

MAJ 2021 Proposed Workers' Compensation Legislative Changes



I. Medical Record Request Costs

Issue:

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

Current Relevant Rule/ Statute:

Minn. Rule 5219.0300

5219.0300 REASONABLE REIMBURSEMENT ALLOWANCE.

Subpart 1. First copy of appropriate record. For the first copy of the appropriate record as defined in part 5221.0100, subpart 1b, when provided by the health care provider to the payer as defined in part 5221.0100, subpart 11, to substantiate the service being billed, a charge not to exceed 75 cents per page is reasonable. This amount applies whether the record is provided with the billing, under separate cover, or in response to a request by the payer for an appropriate record which has not been submitted with the bill.

Subp. 2. Other copies. For all other copies of existing medical records or data that are not specifically addressed in subpart 1 or in Minnesota Statutes, section 176.155, or any other Minnesota statute or rule, a charge is reasonable if the total charge for each submission following a request does not exceed the sum of \$10 as a retrieval fee and 75 cents per page.

Subp. 3. Postage and other charges. In addition to the charges in subparts 1 and 2, the health care provider may charge actual postage, any applicable Minnesota sales tax, and notary fees, if notarization is requested.

Subp. 4. Time for payment. The requester must reimburse the health care provider within 30 days of receipt of the copies requested.

Proposal:

Amend MN Stat. 176.136 to include the following (see attached draft):

Subd. 3. Medical Records Costs

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

Rationale:

Cost of requesting medical records has become an increasing deterrent to representing injured workers. While reasonable costs can be recouped if a claimant attorney is successful, however, the exorbitant amount of costs can add up over the life of a claim. These costs, if lost, the claimant's attorney could potentially recover them against the injured worker. Moreover, companies like Ciox and MRO are frequently charging more than allowed and even charging additional fees such as "e-delivery fees" which are not covered under the current rule. These costs can be a roadblock for injured workers' in obtaining representation and the benefits they may be owed.

Current Rule is Outdated

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

Back in the 1990s records were significantly smaller when compared to today's records. A complete record set could be requested, and one piece of paper could contain multiple dates of service. Now, one date of service can take 20 to 30 pages with only relevant information being contained on 1 to 2 pages. Where back in the 1990s a complete record set would cost \$20-\$30 now or seen records costing hundreds if not thousands of dollars. When the petitioner's attorney is trying to get a \$300 medical bill paid but has to pay \$2000 in medical records and another \$2000 for a narrative report in order to get it paid the economics of that all doesn't make a lot of sense.

Why Now?

Claimant attorneys previously could request a copy of the Claimant's Medical File under the HI-Tech Act for a nominal retrieval fee. This was because in 2009, Congress passed the Health Information and Clinical Health Act (the Hi-Tech Act) which required medical providers to provide patients with an electronic or digital copy of their medical records at a special "patient rate," which was essentially the provider's cost-if those records were maintained in electronic format.

A ruling In January 2020 changed this. The U.S. District Court for the D.C. Circuit in Ciox Health LLC v. Azar, et al., had two harmful holdings: 1) it removed fee restrictions applied when a patient requests records be sent to a third party such as an attorney, and 2) it lifted previous rules requiring providers send records electronically at the patient's request even if the record was not stored electronically.

Ciox, and every other major record copying company, immediately began rejecting the patient's third-party attorney requests for medical records under the Hi-Tech Act and sent the attorneys large bills for copying the records. The decision has sent shockwaves through the legal community, as prices for obtaining client medical records soar and additional hurdles slow the progress of cases.

For attorneys to affordably represent injured workers costs of records need to come down.

More Denials. More Litigation. More Expenses

Attorneys are needed more now than before due to the increasing denial of worker's compensation benefits.

According to the Minnesota Department of labor and industry workers compensation system report of 2018 provides that claimant attorney involvement has increased substantially since 1998. In fact, the percentage of paid indemnity claims with a claimant attorney has risen from 16.8% in 1998 to 24.1% or a 43% increase. Furthermore, the rate of denied indemnity claims was 14.6% for 2018 and increase from 12.2 to 12.25% for a period from 2007 through 2011.

The costs of records are a deterrent for injured workers to have access to adequate council.

III. Minnesota citizens adversely affected by North Dakota Employers

Issue:

Devos v. Rhino Contracting, Inc. 940 N.W.2d 821 (Minn. 2020)

Current Relevant Statute: 176.041, subd. 5b

Subd. 5b. North Dakota employers.

Notwithstanding the provisions of subdivision 4, workers' compensation benefits for an employee hired in North Dakota by a North Dakota employer, arising out of that employee's temporary work in Minnesota, shall not be payable under this chapter. North Dakota workers' compensation law provides the exclusive remedy available to the injured worker. For purposes of this subdivision, temporary work means work in Minnesota for a period of time not to exceed 15 consecutive calendar days or a maximum of 240 total hours worked by that employee in a calendar year.

Proposal:

Repeal Minn. Stat. 176.041, subd. 5b

Rational:

Due to this statute, Minnesota citizens have unfairly been denied Minnesota based benefits for their injuries. We do not believe repealing this statute will impose a hardship on any North Dakota employer, but our primary concern is making certain that Minnesota residents can obtain the workers compensation benefits they are properly entitled to under our law

1 A bill for an act related to workers compensation medical records retrieval fees. Amending
2 Minnesota Statutes 2020, section 176.136 by adding a subdivision.
3

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:
5

6 **ARTICLE 1**
7 **MEDICAL FEE REVIEW**

8 **Subdivision 1. Schedule.**
9

10 (a) The commissioner shall by rule establish procedures for determining whether or not the
11 charge for a health service is excessive. In order to accomplish this purpose, the commissioner
12 shall consult with insurers, associations and organizations representing the medical and other
13 providers of treatment services and other appropriate groups.

14 (b) The procedures established by the commissioner must limit, in accordance with
15 subdivisions 1a, 1b, and 1c, the charges allowable for medical, chiropractic, podiatric, surgical,
16 hospital and other health care provider treatment or services, as defined and compensable under
17 section [176.135](#). The procedures established by the commissioner for determining whether or not
18 the charge for a health service is excessive must be structured to encourage providers to develop
19 and deliver services for rehabilitation of injured workers. The procedures must incorporate the
20 provisions of sections [144.701](#), [144.702](#), and [144.703](#) to the extent that the commissioner finds
21 that these provisions effectively accomplish the intent of this section or are otherwise necessary
22 to ensure that quality hospital care is available to injured employees.

23 **Subd. 1a. Relative value fee schedule.**
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25 (a) The liability of an employer for services included in the medical fee schedule is limited
26 to the maximum fee allowed by the schedule in effect on the date of the medical service, or the
27 provider's actual fee, whichever is lower. The commissioner shall adopt permanent rules
28 regulating fees allowable for medical, chiropractic, podiatric, surgical, and other health care
29 provider treatment or service, including those provided to hospital outpatients, by implementing
30 a relative value fee schedule. The commissioner may adopt by reference, according to the
31 procedures in paragraph (d), clause (2), the relative value fee schedule tables adopted for the
32 federal Medicare program. The relative value fee schedule must contain reasonable
33 classifications including, but not limited to, classifications that differentiate among health care
34 provider disciplines. The conversion factors for the original relative value fee schedule must
35 reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in
36 effect. The reduction need not be applied equally to all treatment or services, but must represent
37 a gross 15 percent reduction.

38 (b) Effective October 1, 2005, the commissioner shall remove all scaling factors from the
39 relative value units and establish four separate conversion factors for each of the following parts
40 of Minnesota Rules:

41 (1) medical/surgical services in Minnesota Rules, part [5221.4030](#), as defined in
42 part [5221.0700](#), subpart 3, item C, subitem (2);

43 (2) pathology and laboratory services in Minnesota Rules, part [5221.4040](#), as defined in
44 part [5221.0700](#), subpart 3, item C, subitem (3);

1 (3) physical medicine and rehabilitation services in Minnesota Rules, part [5221.4050](#), as
2 defined in part [5221.0700](#), subpart 3, item C, subitem (4); and

3 (4) chiropractic services in Minnesota Rules, part [5221.4060](#), as defined in part [5221.0700](#),
4 subpart 3, item C, subitem (5).

5 (c) The conversion factors shall be adjusted as follows:

6 (1) After permanent rules have been adopted to implement this section, the conversion
7 factors must be adjusted annually on October 1 by no more than the percentage change computed
8 under section [176.645](#), but without the annual cap provided by that section.

9 (2) Each time the workers' compensation relative value fee schedule tables are updated
10 under paragraph (d), the commissioner shall adjust the conversion factors so that, for services in
11 both fee schedules, there is no difference between the overall payment in each category of
12 service listed in paragraph (b) under the new schedule and the overall payment for that category
13 under the workers' compensation fee schedule most recently in effect. This adjustment must be
14 made before making any additional adjustment under clause (1).

15 (d) The commissioner shall give notice of the adjusted conversion factors and updates to the
16 relative value fee schedule as follows:

17 (1) The commissioner shall annually give notice in the State Register of the adjusted
18 conversion factors and any amendments to rules to implement Medicare relative value tables
19 incorporated by reference under this subdivision. The notices of the adjusted conversion factors
20 and amended rules to implement the relative value tables are subject to the requirements of
21 section [14.386, paragraph \(a\)](#). The annual adjustments to the conversion factors and the medical
22 fee schedules adopted under this section, including all previous fee schedules, are not subject to
23 expiration under section [14.386, paragraph \(b\)](#).

24 (2) The commissioner shall periodically, but at least once every three years, update the
25 workers' compensation relative value tables by incorporating by reference the relative value
26 tables in the national physician fee schedule relative value file established by the Centers for
27 Medicare and Medicaid Services. The commissioner shall publish the notices of the
28 incorporation by reference in the State Register at least 60 days before the tables are to become
29 effective for purposes of payment under this section. Each notice of incorporation must state the
30 date the incorporated tables will become effective and must include information on how the
31 Medicare relative value tables may be obtained. The published notices of incorporation by
32 reference and the incorporated tables are not rules subject to section [14.386](#) or other provisions
33 of chapter 14, but have the force and effect of law as of the date specified in the notices.

34 **Subd. 1b. Limitation of liability.**
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36 (a) The liability of the employer for treatment, articles, and supplies provided to an
37 employee while an inpatient or outpatient at a Critical Access Hospital certified by the Centers
38 for Medicare and Medicaid Services shall be the hospital's usual and customary charge, unless
39 the charge is determined by the commissioner or a compensation judge to be unreasonably
40 excessive.

41 (b) The liability of the employer for the treatment, articles, and supplies that are not limited
42 by paragraph (a), subdivision 1a or 1c, section [176.1362](#), [176.1363](#), or [176.1364](#), shall be limited

1 to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing
2 charges for similar treatment, articles, and supplies furnished to an injured person when paid for
3 by the injured person, whichever is lower, except as provided in paragraph (e). On this basis, the
4 commissioner or compensation judge may determine the reasonable value of all treatment,
5 services, and supplies, and the liability of the employer is limited to that amount. The
6 commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of
7 the 85 percent limitation in this paragraph. A prevailing charge established under Minnesota
8 Rules, part [5221.0500](#), subpart 2, must be based on no more than two years of billing data
9 immediately preceding the date of the service.

10 (c) The limitation of liability for charges provided by paragraph (b) does not apply to a
11 nursing home that participates in the medical assistance program and whose rates are established
12 by the commissioner of human services.

13 (d) An employer's liability for treatment, articles, and supplies provided under this chapter
14 by a health care provider located outside of Minnesota is limited to the payment that the health
15 care provider would receive if the treatment, article, or supply were paid under the workers'
16 compensation law of the jurisdiction in which the treatment was provided.

17 (e) The limitation of the employer's liability based on 85 percent of prevailing charge does
18 not apply to charges by an ambulatory surgical center as defined in section [176.1363, subdivision](#)
19 [1](#), paragraph (b), or a hospital as defined in section [176.1364, subdivision 1](#), paragraph (e).

20 (f) For purposes of this chapter, "inpatient" means a patient that has been admitted to a
21 hospital by an order from a physician or dentist. If there is no inpatient admission order, the
22 patient is deemed an outpatient. The hospital must provide documentation of an inpatient order
23 upon the request of the employer.

24 **Subd. 1c. Charges for independent medical examinations.**

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26 The commissioner shall adopt rules that reasonably limit amounts which may be charged
27 for, or in connection with, independent or adverse medical examinations requested by any party,
28 including the amount that may be charged for depositions, witness fees, or other expenses. No
29 party may pay fees above the amount in the schedule.

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31 **Subd. 2. Excessive fees.**

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33 If the employer or insurer determines that the charge for a health service or medical service
34 is excessive, no payment in excess of the reasonable charge for that service shall be made under
35 this chapter nor may the provider collect or attempt to collect from the injured employee or any
36 other insurer or government amounts in excess of the amount payable under this chapter unless
37 the commissioner, compensation judge, or court of appeals determines otherwise. In such a case,
38 the health care provider may initiate an action under this chapter for recovery of the amounts
39 deemed excessive by the employer or insurer. A charge for a health service or medical service is
40 excessive if it:

41 (1) exceeds the maximum permissible charge pursuant to subdivision 1, 1a, 1b, or 1c;

42 (2) is for a service provided at a level, duration, or frequency that is excessive, based upon
43 accepted medical standards for quality health care and accepted rehabilitation standards;

1 (3) is for a service that is outside the scope of practice of the particular provider or is not
2 generally recognized within the particular profession of the provider as of therapeutic value for
3 the specific injury or condition treated; or

4 (4) is otherwise deemed excessive or inappropriate pursuant to rules adopted pursuant to
5 this chapter.

6 **Subd. 3 Medical Records Costs**

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