

**Workers' Compensation Draft Legislation**

**For Discussion with the Workers' Compensation Advisory Council**

**January 28, 2009**

## Rehabilitation Services; Job Placement and Medical Management

(Page 17)

### 176.102. Rehabilitation

#### Subd. 9. Plan; costs.

(a) An employer is liable for the following rehabilitation expenses under this section:

(1) cost of rehabilitation evaluation and preparation of a plan;

(2) cost of all rehabilitation services and supplies necessary for implementation of the plan, except as provided in paragraphs c, d and e;

(3) reasonable cost of tuition, books, travel, and custodial day care; and, in addition, reasonable costs of board and lodging when rehabilitation requires residence away from the employee's customary residence;

(4) reasonable costs of travel and custodial day care during the job interview process;

(5) reasonable cost for moving expenses of the employee and family if a job is found in a geographic area beyond reasonable commuting distance after a diligent search within the present community. Relocation shall not be paid more than once during any rehabilitation program, and relocation shall not be required if the new job is located within the same standard metropolitan statistical area as the employee's job at the time of injury. An employee shall not be required to relocate and a refusal to relocate shall not result in a suspension or termination of compensation under this chapter; and

(6) any other expense agreed to be paid.

(b) Charges for services provided by a rehabilitation consultant or vendor must be submitted on a billing form prescribed by the commissioner. No payment for the services shall be made until the charges are submitted on the prescribed form.

(c) Except as provided in this paragraph, an employer is not liable for charges for services provided by a rehabilitation consultant or vendor unless the employer or its insurer receives a bill for those services within 45 days of the provision of the services. The commissioner or a compensation judge may order payment for charges not timely billed under this paragraph if the rehabilitation consultant or vendor can prove that the failure to submit the bill as required by this paragraph was due to circumstances beyond the control of the rehabilitation consultant or vendor. A rehabilitation consultant or vendor

may not collect payment from any other person, including the employee, for bills that an employer is relieved from liability for paying under this paragraph.

(d) A rehabilitation consultant shall not attend an employee's medical appointment unless the employee and employer have both approved the attendance in writing before the date of the appointment;

(e) The employer is not liable for the cost of more than six months of job placement services per rehabilitation plan, or for the cost of more than 20 hours of job placement service hours per month, unless the employer has approved the additional services in writing before they are provided. The six month time period starts with the date that the job placement plan and agreement is signed by all parties. The limitations in this paragraph apply whether the job placement services are provided by a vendor or by the rehabilitation firm of the employee's assigned rehabilitation consultant.

## Make Treatment Parameters Statutorily Enforced

(Page 21)

### 176.135 Treatment; appliances; supplies.

Subdivision 1. Medical, psychological, chiropractic, podiatric, surgical, hospital.

(a) The employer shall furnish any medical, psychological, chiropractic, podiatric, surgical and hospital treatment, including nursing, medicines, medical, chiropractic, podiatric, and surgical supplies, crutches and apparatus, including artificial members, or, at the option of the employee, if the employer has not filed notice as hereinafter provided, Christian Science treatment in lieu of medical treatment, chiropractic medicine and medical supplies, as may **reasonably be required** at the time of the injury and any time thereafter to cure and relieve from the effects of the injury. This treatment shall include treatments necessary to physical rehabilitation. Treatment, articles and supplies that meet all of the criteria and indications of applicable treatment parameters adopted pursuant to Minn. Stat. §176.83, subd. 5 are reasonably required under this section. Treatment, articles and supplies that do not meet all of the criteria and indications of applicable treatment parameters are presumed to be not reasonably required. This presumption is rebuttable only by substantial medical evidence that:

- 1) a reason for departure from the treatment parameters exists, including any reason adopted by the commissioner pursuant to section 176.83, subd. 5;
- 2) the reason for the departure necessitates treatment outside the parameters; and
- 3) the proposed treatment is reasonably required.

### 176.83, subd. 5. Treatment standards for medical services

In consultation with the Medical Services Review Board ~~or the rehabilitation review panel~~, the commissioner shall adopt rules establishing standards and procedures for health care provider treatment. The rules shall apply uniformly to all providers including those providing managed care under section 176.1351. The rules shall be used to determine whether a provider of health care services and rehabilitation services, including a provider of medical, chiropractic, podiatric, surgical, hospital, or other services, is performing procedures or providing services at a level or with a frequency that is excessive, unnecessary, or inappropriate under section 176.135, subdivision 1, ~~based upon accepted medical standards for quality health care and accepted rehabilitation standards.~~ The process in section 14.389 may be used to adopt and amend rules proposed by the commissioner under this subdivision if the Medical Services Review Board has recommended the proposed medical standards or procedures.

The rules shall include, but are not limited to, the following:

- (1) criteria for diagnosis and treatment of the most common work-related injuries including, but not limited to, low back injuries and upper extremity repetitive trauma injuries;
- (2) criteria for surgical procedures including, but not limited to, diagnosis, prior conservative treatment, supporting diagnostic imaging and testing, and anticipated outcome criteria;
- (3) criteria for use of appliances, adaptive equipment, and use of health clubs or other exercise facilities;
- (4) criteria for diagnostic imaging procedures;
- (5) criteria for inpatient hospitalization; and
- (6) criteria for treatment of chronic pain.

If it is determined by the payer that the level, frequency or cost of a procedure or service of a provider is excessive, unnecessary, or inappropriate according to the standards established by the rules, the provider shall not be paid for the procedure, service, or cost by an insurer, self-insurer, or group self-insurer, and the provider shall not be reimbursed or attempt to collect reimbursement for the procedure, service, or cost from any other source, including the employee, another insurer, the special compensation fund, or any government program unless the commissioner or compensation judge determines at a hearing or administrative conference that the level, frequency, or cost was not excessive under the rules in which case the insurer, self-insurer, or group self-insurer shall make the payment deemed reasonable.

A rehabilitation provider who is determined by the Rehabilitation Review Panel Board, after hearing, to be consistently performing procedures or providing services at an excessive level or cost may be prohibited from receiving any further reimbursement for procedures or services provided under this chapter. A prohibition imposed on a provider under this subdivision may be grounds for revocation or suspension of the provider's license or certificate of registration to provide health care or rehabilitation service in Minnesota by the appropriate licensing or certifying body. The commissioner and Medical Services Review Board shall review excessive, inappropriate, or unnecessary health care provider treatment under section 176.103.

## Medical Bill Payment Data

### 176.135 Treatment; appliances; supplies.

#### Subd. 6. Commencement of payment.

As soon as reasonably possible, and no later than 30 calendar days after receiving the bill, the employer or insurer shall pay the charge or any portion of the charge which is not denied, or deny all or a part of the charge with written notification to the employee and the provider explaining the basis for denial, except that the employer or insurer is not required to notify the employee of payment of charges that have been reduced in accordance with section 176.136, subdivisions 1, 1a or 1b. All or part of a charge must be denied if any of the following conditions exists:

- (1) the injury or condition is not compensable under this chapter;
- (2) the charge or service is excessive under this section or section [176.136](#);
- (3) the charges are not submitted on the prescribed billing form; or
- (4) additional medical records or reports are required under subdivision 7 to substantiate the nature of the charge and its relationship to the work injury.

If payment is denied under clause (3) or (4), the employer or insurer shall reconsider the charges in accordance with this subdivision within 30 calendar days after receiving additional medical data, a prescribed billing form, or documentation of enrollment or certification as a provider.

#### Subd. 7. Medical bills and records.

Health care providers shall submit to the insurer an itemized statement of charges in the standard electronic format that is required under section 62J.536, or if there is no prescribed standard electronic format on a billing form prescribed by the commissioner. ~~A paper billing form is not required if the health care provider and insurer agree to electronic submission under section 62J.535.~~ Health care providers shall also submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury. Health care providers may charge for copies of any records or reports that are in existence and directly relate to the items for which payment is sought under this chapter. The commissioner shall adopt a schedule of reasonable charges by rule.

A health care provider shall not collect, attempt to collect, refer a bill for collection, or commence an action for collection against the employee, employer, or any other party until the information required by this section has been furnished.

A United States government facility rendering health care services to veterans is not subject to the uniform billing form requirements of this subdivision.

## Penalty for Improper Collection of Medical Bills from Employee

(Page 21)

### 176.136. Medical Fee Review

#### Subd. 2. Excessive fees.

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

- (1) exceeds the maximum permissible charge pursuant to subdivision 1, 1a, 1b, or 1c;
- (2) is for a service provided at a level, duration, or frequency that is excessive, based upon accepted medical standards for quality health care and accepted rehabilitation standards;
- (3) is for a service that is outside the scope of practice of the particular provider or is not generally recognized within the particular profession of the provider as of therapeutic value for the specific injury or condition treated; or
- (4) is otherwise deemed excessive or inappropriate pursuant to rules adopted pursuant to this chapter.

(b) In addition to any action that may be taken under section 176.103, the commissioner may assess a penalty of \$2500 against a health care provider that collects or attempts to collect payment from the employee payment in violation of paragraph (a) or section 176.83, subd. 5, paragraph (c). Half of the penalty (\$1250) shall be paid to the employee and half of the penalty (\$1250) shall be paid to the commissioner for deposit in the assigned risk safety account.

## IMEs Must Be Performed in a Physician's Office

(Page 23)

### 176.155. Examinations

#### Subdivision 1. Employer's physician.

The injured employee must submit to examination by the employer's physician if requested by the employer, and at reasonable times thereafter upon the employer's request. The examination must take place in a licensed medical facility, or in an existing physician's office established for the diagnosis and treatment of patients. The examination must be scheduled at a location within 150 miles of the employee's residence unless the employer can show cause to the department to order an examination at a location further from the employee's residence. The employee is entitled upon request to have a personal physician present at any such examination. Each party shall defray the cost of that party's physician. Any report or written statement made by the employer's physician as a result of an examination of the employee, regardless of whether the examination preceded the injury or was made subsequent to the injury, shall be made available, upon request and without charge, to the injured employee or representative of the employee. The employer shall pay reasonable travel expenses incurred by the employee in attending the examination including mileage, parking, and, if necessary, lodging and meals. The employer shall also pay the employee for any lost wages resulting from attendance at the examination. A self-insured employer or insurer who is served with a claim petition pursuant to section 176.271, subdivision 1, or 176.291, shall schedule any necessary examinations of the employee, if an examination by the employer's physician or health care provider is necessary to evaluate benefits claimed. The examination shall be completed and the report of the examination shall be served on the employee and filed with the commissioner within 120 days of service of the claim petition.

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

(1) that the extension is necessary because of the limited number of physicians or health care providers available with expertise in the particular injury or disease, or that the extension is necessary due to the complexity of the medical issues, or (2) that the extension is necessary to gather additional information which was not included on the petition as required by section 176.291.

## Electronic Medical Billing and Payment Data

(Page 36)

### 176.135. Treatment; Appliances; Supplies

**Subp. 8. Data.** Each self-insured employer and insurer shall retain or arrange for the retention of (a) all billing data electronically transmitted by health care providers for payment for the treatment of workers' compensation claims; and (b) the employer or insurer's electronically transmitted payment remittance advice. The self-insured employer or insurer shall ensure that the data in clauses (a) and (b) shall be retained for ten years in the standard electronic format that is required by rules adopted by the commissioner of the department of health under section 62J.536. The data shall be provided in the standard electronic format to the commissioner of the department of labor and industry within 120 days of the commissioner of labor and industry's request, and shall be used to analyze the costs and outcomes of treatment in the workers' compensation system. The data collected by the commissioner of labor and industry under this section is confidential data on individuals and protected nonpublic data, except that the commissioner may publish aggregate statistics and other summary data on the costs and outcomes of treatment in the workers' compensation system.

## Incorporate Court Decision Regarding PPD Table (Page 36)

### 176.101. Compensation Schedule.

#### Subd. 2a. **Permanent partial disability.**

(a) Compensation for permanent partial disability is as provided in this subdivision. Permanent partial disability must be rated as a percentage of the whole body in accordance with rules adopted by the commissioner under section 176.105. The percentage determined pursuant to the rules must be multiplied by the corresponding amount in the following table:

Impairment rating (percent)	Amount
<del>0-5.0</del> <u>less than 5.5</u>	\$ 75,000
<del>6-10</del> <u>5.5 to less than 10.5</u>	80,000
<del>11-15</del> <u>10.5 to less than 15.5</u>	85,000
<del>16-20</del> <u>15.5 to less than 20.5</u>	90,000
<del>21-25</del> <u>20.5 to less than 25.5</u>	95,000
<del>26-30</del> <u>25.5 to less than 30.5</u>	100,000
<del>31-35</del> <u>30.5 to less than 35.5</u>	110,000
<del>36-40</del> <u>35.5 to less than 40.5</u>	120,000
<del>41-45</del> <u>40.5 to less than 45.5</u>	130,000
<del>46-50</del> <u>45.5 to less than 50.5</u>	140,000
<del>51-55</del> <u>50.5 to less than 55.5</u>	165,000
<del>56-60</del> <u>55.5 to less than 60.5</u>	190,000
<del>61-65</del> <u>60.5 to less than 65.5</u>	215,000
<del>66-70</del> <u>65.5 to less than 70.5</u>	240,000
<del>71-75</del> <u>70.5 to less than 75.5</u>	265,000
<del>76-80</del> <u>75.5 to less than 80.5</u>	315,000
<del>81-85</del> <u>80.5 to less than 85.5</u>	365,000
<del>86-90</del> <u>85.5 to less than 90.5</u>	415,000
<del>91-95</del> <u>90.5 to less than 95.5</u>	465,000
<del>96-100</del> <u>95.5 to 100</u>	515,000

An employee may not receive compensation for more than a 100 percent disability of the whole body, even if the employee sustains disability to two or more body parts.

## **Incorporate Court Decision Prohibiting Credit Against Penalty**

(Page 36)

### **176.179. Recovery of Overpayments**

Notwithstanding section 176.521, subdivision 3, or any other provision of this chapter to the contrary, except as provided in this section, no lump-sum or weekly payment, or settlement, which is voluntarily paid to an injured employee or the survivors of a deceased employee in apparent or seeming accordance with the provisions of this chapter by an employer or insurer, or is paid pursuant to an order of the workers' compensation division, a compensation judge, or court of appeals relative to a claim by an injured employee or the employee's survivors, and received in good faith by the employee or the employee's survivors shall be refunded to the paying employer or insurer in the event that it is subsequently determined that the payment was made under a mistake in fact or law by the employer or insurer. When the payments have been made to a person who is entitled to receive further payments of compensation for the same injury, the mistaken compensation may be taken as a partial credit against future periodic benefits. The credit applied against further payments of temporary total disability, temporary partial disability, permanent partial disability, permanent total disability, retraining benefits, death benefits, or weekly payments of economic recovery or impairment compensation shall not exceed 20 percent of the amount that would otherwise be payable.

A credit may not be applied against medical expenses due or payable, or against a penalty awarded for late payment or underpayment of benefits. However, a credit may be applied against a lump sum award of interest accrued on the benefit that was overpaid.

Where the commissioner or compensation judge determines that the mistaken compensation was not received in good faith, the commissioner or compensation judge may order reimbursement of the compensation. For purposes of this section, a payment is not received in good faith if it is obtained through fraud, or if the employee knew that the compensation was paid under mistake of fact or law, and the employee has not refunded the mistaken compensation.

## Same Reporting Period for Fatalities as OSHA

(Page 36)

### **176.231. Report of Death or Injury to Commissioner of Department of Labor and Industry**

#### **Subdivision 1. Time limitation.**

Where death or serious injury occurs to an employee during the course of employment, the employer shall report the injury or death to the commissioner and insurer within ~~48~~ 24 hours after its occurrence. Where any other injury occurs which wholly or partly incapacitates the employee from performing labor or service for more than three calendar days, the employer shall report the injury to the insurer on a form prescribed by the commissioner within ten days from its occurrence. An insurer and self-insured employer shall report the injury to the commissioner no later than 14 days from its occurrence. Where an injury has once been reported but subsequently death ensues, the employer shall report the death to the commissioner and insurer within ~~48~~ 24 hours after the employer receives notice of this fact.

**Clarify Penalty Authority and Performance Expectations for the Special  
Compensation Fund; the Minnesota Insurance Guarantee Fund; the Self  
Insured Security Fund and Employer Payers under Minn. Stat. § 176.185**  
(Page 36)

**176.253 Insurer, employer; other payers; performance of acts.**

(a) Where this chapter requires an employer to perform an act, the insurer of the employer may perform that act. Where the insurer acts in behalf of the employer, the employer is responsible for the authorized acts of the insurer and for any delay, failure, or refusal of the insurer to perform the act. This section does not relieve the employer from any penalty or forfeiture which this chapter imposes on the employer.

(b) The commissioner and compensation judges have the authority to assess penalties under this chapter against: the special compensation fund on claims involving uninsured employers as defined by 176.183 subd. 1; employers liable for claims under section 176.185, subd. 8a; the Minnesota insurance guaranty association established under chapter 60C; and the self-insurers security fund established under chapter 79A.

For purposes of assessing a penalty for failure to pay or deny a claim under this chapter against the insurance guaranty association, the self-insurers security fund, or an employer liable for a claim under section 176.185, subd. 8a, the time frame for the entity to pay or deny a claim under this chapter begins when the entity has received the claim file and sufficient information to determine liability for coverage of the claim.

For purposes of assessing a penalty against the special compensation fund for failure to timely pay or deny a claim, the time frame begins when the special compensation fund has received sufficient information to determine liability for coverage of the claim and, if applicable, has provided the ten-day notice provided in section 176.183, subd. 4.

## Hearings Scheduled within Two Years

(Page 24)

### **176.341. Hearing on Petition.**

#### **Subdivision 1. Time.**

Upon receipt of a matter from the commissioner, the chief administrative law judge shall fix a time and place for hearing the petition. The hearing shall be held as soon as practicable and at a time and place determined by the chief administrative law judge to be the most convenient for the parties, keeping in mind the intent of chapter 176 and the requirements of section 176.306. Except where a shorter time period is required under this chapter, all hearings must be held within twenty-six months after a petition has been filed, unless the chief administrative law judge issues an order for a later date for the hearing explaining why the hearing could not be held within 26 months.

#### **Subd. 2. Place.**

Unless otherwise ordered by the chief administrative law judge, the hearing shall be held in the county where the injury or death occurred.

#### **Subd. 3. Notice mailed to each party.**

Unless subdivision 6 applies, at least 30 days prior to the date of hearing, the chief administrative law judge shall mail a notice of the time and place of hearing to each interested party. This subdivision does not apply to hearings which have been continued from an earlier date. In those cases, the notice shall be given in a manner deemed appropriate by the chief administrative law judge after considering the particular circumstances in each case.

#### **Subd. 4. Continuances.**

Only the chief administrative law judge or designee, on a showing of good cause, may grant a continuance of a hearing at the office. Except in cases of emergency or other good cause shown, any request for a continuance must be signed by both the party and the attorney seeking the continuance.

A continuance of a hearing will be granted only upon a showing of good cause. Good cause is established when the underlying eventuality is unforeseen, is not due to lack of preparation, is relevant, is brought to the chief administrative law judge's attention in a timely manner and does not prejudice the adversary.

Continuances will not be granted for the reason that an attorney for one of the parties has scheduled a vacation for the date set for the hearing unless the attorney has, prior to the setting of the hearing date, notified the office of the unavailable dates.

Continuances which are requested during the course of a hearing are subject to the same standards but may be granted or denied by the compensation judge assigned to the hearing. Continuances of prehearing or settlement conferences at the department or at the office are subject to the same standards but may be granted or denied by a compensation

judge, the calendar judge, or other presiding officer assigned to the prehearing or settlement conference.

**Subd. 5.Evidence.**

Absent a clear showing of surprise at the hearing or the unexpected unavailability of a crucial witness, all evidence must be submitted at the time of the hearing. Upon a showing of good cause, the compensation judge may grant an extension not to exceed 30 days following the hearing date.

**Subd. 6.Significant financial hardship; expedited hearings.**

An employee may file a request for an expedited hearing which must be granted upon a showing of significant financial hardship. In determining whether a significant financial hardship exists, consideration shall be given to whether the employee is presently employed, the employee's income from all sources, the nature and extent of the employee's expenses and debts, whether the employee is the sole support of any dependents, whether either foreclosure of homestead property or repossession of necessary personal property is imminent, and any other matters which have a direct bearing on the employee's ability to provide food, clothing, and shelter for the employee and any dependents.

A request for an expedited hearing must be accompanied by a sworn affidavit of the employee providing facts necessary to satisfy the criteria for a significant financial hardship. The request may be made at the time a claim petition is filed or any time thereafter. Unless the employer objects to the request in the answer to the claim petition or within 20 calendar days of the filing of a request made subsequent to the filing of the claim petition, the affidavit is a sufficient showing of significant financial hardship.

If a request for an expedited hearing has been served and filed, the commissioner or compensation judge shall issue an order granting or denying the request, provided that where the parties agree that significant financial hardship exists or no objection to the request is timely filed, the request is automatically granted and the compensation judge or commissioner need not issue an order. If it is denied, the matter will be returned to the regular calendar of cases and the request for an expedited hearing may be renewed at a settlement conference. If no objection has been timely filed or if the request is granted, the commissioner shall immediately refer the matter to the office to commence prehearing procedures.

The calendar judge shall issue a prehearing order and notice of the date, time, and place for a prehearing conference which shall be set for no later than 45 days following the filing of the affidavit of significant financial hardship. The prehearing order shall require the parties to serve and file prehearing statements no later than five working days prior to the date set for the prehearing conference. The prehearing statements shall include those items listed in the joint rules of the division and the office which the calendar judge deems appropriate. Following any prehearing conference and absent an agreement or stipulation from the parties, the commissioner or compensation judge shall issue an order establishing deadlines for the parties to complete their preparation for hearing and, after consultation with the calendar judge, establishing the date, time, and place for a hearing.

## Data Sharing with State Agencies

(Page 37)

### **176.181. Insurance.**

Subd. 8. Data sharing. (a) The Departments of Labor and Industry, Employment and Economic Development, Human Services, Agriculture, Transportation, and Revenue are authorized to share information regarding the employment status of individuals, including but not limited to social security numbers and payroll and withholding and income tax information, and may use that information for purposes consistent with this section and regarding the employment or employer status and federal employer identification numbers of individuals, partnerships, limited liability companies, corporations, or employers, including but not limited to, general contractors, intermediate contractors, and subcontractors. The commissioner shall request data in writing or pursuant to a state agency agreement, and the responding department shall respond to the request by producing the requested data within 30 days.

b) The commissioner is authorized to inspect and to order the production of all payroll and other business records and documents of any alleged employer in order to determine the employment status of persons and compliance with this section. If any person or employer refuses to comply with such an order, the commissioner may apply to the district court of the county where the person or employer is located or may apply to Ramsey County or the county where the nearest office of the Department of Labor and Industry is located, for an order compelling production of the documents.

### **176.186. Records from other state agencies.**

Notwithstanding any other state law to the contrary except chapter 270B, the commissioner may obtain from the department of employment and economic development, and the Office of the Secretary of State, or any other state agency, upon request, the names or lists of employers doing business in the state. ~~This information shall be treated by the commissioner in the manner provided by chapter 13 and shall be used only for insurance verification by the commissioner.)~~

# Meetings of the Medical Services Review and Rehabilitation Review Panel

## 176.103 Medical Health Care Review

### Subd. 3. Medical Services Review Board; selection; powers

(d) Except where the board is making a decision in a contested case matter under paragraph (b), the board may conduct a meeting of its members by telephone or other electronic means so long as the following conditions are met:

(1) all members of the board participating in the meeting, wherever their physical location, can hear one another and can hear all discussion and testimony;

(2) members of the public present at the regular meeting location of the board can hear clearly all discussion and testimony and all votes of members of the board and, if needed, receive those services required by sections 15.44 and 15.441;

(3) at least one member of the board is physically present at the regular meeting location; and

(4) all votes are conducted by roll call, so each member's vote on each issue can be identified and recorded.

Each member of the board participating in a meeting by telephone or other electronic means is considered present at the meeting for purposes of determining a quorum and participating in all proceedings.

If telephone or other electronic means is used to conduct a regular, special, or emergency meeting, the board, to the extent practical, shall allow a person to monitor the meeting electronically from a remote location. The board may require the person making such a connection to pay for documented costs that the board incurs as a result of the additional connection.

If telephone or other electronic means is used to conduct a regular, special, or emergency meeting, the board shall provide notice of the regular meeting location, of the fact that some members may participate by telephone or other electronic means, and that a person may monitor the meeting electronically from a remote location. Any person monitoring the meeting electronically from a remote location may be required to pay documented costs incurred by the board as a result of the additional connection. The timing and method of providing notice is governed by section 13D.04.

## 176.102. Rehabilitation

### Subd. 3c. Rehabilitation Review Panel meetings.

Except where the rehabilitation review panel is making a decision in a contested case matter under subdivisions 3, 3a or 3b, the panel may conduct a meeting of its members by telephone or other electronic means so long as the following conditions are met:

(1) all members of the panel participating in the meeting, wherever their physical location, can hear one another and can hear all discussion and testimony;

(2) members of the public present at the regular meeting location of the panel can hear clearly all discussion and testimony and all votes of members of the panel and, if needed, receive those services required by sections 15.44 and 15.441;

(3) at least one member of the panel is physically present at the regular meeting location; and

(4) all votes are conducted by roll call, so each member's vote on each issue can be identified and recorded.

Each member of the panel participating in a meeting by telephone or other electronic means is considered present at the meeting for purposes of determining a quorum and participating in all proceedings.

If telephone or other electronic means is used to conduct a regular, special, or emergency meeting, the panel, to the extent practical, shall allow a person to monitor the meeting electronically from a remote location. The panel may require the person making such a connection to pay for documented costs that the board incurs as a result of the additional connection.

If telephone or other electronic means is used to conduct a regular, special, or emergency meeting, the panel shall provide notice of the regular meeting location, of the fact that some members may participate by telephone or other electronic means, and that a person may monitor the meeting electronically from a remote location. Any person monitoring the meeting electronically from a remote location may be required to pay documented costs incurred by the panel as a result of the additional connection. The timing and method of providing notice is governed by section 13D.04.