney fees)	
Other fees paid		Total medical expenses paid to date	$15,876.30
Costs and disbursements paid			

Insurer/self-insurer/TPA			Claim representative name	
INSURANCE MUTUAL			PAULA PETERSON	
Address			Phone number (include area code)	Extension
PO BOX 007			(612) 111-1111	325
City	State	ZIP code	Date served on employee	Date served on employee's attorney
MINNEAPOLIS	MN	55400	02/11/2014	

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

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.

Send to: Workers' Compensation Division, employee and the employee's attorney (if any).

Minnesota Department of Labor and Industry
Workers' Compensation Division
www.dli.mn.gov/wc/wcforms.asp

Benefit Addendum

Enter dates in MM/DD/YYYY format.

PRINT IN INK or TYPE

WID or SSN	DATE OF INJURY
12345	09/04/2013
EMPLOYEE	
WILLIAMS, PAT	
INSURER CLAIM NUMBER	DATE SERVED ON EMPLOYEE
WC 0001-0404	02/11/2014

This addendum must be attached to one of the following benefit forms: (check one)
Use this page ONLY if you have paid more benefits than recorded on the benefit form.

- ☐ NB01
- ☑ ND01
- ☐ IS03
- ☐ BD02

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
TEMPORARY PARTIAL	09/10/2013	09/10/2013	.2		$40.00
TEMPORARY PARTIAL	09/23/2013	09/23/2013	.8		$160.00

*Include attorney fees in these totals.

Distribution: Workers' Compensation Division, Employer, Employee, Insurer

Employee's Request for Administrative Conference on Discontinuance of Workers' Compensation Benefits

EQ05

DO NOT USE THIS SPACE

Print in ink or type
Enter dates in MM/DD/YYYY format

WID number or SSN 12345	Date of injury 09/04/2013	
Employee WILLIAMS, PAT	Employer COMPANY ABC	
Employee address 411 MAIN ST		
City PEACEFUL VALLEY	State MN	ZIP code 55800
Insurer claim number WC 0001-0404	Insurer/self-insurer/TPA INSURANCE MUTUAL	

Private or confidential data you supply on this form and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by Department of Labor and Industry staff members who have authorized access to the data and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse, your claim may be delayed or denied or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the Court of Administrative Hearings; the Workers' Compensation Court of Appeals; the Department of Revenue; the Department of Health; and the Workers' Compensation Reinsurance Association.

THIS REQUIRES YOUR IMMEDIATE ATTENTION

Do not complete this form if you agree that your weekly workers' compensation benefits may be stopped or changed.

If you disagree that your benefits may be stopped or changed, you may request an administrative conference. A decision can be made at the conference about your weekly benefits.

- **If box 1 or 2** is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form, your request for a conference must be received by the Workers' Compensation Division **within 30 days after you returned to work.**
- **If box 3** is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form, your request for a conference must be received **within 12 days after a copy of the Notice of Intention to Discontinue Workers' Compensation Benefits form is received by the Workers' Compensation Division.**

Complete this section to request a conference by mail, by fax or in person
(You do not need to complete this section to request a conference by phone)

Box (check one) 1 ☐ 2 ☐ 3 ☐ is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form.

My weekly benefits should not be stopped or changed because

(Attach a separate sheet if needed)

If an interpreter is needed for conference, specify the language/dialect

Employee signature	Employee phone number (include area code)	Date
Attorney (if you have one)	Attorney phone number (include area code)	

To request a conference, take one of the following actions:

Call
(651) 361-7901; or
1-800-342-5354, press number 3

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

Fax this form
(651) 284-5731

Deliver this form
Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road N.
St. Paul, MN 55155

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

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.

Mail or fax to:
Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

Notice of Benefit Payment

Print in ink or type
Enter dates in MM/DD/YYYY format

NB01

Do not use this space

WID number or SSN	Date of injury (DOI)	Average weekly wage at DOI
12345	09/04/2013	

Employee (last, first, MI)	Employer
WILLIAMS, PAT	COMPANY ABC

Employee address
411 MAIN STREET

City	State	ZIP code
PEACEFUL VALLEY	MN	55800

Insurer claim number
WC 0001-0404

☑ **The following permanent partial disability benefit will be paid to you:**

11.000 % of whole body according to Minnesota Workers' Compensation Permanent Partial Disability Schedule rule number(s):
5223.0390 SUBP. 4D (2)

The rating is based on the attached medical report of Dr. _____

dated _____, received by the insurer on _____ (date).

☑ This payment is based on the preliminary rating. If your final disability rating is higher, additional payments may be made.

☑ **For injuries on or after 10/01/1995:**

☐ The initial payment of weekly benefits was or will be made on 02/10/2014 (date). Benefits will be paid at a weekly rate of $ $ 400.00 through 07/28/2014 (date) for a total of $ $ 9,350.00.

☐ A lump-sum payment of $ _____, instead of weekly payments, was or will be made on _____ (date) as requested by the employee on _____ (date).

☐ **For injuries from 01/01/1984 through 09/30/1995** payment of:

☐ $ _____ for **impairment compensation** was or will be paid in a lump sum on _____ (date).

☐ **Periodic impairment compensation** or ☐ **Periodic economic recovery compensation** will be paid at a weekly rate of $ _____ through _____ (date) for a total of $ _____.

☐ **Your final payment of $** _____ **for** _____ **benefits was or will be paid on** _____ **(date) according to:**

☐ **A.** An award on agreement of the parties served and filed on _____ (date).

☐ **B.** A prior Notice of Benefit Payment form for periodic payment of permanent partial disability dated _____.

☐ **C.** An administrative decision under Minnesota Statutes § 176.239 served and filed on _____ (date).

☐ **D.** A judge's decision and order served and filed on _____ (date).

☐ **Amending payment information only at the request of the Workers' Compensation Division in follow-up to a Notice of Intention to Discontinue Benefits form served on the employee on** _____ **(date).**

Instructions to employee

Review this form to make sure your benefits have been properly paid. You do not need to take any action if the benefits listed are correct.

If you have questions about your benefits, contact the claim representative whose telephone number is at the bottom of the page. If you still have questions after talking to the claim representative, contact either Workers' Compensation Division office:

525 Lake Ave. S., Suite 330
Duluth, MN 55802-2368
(218) 733-7810 or 1-800-342-5354

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

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

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.

The following benefits have been paid	From	Through	Weeks	Rate	*Total
☑ Temporary total disability or ☐ Permanent total disability	09/05/2013	09/06/2013	.4	$ 400.00	$ 160.00
	09/11/2013	09/22/2013	1.6	$ 400.00	$ 640.00
	09/27/2013	02/09/2014	19.2	$ 400.00	$ 7,680.00
☑ Benefit addendum attached					
Temporary partial disability	09/04/2013	09/04/2013	.2		$ 20.00
Retraining benefits					
Permanent partial disability 11.000 % ☐ Injuries on or after 10/01/1995 ☐ Impairment compensation (injuries 01/01/1984 through 09/30/1995) ☐ Economic recovery compensation (injuries 01/01/1984 through 09/30/1995) ☐ _____ [part of body] (injuries before 01/01/1984)			2	$ 400.00	$ 800.00

Attorney fees and attorney expenses		Benefit totals	
M.S. § 176.081, subd. 1 contingency fees paid		*Lump-sum payment under award or order	
M.S. § 176.081, subd. 1 contingency fees still withheld		Attorney fees reimbursed to employee (M.S. § 176.081, subd. 7)	
Heaton fees paid		Interest paid	
Roraff fees paid		***Total compensation paid**	$ 9,900.00
M.S. § 176.191 fees paid		*Total supplementary benefits	
Other fees paid		**Total medical expenses paid to date**	$ 15,876.30
Costs and disbursements paid			

Insurer/self-insurer/TPA	Claim representative name	
INSURANCE MUTUAL	PAULA PETERSON	
Address PO BOX 007	Phone number (include area code) (612) 111-1111	Extension 325
City / State / ZIP code MINNEAPOLIS / MN / 55400	Date served on employee 02/24/2014	Date served on attorney 02/24/2014

*Include attorney fees in these totals.

Send to: Workers' Compensation Division, employer, employee, insurer

Minnesota Department of Labor and Industry
Workers' Compensation Division
www.dli.mn.gov/wc/wcforms.asp

Benefit Addendum

Enter dates in MM/DD/YYYY format.

PRINT IN INK or TYPE

WID or SSN	DATE OF INJURY
12345	09/04/2013
EMPLOYEE	
WILLIAMS, PAT	
INSURER CLAIM NUMBER	DATE SERVED ON EMPLOYEE
WC 0001-0404	02/24/2014

This addendum must be attached to one of the following benefit forms: (check one)
Use this page ONLY if you have paid more benefits than recorded on the benefit form.

- [x] NB01
- [ ] ND01
- [ ] IS03
- [ ] BD02

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
TEMPORARY PARTIAL	09/10/2013	09/10/2013	.2		$40.00
TEMPORARY PARTIAL	09/23/2013	09/23/2013	.8		$160.00
TEMPORARY PARTIAL	02/10/2014	02/23/2014	2		$400.00

*Include attorney fees in these totals.

Distribution: Workers' Compensation Division, Employer, Employee, Insurer

MN BA01 (7/10)

Mail or fax to:
Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

Notice of Benefit Payment

Print in ink or type
Enter dates in MM/DD/YYYY format

NB01

Do not use this space

WID number or SSN	Date of injury (DOI)	Average weekly wage at DOI
12345	09/04/2013	$ 600.00

Employee (last, first, MI)	Employer
WILLIAMS, PAT	COMPANY ABC

Employee address
411 MAIN STREET

City	State	ZIP code
PEACEFUL VALLEY	MN	55800

Insurer claim number
WC 0001-0404

☐ **The following permanent partial disability benefit will be paid to you:**

_____ % of whole body according to Minnesota Workers' Compensation Permanent Partial Disability Schedule rule number(s):

_____.

The rating is based on the attached medical report of Dr. _____

dated _____, received by the insurer on _____ (date).

☐ This payment is based on the preliminary rating. If your final disability rating is higher, additional payments may be made.

☐ **For injuries on or after 10/01/1995:**

☐ The initial payment of weekly benefits was or will be made on _____ (date). Benefits will be paid at a weekly rate of $ _____ through _____ (date) for a total of $ _____.

☐ A lump-sum payment of $ _____, instead of weekly payments, was or will be made on _____ (date) as requested by the employee on _____ (date).

☐ **For injuries from 01/01/1984 through 09/30/1995** payment of:

☐ $ _____ for **impairment compensation** was or will be paid in a lump sum on _____ (date).

☐ **Periodic impairment compensation** or ☐ **Periodic economic recovery compensation** will be paid at a weekly rate of $ _____ through _____ (date) for a total of $ _____.

☑ **Your final payment of $** $ 550.00 **for** 1.38 WEEKS OF PPD **benefits was or will be paid on** 07/28/2014 **(date) according to:**

☐ **A.** An award on agreement of the parties served and filed on _____ (date).

☑ **B.** A prior Notice of Benefit Payment form for periodic payment of permanent partial disability dated 02/24/2014.

☐ **C.** An administrative decision under Minnesota Statutes § 176.239 served and filed on _____ (date).

☐ **D.** A judge's decision and order served and filed on _____ (date).

☐ **Amending payment information only at the request of the Workers' Compensation Division in follow-up to a Notice of Intention to Discontinue Benefits form served on the employee on** _____ **(date).**

(over)

Instructions to employee

Review this form to make sure your benefits have been properly paid. You do not need to take any action if the benefits listed are correct.

If you have questions about your benefits, contact the claim representative whose telephone number is at the bottom of the page. If you still have questions after talking to the claim representative, contact either Workers' Compensation Division office:

525 Lake Ave. S., Suite 330
Duluth, MN 55802-2368
(218) 733-7810 or 1-800-342-5354

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

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

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.

The following benefits have been paid	From	Through	Weeks	Rate	*Total
☑ Temporary total disability or ☐ Permanent total disability	09/05/2013	09/06/2013	.4	$ 400.00	$ 160.00
	09/11/2013	09/22/2013	1.6	$ 400.00	$ 640.00
	09/27/2013	02/09/2014	19.2	$ 400.00	$ 7,680.00
☑ Benefit addendum attached					
Temporary partial disability	09/04/2013	09/04/2013	.2		$ 20.00
Retraining benefits					
Permanent partial disability 11.000 % ☐ Injuries on or after 10/01/1995 ☐ Impairment compensation (injuries 01/01/1984 through 09/30/1995) ☐ Economic recovery compensation (injuries 01/01/1984 through 09/30/1995) ☐ _____ [part of body] (injuries before 01/01/1984)			23.38	$ 400.00	$ 9,350.00

Attorney fees and attorney expenses		Benefit totals	
M.S. § 176.081, subd. 1 contingency fees paid		*Lump-sum payment under award or order	
M.S. § 176.081, subd. 1 contingency fees still withheld		Attorney fees reimbursed to employee (M.S. § 176.081, subd. 7)	
Heaton fees paid		Interest paid	
Roraff fees paid		***Total compensation paid**	$ 22,850.00
M.S. § 176.191 fees paid		*Total supplementary benefits	
Other fees paid		**Total medical expenses paid to date**	$ 18,352.97
Costs and disbursements paid			

Insurer/self-insurer/TPA INSURANCE MUTUAL			Claim representative name PAULA PETERSON	
Address PO BOX 007			Phone number (include area code) (612) 111-1111	Extension 325
City MINNEAPOLIS	State MN	ZIP code 55400	Date served on employee 07/28/2014	Date served on attorney 07/28/2014

*Include attorney fees in these totals.

Send to: Workers' Compensation Division, employer, employee, insurer

Minnesota Department of Labor and Industry
Workers' Compensation Division
www.dli.mn.gov/wc/wcforms.asp

Benefit Addendum

Enter dates in MM/DD/YYYY format.

PRINT IN INK or TYPE

WID or SSN	DATE OF INJURY
12345	09/04/2013
EMPLOYEE	
WILLIAMS, PAT	
INSURER CLAIM NUMBER	DATE SERVED ON EMPLOYEE
WC 0001-0404	07/28/2014

This addendum must be attached to one of the following benefit forms: (check one)
Use this page ONLY if you have paid more benefits than recorded on the benefit form.

- [x] NB01
- [ ] ND01
- [ ] IS03
- [ ] BD02

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
TEMPORARY PARTIAL	09/10/2013	09/10/2013	.2		$40.00
TEMPORARY PARTIAL	09/23/2013	09/23/2016	.8		$160.00
TEMPORARY PARTIAL	02/10/2014	07/27/2014	24		$4,800.00

*Include attorney fees in these totals.

Distribution: Workers' Compensation Division, Employer, Employee, Insurer

Minnesota Department of Labor and Industry
Workers' Compensation Division
www.dli.mn.gov/wc/wcforms.asp

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

Interim Status Report

IS 03

DO NOT USE THIS SPACE

WID or SSN	DATE OF INJURY
12345	09/04/2013
EMPLOYEE	EMPLOYER
WILLIAMS, PAT	COMPANY ABC
EMPLOYEE ADDRESS	
411 MAIN STREET	
CITY / STATE / ZIP CODE	
PEACEFUL VALLEY / MN / 55800	
INSURER CLAIM NUMBER	
WC 0001-0404	

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

☑ **Temporary Total*** ☐ **Permanent Total***

	FROM	THROUGH	WEEKS	RATE	*TOTAL
Balance Carried Forward	09/05/2013	02/09/2014	21.2	$400.00	$8,480.00
				TOTAL:	$8,480.00

Temporary Partial

	FROM	THROUGH	WEEKS	RATE	*TOTAL
Balance Carried Forward	09/04/2013	07/27/2014	25.2		$5,020.00
	07/28/2014	07/26/2015	52		$5,300.00
				TOTAL:	$10,320.00

Permanent Partial

Permanent Partial Disability 11.00000 %

☑ Injuries on or after 10/01/95

☐ Impairment Compensation (injuries 01/01/1984 - 09/30/1995)

☐ Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995)

☐ _____ [part of body] (injuries before 01/01/1984)

23.38	$400.00	$9,350.00
	TOTAL:	$9,350.00

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

		FROM	THROUGH	WEEKS	RATE	TOTAL
Retraining Benefits	**Balance Carried Forward**					
					TOTAL:	
Dependency Benefits	**Balance Carried Forward**					
					TOTAL:	
Supplementary Benefits*	**Balance Carried Forward**					
					TOTAL:	

Social Security Benefits or Other Government Benefits* ☐ Retirement ☐ Disability

Name of Program: _____

FROM	THROUGH	PER WEEK

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

Attorney Fees Paid		Interest Paid	
Attorney Fees Still Withheld		Lump Sum Payment Under Award or Order	
Attorney Fees Reimbursed to Employee M.S. 176.081, subd. 7		Total Compensation Paid to Employee	$28,150.00
		Total Dependency Benefits Paid (Please attached copy of worksheet)	

INSURER/SELF-INSURER/TPA INSURANCE MUTUAL	CLAIM REPRESENTATIVE NAME PAULA PETERSON
ADDRESS PO BOX 007	PHONE NUMBER (include area code) (612) 111-1111
CITY / STATE / ZIP CODE MINNEAPOLIS / MN / 55400	DATE SERVED 07/28/2015

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

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

Mail or fax to:
Department of Labor and Industry
Workers' Compensation Division
P.O. Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

Notice of Intention to Discontinue Workers' Compensation Benefits

Print in ink or type
Enter dates in MM/DD/YYYY format

ND01

DO NOT USE THIS SPACE

WID number or SSN	Date of injury		
12345	09/04/2013		
Employee (last, first, middle initial)	Employer		
WILLIAMS, PAT	COMPANY ABC		
Employee address			
441 MAIN STREET			
City	State	ZIP code	
PEACEFUL VALLEY	MN	55800	
Insurer claim number			
WC 0001-0404			

Notes

Your benefits for (check one) ☐ temporary total disability ☑ temporary partial disability ☐ permanent total disability are being discontinued or reduced for the following reason(s):

☑ 1. You returned to work at full wage on 08/17/2015 (date).

☐ 2. You returned to work at reduced hours or wage on _____ (date).

Temporary partial disability benefits ☐ will be paid or ☐ will not be paid. Temporary partial disability benefits are usually two-thirds of the difference between your average weekly wage at the time of the injury and your current weekly wage.

☐ 3. For reasons other than return to work as stated below. (Relevant medical reports or other documents must be attached.) Payment will be made through _____ (date).

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

INSTRUCTIONS TO EMPLOYEE – THIS REQUIRES YOUR IMMEDIATE ATTENTION

Review this form to make sure your benefits have been properly paid.

You do not need to take any action if you agree the discontinuance or the reduction of benefits is proper.

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

If box 3 above is checked, you may request a conference if you think the reason for stopping your benefits is incorrect or you disagree with the proposed discontinuance. Your request must be received within 12 calendar days after this Notice of Intention to Discontinue Workers' Compensation Benefits form is received by the Workers' Compensation Division.

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

To request a conference, you must mail or deliver the attached form to the Workers' Compensation Division so it is received within these time limits. You may also request a conference by calling (651) 361-7901 (Office of Administrative Hearings) or 1-800-342-5354 (Department of Labor and Industry).

The conference will be scheduled within 10 calendar days after your request is received. You, your employer and the insurer will be invited to attend. You are not required to have an attorney for this conference. If you have an attorney, the attorney will also be invited. Bring any reports and return-to-work restrictions that show why your benefits should not be discontinued.

(over)

Instead of requesting a conference, you or your attorney may request a formal hearing by filing an Objection to Discontinuance form with the Workers' Compensation Division. A formal hearing process takes longer than the conference process. You may want to talk with an attorney.

If you have questions about your benefits, contact the claim representative whose telephone number is at the bottom of the page. If you still have questions after talking to the claim representative, contact the Workers' Compensation Division office:

525 Lake Ave. S., Suite 330
Duluth, MN 55802
(218) 733-7810
1-800-342-5354

443 Lafayette Road N.
St. Paul, MN 55155
(651) 284-5030
1-800-342-5354

Average weekly wage at DOI $ 600.00	Include contingent attorney fees in benefit totals				
The following benefits have been paid	**From**	**Through**	**Weeks**	**Rate**	**Total**
☑ Temporary total disability or	09/05/2013	09/06/2013	.4	$400.00	$160.00
☐ Permanent total disability	09/11/2013	09/22/2013	1.6	$400.00	$640.00
Notes	09/27/2013	02/09/2014	19.2	$400.00	$7,680.00
☑ Benefit addendum attached					
Temporary partial disability	09/04/2013	09/04/2013	.2		$20.00
Retraining benefits					
Permanent partial disability 11.00000 % ☑ Injuries on or after 10/01/1995 ☐ Impairment compensation (injuries 01/01/1984 through 09/30/1995) ☐ Economic recovery compensation (injuries 01/01/1984 through 09/30/1995) ☐ Part of body_____ (injuries before 01/01/1984)			23.38	$400.00	$9,350.00

Attorney fees/expenses		Benefit totals	
M.S. § 176.081, subd. 1, contingent fees paid		Lump-sum payment under award or order (include contingent attorney fees)	
M.S. § 176.081, subd. 1, contingent fees still withheld		Attorney fees reimbursed to employee (M.S. § 176.081, subd. 7)	
Heaton fees paid		Interest paid	
Roraff fees paid		**Total compensation paid** (include contingent attorney fees)	$28,450.00
M.S. § 176.191 fees paid		Total supplementary benefits (include contingent attorney fees)	
Other fees paid		Total medical expenses paid to date	$18,352.97
Costs and disbursements paid			

Insurer/self-insurer/TPA			Claim representative name	
INSURANCE MUTUAL			PAULA PETERSON	
Address			Phone number (include area code)	Extension
PO BOX 007			(612) 111-1111	325
City	State	ZIP code	Date served on employee	Date served on employee's attorney
MINNEAPOLIS	MN	55400	08/18/2015	08/18/2015

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

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.

Send to: Workers' Compensation Division, employee and the employee's attorney (if any).

Minnesota Department of Labor and Industry
Workers' Compensation Division
www.dli.mn.gov/wc/wcforms.asp

Benefit Addendum

Enter dates in MM/DD/YYYY format.

PRINT IN INK or TYPE

WID or SSN	DATE OF INJURY
12345	09/04/2013
EMPLOYEE	
WILLIAMS, PAT	
INSURER CLAIM NUMBER	DATE SERVED ON EMPLOYEE
WC 0001-0404	08/18/2015

This addendum must be attached to one of the following benefit forms: (check one)
Use this page ONLY if you have paid more benefits than recorded on the benefit form.

- ☐ NB01
- ☑ ND01
- ☐ IS03
- ☐ BD02

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
TEMPORARY PARTIAL	09/10/2013	09/10/2013	.2		$40.00
TEMPORARY PARTIAL	09/23/2013	09/26/2013	.8		$160.00
TEMPORARY PARTIAL	02/10/2014	08/03/2014	25		$5,000.00
TEMPORARY PARTIAL	08/04/2014	08/16/2015	54		$5,400.00

*Include attorney fees in these totals.

Distribution: Workers' Compensation Division, Employer, Employee, Insurer

Employee's Request for Administrative Conference on Discontinuance of Workers' Compensation Benefits

EQ05

DO NOT USE THIS SPACE

Print in ink or type
Enter dates in MM/DD/YYYY format

WID number or SSN 12345	Date of injury 09/04/2013	
Employee WILLIAMS, PAT	Employer COMPANY ABC	
Employee address 411 MAIN ST		
City PEACEFUL VALLEY	State MN	ZIP code 55800
Insurer claim number WC 0001-0404	Insurer/self-insurer/TPA INSURANCE MUTUAL	

Private or confidential data you supply on this form and in communications or proceedings that occur because you file this form, will be used to process and resolve your workers' compensation dispute. The data will be used by Department of Labor and Industry staff members who have authorized access to the data and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse, your claim may be delayed or denied or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the Court of Administrative Hearings; the Workers' Compensation Court of Appeals; the Department of Revenue; the Department of Health; and the Workers' Compensation Reinsurance Association.

THIS REQUIRES YOUR IMMEDIATE ATTENTION

Do not complete this form if you agree that your weekly workers' compensation benefits may be stopped or changed.

If you disagree that your benefits may be stopped or changed, you may request an administrative conference. A decision can be made at the conference about your weekly benefits.

- **If box 1 or 2** is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form, your request for a conference must be received by the Workers' Compensation Division **within 30 days after you returned to work.**
- **If box 3** is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form, your request for a conference must be received **within 12 days after a copy of the Notice of Intention to Discontinue Workers' Compensation Benefits form is received by the Workers' Compensation Division.**

Complete this section to request a conference by mail, by fax or in person
(You do not need to complete this section to request a conference by phone)

Box (check one) 1 ☐ 2 ☐ 3 ☐ is checked on the Notice of Intention to Discontinue Workers' Compensation Benefits form.

My weekly benefits should not be stopped or changed because

(Attach a separate sheet if needed)

If an interpreter is needed for conference, specify the language/dialect

Employee signature	Employee phone number (include area code)	Date
Attorney (if you have one)	Attorney phone number (include area code)	

To request a conference, take one of the following actions:

Call
(651) 361-7901; or
1-800-342-5354, press number 3

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

Fax this form
(651) 284-5731

Deliver this form
Department of Labor and Industry
Workers' Compensation Division
443 Lafayette Road N.
St. Paul, MN 55155

This document can be given to you in Braille, large print or audio. To request, call (651) 284-5032 or 1-800-342-5354.

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N F 01

DO NOT USE THIS SPACE

Notice of File Closing

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

WID or SSN	DATE OF INJURY
12345	09/04/2013
EMPLOYEE	
WILLIAMS, PAT	
EMPLOYER	
COMPANY ABC	
INSURER CLAIM NUMBER	
WC 0001-0404	

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

CLAIM REPRESENTATIVE NAME			DATE
PAULA PETERSON			09/14/2015
ADDRESS			INSURER/SELF-INSURER/TPA
441 MAIN STREET			INSURANCE MUTUAL
CITY	STATE	ZIP CODE	PHONE NUMBER (include area code)
MINNEAPOLIS	MN	55800	(612) 111-1111

Send completed form to:

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

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