APPENDIX

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STATE OF MINNESOTA
IN SUPREME COURT

A20-1525

DANIEL BIERBACH,
Respondent,

v.

DIGGER'S POLARIS, AND
STATE AUTO/UNITED FIRE & CASUALTY GROUP,
Relators.

Filed: October 13, 2021

OPINION

ANDERSON, Justice.

In 2004, respondent Daniel Bierbach suffered a work-related ankle injury while working for his employer, relator Digger's Polaris. Eventually, Bierbach was diagnosed with intractable pain and enrolled in Minnesota's medical cannabis research program. *See* Minn. Stat. §§ 152.21–.37 (2020). He then filed a claim petition, seeking reimbursement from his former employer for the cost of the medical cannabis. The compensation judge granted the petition. The Workers' Compensation Court of Appeals (WCCA) affirmed. *Bierbach v. Digger's Polaris*, No. WC19-6314, slip op. at 2 (Minn. WCCA Nov. 10, 2020).

On appeal to our court, relators Digger's Polaris and State Auto/United Fire & Casualty Group raise four issues. First, did the WCCA correctly conclude that it lacks subject matter jurisdiction to decide arguments that require interpreting federal law, including a question of preemption? Second, does the federal Controlled Substances Act (CSA), 21 U.S.C. §§ 801-971, preempt the requirement in Minnesota law for an employer to reimburse an injured employee for the cost of medical treatment, Minn. Stat. § 176.135, subd. 1(a) (2020), when the treatment for which payment is sought is medical cannabis? Third, does the expert opinion relied on by the workers' compensation judge lack foundation? Fourth, is medical cannabis reasonable and necessary to treat Bierbach's pain?

We addressed the same questions of jurisdiction and preemption in a companion case, *Musta v. Mendota Heights Dental Center*, A20-1551, 965 N.W.2d 312 (Minn. Oct. 13, 2021). For the reasons stated in that opinion, we hold that the WCCA lacks jurisdiction to decide whether federal law preempts Minnesota law that requires an employer to furnish medical treatment when the treatment for which reimbursement is sought is medical cannabis. We also hold that the CSA preempts the compensation court's order mandating relators to pay for Bierbach's medical cannabis. Because these holdings resolve this dispute, we do not reach the remaining issues.

For the foregoing reasons, we reverse the decision of the Workers' Compensation Court of Appeals.

Reversed.

CONCURRENCE & DISSENT

CHUTICH, Justice (concurring in part, dissenting in part).

For the reasons set forth in my concurrence and dissent in *Musta v. Mendota Heights Dental Center*, No. A20-1551, slip op. at C/D-1, 965 N.W.2d 312, 328 (Minn. Oct. 13, 2021) (Chutich, J., concurring in part, dissenting in part), I join in the court's decision that the Workers' Compensation Court of Appeals (WCCA) lacks subject matter jurisdiction to decide whether federal law preempts state workers' compensation law, Minn. Stat. § 176.135, subd. 1(a) (2020), to the extent that the state law requires an employer to reimburse an employee for the purchase of medical cannabis. But I respectfully dissent from the court's holding that the federal Controlled Substances Act, 21 U.S.C. §§ 801-971, preempts section 176.135 to the extent that this Minnesota law requires an employer to reimburse an employee for the purchase of medical cannabis.

Because I would hold that section 176.135 is *not* preempted by federal law, I would reach the remaining issues, which were not present in *Musta*.[1] I conclude that the opinion of respondent Daniel Bierbach's treating physician, Dr. Coetzee, has adequate foundation, and that substantial evidence supports the findings of the compensation judge—both that medical cannabis can be a reasonable and necessary treatment for intractable pain and that it was reasonable and necessary in Bierbach's case. Because

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[1] In *Musta*, the parties stipulated that medical cannabis was reasonable and necessary to treat the employee's pain. *Musta*, 965 N.W.2d at 316. Consequently, only the preliminary question of WCCA jurisdiction and the issue of preemption were before us in that case.

the court's decision overextends the preemptive scope of the Controlled Substances Act and denies Bierbach treatment that is reasonable, necessary, and crucial to keeping him meaningfully employed, I respectfully dissent.

I.

I begin with an overview of the state's medical cannabis program and then explain the facts giving rise to this dispute.

A.

The Legislature has established a research program to study the benefits of medical cannabis for people with certain painful conditions. Minn. Stat. § 152.21, subd. 1 (2020) ("The intent of this section is to establish an extensive research program to investigate and report on the therapeutic effects of THC under strictly controlled circumstances . . . ."). The statutes governing the program, Minn. Stat. §§ 152.21-.37 (2020), are called the THC Therapeutic Research Act (THC Act). Minn. Stat. § 152.21, subd. 7.

Patients who are enrolled in the state's program are permitted to obtain and use medical cannabis without criminal liability under state law. Minn. Stat. § 152.32. But medical cannabis possession and use remains prohibited under federal law. 21 U.S.C. § 812.

To enroll in the state's medical cannabis program, a patient must submit an application, signed disclosure, and application fee. Minn. Stat. § 152.27, subd. 6(a). The application must include a certification from the patient's health care provider that the patient is diagnosed with a qualifying medical condition. *Id.*, subd. 3(a)(4). Effective in 2016, the Commissioner of Health approved "intractable pain" as a qualifying condition. 45 Minn. Reg. 1299 (June

14, 2021); *see also* Minn. Stat. § 152.22, subd. 14(10) (permitting the commissioner to approve new qualifying conditions).

To remain enrolled in the program, a patient must submit a doctor's certification annually, Minn. Stat. § 152.27, subd. 3(b), and pay the annual fee. The patient may only obtain medical cannabis from one of two registered manufacturers, *see* Minn. Stat. § 152.25, subd. 1(a) (requiring the commissioner to register two in-state manufacturers).

B.

With that overview, I turn to the facts of the case. On April 7, 2004, respondent Daniel Bierbach suffered a work-related ankle injury when the ATV he was driving rolled over. At the time of the accident, he was 25 years old and employed by Digger's Polaris.[2]

Bierbach underwent surgery on his left ankle, performed by Dr. J. Chris Coetzee. After the surgery, he engaged in physical therapy. He also took opioids for a short time but weaned himself off them. Over the next 15 years, under the guidance of Dr. Coetzee and other health care professionals, Bierbach used various techniques to manage the pain as his ankle slowly deteriorated. Those treatments included an ankle brace, compression icing, cortisone ankle injections, an ankle boot, and over-the-counter anti-inflammatory medications. Dr. Coetzee has also stated that Bierbach would likely need an ankle replacement in the future, but that he is currently too young for such a procedure.

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[2] The insurer for Digger's Polaris is United Auto/United Fire & Casualty Group, which is also a party to this appeal. Collectively, I refer to Digger's Polaris and United Auto as "Digger's Polaris."

In April 2018, Dr. Coetzee certified Bierbach as having intractable pain.[3] He was approved to participate in the state's medical cannabis program, and he began purchasing medical cannabis from one of the registered cannabis manufacturers. The manufacturer's records show that, between April 2018 and February 2019, Bierbach's dosage more than doubled. The dosage was increased to "reflect [his] current use," and to help him manage the pain from increased activity, including Bierbach's return to full-time work. According to those records, he was not able to afford as much medical cannabis as he needed and on at least one occasion, he had to wait several weeks after running out before purchasing a refill. Bierbach reported getting good daytime relief, completing more yardwork at home, and sleeping better. The total cost of his current dosage plan is about $1,860 per month.

The opinions of two experts were admitted as evidence. In his June 2018 letter, Dr. Coetzee stated that Bierbach continued to develop progressive degenerative changes in his ankle following his work injury; he was doing reasonably well, but not great, with the ankle injections. Dr. Coetzee observed that Bierbach's ankle continued to be very sore and swollen with or without activity, that he walked with a limp, and that he was limited in his daily activity and continued to gain weight because he could not

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[3] Under the workers' compensation rules, "intractable pain" means "a pain state in which the cause of the pain cannot be removed or otherwise treated with the consent of the patient and in which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts." Minn. Stat. § 152.125, subd. 1; *see* Minn. R. 5221.6040, subp. 8a (2019) (incorporating the definition from section 152.125, subdivision 1).

exercise without pain. Consequently, Dr. Coetzee opined that Bierbach would be a great candidate for medical cannabis "to help with his intractable pain and wean off of narcotic pain medication."

In February 2019, Dr. Christopher Meyer issued an independent medical examination report. Dr. Meyer documented substantial swelling of Bierbach's left ankle and agreed that he had chronic left ankle pain related to his degenerative joint disease resulting from his work-related injury. In assessing whether medical cannabis was an appropriate treatment for Bierbach's pain, Dr. Meyer stated that the treatment of chronic pain is "under significant debate." He explained that classic treatments include "bracing, ice, as well as medications such as anti-inflammatories and has involved the use of narcotics." But he noted that the use of narcotics has come under "significant scrutiny." While acknowledging that medical cannabis is recognized as a safer alternative to opioid use, Dr. Meyer opined that the "medical objective data supporting" its use for chronic pain "continues to be controversial." Consequently, he stated that he was "not a believer in the use of medical cannabis for chronic pain," and Dr. Meyer recommended that Bierbach be evaluated for a chronic pain program.

In March 2019, Dr. Coetzee responded to Dr. Meyer's report. He stated that Bierbach suffered increased ongoing pain that was aggravated by physical activity, and he noted that Bierbach had already tried various treatments, including cortisone injections, a brace, and opioids. He acknowledged that Bierbach had already weaned himself off opioids, but Dr. Coetzee opined that Bierbach would need something more than anti-inflammatory medications to alleviate his intractable pain and concluded that Dr. Meyer's advice would result in ongoing

opioid use. Dr. Coetzee opined that medical cannabis is significantly better for chronic pain than opioids, and he noted that Bierbach had tried, and responded well to, medical cannabis. Accordingly, Dr. Coetzee reiterated his opinion that "medical marijuana is an appropriate medication for Mr. Bierbach's condition."

At a hearing held by the compensation judge, Bierbach testified that he works as a sales associate at a large outfitter store over 60 hours a week and is on his feet for 90 percent of the day. He stated that he gets enormous swelling and discoloration when he is on his feet for extended periods of time. And despite trying various treatments, such as icing, medications, and ankle injections, his pain has slowly increased over the past 15 years since his work injury. He further explained that medical cannabis has provided him substantial relief by taking away the pain during the day and helping him sleep at night. Bierbach also testified that medical cannabis has helped him maintain employment and has improved his relationships with his family. He noted, however, that he sometimes runs out of his supply and cannot afford to refill it immediately and that he would use medical cannabis "a lot more" if he could afford it.

Bierbach admitted that he has misused drugs and alcohol in the past. He acknowledged to using recreational cannabis "[t]hroughout [his] life" but denied using it in recent years. Bierbach also admitted receiving two DWI's, including one in 2017 that was followed by chemical dependency treatment. He stated that he never informed Dr. Coetzee or the cannabis manufacturer of his DWI convictions because he was never asked. Bierbach also acknowledged that Dr. Coetzee has no control over the frequency or amount of medical cannabis that he

receives under the program and that no one monitors his use.

In his Findings and Order, the compensation judge determined that the Workers' Compensation Act, Minn. Stat. §§ 176.001-.862 (2020), requires reimbursement for medical cannabis use, but he determined that he lacked jurisdiction to decide questions involving the federal Controlled Substances Act, 21 U.S.C. §§ 801-971. Under state law, the compensation judge found that medical cannabis was reasonable and necessary because Bierbach faced chronic pain without an effective alternative treatment. The judge found that the opinion of Dr. Coetzee was more persuasive than the opinion of Dr. Meyer, and the judge credited Bierbach's testimony about his pain, the decreasing efficacy of cortisone injections, and the benefits of using medical cannabis. The compensation judge also determined that Bierbach's use of medical cannabis was sufficiently regulated under a general treatment parameter, Minn. R. 5221.6050, subp. 1 (2019), and under the Department of Health's regulation of the medical cannabis program. Accordingly, the compensation judge ordered Digger's Polaris to pay for Bierbach's prior medical cannabis costs.[4]

The Workers' Compensation Court of Appeals (WCCA) affirmed, holding that the compensation judge did not abuse his discretion by crediting the opinion of Dr. Coetzee over the opinion of Dr. Meyer. *Bierbach v. Digger's Polaris*, No. WC19-6314, slip op. at 5 (Minn. WCCA Nov. 10, 2020). The WCCA also upheld the compensation judge's finding that medical cannabis is compensable under state law and that

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[4] Bierbach's counsel acknowledged at oral argument that the compensation judge's order for reimbursement applied only to the specific past expenses submitted to the court.

medical cannabis is reasonable and necessary to treat Bierbach's pain. *Id.* at 6-7. Finally, the WCCA held that it did not have jurisdiction to decide whether the federal Controlled Substances Act preempts state law. *Id.* at 7.

Digger's Polaris sought review by certiorari on four issues: 1) whether the WCCA correctly determined that it did not have subject matter jurisdiction to decide questions that involve federal law, including a question of preemption, 2) whether the Controlled Substances Act, 21 U.S.C. §§ 801-971, preempts state law to the extent that Minnesota Statutes section 176.135, subdivision 1(a), requires an employer to reimburse an employee for reasonably necessary medical treatment, which in this case includes the purchase of medical cannabis, 3) whether the compensation judge abused his discretion by relying on the medical opinion of Dr. Coetzee instead of the opinion of Dr. Meyer, and 4) whether substantial evidence supports the compensation judge's finding that medical cannabis is reasonable and necessary to treat Bierbach's intractable pain.

I agree with the court that WCCA lacks subject matter jurisdiction to decide the preemption question, but I disagree with the court that federal law preempts the reimbursement order made under section 176.135. Because my reasoning on these two issues is set forth in my concurrence and dissent in *Musta*, 965 N.W.2d at 328, I focus here on the issues that are unique to this case. These issues are whether Dr. Coetzee's opinion has adequate foundation and whether substantial evidence supports the finding that medical cannabis is reasonable and necessary to treat Bierbach's intractable pain.

II.

Digger's Polaris challenges Dr. Coetzee's expertise and the factual basis for his opinion. It contends that Dr. Coetzee lacked the relevant expertise to opine that medical cannabis is reasonable and necessary because he is not a pain specialist, has never prescribed medical cannabis, and generally lacks education and experience in treating pain with medical cannabis. Bierbach counters that these objections go only to the weight, and not to the admissibility, of Dr. Coetzee's opinion, and therefore we should defer to the credibility determination by the compensation judge.

We apply "a very deferential standard . . . when reviewing a determination as to expert qualification, reversing only if there has been a clear abuse of discretion." *Teffeteller v. Univ. of Minnesota*, 645 N.W.2d 420, 427 (Minn. 2002) (citation omitted) (internal quotation marks omitted). "The qualifications of an expert do not usually go to the admissibility of the expert's opinion but merely to its weight." *Ruether v. State*, 455 N.W.2d 475, 477 (Minn. 1990); *see also Burke v. Precision Eng'g*, 1997 WL 581202 at *5 (Minn. WCCA Aug. 21, 1997) ("Once [an] expert medical opinion has been admitted into evidence without objection, that evidence may no longer be entirely disregarded by the compensation judge, and the evidentiary issue becomes one of weight rather than of competence.").

Because Digger's Polaris did not object to the admission of Dr. Coetzee's written opinions into evidence—in fact, Digger's Polaris offered the letters into evidence—their challenge to his expertise goes

to evidentiary weight, not admissibility. *Burke*, 1997 WL 581202 at *5.[5]

Digger's Polaris also claims that Dr. Coetzee lacked a sufficient factual foundation to opine because he relied on two pieces of medical literature that are not in the record, his first opinion incorrectly assumed that Bierbach was still using opioids, and he may have been unaware of Bierbach's prior alcohol and drug misuse. Accordingly, Digger's Polaris asserts that the compensation judge erred by relying on the opinion of Dr. Coetzee rather than the opinion of Dr. Meyer. Bierbach responds that, as his treating provider, Dr. Coetzee had an adequate factual foundation for the opinions provided and that the compensation judge permissibly weighed the conflicting expert opinions and found the opinion of Dr. Coetzee to be more persuasive than that of Dr. Meyer.

"It is well established that a compensation judge's choice among conflicting expert opinions must be upheld unless the opinion lacked adequate factual foundation." *Mattick v. Hy-Vee Foods Stores*, 898

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[5] Even if the question of admissibility were properly preserved, I would conclude that Dr. Coetzee is adequately qualified because he has extensive training and experience in treating ankle injuries. *See Marquardt v. Schaffhausen*, 941 N.W.2d 715, 719 (Minn. 2020) (requiring an expert to have "the necessary schooling and training" plus "practical or occupational experience" with the subject matter to testify). Dr. Coetzee is an orthopedic surgeon sub-specializing in foot and ankle surgery who performed Bierbach's surgery and has directed his course of pain management treatment for over 15 years. Although the full extent of Dr. Coetzee's training or experience with medical cannabis is unclear, Dr. Coetzee has observed Bierbach's response to the use of medical cannabis and has knowledge of medical literature relating to medical cannabis use. Consequently, the compensation judge did not abuse his discretion in admitting Dr. Coetzee's letters.

N.W.2d 616, 621 (Minn. 2017). An expert opinion lacks adequate foundation when it "does not include the facts and/or data upon which the expert relied in forming [the] opinion," *Steffen v. Target Stores*, 517 N.W.2d 579, 581 (Minn. 1994), does not "explain the basis for [the] opinion," *Welton v. Fireside Foster Inn*, 426 N.W.2d 883, 887 (Minn. 1988), or when the expert assumes facts that "are not supported by the evidence," *Schuette v. City of Hutchinson*, 843 N.W.2d 233, 237 (Minn. 2014). *See Hudson v. Trillium Staffing*, 896 N.W.2d 536, 540 (Minn. 2017) (concluding that an expert opinion lacked foundation on each of these grounds). "An expert need not be provided with every possible fact, but must have enough facts to form a reasonable opinion that is not based on speculation or conjecture." *Gianotti v. Indep. Sch. Dist. 152*, 889 N.W.2d 796, 802 (Minn. 2017). Whether an expert's opinion has adequate foundation is a determination for the compensation judge, subject to review for an abuse of discretion. *Mattick*, 898 N.W.2d at 621.

Based on my review of the record, I conclude that Dr. Coetzee had an adequate factual basis for opining that medical cannabis is reasonable and necessary to treat Bierbach's pain. The record amply supports Dr. Coetzee's opinion that traditional pain management treatments are not adequate for Bierbach's pain. The record establishes that Bierbach tried physical therapy, an ankle brace, an ankle boot, compression icing, cortisone injections, and anti-inflammatory drugs with decreasing effectiveness over 15 years. And because of Bierbach's relatively young age, ankle-replacement surgery is not advisable at this time.

Dr. Coetzee's opinion that medical cannabis is substantially better for chronic pain than opioids is

also amply supported. Dr. Coetzee cited two articles indicating that medical cannabis is currently being used to replace opioids for pain management,[6] and even Dr. Meyer agreed that medical cannabis is safer than opioids. Moreover, Dr. Coetzee observed Bierbach's positive response to the use of medical cannabis between April 2018 and February 2019. *See* Minn. Stat. § 152.28, subd. 1(a)(5) (requiring a certifying provider to "agree to continue treatment of the patient's qualifying medical condition and report medical findings to the commissioner [of health]").

The attempts by Digger's Polaris to undermine Dr. Coetzee's opinion are not persuasive. Digger's Polaris is correct that Dr. Coetzee mistakenly reasoned that medical cannabis would help Bierbach wean off opioids, when in fact he had not used opioids for years. But Dr. Coetzee gave additional reasons why medical cannabis is reasonable and necessary, which are independently sufficient to sustain his opinion. Specifically, he explained that Bierbach needs more than anti-inflammatory medications and that, while helpful, cortisone injections do not provide adequate relief. He further explained that apart from medical cannabis, Bierbach would have to resort to long-term use of opioids, which Dr. Meyer agreed is more dangerous than use of medical cannabis. Consequently, Dr. Coetzee's opinion is adequately supported.

In addition, although the evidence does not show that Dr. Coetzee knew of Bierbach's history of chemi-

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[6] Although the medical articles cited by Dr. Coetzee are not in the record, workers' compensation proceedings are not bound by the usual rules of evidence, pleading, or procedure. Minn. Stat. § 176.411, subd. 1 (2020). Even if they were, Minnesota Rule of Evidence 703(a) permits an expert to rely on inadmissible facts or data if commonly relied on by experts in the field.

cal substance use, an expert "need not be provided with every possible fact," but need only "have enough facts to form a reasonable opinion that is not based on speculation or conjecture." *Gianotti*, 889 N.W.2d at 802. I conclude that this standard is met here, particularly given that the record does not show any current or recent chemical substance misuse.

Because Dr. Coetzee's opinion was admitted without objection and had an adequate factual basis, the compensation judge acted within his discretion when he weighed the conflicting opinions of Dr. Coetzee and Dr. Meyer and found that Dr. Coetzee's opinion was "more persuasive and in line" with the medical evidence in the case. *See Ruether*, 455 N.W.2d at 478 ("[I]t is axiomatic that a conflict in the opinions of expert medical witnesses is to be resolved by the trier of fact."). I therefore conclude that the compensation judge did not abuse his discretion in relying on the opinion of Dr. Coetzee instead of the opinion of Dr. Meyer.

III.

Having addressed the dispute over Dr. Coetzee's opinion, I now consider whether substantial evidence supports the compensation judge's finding that medical cannabis is reasonable and necessary to treat Bierbach's intractable pain. Although the primary question is an evidentiary one, the parties also raise questions about the interpretation of various statutes and administrative rules.

Digger's Polaris makes many arguments why medical cannabis cannot be reasonable and necessary to treat Bierbach's pain. Because possession of medical cannabis is illegal under federal law, Digger's Polaris contends that medical cannabis is per se unreasonable and unnecessary under the

workers' compensation laws. Even if it is not per se unreasonable and unnecessary, Digger's Polaris maintains, medical cannabis is not "medically necessary treatment" under the administrative rules because there is no prescribing "provider" and because medical cannabis is not "consistent with the current accepted standards of practice." *See* Minn. R. 5221.6040, subp. 10 (2019), Minn. R. 5221.6050, subp. 1(A) (2019). It further argues that the compensation judge and WCCA relied on a mistaken understanding of the definition of "illegal substance" in the workers' compensation administrative rules. *See* Minn. R. 5221.6040, subp. 7a (2019). Finally, Digger's Polaris asserts that the record does not support a finding that medical cannabis is reasonable and necessary for Bierbach's pain.

Bierbach responds that substantial evidence supports the compensation judge's finding. He points to his treatment history, his own testimony, and the opinion of Dr. Coetzee. Bierbach further argues that the accepted standards of practice for using medical cannabis are the requirements established by the Legislature for a patient to participate in the state's medical cannabis research program. I address each of the parties' arguments in turn.

Construing a statute or administrative rule is a question of law subject to de novo review. *Ross v. N. States Power Co.*, 442 N.W.2d 296, 297 (Minn. 1989) (statute); *Johnson v. Darchuks Fabrication, Inc.*, 926 N.W.2d 414, 419 (Minn. 2019) (administrative rule). We first determine whether the language of the statute or rule is ambiguous. *Johnson*, 926 N.W.2d at 419. If the language is subject to more than one reasonable interpretation, the statute or rule is ambiguous. *Id.* But if the language is unambiguous,

we construe it according to its plain meaning in light of the statute or rule as a whole. *Id.*

We "will not disturb findings affirmed by the WCCA unless the findings are manifestly contrary to the evidence or unless the evidence clearly requires reasonable minds to adopt a contrary conclusion." *Pelowski v. K-Mart Corp.*, 627 N.W.2d 89, 92 (Minn. 2001). Rather, when a compensation judge's findings are supported by substantial evidence, we affirm a decision of the WCCA upholding those findings. *See Oseland by Oseland v. Crow Wing Cnty.*, 928 N.W.2d 744, 756 (Minn. 2019).

A.

I turn first to the argument by Digger's Polaris that medical cannabis is per se unreasonable and unnecessary.[7] The Workers' Compensation Act

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[7] As a preliminary matter, Bierbach argues that the compensation judge and the WCCA did not have jurisdiction to determine whether medical cannabis is per se unreasonable based on its status as a Schedule I drug, because determining whether cannabis is illegal under federal law requires interpreting federal law. The compensation judge held that he did not have jurisdiction, but the WCCA disagreed. The court does not reach this question because it resolved the case on other grounds.

The WCCA is correct. The determination of the compensability of a particular medical treatment for a work-related injury is squarely within the jurisdiction of the WCCA. *See* Minn. Stat. § 175A.01, subd. 5 (2020) (conferring jurisdiction over "all questions of law and fact arising under the workers' compensation laws of the state"). Although the WCCA may not interpret and apply foreign law, *see*, *e.g.*, *Martin v. Morrison Trucking, Inc.*, 803 N.W.2d 365, 369 (Minn. 2011), it may determine certain questions ancillary to a compensation claim, *see*, *e.g.*, *Seehus v. Bor-Son Constr., Inc.*, 783 N.W.2d 144, 152 (Minn. 2010), or look to foreign law for instruction in limited circumstances, *see*, *e.g.*, *Sundby v. City of St. Peter*, 693 N.W.2d 206, 215-16 (Minn. 2005). I conclude that the compensation judge and the WCCA

requires employers to furnish "any medical . . . treatment . . . as may *reasonably be required* . . . to . . . relieve from the effects of the injury." Minn. Stat. § 176.135, subd. 1(a) (emphasis added). Under federal law, cannabis is classified as a Schedule I controlled substance, 21 U.S.C. § 812(c), and therefore its possession is illegal, 21 U.S.C. § 844(a). Accordingly, the question is whether medical cannabis can be a reasonable and necessary treatment within the scope of section 176.135, subdivision 1, when its possession is illegal under federal law. This question of statutory interpretation is reviewed de novo. *Ross*, 442 N.W.2d at 297.

Digger's Polaris asserts that medical cannabis is per se *unreasonable* because Bierbach cannot knowingly possess cannabis without committing a federal crime and because it cannot reimburse him for his purchase without aiding, abetting, and conspiring to further that crime. This argument is incorrect. For the reasons explained in my concurring and dissenting opinion in *Musta*, 965 N.W.2d at 328, Digger's Polaris cannot be liable for aiding and abetting. Moreover, it cannot be liable for conspiring to further a possession offense because it shared no goal of helping Bierbach possess cannabis. *See Hager v. M&K Constr.*, 246 N.J. 1, 247 A.3d 864, 889 (2021) (holding that an employer would not be liable for conspiracy by reimbursing an employee for the purchase of medical cannabis under court order because there would be no "unity of purpose").

Next, Digger's Polaris contends that medical cannabis is per se *unnecessary* because Congress has

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were permitted to look to federal law to determine the narrow question of the legality of possessing medical cannabis to resolve a claim of compensability raised by Bierbach.

found that Schedule I drugs—and therefore cannabis—have "a high potential for abuse," have "no currently accepted medical use in treatment in the United States," and lack "accepted safety for use of the drug or other substance under medical supervision." 21 U.S.C. § 812(b)(1).

This argument is flawed because Minnesota workers' compensation law does not entrust the finding of medical necessity to Congress. To the contrary, state law entrusts a state official, the Commissioner of Labor and Industry, with establishing guidelines for determining whether a treatment is reasonable and necessary. *See* Minn. Stat. § 176.83, subd. 5(a) (2020) (requiring the commissioner to adopt rules for determining when treatment is "excessive, unnecessary, or inappropriate under section 176.135, subdivision 1"). Those determinations, in turn, must be "based upon accepted medical standards." *Id.*

Generally, whether a treatment is medically necessary depends on its consistency with an applicable treatment parameter. *See* Minn. R. 5221.6040, subp. 10 (defining "[m]edically necessary treatment" as those health services that are "consistent with any applicable treatment parameter"). The treatment parameters are rules that establish criteria for determining when a treatment is advisable for a particular condition, consistent with accepted medical standards. *See Johnson*, 926 N.W.2d at 418 (explaining that the treatment parameters are standards that set out reasonable medical treatment based on certain accepted medical and rehabilitation standards that are intended to control the costs for compensable medical treatment). For example, parameters govern the use of medications, *see* Minn. R. 5221.6105 (2019), long-term opioid use, Minn. R. 5221.6110 (2019), and chronic pain management, Minn. R. 5221.6600

(2019). The parameters also establish various limitations, such as how long a treatment may continue, *see*, *e.g.*, Minn. R. 5221.6600, subp. 2(B)(3) (permitting use of a health club for 13 weeks), or in what order treatment must progress, *see*, *e.g.*, Minn. R. 5221.6105, subp. 2(B) (requiring a generic ibuprofen or naproxen to be used before other drugs of the same type). When a specific treatment parameter does not apply, as is the case here, a treatment may be medically necessary if it is "consistent with the current accepted standards of practice within the scope of the provider's licensure or certification." Minn. R. 5221.6040, subp. 10.

Certainly, the congressional finding that there is "no currently accepted medical use in treatment in the United States" is relevant *evidence* of the absence of an accepted medical standard. But it need not be determinative of the "current standards of practice" if other evidence suggests otherwise. Accordingly, I conclude that medical cannabis is not per se unreasonable or unnecessary medical treatment, and instead requires a case-by-case determination.[8]

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[8] Because I resolve this question under a plain-language analysis, I need not address additional arguments by Digger's Polaris that are based on the absurdity and constitutional-avoidance canons. As it admits, those canons generally apply only to ambiguous statutes. *See Schatz v. Interfaith Care Ctr.*, 811 N.W.2d 643, 651 (Minn. 2012) (absurdity canon); *State v. Altepeter*, 946 N.W.2d 871, 877 (Minn. 2020) (constitutional-avoidance canon).

Similarly, I need not address an argument of Digger's Polaris based on amendments to the THC Act because the argument is premised on the canon of *in pari materia*, which applies only to ambiguous statutes. *State v. Thonesavanh*, 904 N.W.2d 432, 437 (Minn. 2017) (explaining that, under the canon of *in pari materia*, two statutes with common purposes and subject matter may be construed together to resolve an ambiguity).

B.

Next, I turn to the argument by Digger's Polaris that medical cannabis is not medically necessary treatment under the workers' compensation administrative rules because there is no prescribing "provider" and because the use of medical cannabis to treat a work-related injury is not consistent with accepted standards of practice.

1.

Because no specific treatment parameter governs the use of medical cannabis, *see* Minn. R. 5221.6050-.6600 (2019), medical cannabis is medically necessary, and therefore compensable, if it is "for the diagnosis or cure and significant relief of a condition consistent with the *current accepted standards of practice* within the scope of the *provider's* license or certification." Minn. R. 5221.6040, subp. 10 (emphasis added).

The question here is what role the "provider" must play in relation to the "treatment." According to Digger's Polaris, the provider must "order" the

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I agree with Digger's Polaris that the compensation judge and the WCCA improperly relied on the definition of "illegal substance" in the administrative rules to determine that medical cannabis is compensable. *See* Minn. R. 5221.6040, subp. 7a (defining "illegal substance" by excluding the use of medical cannabis by patients in the medical cannabis research program). As acknowledged by the Department of Labor & Industry, which promulgated the administrative rules that govern medical services for workers' compensation claimants, the definition of illegal substance and the related rules "do not address whether treatment with medical cannabis is compensable under workers' compensation law." *Compact*, Minn. Dep't Lab. & Ind., Aug. 2015, at 2. Nevertheless, I reject the arguments by Digger's Polaris that medical cannabis is per se unreasonable and unnecessary for the reasons already explained.

treatment. Because Dr. Coetzee did not order or prescribe medical cannabis for Bierbach—he merely certified that Bierbach has a qualifying condition and opined that Bierbach was a good candidate for the state's medical cannabis program—Digger's Polaris maintains that the provider requirement is not met.

I disagree. Although it is apparent that a provider must have some role to play in the employee's acquiring of the treatment, limiting a provider's role to "ordering" a treatment is not reasonable in light of the meanings of "treatment" and "provider." "Treatment" is defined in the rules as "any procedure, operation, consultation, supply, product, or other thing *performed or provided* for the purpose of curing or relieving an injured worker from the effects of a compensable injury under [section 176.135, subdivision 1]." Minn. R. 5221.0100 subp. 15 (emphasis added). And "provider" means "a physician . . . or any other person who *furnishes* a medical or health service to an employee under this chapter." Minn. Stat. § 176.011, subd. 12a (emphasis added); *see* Minn. R. 5221.0100, subp. 12 (incorporating the definition of "provider" from section 176.011). These definitions show that, at a minimum, a provider may "furnish," "perform," or "provide" a treatment. Moreover, other rules use an even greater variety of words to describe the relationship between a provider and treatments. *See*, *e.g.*, Minn. R. 5221.6050, subps. 1(B) ("ordered"), 2 ("provided"), 3 ("offering or performing"), 4 ("prescribed"), 5 ("offer"), 6(B)(3) ("use"), 8(C) ("delivered"), 9 ("provide").

Given the variety of ways that the rules describe the relationship between a provider and the treatment at issue, the role of a provider in rule 5221.6040, subpart 10, cannot be read narrowly. *See Johnson*, 926 N.W.2d at 420 (adopting an interpreta-

tion that made sense "in light of the other language" in the rule). At the very least, a provider must include one who "provides" a treatment, which means "to supply or make [that treatment] available." *Provide*, *Merriam Webster's Collegiate Dictionary* 940 (10th ed. 1996). Unquestionably, Dr. Coetzee is a healthcare provider because he is an experienced surgeon. Although Dr. Coetzee did not prescribe Bierbach's medical cannabis, he certified that Bierbach has a qualifying condition, which is a prerequisite to participating in the state's medical cannabis program. Accordingly, Dr. Coetzee's certification made medical cannabis available to Bierbach. And similar to a prescription that may be valid for only a fixed period of time, Bierbach is required to seek re-certification from a doctor annually. Minn. Stat. § 152.27, subd. 3(b). I therefore conclude that the "provider" requirement of the definition is satisfied.

2.

Digger's Polaris next argues that medical cannabis is not a medically necessary treatment because no amount of medical cannabis is "consistent with the current accepted standards of practice." It argues that because doctors cannot lawfully prescribe medical cannabis, no accepted standards of practice could have developed. For the same reason, Digger's Polaris insists that any amount of medical cannabis is excessive. *See* Minn. Stat. § 176.136, subd. 2 (permitting an employer or insurer to refuse to pay an "excessive" fee, including a charge for a service that is "provided at a level, duration, or frequency that is excessive, based upon accepted medical standards").

Bierbach responds that the accepted standards of practice are the requirements for participating in the state's medical cannabis program. By finding that

medical cannabis was reasonable and necessary for him, the compensation judge impliedly found that using medical cannabis to manage intractable pain is consistent with accepted standards of practice. Accordingly, I must determine whether this implied finding is "manifestly contrary to the evidence." *Pelowski*, 627 N.W.2d at 92.

The requirements for participating in the state's medical cannabis program do not reveal the accepted standards of medical practice because the Legislature, not medical professionals, established a *research* program. Nevertheless, other evidence in the record adequately supports the compensation judge's implied finding that treating intractable pain with medical cannabis is consistent with accepted medical standards.

The compensation judge's finding is supported by various parts of each expert's opinion. Dr. Coetzee and Dr. Meyer agreed that medical professionals are reasonably certain that medical cannabis is safer than opioids for long-term use to treat chronic pain. Although Dr. Meyer opined that the objective medical data in support of medical cannabis is "controversial" and does not himself support the use of medical cannabis for pain management, he acknowledged the significant anecdotal evidence of the effectiveness of medical cannabis for that purpose. In addition, Dr. Coetzee opined with "a reasonable degree of medical certainty" that medical cannabis is an "appropriate medication" for Bierbach's intractable pain, relying on two articles that he interprets as showing that medical cannabis is currently replacing opioids as a safer treatment alternative. Dr. Coetzee's position is seemingly corroborated by the author of one of those articles, who, according to Dr. Coetzee, strongly encouraged patients to talk with their doctors about

using medical cannabis instead of opioids for managing long-term pain.

Digger's Polaris and amici curiae cite to publicly available studies or reports concerning the use of medical cannabis to treat pain.[9] For example, Digger's Polaris points to findings by Congress and the Drug Enforcement Agency that use of cannabis to treat medical conditions lacks acceptance in the United States. *See* 21 U.S.C. § 812(b)(1)(B); Denial of Petition to Initiate Proceedings to Reschedule Marijuana, 81 Fed. Reg. 53767 (Aug. 12, 2016). Digger's Polaris also cites to reports that conclude the clinical evidence supporting the use of medical cannabis to treat pain is weak. *See*, *e.g.*, Mary Butler, Ph.D., M.B.A., et al. Office of Medical Cannabis, Minn. Dep't of Health, *Medical Cannabis for Non-Cancer Pain: A Systematic Review* 24 (undated) (concluding that the medical literature studying the use of medical cannabis to treat chronic non-cancer pain "is sparse, patchy, of low quality, and leads to generally insufficient evidence for most patient populations and treatments"). On the other hand, amicus curiae Minnesota Association for Justice cites to a 2018 study stating that medical cannabis has been an effective alternative to opioids for pain relief for

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[9] We may take judicial notice of government websites and commissioned studies even though not part of the record below. *See State v. Jobe*, 486 N.W.2d 407, 420 n.3 (Minn. 1992) (taking judicial notice of a report issued by the Committee on DNA Technology in Forensic Science of the National Research Council); *Missourians for Fiscal Accountability v. Klahr*, 830 F.3d 789, 793 (8th Cir. 2016) (recognizing that a court may take judicial notice of government websites). Because Bierbach did not object to the request of Digger's Polaris for judicial notice, I consider the government sources cited by Digger's Polaris and amici curiae.

patients in the state's medical cannabis research program. Press Release, Minn. Dep't of Health, *Medical Cannabis Study Shows Significant Number of Patients Saw Pain Reduction of 30 Percent or More* (Mar. 1, 2018).

Notably, Dr. Coetzee's opinion and the study cited by amicus curiae Minnesota Association for Justice in support of the use of medical cannabis to treat pain are more recent than the report cited by Digger's Polaris to assert that the data is sparse and of low quality. Although the evidence is mixed, I conclude that substantial evidence supports a finding that using medical cannabis for intractable pain relief as an alternative to opioids is consistent with accepted standards of practice. Accordingly, the compensation judge's finding is not manifestly contrary to the evidence and deserves deference. *Oseland*, 928 N.W.2d at 755.

C.

I turn now to the question of whether medical cannabis is reasonable and necessary to treat Bierbach's pain under the facts of this case. Digger's Polaris challenges the evidentiary basis for the compensation judge's finding that medical cannabis is reasonable and necessary to treat Bierbach's intractable pain. Bierbach responds that the record contains ample evidence to support the compensation judge's finding, including Bierbach's treatment records, his testimony, and Dr. Coetzee's opinion. Again, I must defer to the findings of the compensation judge unless they are manifestly contrary to the evidence. *Pelowski*, 627 N.W.2d at 92.

The record contains substantial evidence that medical cannabis is appropriate to treat Bierbach's pain. Digger's Polaris does not dispute that he has

intractable pain and that traditional treatments, including icing, ankle injections, and over-the-counter anti-inflammatories are no longer adequate for managing the pain from his degenerative ankle condition. Digger's Polaris also does not deny that an ankle-replacement surgery is inappropriate for Bierbach at this time because of his age. In addition, Dr. Coetzee opined with a reasonable degree of certainty that medical cannabis is appropriate to treat Bierbach's pain, and Dr. Meyer agreed that cannabis is safer than opioids for long-term use. Further, not only does the record contain evidence that medical cannabis is necessary, it also shows that medical cannabis is helping Bierbach live a full life. Dr. Coetzee opined that he responded well to medical cannabis, and the compensation judge was persuaded by Bierbach's testimony that using medical cannabis reduces his pain and allows him to continue in a full-time job that requires him to be on his feet for many hours. This evidence is adequate to support the finding of the compensation judge.

Digger's Polaris contends that Bierbach's use is not reasonable because it is not limited by any external constraint. It points out that his cannabis dosage more than doubled in his first year of use and that he testified he would buy even more if he could afford it.

This concern is understandable but overstated. That Bierbach's use doubled during the first year sounds extreme, but it likely reflects that he eased into the new treatment and increased his dosage when he found it effective and could afford more. In addition, the requirement that a doctor must recertify his participation in the program every year places constraints on his usage.

In any event, I need not speculate about Bierbach's future use. The compensation judge's order does not

require Digger's Polaris to give him a blank check. The order requires only that it reimburse him for purchases that he had already made. Whether Digger's Polaris has a statutory obligation to reimburse Bierbach for purchases made after the date of the order will depend on the facts and circumstances that exist at the time of those purchases, which may change as his condition changes and as research develops. *See* Minn. Stat. § 152.25, subd. 2 (requiring the commissioner of health to "review and publicly report the existing medical and scientific literature regarding the range of recommended dosages for each qualifying condition" and to update the information annually). At any time, Digger's Polaris is free to withhold payment for treatment that becomes unreasonable, unnecessary, or excessive. *See* Minn. Stat. § 176.136, subd. 2. For present purposes, the compensation judge determined that Bierbach's use was reasonable and necessary and should be reimbursed, and I see no clear error in the judge's finding.

IV.

In sum, I would hold that the order of the compensation judge for Digger's Polaris to reimburse Bierbach for his purchases of medical cannabis is supported by substantial evidence and is not preempted. Accordingly, I would affirm the decision of the Workers' Compensation Court of Appeals upholding that order. Because the court's decision overextends the preemptive reach of federal law and denies Bierbach reimbursement for the best means of managing his painful, work-related injury while staying meaningfully employed, I respectfully dissent.

STATE OF MINNESOTA
IN SUPREME COURT

A20-1551

SUSAN K. MUSTA,
Respondent,

v.

MENDOTA HEIGHTS DENTAL CENTER
& HARTFORD INSURANCE GROUP,
Relators.

Filed: October 13, 2021

OPINION

ANDERSON, Justice.

The question presented here is whether the federal Controlled Substances Act (CSA), 21 U.S.C. §§ 801-971, which makes the possession of cannabis a federal crime, preempts provisions of the Minnesota Workers' Compensation Act that make an employer liable for an injured employee's cost of treating a work-related injury. More specifically, does the statutory requirement for an employer to "furnish any medical . . . treatment," reasonably necessary to treat a work-related injury, Minn. Stat. § 176.135, subd. 1 (2020), conflict with federal law that prohibits the possession of cannabis when the employer would be required to pay for the expense of treatment using medical cannabis? If federal law preempts state law

in this specific instance, then an employer cannot be ordered to reimburse an injured employee for the cost of medical cannabis used to treat the effects of a work-related injury.

Respondent Susan Musta was injured while working for her employer, relator Mendota Heights Dental Center (Mendota Heights). After multiple rounds of medical intervention were unsuccessful, Musta's doctor certified her for participation in Minnesota's medical cannabis program. Musta then sought reimbursement for the cost of the medical cannabis from Mendota Heights, which agrees that medical cannabis is a reasonable and necessary treatment for Musta's chronic pain. Mendota Heights asserted, however, that the federal prohibition in the CSA on the possession of cannabis preempts the requirement under Minnesota's workers' compensation laws for an employer to pay for an injured employee's medical treatment when that treatment is medical cannabis. The Workers Compensation Court of Appeals (WCCA) declined to address the preemption argument, concluding that it did not have the subject matter jurisdiction to do so, and then upheld the compensation judge's order requiring Mendota Heights to reimburse Musta for medical cannabis.

We conclude that the WCCA lacks subject matter jurisdiction to determine the preemption issue presented in this case because it requires the interpretation and application of federal law. We further conclude that the CSA preempts an order made under Minn. Stat. § 176.135, subd. 1, that obligates an employer to reimburse an employee for the cost of medical cannabis because compliance with that order would expose the employer to criminal liability under federal law for aiding and abetting Musta's unlawful possession of cannabis. We therefore reverse the

decision of the Workers' Compensation Court of Appeals.

FACTS

Musta was employed by Mendota Heights[1] as a dental hygienist when she suffered a work-related neck injury in February 2003. Musta received conservative care, including chiropractic treatment, medication management, physical therapy, and injection therapy. She then underwent surgery in November 2003 and August 2006, which provided some temporary relief. She was ultimately prescribed medication to manage the continuing pain, including Vicodin and fentanyl. In late 2009, Musta discontinued using narcotics to treat her pain because of the side effects. At this point, Musta was permanently and totally disabled.

In April 2019, after she was certified as eligible to participate in the state's medical cannabis program, Musta began using medical cannabis, in compliance with the THC Therapeutic Research Act (THC Act), Minn. Stat. §§ 152.21-.37 (2020), to treat her work-related injury. She then requested reimbursement for the cost of that treatment from Mendota Heights under Minn. Stat. § 176.135, subd. 1 (2020). In the proceedings before the compensation judge, the parties stipulated that Musta's use of medical cannabis complies with the THC Act and is reasonable, medically necessary, and causally related to her work injury. Mendota Heights opposed Musta's request for reimbursement, however, asserting before the compensation judge that paying for someone to possess cannabis is prohibited by federal law,

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[1] The insurer for Mendota Heights is relator Hartford Insurance Group, and we refer to relators collectively as "Mendota Heights."

specifically the CSA. Thus, the sole issue before the workers' compensation judge was whether the CSA preempts the employer reimbursement requirement in Minnesota's workers' compensation laws when that reimbursement is for medical cannabis.

Cannabis is a Schedule I controlled substance—the most restrictive level—and therefore cannot be lawfully prescribed. 21 U.S.C. § 812(c)(c)(10). Federal law provides that a Schedule I controlled substance has a high potential for abuse, has no currently accepted medical use in treatment in the United States, and lacks accepted safety for use of the substance under medical supervision. 21 U.S.C. § 812(b)(1). The CSA makes it a federal crime to possess a controlled substance knowingly or intentionally without a valid prescription. 21 U.S.C. § 844(a).[2] Anyone guilty of such an offense may be sentenced up to one year in prison and fined at least $1,000. *Id.* And anyone who aids and abets a federal crime is liable to the same extent as the principal. 18 U.S.C. § 2(a).

The compensation judge declined to resolve the issue of preemption, recommending instead to the Chief Administrative Law Judge that the question be certified to us. The Chief ALJ did so, but we declined to accept the certified question, stating that "the legal issue presented by this workers' compensation matter is best addressed through the decision process

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[2] Under Minnesota's THC Act, a physician does not prescribe medical cannabis for a patient's medical condition; rather, the physician determines whether the patient "suffers from a qualifying medical condition," Minn. Stat. § 152.28, subd. 1(a)(1), which if found allows the patient to apply for enrollment in the medical cannabis program, *see* Minn. Stat. §§ 152.27, subd. 3(a)(4), .30(a).

established by the Legislature." *Musta v. Mendota Heights Dental Ctr.*, No. A19-1365, Order at 2 (Minn. filed Oct. 16, 2019).

On remand, the compensation judge then analyzed the preemption issue. The judge observed that use of medical cannabis is legal under Minnesota law, and nothing in the workers' compensation laws prohibits reimbursement for medical cannabis when used to treat a work-related injury. Further, the judge noted that ongoing congressional appropriations riders prohibit the United States Department of Justice from criminally prosecuting an act that is compliant with a state's medical cannabis laws. The compensation judge stated that a federal prosecution would "prevent Minnesota from implementing its own laws" regarding medical cannabis use. Thus, the compensation judge concluded, there was no risk that Mendota Heights would be criminally prosecuted under federal law, and therefore no preemptive conflict between federal law and Minnesota law existed. Mendota Heights was accordingly required to reimburse Musta for her medical cannabis expenses.

The Workers' Compensation Court of Appeals affirmed. *Musta v. Mendota Heights Dental Ctr.,* No. WC19-6330, 2020 WL 6799288 (Minn. WCCA Nov. 10, 2020). The WCCA concluded that it lacked subject matter jurisdiction over the preemption issue because it "would need to interpret and apply laws beyond the Workers' Compensation Act and beyond [its] limited jurisdiction." *Id.* at *3. Instead, the WCCA believed that the preemption issue was "best addressed by a court of broader jurisdiction." *Id.* Thus, the court rejected the compensation judge's analysis on that issue and struck certain findings made regarding federal law. But, concluding that the legal question—the employer's reimbursement

liability—could be resolved based on the stipulated facts and the remaining findings, the WCCA affirmed the award of reimbursement. Mendota Heights appealed to us by writ of certiorari.

ANALYSIS

This case presents two issues. First, we must determine whether the WCCA correctly concluded that it lacks subject matter jurisdiction to decide whether federal law—the CSA—preempts Minnesota law that requires an employer to reimburse an employee for treatment of a work-related injury. Second, we must determine whether the CSA preempts the requirement in Minnesota law for an employer to reimburse an injured employee for the cost of medical treatment when the treatment for which payment is sought is medical cannabis.

I.

We begin with jurisdiction. "The subject matter jurisdiction of the workers' compensation courts is a question of law," which we review de novo. *Giersdorf v. A & M Constr., Inc.*, 820 N.W.2d 16, 20 (Minn. 2012). "Subject matter jurisdiction is the court's authority to hear the type of dispute at issue and to grant the type of relief sought." *Seehus v. Bor-Son Constr., Inc.*, 783 N.W.2d 144, 147 (Minn. 2010). The WCCA "is a tribunal of limited jurisdiction, restricted by statute to the construction and application of the Workers' Compensation Act."[3] *Hagen v. Venem*, 366 N.W.2d 280, 283 (Minn. 1985); *see also* Minn. Stat.

[3] A compensation judge decides questions of fact and law to make "an award or disallowance of compensation" based on the pleadings. Minn. Stat. § 176.371 (2020); *see also* Minn. Stat. § 176.291(a) (2020) (allowing a party to initiate a proceeding by filing a petition when "there is a dispute as to a question of law or fact in connection with a claim for compensation").

§ 175A.01, subd. 5 (stating that the WCCA has jurisdiction over "questions of law and fact arising under the workers' compensation laws of the state"). The WCCA's "powers are plenary" in cases arising under the Workers' Compensation Act, allowing that court to hear and determine the legal and factual questions presented by a case appealed to that court. *Hagen*, 366 N.W.2d at 283.

The WCCA may decide certain questions ancillary to the employee's compensation claim, such as determining insurance coverage, *Giersdorf*, 820 N.W.2d at 20-21; awarding certain fees and costs, *Botler v. Wagner Greenhouses*, 754 N.W.2d 665, 668-70 (Minn. 2008); and determining the liability of a guaranty association, *Seehus*, 783 N.W.2d at 151-52. The WCCA may also look to the laws of other states and federal law "for instruction" in narrow circumstances. *See Sundby v. City of St. Peter*, 693 N.W.2d 206, 215-16 (Minn. 2005) (holding that the WCCA could look to the Social Security Act for instruction because the workers' compensation provision at issue was a means for coordinating workers' compensation benefits with the social security system, and the WCCA "neither construed nor applied federal law").

The WCCA is not authorized, however, "to consider questions of law arising under the workers' compensation statutes of other states." *Martin v. Morrison Trucking, Inc.*, 803 N.W.2d 365, 369 (Minn. 2011). The WCCA similarly may not "construe Minnesota statutes other than the Minnesota Act." *Id.* And its jurisdiction "does not extend to interpreting or applying legislation designed specially for the handling of claims outside the workers' compensation system." *Sundby*, 693 N.W.2d at 215; *see also Martin*, 803 N.W.2d at 369-70 (distinguishing between the WCCA's statutory authority to order reimbursement to a no-

fault insurance carrier and the WCCA's lack of jurisdiction to construe statutes other than those governing workers' compensation claims).

Mendota Heights asserts that this is a case "arising under" Minnesota's workers' compensation laws, and because the WCCA may hear and determine "all questions of law and fact" in such cases, the court possessed subject matter jurisdiction to decide the preemption issue. Mendota Heights emphasizes that requiring the preemption issue to be decided by a district court, while the merits of the workers' compensation action are decided by the compensation courts, would result in case-splitting and squander judicial resources with parallel proceedings. It cites to our decision in *In re McCannel*, 301 N.W.2d 910, 920 (Minn. 1980), in which we held that the tax court may decide constitutional claims in some instances. Mendota Heights asserts that the tax court's jurisdictional statute and that of the WCCA use "substantively identical language," while noting that *McCannel* was decided one year before the statute establishing the WCCA's jurisdiction was enacted.[4]

Musta responds that deciding the preemption issue would require the WCCA to interpret federal civil and criminal law as well as the statutes that govern Minnesota's THC Act, all of which are outside the scope of Minnesota's workers' compensation laws. Thus, she maintains, the WCCA did not have the necessary jurisdiction to decide the preemption issue

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[4] Mendota Heights also suggests that the WCCA's refusal to decide the jurisdictional question was a denial of due process. We need not decide this issue because we have resolved the preemption issue in favor of Mendota Heights. *See*, *e.g.*, *State v. N. Star Rsch. & Dev. Inst.*, 294 Minn. 56, 200 N.W.2d 410, 425 (1972) (stating that we do not "decide important constitutional questions unless it is necessary to do so").

in this case given our consistent conclusion that the WCCA does not have the authority to interpret the laws of other jurisdictions or other Minnesota statutes.

We agree with Musta. Although Musta's claim certainly arises under Minnesota's workers' compensation law—she seeks only reimbursement for the medical treatment she now uses, *see* Minn. Stat. § 176.135, subd. 1(a) (requiring the employer to "furnish any medical . . . treatment, including . . . medicines")—the precise legal *question* before the WCCA falls squarely outside of workers' compensation laws: does federal law, properly interpreted, preempt the broad requirement in section 176.135 for employers to reimburse injured employees for "any" medical treatment, including when the treatment at issue is medical cannabis. The Legislature has described the WCCA's jurisdiction over legal questions as specific to those "*arising under the workers' compensation laws*" of Minnesota. Minn. Stat. § 175A.01, subd. 5 (emphasis added). By requiring an interpretation and analysis of federal law, the preemption issue presented in this case does not arise under Minnesota's workers' compensation laws; it arises under federal law and legal principles that govern statutory interpretation when resolving claims of alleged conflicts between state and federal laws. *See*, *e.g.*, *In re Est. of Barg*, 752 N.W.2d 52, 63 (Minn. 2008) (explaining the importance of congressional intent and purpose in a preemption inquiry based on federal law).

Indeed, we have consistently held that when resolution of an issue would require the WCCA to interpret and apply, not merely look to, the laws of another sovereign, the WCCA is without jurisdiction to do so. *See Martin*, 803 N.W.2d at 371; *Hale v.*

Viking Trucking Co., 654 N.W.2d 119, 124 (Minn. 2002). For example, in *Sundby*, the WCCA held that children's benefits under Social Security Disability Insurance (SSDI) should be included in reducing an employer's payment of workers' compensation benefits. 693 N.W.2d at 213. We affirmed that decision, observing that the Workers' Compensation Act expressly permits "any government disability benefits" in the offset. *Id.* at 211 (citing Minn. Stat. § 176.101, subd. 4 (2004)). Although we noted that "[t]he WCCA's jurisdiction does not extend to interpreting or applying legislation designed specially for the handling of claims outside the workers' compensation system," we concluded that the WCCA had merely looked to federal law to ultimately "ascertain[] the appropriate inclusion of SSDI benefits in the workers' compensation benefits offset calculation" under Minnesota's workers' compensation laws. *Id.* at 215. Here, the WCCA correctly recognized that, consistent with our statement in *Sundby*, deciding the preemption issue would impermissibly require it "to interpret and apply laws beyond the Workers' Compensation Act." *Musta*, 2020 WL 6799288, at *3.

Mendota Heights contends that our order denying certification, which cited the decision process provided for in Minn. Stat. § 176.322 (2020) (authorizing a decision based on stipulated facts), reflected our expectation that the compensation judge or the WCCA would decide the preemption issue on the merits. We disagree. In denying certification, we relied primarily on the principle that certification is not a substitute for the normal appellate process, even for important and doubtful questions. *See Musta v. Mendota Heights Dental Ctr.*, No. A19-1365, Order at 1-2 (Minn. filed Oct. 16, 2019) (stating that "'not every vexing question is important and doubt-

ful' and questions of first impression are not alone sufficient 'to justify certification as doubtful.'" (quoting *Emme v. C.O.M.B., Inc.*, 418 N.W.2d 176, 179-80 (Minn. 1988))).

Finally, our decision in *McCannel* does not support the conclusion that the WCCA has subject matter jurisdiction over the preemption issue presented here. In *McCannel*, we noted that "[a]s a general rule, administrative agencies lack the power to declare legislation unconstitutional" and that "[i]nstead, these issues must be raised in a court of the judiciary." 301 N.W.2d at 919. Nevertheless, we recognized the importance of allowing the tax court to operate "effectively and expeditiously" by deciding all issues presented by the case. *Id.* at 920. Thus, when a constitutional issue is presented in a tax dispute, we noted, the tax court could "acquire jurisdiction in the first instance through *transfers of cases* from the district court, which does have the jurisdiction to determine the constitutionality of legislative acts." *Id.* at 919 (emphasis added); *see Guilliams v. Comm'r of Revenue*, 299 N.W.2d 138, 139 n.1 (Minn. 1980) (noting that the tax court has jurisdiction over a constitutional claim when the claim is raised "in the first instance . . . in the district court before the case is transferred to the tax court"); *see also Erie Mining Co. v. Comm'r of Revenue*, 343 N.W.2d 261, 264 (Minn. 1984) (explaining that because the tax court does not have "original jurisdiction to decide constitutional issues," it must "refer the constitutional question to the district court," which can choose to "refer the matter back to the tax court which will then have subject matter jurisdiction" over that issue). No one contends that a district court conferred its original jurisdiction over the preemption issue presented here on the compensation judge or the WCCA. Thus,

the general rule stated in *McCannel*—constitutional issues must be decided by "a court of the judiciary" rather than an executive branch agency—controls here, rather than the process used in tax cases to secure a district court's jurisdiction over a constitutional claim. *See Irwin v. Surdyk's Liquor*, 599 N.W.2d 132, 139-40 (Minn. 1999) (acknowledging that the WCCA does not have subject matter jurisdiction over constitutional claims).

We have reiterated that the statutory jurisdiction of the compensation courts does not extend to interpretation of laws outside of legal questions and facts arising under the workers' compensation law.[5] *See Martin*, 803 N.W.2d at 371 (holding that WCCA lacked jurisdiction to declare insurance contract invalid under Wisconsin law); *see also Freeman v. Armour Food Co.*, 380 N.W.2d 816, 820 (Minn. 1986); *Taft v. Advance United Expressways*, 464 N.W.2d 725, 727 (Minn. 1991). Consequently, we hold that the WCCA lacks jurisdiction to decide whether federal law preempts Minnesota law that requires an employer to "furnish" medical treatment when the treatment for which reimbursement is sought is medical cannabis.

II.

Having concluded that the WCCA correctly determined that it lacks jurisdiction over the preemption issue in this case, we now turn to that issue. *See Gist*

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[5] When a case requires "judicial construction" of a statute outside of workers' compensation laws, the remedy is to bring "a declaratory judgment action in district court." *Taft v. Advance United Expressways*, 464 N.W.2d 725, 727 (Minn. 1991). Although Mendota Heights is correct that requiring a district court to determine a preemption issue may be an inefficient use of judicial resources, efficiency does not permit the WCCA to exceed the carefully defined limits of its specialized jurisdiction.

v. Atlas Staffing, Inc., 910 N.W.2d 24, 31-33 (Minn. 2018) (deciding a preemption issue under federal Medicaid and Medicare law that was not addressed by the WCCA, which concluded that it lacked jurisdiction over that issue); *see also In re Lauritsen*, 99 Minn. 313, 109 N.W. 404, 407-08 (1906) (recognizing that "a court of final resort" can provide "peremptory and prompt relief").

Preemption of a state law by federal law is based on the Supremacy Clause of the United States Constitution. *See Gist*, 910 N.W.2d at 33; *see also Gonzales v. Raich*, 545 U.S. 1, 29, 125 S.Ct. 2195, 162 L.Ed.2d 1 (2005) (stating that when "there is any conflict between federal and state law, federal law shall prevail"). "Preemption is primarily an issue of statutory interpretation, which is subject to de novo review." *DSCC v. Simon*, 950 N.W.2d 280, 287 (Minn. 2020) (citation omitted) (internal quotation marks omitted). "In all preemption cases, and particularly those in which Congress has legislated in a field that the states have traditionally occupied"—like workers' compensation—we begin "with the assumption that the historic police powers of the states were not superseded by the federal act unless that was the clear and manifest purpose of Congress." *Gretsch v. Vantium Cap., Inc.*, 846 N.W.2d 424, 433 (Minn. 2014). Accordingly, "preemption is generally disfavored." *Id.* At issue here is conflict preemption, which may occur when it is impossible to comply with both state law and federal law (impossibility preemption) or when the state law stands as an impermissible obstacle to accomplishing the objectives of the federal law (obstacle preemption). *DSCC*, 950 N.W.2d at 288.

"Congressional purpose is the ultimate touchstone" of our inquiry into preemption by federal law. *Barg*,

752 N.W.2d at 63 (citation omitted) (internal quotation marks omitted). "The main objectives of the CSA were to conquer drug abuse and control the legitimate and illegitimate traffic in controlled substances." *Raich*, 545 U.S. at 12, 125 S.Ct. 2195. And "Congress was particularly concerned with the need to prevent the diversion of drugs from legitimate to illicit channels." *Id.* at 12-13, 125 S.Ct. 2195. The CSA explicitly defines the scope of its preemptive reach. A state law is preempted by the CSA only when "there is a positive conflict between" a provision of the CSA and that state law "so that the two cannot consistently stand together." 21 U.S.C. § 903. This provision "is an express invocation of conflict preemption." *Or. Prescription Drug Monitoring Program v. U.S. Drug Enf't Admin.*, 860 F.3d 1228, 1236 (9th Cir. 2017).

Mendota Heights contends that it is not possible to comply with both state and federal law because if it complies with the order made under the Minnesota workers' compensation law to reimburse Musta for the medical cannabis expense, then Mendota Heights cannot comply with the federal prohibition against aiding and abetting the possession of cannabis. *See Rosemond v. United States*, 572 U.S. 65, 76, 134 S.Ct. 1240, 188 L.Ed.2d 248 (2014) ("[A] person aids and abets a crime when (in addition to taking the requisite act) he intends to facilitate that offense's commission."). Stated another way, Mendota Heights asserts that compelling it, by judicial order, to reimburse Musta for medical cannabis "require[d it] to commit a federal crime." Mendota Heights relies on the decision of the Maine Supreme Judicial Court case *Bourgoin v. Twin Rivers Paper Co., LLC*, which held that the CSA preempts an order to reimburse an employee for medical cannabis under the Maine workers' compensation laws because that order

required the employer to "engage in conduct that would violate the CSA." 187 A.3d 10, 20 (Me. 2018). Mendota Heights also argues that the likelihood of prosecution for violating the CSA—minimal or otherwise—is a legally irrelevant factor in the preemption analysis.

In response, Musta contends that Congress has demonstrated an intent to *not* obstruct state medical cannabis programs by annually prohibiting the United States Department of Justice from spending funds to prosecute persons who use medical cannabis consistent with their state's laws. She relies on decisions from state courts that have found no conflict between the federal law and state law requirements to reimburse for medical cannabis, including the dissenting opinion in *Bourgoin*, 187 A.3d at 23 (Jabar, J., dissenting). Finally, Musta asserts that Mendota Heights cannot be deemed to aid and abet her possession of cannabis because the crime of possession has already occurred, a completed crime cannot be aided and abetted, and Mendota Heights does not possess the specific intent required for aiding and abetting.

We acknowledge that this issue represents a unique and challenging intersection between the law of preemption, federal aiding and abetting jurisprudence, the ongoing tension between the states and the federal government regarding cannabis regulation, and the objectives of the Minnesota workers' compensation system. But we are not the first state court of last resort to decide this specific issue. Thus, we begin with the decisions that have already addressed the preemptive effect of the CSA on orders for reimbursement of medical cannabis made under state workers' compensation laws.

In *Bourgoin*, the Maine Supreme Judicial Court was the first state supreme court to decide a preemption challenge in the context of employer reimbursement for workers' compensation benefits. *Id.* at 19-20. As here, an employee sought reimbursement from the employer for medical cannabis, which was used to treat a work-related injury. *Id.* at 13. The employer opposed the reimbursement request, asserting that, even if the employee's medical cannabis use is permitted by state law, requiring the employer to pay for it is barred by federal law. *Id.* The *Bourgoin* court concluded that a right provided by state law to use medical cannabis "cannot be converted into a sword that would require" an employer "to engage in conduct that would violate the CSA." *Id.* at 20. The court recognized that an employer would be liable under federal law on an aiding and abetting theory because the employer—required to reimburse the employee for his use of medical cannabis—would be "acting with knowledge that it was subsidizing Bourgoin's purchase of marijuana." *Id.* at 19. On the other hand, the employer would violate state law if it refused to reimburse the employee. *Id.* The *Bourgoin* court therefore concluded that "[c]ompliance with [state and federal law] is an impossibility." *Id.*; *see also Wright's Case*, 486 Mass. 98, 156 N.E.3d 161, 166 (2020) (stating that a state may "authorize those who want to use medical marijuana . . . to do so and assume the potential risk of Federal prosecution," but it is "quite another" thing for the state "to require unwilling third parties to pay for such use and risk such prosecution").[6]

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[6] The Massachusetts Supreme Judicial Court concluded in this case that an employer is not required to reimburse an employee for medical cannabis used to treat a work-related

Two state supreme courts have reached a different conclusion. In *Appeal of Panaggio*, 174 N.H. 89, —— A.3d —— (2021), the New Hampshire Supreme Court rejected the conclusion reached by the Maine Supreme Judicial Court in *Bourgoin*—that the employer would be criminally liable under federal law, 187 A.3d at 19—stating that federal law "does not criminalize the act of insurance reimbursement for an employee's purchase of medical marijuana." 174 N.H. at ——, —— A.3d ——. The *Panaggio* court concluded instead that the employer lacked the requisite mens rea for an aiding and abetting offense under federal law because the employer's reimbursement is compelled by state law, rather than voluntary participation in an offense. *Id.* at ——, —— A.3d ——. Thus, the court concluded, it was not impossible to comply with both state and federal law. *Id.*[7]

The New Jersey Supreme Court reached the same conclusion, though on different reasoning, in *Hager v. M&K Construction*, 246 N.J. 1, 247 A.3d 864 (2021). Looking to "appropriations acts as expressions of legislative intent," *id.* at 885, the *Hager* court observed that "Congress has, for seven consecutive fiscal years,

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injury, based on language in that state's medical cannabis law that relieves "any health insurance provider" from a reimbursement obligation. 156 N.E.3d at 172, 175.

[7] The *Panaggio* court also analyzed, then rejected, obstacle preemption, stating that "the CSA does not make it illegal for an insurer to reimburse an employee" for medical cannabis, "does [not] purport to regulate insurance practices in any manner," and the reimbursement order "does not interfere with the federal government's ability to enforce the CSA" by prosecuting the employee for possession. *Id.* at ——, —— A.3d ——. Because we conclude that the CSA preempts the order for reimbursement under the impossibility theory of conflict preemption, we need not—and decline to—analyze the obstacle theory of conflict preemption.

prohibited the [Department of Justice] from using funds to interfere with state medical marijuana laws through appropriations riders." *Id.* at 886. The court concluded that this "clear, volitional act in the form of appropriations law takes precedence over" the CSA. *Id.* at 887. Thus, there was no conflict between federal and state law, and state law did not stand as "an obstacle" to congressional objectives. *Id.*

Apart from the workers' compensation context, courts have found preemption by the CSA in some situations, and no conflict or preemption in others. *Compare Garcia v. Tractor Supply Co.*, 154 F. Supp.3d 1225, 1229-30 (D.N.M. 2016) (concluding that an employer is not required to accommodate an employee's use of medical cannabis as a matter of state law), and *Emerald Steel Fabricators, Inc. v. Bureau of Labor & Indus.*, 348 Or. 159, 230 P.3d 518, 536 (2010) (concluding that portion of Oregon law governing use of medical cannabis is preempted by CSA), *with White Mountain Health Ctr., Inc. v. Maricopa Cnty.*, 241 Ariz. 230, 386 P.3d 416, 432-33 (Ct. App. 2016) (concluding that requiring county to process application for medical cannabis provider as directed by state zoning law is not preempted by CSA), *and Ter Beek v. City of Wyoming*, 495 Mich. 1, 846 N.W.2d 531, 537-41 (2014) (holding that immunity provision in Michigan medical cannabis law is not preempted by CSA). We ultimately agree with the reasoning set forth by the Maine Supreme Judicial Court in *Bourgoin*: the CSA preempts mandated reimbursement of an employee's medical cannabis purchases under an impossibility theory of conflict preemption. Specifically, we agree that a right provided to an individual under Minnesota's workers' compensation law to secure reimbursement for the use of medical cannabis to treat a diagnosed medical

condition cannot be "converted into a sword that" requires an employer to pay for those purchases and thus "engage in conduct that would violate the CSA." 187 A.3d at 20.

We recognize that the federal government's position on criminal prosecution of cannabis offenses has been in a state of flux for over a decade. At one point, the United States Department of Justice announced that it would not prosecute cannabis offenses under the CSA when a cannabis user complies with state law; but the Department later rescinded those directions. *See Hager*, 247 A.3d at 882-83. Further, Congress has prohibited the Department of Justice from using allocated funds to prevent states from implementing medical cannabis laws. *Id.* at 883-84. We disagree with the *Hager* court that these actions—and the congressional appropriation riders in particular—suspend the illegality of cannabis under the CSA or take precedence over that law. *See id.* at 887. Repeal by implication is heavily disfavored, especially when "the subsequent legislation is an *appropriations* measure." *Tenn. Valley Auth. v. Hill*, 437 U.S. 153, 190, 98 S.Ct. 2279, 57 L.Ed.2d 117 (1978) (citation omitted) (internal quotation marks omitted). As the Ninth Circuit observed in *United States v. McIntosh*, the appropriation riders "do[] not provide immunity from prosecution for federal marijuana offenses." 833 F.3d 1163, 1179 n.5 (9th Cir. 2016). The riders are merely temporary measures that can be rescinded at any time, thus allowing the government to "prosecute individuals who committed offenses *while the government lacked funding*." *Id.* (emphasis added); *see also Bourgoin*, 187 A.3d at 20-21 & n.10 (rejecting reliance on the Department's nonenforcement memorandum because it was a "transitory" policy, as evidenced by its later revocation by Attorney General Sessions).

Nor can we agree that, as a practical matter, Mendota Heights is unlikely to be prosecuted. Impossibility preemption does not turn on speculation about future prosecutorial decisions, but on whether compliance with both state and federal law is impossible. *See DSCC*, 950 N.W.2d at 288. The conflict here is real, not speculative. *See Exxon Corp. v. Governor of Md.*, 437 U.S. 117, 131, 98 S.Ct. 2207, 57 L.Ed.2d 91 (1978) (stating that a "hypothetical conflict" does not warrant preemption). Despite action in multiple states relating to medical cannabis and other cannabis-related issues, Congress has never chosen to de-schedule or re-schedule cannabis; it has instead used funding mechanisms to institute temporary, short-term stays of enforcement. Possession of cannabis remains prohibited by the CSA, and we cannot read these riders as implicit suspensions of a legislative determination of illegality.

Even setting aside the prosecution risk, the heart of Musta's argument—an order made under state law that compels reimbursement negates mens rea and the specific intent necessary to satisfy federal aiding and abetting—is misplaced. The Supreme Court of the United States has consistently held that compelling a person to act does not necessarily negate the actor's mens rea. *See Dixon v. United States*, 548 U.S. 1, 6-7, 126 S.Ct. 2437, 165 L.Ed.2d 299 (2006). Instead, necessity (like duress and self-defense) is an affirmative defense that goes to motive, not intent. *Rosemond*, 572 U.S. at 89, 134 S.Ct. 1240 (Alito, J., concurring in part, dissenting in part) ("[O]ur cases have recognized that a lawful motive (such as necessity, duress, or self-defense) is consistent with the *mens rea* necessary to satisfy a requirement of intent."). As the *Rosemond* Court put it, "The law does not, nor should it, care whether [the

aider and abettor] participates with a happy heart or a sense of foreboding. Either way, he has the same culpability . . . ." *Id.* at 79-80, 134 S.Ct. 1240.[8]

The intent requirement of federal aiding and abetting is satisfied "when a person actively participates in a criminal venture with full knowledge of the circumstances constituting the charged offense."[9] *Id.* at 77, 134 S.Ct. 1240. Here, Mendota Heights is fully knowledgeable about the circumstances advanced by its compelled reimbursement: Musta's possession of cannabis that is unlawful under the CSA. This

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[8] The dissent brushes aside the distinction between intent and motive, claiming that the *Rosemond* Court rejected a similar criticism when it held that a defendant must have "advance knowledge" of the presence of a firearm for the defendant to be guilty of aiding and abetting a crime involving the use of a firearm. 572 U.S. at 78, 134 S.Ct. 1240. The *Rosemond* Court reasoned that the "distinctive intent standard for aiding and abetting" cannot be satisfied when a defendant learns of the presence of the firearm "only after he can realistically walk away." *Id.* at 81, 134 S.Ct. 1240 n.10. But this reasoning lends no support to the dissent's position because Mendota Heights unquestionably has advance knowledge of the underlying conduct that it would be aiding.

[9] The *Rosemond* Court differentiated the knowledge and active participation that it found satisfied specific intent by describing the hypothetical case of a gun store owner "who sells a firearm to a criminal, knowing but not caring how the gun will be used." 572 U.S. at 77 n.8, 134 S.Ct. 1240. Several courts, including the *Panaggio* court, 174 N.H. at —— n. 1, —— A.3d ——, have read this footnote as describing a situation in which specific intent is lacking. But the very next sentence in the footnote explains: "We express no view about what sort of facts, if any, would suffice to show that such a third party has the intent necessary to be convicted of aiding and abetting." *Rosemond*, 572 U.S. at 77 n.8, 134 S.Ct. 1240. Rather than explaining that this situation was not aiding and abetting, the Court merely described one situation in which it *has not yet decided* whether aiding and abetting was satisfied.

reimbursement, which Mendota Heights must comply with as it is embedded in a judicial order, finances Musta's possession and effectively facilitates future possession. Thus, the order compels Mendota Heights' active participation in the possession that is criminalized by the CSA.[10]

Our conclusion finds support in federal case law. In *Garcia*, an employee was fired after testing positive for cannabis despite informing his employer that he consumed medical cannabis to alleviate symptoms of HIV/AIDS. 154 F. Supp. 3d at 1226-27. The employee sued, alleging discrimination based on a medical condition under the New Mexico equivalent

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[10] The dissent offers several hypotheticals to challenge our application of the *Rosemond* framework. The first is an employee who informs her employer that her paycheck will be used to purchase cannabis. But this hypothetical fails to appreciate the close connection between the aid provided and the crime committed. In the case at issue here, the reimbursement ordered is explicitly and exclusively for cannabis. In the dissent's hypothetical, the paycheck can be, and indeed ordinarily is, used for any number of purchases wholly outside the control of the employer.

The same is true with the bus driver hypothetical. The route driven is not solely for the benefit of a passenger to obtain cannabis, and the nexus between the transportation provided and results obtained is far weaker than the case here.

The taxi driver hypothetical is a closer call. For a taxi driver to knowingly transport a passenger to a location to commit a crime may implicate aiding and abetting. Consider the counter-hypothetical where a passenger informs the taxi driver, "I am going to rob a bank, wait for me outside so we can drive away afterwards." Setting aside affirmative defenses like duress, the taxi driver may be acting with full knowledge of the crime of robbery to be committed, and the taxi driver knowingly transporting a person to a dispensary for the sole purpose of purchasing cannabis in violation of federal law may in fact be doing the same.

of the Minnesota Human Rights Act. *Id.* at 1227. The federal district court held that the employer was not required to accommodate the employee's use of medical cannabis. *Id.* at 1230. It concluded that, "[t]o affirmatively require Tractor Supply to accommodate Mr. Garcia's illegal drug use would mandate Tractor Supply to permit the very conduct the CSA proscribes." *Id.*; *see also Emerald Steel Fabricators*, 230 P.3d at 536 (concluding that the CSA preempted state law such that an employer was not prohibited from firing an employee for using medical cannabis).

Although the district court in *Garcia* did not explicitly find that the employer would be aiding and abetting the employee's possession of medical cannabis, the logic is the same: the state cannot force an employer to facilitate an employee's unlawful possession of cannabis, either through work accommodations or reimbursement for its purchase.[11]

We also reject Musta's argument and the dissent's conclusion that Mendota Heights cannot aid and abet her possession because that possession has already occurred by the time Mendota Heights reimburses her. Generally, "a person cannot be found guilty of aiding and abetting a crime that has already been

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[11] The dissent criticizes our citation to *Garcia* because the implicit basis for that decision was obstacle preemption; and the case on which *Garcia* relies, *Emerald Steel Fabricators*, was decided explicitly under obstacle preemption. *Garcia*, 154 F.Supp.3d at 1230; *Emerald Steel Fabricators*, 230 P.3d at 536. But that fact alone does not undermine the persuasive nature of the analysis in those cases. And the case for preemption is indeed stronger here because an actual conflict exists that makes it impossible for Mendota Heights to comply with both federal and state law, as opposed to *Garcia* and *Emerald Steel Fabricators*, where compliance with state accommodations law was simply an obstacle to congressional purpose in enacting the federal prohibition on cannabis possession under the CSA.

committed." *United States v. Hamilton*, 334 F.3d 170, 180 (2d Cir. 2003). But "aiding and abetting a drug offense may encompass activities, intended to ensure the success of the underlying crime, that take place after . . . the principal no longer possesses the [illegal substance]." *United States v. Ledezma*, 26 F.3d 636, 643 (6th Cir. 1994). The same is true with money laundering, which occurs after the distribution of illegal substances, but may nevertheless aid and abet the underlying crime because it is "*integral* to the success of a drug venture."[12] *United States v. Orozco-Prada*, 732 F.2d 1076, 1080 (2d Cir. 1984).

Although the compensation court's order does not require Mendota Heights to reimburse Musta on an ongoing basis, neither does that order limit Mendota Heights's reimbursement obligation to a one-time purchase. Musta obtained and possessed medical cannabis, and will continue to do so in the future,[13] based on the expectation that Mendota Heights's reimbursement obligation is established by state law. *See* Minn. Stat. § 176.135, subd. 1(a).[14] Indeed, the

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[12] Although *Orozco-Prada* was technically about conspiracy to aid and abet, in finding probable cause to support the conspiracy charge, the court implicitly recognized that aiding and abetting was also satisfied by the postdistribution act. *See United States v. Perez*, 922 F.2d 782, 786 (11th Cir. 1991) (citing *Orozco-Prada* in upholding a conviction of aiding and abetting illegal narcotics possession and distribution when the conduct at issue occurred after the underlying possession).

[13] Musta's qualifying condition under the THC act is chronic pain, and there is nothing in the record to suggest that she will purchase and possess medical cannabis on only a single occasion. Quite the opposite, Musta had undergone extensive, unsuccessful medical intervention before she began using medical cannabis, which appears to provide her at least some relief.

[14] It also strikes us as odd to suppose that Musta's first reimbursement of medical cannabis would not be preempted by

entire purpose of reimbursement under our workers' compensation scheme is to fulfill the legislative policy to provide injured employees with "quick and efficient delivery of . . . medical benefits" that are reasonable and necessary to treat the work-related injury. *See* Minn. Stat. § 176.001 (2020). And as long as medical cannabis remains "reasonably . . . required" to treat and cure the effects of Musta's injury, the Workers' Compensation Act requires Mendota Heights to fund Musta's ongoing use and possession that is illegal under federal law.

Thus, we conclude that mandating Mendota Heights to pay for Musta's medical cannabis, by way of a court order, makes Mendota Heights criminally liable for aiding and abetting the possession of cannabis under federal law.[15] Finally, we note the argument by the dissent that preemption here frustrates the intention of the Legislature to make medical cannabis available to patients suffering from intractable pain. We agree that if the result here is not beneficial to the employee, the remedy is for

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the CSA, but each subsequent request would be. Or similarly, that Musta's reimbursement would not be preempted because she can afford her medical cannabis while another employee's reimbursement would be preempted if that employee could not afford the medical cannabis without reimbursement. It is far sounder, based on the expectations and obligations designed into our workers' compensation laws, to conclude that all of these reimbursements are preempted.

[15] We note the constitutional danger lurking in Musta's argument that a state court order can negate the mens rea for a federal crime. Were we to adopt her reasoning, then a state could nullify *any* federal specific intent crime by simply passing legislation that mandates a person to perform the criminal act. Under our constitutional order, that cannot be. To do so would undermine the entire purpose of the Supremacy Clause of the United States Constitution.

Congress to pass, and the President to sign, legislation that addresses the preemption issues created by the conflict between federal and state law.

As it is impossible to comply with both state and federal law, the compensation court's order is preempted by the CSA.[16] Accordingly, we reverse the decision of the Workers' Compensation Court of Appeals.

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[16] Because we conclude that the CSA preempts the order for reimbursement under impossibility preemption, we need not—and decline to—analyze obstacle preemption. We note that there may be other legal theories under which the CSA preempts such an order, but we confine our analysis to the theories raised and argued by the parties. *See State v. Caldwell*, 803 N.W.2d 373, 382 n.3 (Minn. 2011).

Although the dissent finds our interpretation of the intent standard for aiding and abetting liability to be "expansive[]" and "troubling," our decision is based on the authoritative statements by the *Rosemond* Court, which itself reflects the uncertainty and breadth of accomplice liability in the law as it stands. *See* Stephen P. Garvey, *Reading Rosemond*, 12 Ohio St. J. Crim. L. 233, 241 (2014) (stating that the Supreme Court's guidance on the mental state required for aiding and abetting liability "is no model of clarity" and offering three frameworks for interpreting *Rosemond*); Lauren A. Newell, *Hitting the Trip Wire: When Does a Company Become a "Marijuana Business"?*, 101 B.U. L. Rev. 1105, 1131-32 (2021) (explaining that the CSA "casts a wide net of potential liability" and that the "most difficult cases" involve potential liability under conspiracy or aiding and abetting theories).

Consequently, we emphasize that our decision here finding preemption by the CSA is limited to the unique facts and setting of this dispute: a claim for reimbursement of medical expenses, incurred to treat a work-related injury, where the treatment for which the expense is incurred is the purchase and use of medical cannabis, with the reimbursement liability determined in a legal proceeding. We express no opinion on whether the CSA preempts any component of Minnesota's medical cannabis program, nor does our preemption decision here extend to any other form of medical treatment.

CONCLUSION

For the foregoing reasons, we reverse the decision of the workers' compensation court of appeals.

Reversed.

CONCURRENCE & DISSENT

CHUTICH, Justice (concurring in part, dissenting in part).

I agree with Part I of the court's decision, which holds that the Workers' Compensation Court of Appeals lacks subject matter jurisdiction to *decide* whether federal law preempts a provision of Minnesota's workers' compensation law that requires an employer to reimburse an employee who purchases medical cannabis. *See* Minn. Stat. § 176.135, subd. 1(a) (2020) (requiring an employer to "furnish any medical . . . treatment . . . as may reasonably be required" to treat a work-related injury). I write separately because I disagree with the court's holding in Part II that the federal Controlled Substances Act, 21 U.S.C. §§ 801-971, *preempts* an employer's obligation under state workers' compensation law, Minn. Stat. § 176.135, subd. 1(a), to reimburse an employee who buys medical cannabis that is reasonably required to treat the employee's work-related injury. Because the court's conclusion that a conflict of law exists rests on an unduly expansive view of aiding and abetting liability, with the result of denying injured employees reasonable and necessary medical treatment,[1] I respectfully dissent.

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[1] The parties stipulated that medical cannabis is reasonable and necessary to treat Musta's work-related injury.

Federal law establishes that a person who "aids, abets, counsels, commands, induces or procures" the commission of a federal offense "is punishable as a principal." 18 U.S.C. § 2. As explained in *Rosemond v. United States*, 572 U.S. 65, 71, 134 S.Ct. 1240, 188 L.Ed.2d 248 (2014), aiding and abetting has two elements. A person must carry out an "affirmative act in furtherance of" the crime with "the intent of facilitating the offense's commission." *Id.* Reimbursing Musta for her prior purchase of cannabis pursuant to the order of the compensation judge satisfies neither element. Nor is Minnesota's workers' compensation law, Minn. Stat. § 176.135, subd. 1(a), an impermissible "obstacle" to the purposes of the Controlled Substances Act.

I.

I begin with the element of an affirmative act in furtherance of the crime. A defendant can be convicted of aiding and abetting without proof of participating in every aspect of the crime, but the defendant must have aided in *some* aspect of the crime. *Rosemond*, 572 U.S. at 74-75, 134 S.Ct. 1240 ("It is inconsequential . . . that [a defendant's] acts did not advance each element of the offense; all that matters is that they facilitated one component."). Accordingly, a person cannot aid and abet a crime after it is complete, as is well established. *See United States v. Centeno*, 793 F.3d 378, 390 (3d Cir. 2015); *United States v. Figueroa-Cartagena*, 612 F.3d 69, 74 (1st Cir. 2010); *United States v. Hamilton*, 334 F.3d 170, 180 (2d Cir. 2003); *United States v. Delpit*, 94 F.3d 1134, 1150-51 (8th Cir. 1996).

Here, the compensation judge ordered relators Mendota Heights Dental Center and Hartford Insurance Group (collectively, Mendota Heights) to reimburse Musta for her prior purchase of medical

cannabis. Because that purchase and the related possession are already complete, reimbursing Musta now would not further any element of an offense of possession. *See United States v. Ledezma*, 26 F.3d 636, 642-43 (6th Cir. 1994) (holding that the evidence did not support an aiding and abetting conviction when the defendant entered the conspiracy *after* the illegal possession was complete). Consequently, Mendota Heights can comply with the reimbursement order without violating federal law.

The court tries to circumvent the completed-crime rule in two ways. First, the court concludes that an exception to the rule applies, citing *Ledezma*. Under that exception, aiding and abetting drug offenses "may encompass activities, intended to ensure the success of the underlying crime, that take place after . . . the principal no longer possesses the [illegal substance]." *Id.* at 643. But *Ledezma* recognized that exception in only two contexts. First, after-the-fact actions may be aiding and abetting when the crime is still *on-going*, such as when the drugs have changed hands but the money has not. *Id.* (citing *United States v. Coady*, 809 F.2d 119, 124 (1st Cir. 1987)). Second, after-the-fact measures may aid and abet when the defendant's action is a "recurring contribution to a *continuing* crime," such as laundering money proceeds of a drug sale. *Id.* (citing *United States v. Orozco-Prada*, 732 F.2d 1076, 1080 (2d Cir. 1984)). Neither circumstance is present in this case.

Unlike the transaction in *Coady*, Musta's purchase is already complete. So too is the related possession, or at least, if ongoing, it would not be affected by any reimbursement now. And unlike *Orozco-Prada*, reimbursement after the fact is not "*integral* to the success" of unlawful possession in the same way that money-laundering is integral to a drug distribution

scheme. *Orozco-Prada*, 732 F.2d at 1080. After all, selling drugs is useless if the proceeds are unusable, but a person may find any number of ways to fund a purchase of medical cannabis. Here, Musta purchased the medical cannabis on her own without knowing whether she would ultimately be reimbursed.

Second, the court relies heavily on Musta's *expectation* of reimbursement and assumes that Musta will continue to buy medical cannabis with the expectation of being reimbursed. But Musta's unilateral expectation does not extend the duration of a crime of possession after it is complete, at least when Mendota Heights does not agree in advance to reimburse her. Mendota Heights has not stated that it will reimburse any future purchase, and whatever statutory obligation it may have to reimburse Musta in the future will depend on the facts and circumstances existing at that time. *See* Minn. Stat. § 176.135, subd. 1(a) (requiring an employer to furnish treatment that is reasonably required "at the time of the injury and *any time thereafter*" (emphasis added)); Minn. Stat. § 176.136, subd. 2(2) (2020) (permitting an employer to refuse to pay for treatment that is excessive).

Musta's personal expectation of future reimbursement is therefore far different from the recurring contribution of a defendant who, by agreeing to launder proceeds of illegal sales on a recurring basis, has offered encouragement and aid for the completed sale—and potentially for future sales too. *See Orozco-Prada*, 732 F.2d at 1080. Accordingly, Mendota Heights can comply with the reimbursement order without violating federal law because reimbursement would not contribute to any element of a crime "before or at the time the crime was committed." *Delpit*, 94 F.3d at 1151.

II.

Even assuming that the affirmative-act requirement would be met, Mendota Heights could not be liable under an aiding and abetting theory because it lacks the required intent. Under the "canonical formulation" of intent for aiding and abetting, "a defendant must not just 'in some sort associate himself with the venture,' but also 'participate in it as in something that he wishes to bring about' and 'seek by his action to make it succeed.'" *Rosemond*, 572 U.S. at 76, 134 S.Ct. 1240 (quoting *Nye & Nissen v. United States*, 336 U.S. 613, 619, 69 S.Ct. 766, 93 L.Ed. 919 (1949)). In other words, the defendant must act with the *purpose* of furthering the crime.

Undoubtedly, Mendota Heights has no desire to help Musta possess cannabis. This lawsuit and appeal are ample evidence of that fact. *See Hager v. M&K Constr.*, 246 N.J. 1, 247 A.3d 864, 889 (2021) (observing that, "[b]y the very nature of its appeals," the employer "has made it clear that it does not wish" to aid in an employee's possession of medical cannabis). Accordingly, the court turns to a different formulation of the intent standard in *Rosemond*, namely, that the intent requirement may be satisfied "when a person actively participates in a criminal venture with full knowledge of the circumstances constituting the charged offense." 572 U.S. at 77, 134 S.Ct. 1240. The court reasons that because reimbursement would finance Musta's possession and effectively facilitate her future possession, Mendota Heights would actively participate in Musta's possession of medical cannabis if it reimburses her. And because Mendota Heights is "fully knowledgeable about the circumstances advanced" by its compelled reimbursement, the knowledge requirement is met.

I agree with the court that active participation with full knowledge of the criminal scheme can satisfy the intent requirement for aiding and abetting, as is clearly stated in *Rosemond*. 572 U.S. at 77, 134 S.Ct. 1240. But I disagree that reimbursing an employee to fulfill a statutory duty that is determined by a court order is "active participation" in a crime that the employee chooses to commit.

Rosemond does not suggest that knowingly active participation represents a *lesser* mens rea than acting with the specific purpose of furthering the crime. Instead, active participation operates as a *means of demonstrating* that a person intends to facilitate a crime, as both the majority and dissent in *Rosemond* recognized. *See id.* ("[A] person who *actively participates* in a criminal scheme *knowing* its extent and character *intends* that scheme's commission." (emphasis added)); *id.* at 85, 134 S.Ct. 1240 (Alito, J., dissenting) ("[T]he difference between acting purposefully (when that concept is properly understood) and acting knowingly is slight.").

The cases cited by the *Rosemond* Court as examples of knowingly active participation are instructive. *See* 572 U.S. at 77, 134 S.Ct. 1240. In *Pereira v. United States*, 347 U.S. 1, 12, 74 S.Ct. 358, 98 L.Ed. 435 (1954), the Court found that the defendant had the requisite intent for aiding and abetting mail fraud when he deceptively obtained a check from the victim knowing that a confederate would do the actual mailing to collect on the check. And in *Bozza v. United States*, 330 U.S. 160, 165, 67 S.Ct. 645, 91 L.Ed. 818 (1947), the Court upheld a conviction for aiding and abetting the evasion of liquor taxes because the defendant "helped operate a clandestine

distillery" while he was aware of the illegal nature of the business.

In each case, the defendant's purpose of furthering the illegal scheme is inferable from his active participation in, with full knowledge of, the underlying crime. In *Pereira*, the defendant's desire that the check be mailed was clear from his part in deceiving the victim and obtaining the check, knowing that the check would later be mailed. 347 U.S. at 12, 74 S.Ct. 358 ("[I]t is also clear that an intent to collect on the check would include an intent to use the mails or to transport the check in interstate commerce."). And in *Bozza*, assisting with a secret distillery operation implied an intent to help the owner evade taxes. 330 U.S. at 165, 67 S.Ct. 645 ("[A] person who actively helps to operate a secret distillery knows that he is helping to violate Government revenue laws. That is a well known object of an illicit distillery."). In short, each defendant's actions showed that he had chosen "to align himself with the illegal scheme in its entirety." *Rosemond*, 572 U.S. at 78, 134 S.Ct. 1240.

But the conduct that satisfied active participation in *Pereira* or *Bozza* was far more involved in the underlying scheme than the conduct here. Unlike Bozza, Mendota Heights is not directly involved in carrying out the illegal scheme: Mendota Heights is not participating in the transaction between Musta and the cannabis dispensary nor in Musta's related possession of the cannabis. Any reimbursement would be paid after the purchase and possession are already complete, and any ongoing possession of that cannabis would be unaffected by the reimbursement. Unlike Pereira, Mendota Heights is not seeking to facilitate a criminal act by a confederate. Mendota Heights is not encouraging Musta to buy or possess cannabis; neither is it paying her for future purchases

ahead of time. Musta's past decision to purchase cannabis, and any decision to purchase cannabis in the future, is her own. Further, Mendota Heights is doing everything it can to *distance* itself from Musta's purchase and possession of medical cannabis. Consequently, there simply is no sign that Mendota Heights has "align[ed]" itself with Musta's choice to possess cannabis or desires in any way to "make [any plan of Musta's] succeed." *Rosemond*, 572 U.S. at 78, 134 S.Ct. 1240. Accordingly, Mendota Heights lacks the required intent to aid and abet.

The court cites to *Garcia v. Tractor Supply Co.*, 154 F. Supp. 3d 1225, 1226 (D.N.M. 2016), to support its conclusion that Mendota Heights would have the required intent to aid and abet. This reliance on *Garcia* is misplaced. *Garcia* held that an employer was not required to accommodate an employee's use of medical cannabis because the New Mexico Human Rights Act was preempted by federal law to the extent that the act required the employer to accommodate the employee's illegal drug use. *Id.* at 1230. But *Garcia* did not rely on impossibility preemption based on a theory of aiding and abetting liability. It relied on *obstacle* preemption, *see id.*, the form of preemption applied in *Emerald Steel Fabricators, Inc. v. Bureau of Lab. & Indus.*, 348 Or. 159, 230 P.3d 518, 536 (2010), which is a theory that the court does not reach and that I will address later. Therefore, *Garcia* offers no support for the court's conclusion that federal law preempts section 176.135, subdivision 1(a), based on impossibility preemption.

The court also stakes its analysis on the difference between intent and motive. The court implicitly acknowledges that the compensation judge's order may be relevant to a defense of necessity but insists that the order has no relevance to the question of

intent. Notably, a similar criticism was leveled at, and rejected by, the Court in *Rosemond*. The Court held that, to be liable for aiding and abetting, a defendant must have "advance knowledge" of the facts constituting the entire crime such that the defendant can "do something with" that knowledge. *Rosemond*, 572 U.S. at 78, 134 S.Ct. 1240. For example, if an accomplice to a drug transaction knows nothing of a gun until it appears on the scene, that accomplice may not be liable for aiding and abetting a gun crime if there was no realistic opportunity for him or her to leave the scene. *Id.* Justice Alito, dissenting in part, accused the Court of confusing intent to commit an act with the motive for committing an act, *id.* at 88, 134 S.Ct. 1240 (Alito, J., concurring in part, dissenting in part), but the Court explained that aiding and abetting has a "distinctive intent standard" that requires a defendant to participate in the venture as something to be brought about and not just "in some sort associate himself with the venture." *Id.* at 81, 134 S.Ct. 1240 n.10 (internal quotation marks omitted).

Here, the record clearly shows that Mendota Heights has no desire to help Musta possess cannabis. Neither has Mendota Heights chosen to "align [itself] with the illegal scheme in its entirety." *Id.* at 78, 134 S.Ct. 1240. Although Mendota Heights has advance knowledge that Musta seeks reimbursement for medical cannabis, it reimburses her for this medical treatment only under the obligation of state law and at the order of a court. I therefore conclude that the "distinctive intent standard" for aiding and abetting is not met.

The expansiveness of the court's interpretation of the intent standard for aiding and abetting is

troubling.[2] Mendota Heights would reimburse Musta only after the fact and only to fulfill a statutory duty as determined by a court. If that counts as active participation in Musta's possession solely because Mendota Heights would be knowingly "financing" or "facilitating" that possession, then other actions thought to be innocent could likewise trigger criminal liability.

For example, if an employee tells her employer, "I'm going to use my next three paychecks to buy medical cannabis," and the employer pays the employee those three paychecks, has the employer then knowingly "financed" that employee's unlawful possession? It would be absurd to suppose that, in such a situation, state fair labor laws requiring an employer to pay an employee a minimum hourly wage are partially preempted. Or, if a bus route passes a cannabis dispensary, and the bus driver knows that a passenger is on his way to purchase medical cannabis, has the bus driver knowingly "facilitated" a future possession of cannabis? Is the same true of a taxi driver who knows the purpose of the trip? Surely those facts alone are not enough to convict the bus or taxi driver of aiding and abetting the possession of cannabis. If intent is inferable from those circumstances—which are nothing more than incidental participation in the crime[3]—then the

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[2] The court tries to shield responsibility for its expansive interpretation behind the "authoritative statements" by the Supreme Court in *Rosemond*. But as I have explained and other courts of last resort have found, *Rosemond* by no means compels the interpretation or result that the court reaches today.

[3] The Court in *Rosemond* distinguished between incidental and active participants, stating that the owner of a gun store, who sells a gun to a criminal while knowing but not caring how the gun will be used, would be only an *incidental* participant in

government's burden of proving intent is effectively eliminated.[4]

The law of aiding and abetting does not allow for such expansive liability. *Rosemond* dictates that the government prove "inten[t] to facilitate that offense's commission." 572 U.S. at 76, 134 S.Ct. 1240. It is not enough that a person is "in some sort associate[d]" with the offense; a person must "'participate in it as in something that he wishes to bring about.'" *Id.* (quoting *Nye & Nissen*, 336 U.S. at 619, 69 S.Ct. 766). Consistent with the holdings of the New Jersey and New Hampshire Supreme Courts, I conclude

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the subsequent crime. *See* 572 U.S. at 77 n.8, 134 S.Ct. 1240. Although the Court declined to decide whether incidental participants are guilty of aiding and abetting an offense, the logical answer is no. The whole point of specific intent is that the defendant is aligned with the venture as something the defendant wishes to bring about. *Id.* at 76, 134 S.Ct. 1240. Incidental participants lack this alignment and are more like those who are merely associated "'in some sort'" with a venture than those who actively participate in bringing the venture about. *Id.* (citation omitted).

Notably, Mendota Heights is even *less* involved than the Court's hypothetical gun store owner who willingly sells the gun. Mendota Heights would be like a gun store owner who staunchly refuses to sell the gun to a customer until ordered to do so by a court.

[4] The court tries to distinguish the employer hypothetical by stating that a paycheck is ordinarily used "for any number of purchases" other than cannabis. That distinction is irrelevant. Under my hypothetical, the paycheck is used to purchase cannabis and, following the court's reasoning, the employer is aiding and abetting the purchase by knowingly financing it.

The court tries to distinguish the bus driver hypothetical by stating that the route is driven "not solely for the benefit of the passenger to obtain cannabis." But that distinction resorts to the motive of the driver, an argument which the court itself rejects.

that Mendota Heights does not have a specific intent to aid Musta in unlawfully possessing cannabis merely by reimbursing her after the fact based on a court order applying state law. *See Hager*, 247 A.3d at 889; *Appeal of Panaggio*, 174 N.H. 89, ——, —— A.3d —— (2021).[5]

III.

Because it is not impossible for Mendota Heights to comply with the compensation judge's order and federal law, I next address the question of obstacle preemption. Obstacle preemption exists when "state law is an obstacle to the accomplishment of the purposes of the federal scheme." *Martin ex rel. Hoff v. City of Rochester*, 642 N.W.2d 1, 11 (Minn. 2002). Under Minnesota's workers' compensation laws, an employer must "furnish any medical . . . treatment" as "may reasonably be required" to "cure and relieve from the effects of the injury." Minn. Stat. § 176.135, subd. 1(a). The question, then, is whether section 176.135, subdivision 1(a), stands as an obstacle to the purpose of the Controlled Substances Act if section 176.135 requires an employer to reimburse an employee for the purchase of medical cannabis.

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[5] The court claims that, following my reasoning, a state could nullify *any* federal specific intent crime by simply passing legislation that commands a person to perform the criminal act. Not so. A person could still be liable for aiding and abetting an offense if there were facts demonstrating that the person had aligned themselves with the criminal scheme. Further, even if *impossibility* preemption did not apply, there would still be a serious question of *obstacle* preemption, which is triggered when a state law thwarts Congress's intent. As I will explain, obstacle preemption does not exist under the specific facts of this case, but it may apply if a state attempted what the court describes.

"Congressional purpose is the ultimate touchstone of the preemption inquiry." *Gretsch v. Vantium Cap., Inc.*, 846 N.W.2d 424, 432-33 (Minn. 2014). But preemption is usually disfavored. *Martin*, 642 N.W.2d at 11. Because workers' compensation is traditionally a matter of state law, I start with the assumption that section 176.135 is not preempted "'unless that [is] the clear and manifest purpose of Congress.'" *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 516, 112 S.Ct. 2608, 120 L.Ed.2d 407 (1992) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 67 S.Ct. 1146, 91 L.Ed. 1447 (1947)) (alteration in original). The case for preemption is also particularly weak when Congress knew that state law operated in an area of federal interest, but "nonetheless decided to stand by both concepts and to tolerate whatever tension there was between them." *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 256, 104 S.Ct. 615, 78 L.Ed.2d 443 (1984).

"The main objectives of the [Controlled Substances Act] were to conquer drug abuse and to control the legitimate and illegitimate traffic in controlled substances." *Gonzales v. Raich*, 545 U.S. 1, 12, 125 S.Ct. 2195, 162 L.Ed.2d 1 (2005). "Congress was particularly concerned with the need to prevent the diversion of drugs from legitimate to illicit channels." *Id.* at 12-13, 125 S.Ct. 2195. "To effectuate these goals, Congress devised a closed regulatory system making it unlawful to manufacture, distribute, dispense, or possess any controlled substance except in a manner authorized by the [Act]." *Id.* at 13, 125 S.Ct. 2195.

Consistent with the decisions of courts of last resort in other states, I conclude that the reimbursement of medical cannabis that is purchased and used within the strictures of the state's medical cannabis

research program does not stand as an impermissible obstacle to the purposes of the Act. As observed by the New Hampshire Supreme Court, the Act does not make it illegal for an insurer to reimburse an employee for a purchase of medical cannabis or purport to regulate insurance practices in any manner. *Appeal of Panaggio*, 174 N.H. at ——, —— A.3d ——. In addition, the compensation judge's order in no way prevents the federal government from using its own resources to enforce the Act. *Id.*; *see* Erwin Chemerinsky et al., *Cooperative Federalism & Marijuana Regulation*, 62 UCLA L. Rev. 74, 111-12 (2015) (arguing that, because the federal government cannot commandeer state legislatures and require them to prohibit cannabis altogether, a state's regulation of medical cannabis does not stand as an obstacle to the objectives of the Controlled Substances Act).

Furthermore, as explained by the New Jersey Supreme Court, since 2015, Congress has prohibited the Department of Justice from using its funds to prevent states from implementing their medical cannabis laws. *Hager*, 247 A.3d at 886. These appropriation riders at the very least show that Congress has chosen to "tolerate" the tension between state medical cannabis laws and the Controlled Substances Act, *see Bonito Boats, Inc. v. Thunder Craft Boats, Inc.*, 489 U.S. 141, 166-67, 109 S.Ct. 971, 103 L.Ed.2d 118 (1989), and may even have eliminated liability under federal law for the possession of medical cannabis that was permitted under state law during those years, *see Hager*, 247 A.3d at 887. For these reasons, I conclude that the high bar for obstacle preemption is not met.

IV.

In sum, because it is not impossible for Mendota Heights to comply with state and federal law, and

because reimbursing Musta does not stand as an impermissible obstacle to federal law, I would hold that the section 176.135, subdivision 1(a), is not preempted by federal law. Consequently, I would affirm the decision of the Workers' Compensation Court of Appeals.

The court has chosen to do otherwise, and the effect of today's decision is to prevent Musta and other injured workers who suffer intractable pain from receiving the relief that medical cannabis can bring. In doing so, the court frustrates the Legislature's goal of providing "quick and efficient delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers." Minn. Stat. § 176.001 (2020). Because today's decision misconstrues the scope of the specific intent underlying an aiding and abetting offense—with the effect of denying reimbursement for reasonable and necessary treatment for injured workers—I respectfully dissent.

DANIEL BIERBACH, Employee/Respondent, v. DIGGER'S POLARIS and STATE AUTO/UNITED FIRE & CAS. GRP., Employer-Insurer/Appellants.

WORKERS' COMPENSATION COURT OF APPEALS
NOVEMBER 10, 2020
WC19-6314

JURISDICTION – SUBJECT MATTER. The compensation judge had subject matter jurisdiction under Minnesota law to determine whether the employee was entitled to reimbursement for medical cannabis. This court declines to rule on whether the Minnesota medical cannabis laws are preempted by federal criminal statutes.

MEDICAL TREATMENT & EXPENSE – REASONABLE & NECESSARY. Substantial evidence, including medical records, expert medical opinion, and lay testimony supports the award reimbursing costs incurred by the employee for medical cannabis as reasonable and necessary treatment for intractable pain caused by the employee's work injury.

Determined by:

Deborah K. Sundquist, Judge
Patricia J. Milun, Chief Judge
David A. Stofferahn, Judge
Gary M. Hall, Judge
Sean M. Quinn, Judge

Compensation Judge: William J. Marshall

Attorneys: Michael G. Schultz, Sommerer & Schultz, Minneapolis, Minnesota, for the Respondent. Susan K.H. Conley and Jeffrey M. Markowitz, Arthur,

Chapman, Ketterling, Smetak & Pikala, P.A., Minneapolis, Minnesota, for the Appellants. Charles A. Bird, Danielle T. Bird, Bird, Jacobsen & Stevens, P.C., Rochester, Minnesota, for amicus curiae Minnesota Association for Justice. Beth A. Butler, Kristine L. Cook, Peterson, Logren & Kilbury, P.A., Roseville, Minnesota, for amicus curiae Minnesota Defense Lawyers.

Affirmed.

OPINION

DEBORAH K. SUNDQUIST, Judge

The employer and insurer appeal the compensation judge's award of reimbursement for costs incurred by the employee for medical cannabis used to treat his work-related injury. We affirm.

BACKGROUND

In 2004, Daniel Bierbach, the employee, was at work for his employer, Digger's Polaris, when an ATV he was operating rolled, landing on his ankle. The employer and its insurer admitted liability. The employee sought care with J. Chris Coetzee, M.D., an orthopedic surgeon with a sub-specialty in foot and ankle surgery, who diagnosed fractures of the distal tibial pilon and fibula. A few weeks after the injury, the employee underwent surgery. A year post surgery, the employee continued to walk with a limp and had significant swelling of his ankle.

Physical therapy was prescribed, and the employee incorporated its recommended exercises in his regular gym routine and wore an ankle brace. By 2007, he reported a return to his normal activity level but continued to experience intermittent pain and swelling. Three years later, his symptoms worsened, and he again saw Dr. Coetzee, who noted the need for

an ankle fusion. Due to the employee's young age, however, Dr. Coetzee wanted to postpone ankle fusion surgery for as long as possible.

In April 2013, the employee filed a claim petition alleging a consequential neck and back injury. In 2014, the parties settled the employee's claims for workers' compensation benefits and closed out some medical expenses, which included opioids/narcotic therapy, psychiatric and psychological treatment, mental health, health clubs, implantable stimulators, and future chronic pain management. (Ex. 33.)

The employee underwent a series of injections in 2017, but by 2018, he had developed progressive degenerative changes in the left ankle and was limited in his activities of daily living. He continued to gain weight due to his inability to exercise. On June 13, 2018, Dr. Coetzee opined that the employee was a candidate for medical cannabis to help with his intractable pain and to wean him off narcotic pain medication.

The employee's application for the Minnesota medical cannabis registry[1] was submitted to and accepted by the Minnesota Department of Health (MDH). The employee was referred to Leafline, a manufacturer of medical cannabis, for evaluation and distribution of medical cannabis. A registered pharmacist with Leafline recommended two types of medical cannabis oil, "tangerine" for nighttime use due to the employee's pain at night and "cobalt" for day to day activity. The employee placed the oil in a device allowing him to inhale the oil as a vapor. The employee met with a Leafline professional to discuss his mental and physical response and to refill his

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[1] *See* Minn. Stat. § 152.27.

medical cannabis. Dr. Coetzee reported that the treatment appeared to be effective in reducing the employee's complaints of intractable pain. He opined that, within a reasonable degree of medical certainty, medical cannabis was an appropriate treatment for the employee's condition.

Chris Meyer, M.D., examined the employee on behalf of the employer and insurer. He reviewed medical records, took a history from the employee, and conducted a physical examination. In his narrative report of December 10, 2018, Dr. Meyer opined that the work injury was a substantial contributing factor to the employee's chronic pain. Based on the medical literature, Dr. Meyer stated that he was "not a believer in the use of medical cannabis for chronic pain," but noted that "there is a reasonable degree of certainty that medical marijuana is a safer alternative to opioid use." (Ex. 1.) Because the employee had not undergone a pain clinic program in the past, Dr. Meyer recommended a pain clinic for the employee's chronic pain.

In 2018, the employee was hired by a new employer as a professional sales associate. The job required him to be on his feet 90 percent of the day. He generally worked over 60 hours a week. He testified that, due to the medical cannabis, his quality of life improved and he was able to continue working at his job.

The employee had a prior history of drug use. He admitted that he had used recreational marijuana for years. He had also taken narcotic medication after the work injury, but he did not like the effects of narcotics and weaned off them in 2004. Since admitted into the medical cannabis program in 2018, the employee's medical cannabis dosage has doubled. At

the time of hearing, the monthly cost for his medical cannabis was $1,863.71.

On June 29, 2018, the employee filed a claim petition seeking reimbursement for out-of-pocket costs incurred for medical cannabis used to treat his work-related injury.

The matter was heard before a compensation judge on May 14, 2019. The issues presented included whether the compensation judge had jurisdiction under Minn. Stat. §§ 152.22-.37 (2018) to order reimbursement of costs incurred for medical cannabis and whether the employee's medical cannabis was reasonable, necessary and causally related to the work injury. The compensation judge awarded reimbursement, concluding that he had authority to order reimbursement of such costs, and that the employee's use of medical cannabis was reasonable and necessary medical treatment and causally related to the work injury. The employer and insurer appeal.

STANDARD OF REVIEW

On appeal, the Workers' Compensation Court of Appeals must determine whether "the findings of fact and order [are] clearly erroneous and unsupported by substantial evidence in view of the entire record as submitted." Minn. Stat. § 176.421, subd. 1(3). Substantial evidence supports the findings if, in the context of the entire record, "they are supported by evidence that a reasonable mind might accept as adequate." *Hengemuhle v. Long Prairie Jaycees*, 358 N.W.2d 54, 59, 37 W.C.D. 235, 239 (Minn. 1984). Where evidence conflicts or more than one inference may reasonably be drawn from the evidence, the findings are to be affirmed. *Id.* at 60, 37 W.C.D. at 240. Similarly, findings of fact should not be disturbed, even though the reviewing court might

disagree with them, "unless they are clearly erroneous in the sense that they are manifestly contrary to the weight of evidence or not reasonably supported by the evidence as a whole." *Northern States Power Co. v. Lyon Food Prods., Inc.*, 304 Minn. 196, 201, 229 N.W.2d 521, 524 (1975).

A decision which rests upon the application of a statute or rule to essentially undisputed facts generally involves a question of law which the Workers' Compensation Court of Appeals may consider de novo. *Krovchuk v. Koch Oil Refinery*, 48 W.C.D. 607, 608 (W.C.C.A. 1993), *summarily aff'd* (Minn. June 3, 1993).

DECISION

On appeal, the employer and insurer ask this court to reverse the compensation judge's award of reimbursement for out-of-pocket costs related to the employee's use of medical cannabis. The appellants raise four issues on appeal: whether the compensation judge improperly relied upon medical opinions which lacked foundation, whether the judge erred in finding that the use of medical cannabis was reasonable and necessary to cure or relieve the effects of the employee's injury, whether the compensation judge had jurisdiction to order the employer and insurer to finance the employee's medical cannabis use, and whether the federal law making it illegal to possess, distribute or manufacture cannabis preempts the state's medical cannabis law, making it a crime for the employer and insurer to reimburse out-of-pocket costs of the employee for state-authorized use of medical cannabis.

Foundation and Medical Expertise

The employer and insurer argue that the judge erred in adopting the medical opinion of Dr. Coetzee because that opinion lacked foundation. Specifically,

they argue that Dr. Coetzee's opinion that the employee was a good candidate for medical cannabis is based on faulty information that the employee was taking narcotic medication and that he had no history of substance abuse. They argue that Dr. Coetzee was not an expert in pain medicine and cited no meaningful literature, and therefore lacked the necessary expertise to render an opinion on the employee's use of medical cannabis. Moreover, they argue that Dr. Meyer's opinion was more persuasive because he questioned the use of cannabis as medically controversial and questioned its effectiveness. We are not persuaded that Dr. Coetzee lacked either the necessary foundation or expertise.

In weighing the evidence, a compensation judge has discretion as the trier of fact to choose between competing and conflicting medical opinions. *Gianotti v. Indep. Sch. Dist. 152*, 889 N.W.2d 796, 803, 77 W.C.D. 117, 126 (Minn. 2017). This assessment of the weight to be given to conflicting opinions is upheld on appeal, absent an abuse of discretion. *Mattick v. HyVee Food Stores*, 898 N.W.2d 616, 77 W.C.D. 617 (Minn. 2017). The opinion need only be based on enough facts to form a reasonable opinion that is not based on speculation or conjecture. *Gianotti*, 889 N.W.2d at 802, 77 W.C.D. at 124.

As the employee's physician since 2004, Dr. Coetzee was familiar with the employee's history and treatment. He had recommended medications, injections, surgery and physical therapy, but all failed to relieve the employee's pain. Dr. Coetzee did not prescribe[2] medical cannabis, but instead

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[2] In Finding 17, the compensation judge indicates that "The preponderance of the evidence shows that this Compensation Judge has authority to order reimbursement of the employee's

diagnosed the employee with intractable pain which is a qualifying condition for medical cannabis registration and certification. Minn. Stat. § 152.27, subd. 2(b); Medical Cannabis and Intractable Pain, Op. Off. of Medical Cannabis, Minn. Dep't of Health (Dec. 2, 2015). Dr. Coetzee did not set the cannabis dose, which was regulated through Leafline, one of only two Minnesota medical cannabis dispensaries registered under Minn. Stat. § 152.25. Having years of a doctor-patient relationship with the employee, Dr. Coetzee observed the employee's condition both before and during the employee's use of medical cannabis and opined that the employee had responded well to that treatment. The employee testified that the medical cannabis improved his pain and functioning so he could continue full-time work in sales while spending much of the workday on his feet. Even Dr. Meyer agreed that medical cannabis was a safer alternative to opioid use. While there is a discrepancy between Dr. Coetzee's 2018 statement that the employee needed to wean off narcotics and the employee's testimony that he had not used narcotics since 2004, we conclude the compensation judge could reasonably reconcile this discrepancy as the trier of fact. The compensation judge did not err by accepting Dr. Coetzee's adequately founded opinion that the treatment was an appropriate modality to address the employee's intractable pain and a better option than chronic use of opioid medication.

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payments and costs associated with his medical cannabis prescription." Although the term "prescription" is used here, there is no evidence in the record that Dr. Coetzee "prescribed" or wrote a script for medical cannabis.

Reasonable and Necessary Medical Treatment

The employer and insurer argue that medical cannabis is not reasonable and necessary treatment because it is not currently accepted for medical treatment use, the employee is a poor candidate due to his history of substance abuse, Dr. Coetzee did not manage the employee's medical cannabis treatment, the treatment parameters do not support the use of medical cannabis as a reasonable treatment, and as cannabis is an illegal substance, medical cannabis cannot be considered a reasonable treatment. This issue raises questions of fact and law, and we begin with an analysis of the legal issue, which we review de novo.

In 2014, the Minnesota legislature passed the Medical Cannabis Therapeutic Research Act (MCTRA), which established a patient registry and allowed qualifying Minnesotans to possess and use cannabis to treat significant medical conditions. Minn. Stat. §§ 152.22-.37. Regulated by MDH, the law provides rules for the registration, certification, dispensation and use of medical cannabis. The statute presumes that a patient enrolled in the registry program is engaged in the state-authorized use of medical cannabis. Minn. Stat. § 152.32, subd. 1.

Noticeably absent in MCTRA is language requiring payment by health insurers or workers' compensation insurers. Minn. Stat. § 152.23 provides that "nothing in sections 152.22 to 152.37 require the medical assistance and MinnesotaCare programs to reimburse an enrollee or a provider for costs associated with the medical use of cannabis," but does not include the same language for health insurers or workers' compensation insurers. The Minnesota Workers' Compensation Act requires an employer to provide "any" medical treatment as may reasonably

be required at the time of the injury and any time thereafter to cure and relieve the effects of the injury. Minn. Stat. § 176.135, subd. 1. That the Minnesota Department of Labor & Industry has not promulgated rules under the treatment parameters for guided use of medical cannabis does not render ineffective the plain language of section 176.135. Moreover, the treatment parameters unequivocally state that medical cannabis permitted under the medical cannabis program is not an illegal substance. Minn. R. 5221.6040, subp. 7a.

Dr. Coetzee diagnosed the employee with intractable pain, which is a qualifying condition for registration. The employee sent an application to MDH, which issued a registry verification to the employee, to Dr. Coetzee, and to Leafline. The employee obtained medical cannabis from Leafline, and Dr. Coetzee continued to see employee for visits related to intractable pain. Under the MCTRA, both Dr. Coetzee and Leafline would then report to MDH, which then submits research findings to the legislature. Given the facts of this case and the requirements under the MCTRA, we see nothing unreasonable about the employee's use of medical cannabis to treat his intractable pain caused by his work injury.

The compensation judge's determination that the employee's use of medical cannabis was reasonable and necessary treatment is supported by substantial evidence. Over the course of 15 years, the employee underwent numerous treatments for his work injury. He tried narcotic medication, physical therapy and cortisone injections, but continued to have intractable pain. Surgery was performed within weeks of the injury, but the employee will need fusion surgery in the future. Because fusion surgery is not presently indicated due to the employee's young age, the

employee has been left with chronic pain and limited means of relieving it. The 2014 settlement closed out pain management and opioid/narcotic therapy. In determining that medical cannabis was reasonable and necessary, the compensation judge was persuaded by the employee's testimony that the use of medical cannabis decreased his pain and increased his functional ability. The judge adopted the opinion of Dr. Coetzee, and not the opinion of Dr. Meyer. In weighing the evidence, a compensation judge has discretion as the trier of fact to choose between competing and conflicting medical opinions. The judge's assessment of the weight to be given to the conflicting opinions is upheld on appeal, absent an abuse of discretion. *Mattick*, 898 N.W.2d at 621, 77 W.C.D. 624. Substantial evidence supports the compensation judge's award of reimbursement to the employee and we affirm.

Subject Matter Jurisdiction

The employer and insurer argue that the compensation judge lacked subject matter jurisdiction to award reimbursement of the employee's out-of-pocket expenses for medical cannabis. They argue that because medical cannabis is an illegal substance under federal law, a compensation judge does not have jurisdiction to address the use of medical cannabis. We agree that a compensation judge does not have jurisdiction to decide issues of federal criminal law. However, a compensation judge does have jurisdiction to adjudicate issues which fall under the Workers' Compensation Act. *Hale v. Viking Trucking Co.*, 654 N.W.2d 119, 62 W.C.D. 701 (Minn. 2002); *Hagen v. Venem*, 366 N.W.2d 280, 37 W.C.D. 674 (Minn. 1985). The determination of the compensability of a particular medical treatment for a work-related injury is squarely within a compensation

judge's jurisdiction. Minn. Stat. § 176.135. This includes the use of medical cannabis under the MCTRA.

Federal Preemption

Finally, the employer and insurer argue that a "positive conflict" exists between the Controlled Substances Act, 21 U.S.C. 801, et seq., a federal law which makes any use of cannabis a criminal act, and the MCTRA, which allows cannabis to be restricted to use in a medical setting. Due to federal preemption, they argue that they cannot be ordered to violate federal law by reimbursing out-of-pocket costs incurred by the employee for state-authorized use of medical cannabis.

The WCCA has statewide jurisdiction and, except for matters appealed to the supreme court, has the sole, exclusive, and final authority to hear and determine all questions of law and fact arising under the workers' compensation laws of this state in those cases that have been appealed to our court. Minn. Stat. § 175A.01, subd. 5. We have no jurisdiction in "any case that does not arise under the workers' compensation laws" or "in any criminal case." *Id.* As such, we decline to address the employer and insurer's argument that the Controlled Substances Act preempts our state medical cannabis law.

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

WID: 9349796 OAH Case No. 9349796-CP-6107
DOI: 04-07-2004 Workers' Compensation Judge
William J. Marshall

Daniel Bierbach,
Employee,
v. **FINDINGS AND ORDER**

Digger's Polaris,
Employer,
and

State Auto/United Fire & Casualty Group,
Insurer.

Following the June 29, 2018, filing of a Claim Petition, this matter came on for hearing before Workers' Compensation Judge William J. Marshall on May 14, 2019, in St. Paul, Minnesota.

Ronald M. Stark, Sommerer & Schultz, PLLC, appeared on behalf of Daniel Bierbach. Susan K H Conley, Arthur Chapman, appeared on behalf of Digger's Polaris and State Auto/United Fire & Casualty Group.

The record in this matter closed on June 28, 2019.

STATEMENT OF ISSUES

1. Does this Compensation Judge have jurisdiction under Minn. Stat. § 152.22 - .37 (2018) to order reimbursement for medical marijuana?

2. If so, is the employee's prescription for medical marijuana reasonable, necessary, and causally related to the work injury of April 7, 2004?

Based upon all of the files, records, and proceedings in this matter, the undersigned Workers' Compensation Judge issues the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. On April 7, 2004, the employee was responsible for driving all terrain vehicles (ATVs) from the employer's buildings to a designated spot along the highway. While the employee was driving an ATV, it rolled over and the employee landed on his feet, injuring his left ankle.

2. At the time of the accident, the employee was 25 years old.

3. On April 12, 2004, Dr. David Gesensway evaluated the employee and diagnosed a left ankle type C pilon fracture with transverse distal fibular fracture. Dr. Gesensway noted there was significant potential for future problems including stiffness, chronic pain, early posttraumatic arthritis, and a potential ankle fusion.

4. On April 20, 2004, the employee underwent a left distal tibia and fibula open reduction and internal fixation performed by Dr. J. Chris Coetzee.

5. On April 18, 2005, the employee was seen by Dr. Coetzee for a follow-up appointment. The employee reported he had a minimal limp and at the end of each day he had significant swelling of his ankle. Dr. Coetzee again opined that the employee would likely develop degenerative changes in the future.

6. On August 15, 2005, the employee had a screw in his left ankle removed.

7. On February 15, 2007, the employee was seen for a follow-up by PA-C Larry Nilsson. The employee reported returning to his normal activity level, but he was still bothered by intermittent pain and swelling. The employee reported that he had not gone to physical therapy for some time, but he did use many of the principles he learned in physical therapy in his regular gym routine. PA-C Nilsson provided the employee with an ankle brace.

8. The employee returned to see PA-C Nilsson on April 29, 2010. PA-C Nilsson noted the employee had gained weight recently and his ankle had been more symptomatic. The employee reported he was still experiencing the same type of pain with an increase in frequency. PA-C Nilsson opined that the employee might have to undergo more surgery at some point in the future.

9. On August 30, 2012, Dr. Coetzee evaluated the employee for ongoing left ankle pain. The employee reported an inability to sleep through the night. Dr. Coetzee opined the employee would need an ankle fusion but, should postpone undergoing this surgery as long as possible. A left ankle injection was administered.

10. The employee continued to receive periodic left ankle injections through September 21, 2017.

11. The employee was again seen by Dr. Coetzee on June 13, 2018. Dr. Coetzee noted the employee continued to develop progressive degenerative changes in his left ankle. The employee reported he was limited in his activities of daily living and continued to gain weight due to his inability to workout. Dr. Coetzee opined the employee was a

candidate for medical cannabis for his intractable pain and should wean off of narcotic pain medications.

12. On December 10, 2018, Dr. Christopher Meyer issued an Independent Medical Examination (IME) report. Dr. Meyer documented a large amount of swelling on the employee's left ankle. Dr. Meyer agreed the employee had chronic left ankle pain related to his post-traumatic degenerative joint disease noting that the classic treatment for chronic pain involves bracing, ice, medications, anti-inflammatories, and the use of narcotic pain medication. Dr. Meyer stated he did not believe in the use of medical cannabis for chronic pain. Dr. Meyer recommended that the employee undergo treatment with a pain clinic.

13. On March 28, 2019, Dr. Coetzee issued his opinion via a narrative report. Dr. Coetzee reiterated that the employee had progressive degenerative changes in his ankle and would likely need an ankle fusion or replacement in the future. However, due to his young age, Dr. Coetzee wanted the employee to avoid surgery at that time. Dr. Coetzee also noted the employee had weaned himself off of narcotic medications, but his symptoms were severe enough to warrant more than just anti-inflammatories. Dr. Coetzee concluded that medical cannabis was an appropriate treatment modality to treat the employee's intractable pain and was a much better option than chronic narcotic use.

14. The employee currently works as a sales associate for Camping World and Gander Outdoors. During the day, the employee is on his feet for most of the day showing customers motor homes, travel trailers, and other recreational vehicles.

15. The employee's hearing testimony was credible in that when he is on his feet for extended periods of time, he experiences swelling, discoloration, and pain in his ankle. Prior to being certified for medical cannabis, the employee treated his pain with periodic cortisone injections, which had decreasing efficacy, and by icing. The employee persuasively testified that the medical cannabis helps with sleeping and the pain that comes from being on his feet for work.

16. Minn. Stat. § 152.22 - .37 (2018) specifically states that medical assistance and MinnesotaCare are not required to reimburse an enrollee or a provider for medical cannabis.

17. The preponderance of the evidence shows that this Compensation Judge has authority to order reimbursement of the employee's payments and costs associated with his medical cannabis prescription.

Based upon these Findings of Fact and Conclusions of Law, and for the reasons set forth in the incorporated memorandum, the undersigned Workers' Compensation Judge makes the following:

ORDER

1. NOW THEREFORE, IT IS ORDERED that the employee's request for reimbursement of payments made for medical cannabis is granted and the employer and insurer shall reimburse the employee for payments and costs associated with his medical cannabis prescription.

2. IT IS FURTHER ORDERED that all pending pleadings are dismissed.

Dated: August 23, 2019

/s/ William J. Marshall
William J. Marshall
Interim Chief Administrative
Law Judge

Digitally Recorded

NOTICE

Notice is hereby given that any party aggrieved by this Order may appeal it, or any portion thereof, to the Workers' Compensation Court of Appeals. An appeal must be filed with the Chief Administrative Law Judge no later than 30 days following service of this Order. An appeal must contain the information required by Minn. Stat. § 176.421 (2018), including the required $25.00 filing fee.

MEMORANDUM

Legality of Medical Cannabis under Federal Law

The Compensation Judge only has jurisdiction to address questions of law and fact arising under Minnesota's workers' compensation laws. *Hale v. Viking Trucking Co.*, 654 N.W.2d 119, 123 (Minn. 2002); Minn. Stat. § 175A.01, subd. 5 (2018). Whether payment of medical cannabis is a violation of federal law is outside the scope of the Minnesota Workers' Compensation Act. Therefore, that argument is reserved for a court of competent jurisdiction.

Constitutional Arguments Raised by the Employer and Insurer

The employer and insurer contend that the Medical Cannabis Program contains provisions which exempt Medicare and Medicare, federal programs, and Workers Compensation insurers are not included in those provisions. The employer and the insurer contend that this exclusion is disparate treatment and violates the equal protection clause and the due process clause of the United States Constitution. Additionally, the employer and the insurer argue that requiring them to pay for medical cannabis would violate the dormant commerce clause. As stated above, the Compensation Judge only has jurisdiction to address questions of law and fact arising under Minnesota's workers' compensation laws, and questions regarding equal protection violations and dormant commerce clause are outside the scope of the Minnesota Worker's Compensation Act. Therefore, that argument is reserved for a court of competent jurisdiction.

Minnesota

The Compensation Judge does have authority under the Minnesota Workers' Compensation Act to award medical treatment that is reasonable and necessary to cure and relieve the effects of injury. Minn. Stat. § 176.135, subd. 1 (2018). The Minnesota Medical Cannabis Program, Minn. Stat. § 152.21 – 52.37 (2018) states that Minnesota residents who have been diagnosed with a qualifying medical condition by a health care practitioner can be enrolled in a patient registry maintained by the Minnesota Department of Health. Once a person is enrolled in the program, they are then able to obtain medical cannabis from a dispensary. On December 2, 2015,

the Commissioner of the Minnesota Department of Health designated intractable pain as a qualifying medical condition for medical cannabis. Intractable pain is defined by the Department of Health as, "pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for this patient has been used without adequate result or with intolerable side effects."[1] Additionally, the treatment parameters state that medical cannabis permitted under the Minnesota Medical Cannabis Program is not an illegal substance. Minn. R. 5221.6040, subp. 7a (2017).

In this case, Dr. Coetzee diagnosed the employee with intractable pain and provided the employee with a certification of the diagnosis. The employee was then enrolled in the Medical Cannabis Registry and began receiving medical cannabis from a dispensary. Therefore, the employee is not in violation of Minnesota law when he received medical cannabis.

Reasonable and Necessary Medical Treatment

The employer and the insurer raise several arguments as to why medical cannabis is not reasonable or necessary medical treatment. The employer and insurer first argue that Dr. Coetzee's opinion was based on inadequate foundation. The employer and the insurer then argue that medical marijuana is per se unreasonable because it is illegal under federal law.

The employer and insurer's concerns about Dr. Coetzee are unpersuasive. Although, Dr. Coetzee

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[1] Minn. Dept. of Health, Medical Cannabis, *Intractable Pain*, https://www.health.state.mn.us/people/cannabis/intractable/definition.html (Last visited on July 25, 2019).

mentions long-term opioid use as a justification in his March 28, 2019, narrative report, in his June 13, 2018, medical cannabis certification he notes the fact that cortisone injections do not provide adequate relief as justification for the certification. Therefore, Dr. Coetzee's statement about opioid medication is not the only justification for recommending medical cannabis for the employee.

The Compensation Judge does not find the opinions of Dr. Meyer to be persuasive. Dr. Meyer recommended that the employee undergo treatment with a pain clinic but did not note what treatment the pain clinic could provide for the employee that could help. In the employee's 15-year treatment history, he has tried medication, physical therapy, and cortisone injections which have all failed to relieve the employee's chronic pain. In addition, Dr. Meyer's concerns about medical cannabis are unpersuasive. Dr. Meyer states that medical cannabis is an evolving area and more research is required. Dr. Coetzee points to persuasive studies to support his opinion that medical cannabis is a reasonable treatment for the employee. Therefore, the Compensation Judge adopts Dr. Coetzee's opinions as more persuasive and in line with the weight of medical evidence in the case.

The Compensation Judge lacks jurisdiction to determine the employer and insurer's argument that medical cannabis is per se unreasonable because it is illegal under federal law. As previously stated, the Compensation Judge can only address questions of law arising under Minnesota's workers' compensation laws, and the question of legality of medical cannabis under federal law is outside the scope of workers' compensation laws. Under the Minnesota

Medical Cannabis program, medical cannabis is legal and therefore is not per se unreasonable under Minnesota law.

The employer and the insurer raise additional concerns regarding the lack of treatment parameters regarding medical cannabis. The employer and insurer point to the lack of treatment parameters and guidelines as proof that that treatment could end up continuing indefinitely and become expensive. Minn. Stat. § 176.83, subd. 5 (2018) places the burden of developing rules regarding treatment parameters on the Department of Labor and Industry. Since Minnesota signed medical cannabis into law in 2014 and the first registered patients began receiving medical cannabis in 2015, the Department of Labor and Industry has not promulgated any rules regarding medical cannabis billing or treatment parameters. In addition, the employer and insurer's concern about the treatment parameters is unfounded given that Minn. R. 5221.6050, subp. 1 (2017) applies to all treatment. The employer and insurer's general concern that medical cannabis is an unregulated landscape is unpersuasive given the Minnesota Department of Health's regulation of the medical cannabis program. The employer and insurer's argument that the employee should have undergone a chemical dependency evaluation outlined in Minn. R. 5221.6110, subp. 6 (2017), is unpersuasive. That rule applies to opioid medication and does not apply to medical cannabis. Therefore, the Compensation Judge does not find any of the employer and insurer's arguments that medical cannabis is not reasonable and necessary persuasive.

Under Minn. Stat. § 176.135, subd. 1, the employer is required to furnish medical care and treatment

that is reasonable and necessary to cure and relieve from the effects of the injury. The reasonableness and necessity of medical treatment is a question of fact for the compensation judge. *Hopp v. Grist Mill* 499 N.W.2d 812 (Minn. 1993). In this case, the employee's testimony about his increased functional status was persuasive. The employee credibly testified about his decreased pain and increased function as a result of medical cannabis. Since 2010, medical providers have opined that the employee will need surgery in the future, but it was not appropriate at the present time because of his young age and the possibility that the ankle surgery would wear out. These circumstances left the employee with chronic pain and without the primary means of relieving that pain. In the 15 years since the work injury, the employee has tried various medical treatments that have been ineffective in reducing his chronic pain to acceptable levels. Dr. Coetzee's testimony about the reasonableness and effectiveness of medical cannabis is persuasive.

W. J. M.

[Proof of Service Omitted]

STATUTORY PROVISIONS INVOLVED

1. Section 202 of the Controlled Substances Act, 21 U.S.C. § 812, provides:

§ 812. Schedules of controlled substances

(a) Establishment

There are established five schedules of controlled substances, to be known as schedules I, II, III, IV, and V. Such schedules shall initially consist of the substances listed in this section. The schedules established by this section shall be updated and republished on a semiannual basis during the two-year period beginning one year after October 27, 1970, and shall be updated and republished on an annual basis thereafter.

(b) Placement on schedules; findings required

Except where control is required by United States obligations under an international treaty, convention, or protocol, in effect on October 27, 1970, and except in the case of an immediate precursor, a drug or other substance may not be placed in any schedule unless the findings required for such schedule are made with respect to such drug or other substance. The findings required for each of the schedules are as follows:

(1) SCHEDULE I.—

(A) The drug or other substance has a high potential for abuse.

(B) The drug or other substance has no currently accepted medical use in treatment in the United States.

(C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.

(2) SCHEDULE II.—

(A) The drug or other substance has a high potential for abuse.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.

(C) Abuse of the drug or other substances may lead to severe psychological or physical dependence.

(3) SCHEDULE III.—

(A) The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

(4) SCHEDULE IV.—

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule III.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.

(5) SCHEDULE V.—

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule IV.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.

(c) Initial schedules of controlled substances

Schedules I, II, III, IV, and V shall, unless and until amended pursuant to section 811 of this title, consist of the following drugs or other substances, by whatever official name, common or usual name, chemical name, or brand name designated:

SCHEDULE I

(a) Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

(1) Acetylmethadol.

(2) Allylprodine.

(3) Alphacetylmathadol.

(4) Alphameprodine.

(5) Alphamethadol.

(6) Benzethidine.

(7) Betacetylmethadol.

(8) Betameprodine.

(9) Betamethadol.
(10) Betaprodine.
(11) Clonitazene.
(12) Dextromoramide.
(13) Dextrorphan.
(14) Diampromide.
(15) Diethylthiambutene.
(16) Dimenoxadol.
(17) Dimepheptanol.
(18) Dimethylthiambutene.
(19) Dioxaphetyl butyrate.
(20) Dipipanone.
(21) Ethylmethylthiambutene.
(22) Etonitazene.
(23) Etoxeridine.
(24) Furethidine.
(25) Hydroxypethidine.
(26) Ketobemidone.
(27) Levomoramide.
(28) Levophenacylmorphan.
(29) Morpheridine.
(30) Noracymethadol.
(31) Norlevorphanol.
(32) Normethadone.
(33) Norpipanone.
(34) Phenadoxone.
(35) Phenampromide.
(36) Phenomorphan.
(37) Phenoperidine.
(38) Piritramide.

(39) Proheptazine.

(40) Properidine.

(41) Racemoramide.

(42) Trimeperidine.

(b) Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Acetorphine.

(2) Acetyldihydrocodeine.

(3) Benzylmorphine.

(4) Codeine methylbromide.

(5) Codeine-N-Oxide.

(6) Cyprenorphine.

(7) Desomorphine.

(8) Dihydromorphine.

(9) Etorphine.

(10) Heroin.

(11) Hydromorphinol.

(12) Methyldesorphine.

(13) Methylhydromorphine.

(14) Morphine methylbromide.

(15) Morphine methylsulfonate.

(16) Morphine-N-Oxide.

(17) Myrophine.

(18) Nicocodeine.

(19) Nicomorphine.

(20) Normorphine.

(21) Pholcodine.

(22) Thebacon.

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) 3,4-methylenedioxy amphetamine.

(2) 5-methoxy-3,4-methylenedioxy amphetamine.

(3) 3,4,5-trimethoxy amphetamine.

(4) Bufotenine.

(5) Diethyltryptamine.

(6) Dimethyltryptamine.

(7) 4-methyl-2,5-dimethoxyamphetamine.

(8) Ibogaine.

(9) Lysergic acid diethylamide.

(10) Marihuana.

(11) Mescaline.

(12) Peyote.

(13) N-ethyl-3-piperidyl benzilate.

(14) N-methyl-3-piperidyl benzilate.

(15) Psilocybin.

(16) Psilocyn.

(17) Tetrahydrocannabinols, except for tetrahydrocannabinols in hemp (as defined under section 1639o of title 7).

(18) 4-methylmethcathinone (Mephedrone).

(19) 3,4-methylenedioxypyrovalerone (MDPV).

(20) 2-(2,5-Dimethoxy-4-ethylphenyl)ethanamine (2C–E).

(21) 2-(2,5-Dimethoxy-4-methylphenyl)ethanamine (2C–D).

(22) 2-(4-Chloro-2,5-dimethoxyphenyl)ethanamine (2C–C).

(23) 2-(4-Iodo-2,5-dimethoxyphenyl)ethanamine (2C–I).

(24) 2-[4-(Ethylthio)-2,5-dimethoxyphenyl]ethanamine (2C–T–2).

(25) 2-[4-(Isopropylthio)-2,5-dimethoxyphenyl] ethanamine (2C–T–4).

(26) 2-(2,5-Dimethoxyphenyl)ethanamine (2C–H).

(27) 2-(2,5-Dimethoxy-4-nitro-phenyl)ethanamine (2C–N).

(28) 2-(2,5-Dimethoxy-4-(n)-propylphenyl)ethanamine (2C–P).

(d)(1) Unless specifically exempted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of cannabimimetic agents, or which contains their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

(2) In paragraph (1):

(A) The term "cannabimimetic agents" means any substance that is a cannabinoid receptor type 1 (CB1 receptor) agonist as demonstrated by binding studies and functional assays within any of the following structural classes:

(i) 2-(3-hydroxycyclohexyl)phenol with substitution at the 5-position of the phenolic ring by

alkyl or alkenyl, whether or not substituted on the cyclohexyl ring to any extent.

(ii) 3-(1-naphthoyl)indole or 3-(1-naphthylmethane)indole by substitution at the nitrogen atom of the indole ring, whether or not further substituted on the indole ring to any extent, whether or not substituted on the naphthoyl or naphthyl ring to any extent.

(iii) 3-(1-naphthoyl)pyrrole by substitution at the nitrogen atom of the pyrrole ring, whether or not further substituted in the pyrrole ring to any extent, whether or not substituted on the naphthoyl ring to any extent.

(iv) 1-(1-naphthylmethylene)indene by substitution of the 3-position of the indene ring, whether or not further substituted in the indene ring to any extent, whether or not substituted on the naphthyl ring to any extent.

(v) 3-phenylacetylindole or 3-benzoylindole by substitution at the nitrogen atom of the indole ring, whether or not further substituted in the indole ring to any extent, whether or not substituted on the phenyl ring to any extent.

(B) Such term includes—

(i) 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (CP–47,497);

(ii) 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (cannabicyclohexanol or CP–47,497 C8-homolog);

(iii) 1-pentyl-3-(1-naphthoyl)indole (JWH–018 and AM678);

(iv) 1-butyl-3-(1-naphthoyl)indole (JWH–073);

(v) 1-hexyl-3-(1-naphthoyl)indole (JWH–019);

(vi) 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl) indole (JWH–200);

(vii) 1-pentyl-3-(2-methoxyphenylacetyl)indole (JWH–250);

(viii) 1-pentyl-3-[1-(4-methoxynaphthoyl)]indole (JWH–081);

(ix) 1-pentyl-3-(4-methyl-1-naphthoyl)indole (JWH–122);

(x) 1-pentyl-3-(4-chloro-1-naphthoyl)indole (JWH–398);

(xi) 1-(5-fluoropentyl)-3-(1-naphthoyl)indole (AM2201);

(xii) 1-(5-fluoropentyl)-3-(2-iodobenzoyl)indole (AM694);

(xiii) 1-pentyl-3-[(4-methoxy)-benzoyl]indole (SR–19 and RCS–4);

(xiv) 1-cyclohexylethyl-3-(2-methoxyphenylacetyl) indole (SR–18 and RCS–8); and

(xv) 1-pentyl-3-(2-chlorophenylacetyl)indole (JWH–203).

SCHEDULE II

(a) Unless specifically excepted or unless listed in another schedule, any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate.

(2) Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in

clause (1), except that these substances shall not include the isoquinoline alkaloids of opium.

(3) Opium poppy and poppy straw.

(4) coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives of ecgonine or their salts have been removed; cocaine, its salts, optical and geometric isomers, and salts of isomers; ecgonine, its derivatives, their salts, isomers, and salts of isomers; or any compound, mixture, or preparation which contains any quantity of any of the substances referred to in this paragraph.

(b) Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

(1) Alphaprodine.

(2) Anileridine.

(3) Bezitramide.

(4) Dihydrocodeine.

(5) Diphenoxylate.

(6) Fentanyl.

(7) Isomethadone.

(8) Levomethorphan.

(9) Levorphanol.

(10) Metazocine.

(11) Methadone.

(12) Methadone-Intermediate, 4-cyano-2-dimethyl-amino-4,4-diphenyl butane.

(13) Moramide-Intermediate, 2-methyl-3-morpholino-1, 1-diphenylpropane-carboxylic acid.

(14) Pethidine.

(15) Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine.

(16) Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate.

(17) Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid.

(18) Phenazocine.

(19) Piminodine.

(20) Racemethorphan.

(21) Racemorphan.

(c) Unless specifically excepted or unless listed in another schedule, any injectable liquid which contains any quantity of methamphetamine, including its salts, isomers, and salts of isomers.

SCHEDULE III

(a) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

(1) Amphetamine, its salts, optical isomers, and salts of its optical isomers.

(2) Phenmetrazine and its salts.

(3) Any substance (except an injectable liquid) which contains any quantity of methamphetamine, including its salts, isomers, and salts of isomers.

(4) Methylphenidate.

(b) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system:

(1) Any substance which contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid.

(2) Chorhexadol.

(3) Glutethimide.

(4) Lysergic acid.

(5) Lysergic acid amide.

(6) Methyprylon.

(7) Phencyclidine.

(8) Sulfondiethylmethane.

(9) Sulfonethylmethane.

(10) Sulfonmethane.

(c) Nalorphine.

(d) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof:

(1) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium.

(2) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, non-narcotic ingredients in recognized therapeutic amounts.

(3) Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or

greater quantity of an isoquinoline alkaloid of opium.

(4) Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(5) Not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(6) Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(7) Not more than 500 milligrams of opium per 100 milliliters or per 100 grams, or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(8) Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(e) Anabolic steroids.

SCHEDULE IV

(1) Barbital.

(2) Chloral betaine.

(3) Chloral hydrate.

(4) Ethchlorvynol.

(5) Ethinamate.

(6) Methohexital.

(7) Meprobamate.

(8) Methylphenobarbital.

(9) Paraldehyde.

(10) Petrichloral.

(11) Phenobarbital.

Schedule V

Any compound, mixture, or preparation containing any of the following limited quantities of narcotic drugs, which shall include one or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:

(1) Not more than 200 milligrams of codeine per 100 milliliters or per 100 grams.

(2) Not more than 100 milligrams of dihydrocodeine per 100 milliliters or per 100 grams.

(3) Not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams.

(4) Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit.

(5) Not more than 100 milligrams of opium per 100 milliliters or per 100 grams.

2. Section 404 of the Controlled Substances Act, 21 U.S.C. § 844, provides:

§ 844. Penalties for simple possession

(a) Unlawful acts; penalties

It shall be unlawful for any person knowingly or intentionally to possess a controlled substance unless such substance was obtained directly, or pursuant to a valid prescription or order, from a practitioner, while acting in the course of his professional practice, or except as otherwise authorized by this subchapter or subchapter II. It shall be unlawful for any person knowingly or intentionally to possess any list I chemical obtained pursuant to or under authority of a registration issued to that person under section 823 of this title or section 958 of this title if that registration has been revoked or suspended, if that registration has expired, or if the registrant has ceased to do business in the manner contemplated by his registration. It shall be unlawful for any person to knowingly or intentionally purchase at retail during a 30 day period more than 9 grams of ephedrine base, pseudoephedrine base, or phenylpropanolamine base in a scheduled listed chemical product, except that, of such 9 grams, not more than 7.5 grams may be imported by means of shipping through any private or commercial carrier or the Postal Service. Any person who violates this subsection may be sentenced to a term of imprisonment of not more than 1 year, and shall be fined a minimum of $1,000, or both, except that if he commits such offense after a prior conviction under this subchapter or subchapter II, or a prior conviction for any drug, narcotic, or chemical offense chargeable under the law of any State, has become final, he shall be sentenced to a term of imprisonment for not less than 15 days but not more than 2 years, and shall be fined a minimum of

$2,500, except, further, that if he commits such offense after two or more prior convictions under this subchapter or subchapter II, or two or more prior convictions for any drug, narcotic, or chemical offense chargeable under the law of any State, or a combination of two or more such offenses have become final, he shall be sentenced to a term of imprisonment for not less than 90 days but not more than 3 years, and shall be fined a minimum of $5,000. Notwithstanding any penalty provided in this subsection, any person convicted under this subsection for the possession of flunitrazepam shall be imprisoned for not more than 3 years, shall be fined as otherwise provided in this section, or both. The imposition or execution of a minimum sentence required to be imposed under this subsection shall not be suspended or deferred. Further, upon conviction, a person who violates this subsection shall be fined the reasonable costs of the investigation and prosecution of the offense, including the costs of prosecution of an offense as defined in sections 1918 and 1920 of title 28, except that this sentence shall not apply and a fine under this section need not be imposed if the court determines under the provision of title 18 that the defendant lacks the ability to pay.

(b) Repealed. Pub. L. 98-473, title II, § 219(a), Oct. 12, 1984, 98 Stat. 2027

(c) "Drug, narcotic, or chemical offense" defined

As used in this section, the term "drug, narcotic, or chemical offense" means any offense which proscribes the possession, distribution, manufacture, cultivation, sale, transfer, or the attempt or conspiracy to possess, distribute, manufacture, cultivate, sell or transfer any substance the possession of which is prohibited under this subchapter.

3. Section 708 of the Controlled Substances Act, 21 U.S.C. § 903, provides:

§ 903. Application of State law

No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together.

4. Section 531 of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182, 1282-83 (2020), provides:

Sec. 531. None of the funds made available under this Act to the Department of Justice may be used, with respect to any of the States of Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming, or with respect to the District of Columbia, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Guam, or Puerto Rico, to prevent any of them from implementing their own laws that authorize the use, distribution, possession, or cultivation of medical marijuana.

5. Minnesota Statutes § 152.27 provides:

152.27 PATIENT REGISTRY PROGRAM ESTABLISHED.

Subdivision 1. **Patient registry program; establishment.** (a) The commissioner shall establish a patient registry program to evaluate data on patient demographics, effective treatment options, clinical outcomes, and quality-of-life outcomes for the purpose of reporting on the benefits, risks, and outcomes regarding patients with a qualifying medical condition engaged in the therapeutic use of medical cannabis.

(b) The establishment of the registry program shall not be construed or interpreted to condone or promote the illicit recreational use of marijuana.

Subd. 2. **Commissioner duties.** (a) The commissioner shall:

(1) give notice of the program to health care practitioners in the state who are eligible to serve as health care practitioners and explain the purposes and requirements of the program;

(2) allow each health care practitioner who meets or agrees to meet the program's requirements and who requests to participate, to be included in the registry program to collect data for the patient registry;

(3) provide explanatory information and assistance to each health care practitioner in understanding the nature of therapeutic use of medical cannabis within program requirements;

(4) create and provide a certification to be used by a health care practitioner for the practitioner to certify whether a patient has been diagnosed with a qualifying medical condition and include in the certification an option for the practitioner to certify whether the patient, in the health care practitioner's medical

opinion, is developmentally or physically disabled and, as a result of that disability, the patient requires assistance in administering medical cannabis or obtaining medical cannabis from a distribution facility;

(5) supervise the participation of the health care practitioner in conducting patient treatment and health records reporting in a manner that ensures stringent security and record-keeping requirements and that prevents the unauthorized release of private data on individuals as defined by section 13.02;

(6) develop safety criteria for patients with a qualifying medical condition as a requirement of the patient's participation in the program, to prevent the patient from undertaking any task under the influence of medical cannabis that would constitute negligence or professional malpractice on the part of the patient; and

(7) conduct research and studies based on data from health records submitted to the registry program and submit reports on intermediate or final research results to the legislature and major scientific journals. The commissioner may contract with a third party to complete the requirements of this clause. Any reports submitted must comply with section 152.28, subdivision 2.

(b) The commissioner may add a delivery method under section 152.22, subdivision 6, or add, remove, or modify a qualifying medical condition under section 152.22, subdivision 14, upon a petition from a member of the public or the task force on medical cannabis therapeutic research or as directed by law. The commissioner shall evaluate all petitions to add a qualifying medical condition or to remove or modify an existing qualifying medical condition submitted

by the task force on medical cannabis therapeutic research or as directed by law and may make the addition, removal, or modification if the commissioner determines the addition, removal, or modification is warranted based on the best available evidence and research. If the commissioner wishes to add a delivery method under section 152.22, subdivision 6, or add or remove a qualifying medical condition under section 152.22, subdivision 14, the commissioner must notify the chairs and ranking minority members of the legislative policy committees having jurisdiction over health and public safety of the addition or removal and the reasons for its addition or removal, including any written comments received by the commissioner from the public and any guidance received from the task force on medical cannabis research, by January 15 of the year in which the commissioner wishes to make the change. The change shall be effective on August 1 of that year, unless the legislature by law provides otherwise.

Subd. 3. **Patient application.** (a) The commissioner shall develop a patient application for enrollment into the registry program. The application shall be available to the patient and given to health care practitioners in the state who are eligible to serve as health care practitioners. The application must include:

(1) the name, mailing address, and date of birth of the patient;

(2) the name, mailing address, and telephone number of the patient's health care practitioner;

(3) the name, mailing address, and date of birth of the patient's designated caregiver, if any, or the patient's parent, legal guardian, or spouse if the

parent, legal guardian, or spouse will be acting as a caregiver;

(4) a copy of the certification from the patient's health care practitioner that is dated within 90 days prior to submitting the application that certifies that the patient has been diagnosed with a qualifying medical condition; and

(5) all other signed affidavits and enrollment forms required by the commissioner under sections 152.22 to 152.37, including, but not limited to, the disclosure form required under paragraph (c).

(b) The commissioner shall require a patient to resubmit a copy of the certification from the patient's health care practitioner on a yearly basis and shall require that the recertification be dated within 90 days of submission.

(c) The commissioner shall develop a disclosure form and require, as a condition of enrollment, all patients to sign a copy of the disclosure. The disclosure must include:

(1) a statement that, notwithstanding any law to the contrary, the commissioner, or an employee of any state agency, may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37; and

(2) the patient's acknowledgment that enrollment in the patient registry program is conditional on the patient's agreement to meet all of the requirements of sections 152.22 to 152.37.

Subd. 4. **Registered designated caregiver.** (a) The commissioner shall register a designated caregiver for a patient if the patient requires assistance

in administering medical cannabis or obtaining medical cannabis from a distribution facility and the caregiver has agreed, in writing, to be the patient's designated caregiver. As a condition of registration as a designated caregiver, the commissioner shall require the person to:

(1) be at least 18 years of age;

(2) agree to only possess the patient's medical cannabis for purposes of assisting the patient; and

(3) agree that if the application is approved, the person will not be a registered designated caregiver for more than six registered patients at one time. Patients who reside in the same residence shall count as one patient.

(b) The commissioner shall conduct a criminal background check on the designated caregiver prior to registration to ensure that the person does not have a conviction for a disqualifying felony offense. Any cost of the background check shall be paid by the person seeking registration as a designated caregiver. A designated caregiver must have the criminal background check renewed every two years.

(c) Nothing in sections 152.22 to 152.37 shall be construed to prevent a person registered as a designated caregiver from also being enrolled in the registry program as a patient and possessing and using medical cannabis as a patient.

Subd. 5. **Parents, legal guardians, and spouses.** A parent, legal guardian, or spouse of a patient may act as the caregiver to the patient without having to register as a designated caregiver. The parent, legal guardian, or spouse shall follow all of the requirements of parents, legal guardians, and spouses listed in sections 152.22 to 152.37. Nothing in sections 152.22 to 152.37 limits any legal authority a parent,

legal guardian, or spouse may have for the patient under any other law.

Subd. 6. **Patient enrollment.** (a) After receipt of a patient's application, application fees, and signed disclosure, the commissioner shall enroll the patient in the registry program and issue the patient and patient's registered designated caregiver or parent, legal guardian, or spouse, if applicable, a registry verification. The commissioner shall approve or deny a patient's application for participation in the registry program within 30 days after the commissioner receives the patient's application and application fee. The commissioner may approve applications up to 60 days after the receipt of a patient's application and application fees until January 1, 2016. A patient's enrollment in the registry program shall only be denied if the patient:

(1) does not have certification from a health care practitioner that the patient has been diagnosed with a qualifying medical condition;

(2) has not signed and returned the disclosure form required under subdivision 3, paragraph (c), to the commissioner;

(3) does not provide the information required;

(4) has previously been removed from the registry program for violations of section 152.30 or 152.33; or

(5) provides false information.

(b) The commissioner shall give written notice to a patient of the reason for denying enrollment in the registry program.

(c) Denial of enrollment into the registry program is considered a final decision of the commissioner and is subject to judicial review under the Administrative Procedure Act pursuant to chapter 14.

(d) A patient's enrollment in the registry program may only be revoked upon the death of the patient or if a patient violates a requirement under section 152.30 or 152.33.

(e) The commissioner shall develop a registry verification to provide to the patient, the health care practitioner identified in the patient's application, and to the manufacturer. The registry verification shall include:

(1) the patient's name and date of birth;

(2) the patient registry number assigned to the patient; and

(3) the name and date of birth of the patient's registered designated caregiver, if any, or the name of the patient's parent, legal guardian, or spouse if the parent, legal guardian, or spouse will be acting as a caregiver.

Subd. 7. **Notice requirements.** Patients and registered designated caregivers shall notify the commissioner of any address or name change within 30 days of the change having occurred. A patient or registered designated caregiver is subject to a $100 fine for failure to notify the commissioner of the change.

6. Minnesota Statutes § 176.001 provides:

176.001 INTENT OF THE LEGISLATURE.

It is the intent of the legislature that chapter 176 be interpreted so as to assure the quick and efficient delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter. It is the specific intent of the legislature that workers'

compensation cases shall be decided on their merits and that the common law rule of "liberal construction" based on the supposed "remedial" basis of workers' compensation legislation shall not apply in such cases. The workers' compensation system in Minnesota is based on a mutual renunciation of common law rights and defenses by employers and employees alike. Employees' rights to sue for damages over and above medical and health care benefits and wage loss benefits are to a certain degree limited by the provisions of this chapter, and employers' rights to raise common law defenses such as lack of negligence, contributory negligence on the part of the employee, and others, are curtailed as well. Accordingly, the legislature hereby declares that the workers' compensation laws are not remedial in any sense and are not to be given a broad liberal construction in favor of the claimant or employee on the one hand, nor are the rights and interests of the employer to be favored over those of the employee on the other hand.

7. Minnesota Statutes § 176.135 provides:

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.

(b) The employer shall pay for the reasonable value of nursing services provided by a member of the employee's family in cases of permanent total disability.

(c) Exposure to rabies is an injury and an employer shall furnish preventative treatment to employees exposed to rabies.

(d) The employer shall furnish replacement or repair for artificial members, glasses or spectacles, artificial eyes, podiatric orthotics, dental bridge work, dentures or artificial teeth, hearing aids, canes, crutches, or wheel chairs damaged by reason of an injury arising out of and in the course of the employment. For the purpose of this paragraph, "injury" includes damage wholly or in part to an artificial member. In case of the employer's inability or refusal seasonably to provide the items required to be provided under this paragraph, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing the same, including costs of copies of any medical records or medical reports that are in existence, obtained from health care providers, and that directly relate to the items for which payment is sought under this chapter, limited to the charges allowed by subdivision 7, and attorney fees incurred by the employee.

(e) Both the commissioner and the compensation judges have authority to make determinations under this section in accordance with sections 176.106 and 176.305.

(f) An employer may require that the treatment and supplies required to be provided by an employer by this section be received in whole or in part from a

managed care plan certified under section 176.1351 except as otherwise provided by that section.

(g) An employer may designate a pharmacy or network of pharmacies that employees must use to obtain outpatient prescription and nonprescription medications. An employee is not required to obtain outpatient medications at a designated pharmacy unless the pharmacy is located within 15 miles of the employee's place of residence.

(h) Notwithstanding any fees established by rule adopted under section 176.136, an employer may contract for the cost of medication provided to employees. All requests for reimbursement from the special compensation fund formerly codified under section 176.131 for medication provided to an employee must be accompanied by the dispensing pharmacy's invoice showing its usual and customary charge for the medication at the time it was dispensed to the employee. The special compensation fund shall not reimburse any amount that exceeds the maximum amount payable for the medication under Minnesota Rules, part 5221.4070, subparts 3 and 4, notwithstanding any contract under Minnesota Rules, part 5221.4070, subpart 5, that provides for a different reimbursement amount.

Subd. 1a. **Nonemergency surgery; second surgical opinion.** The employer is required to furnish surgical treatment pursuant to subdivision 1 when the surgery is reasonably required to cure and relieve the effects of the personal injury or occupational disease. An employee may not be compelled to undergo surgery. If an employee desires a second opinion on the necessity of the surgery, the employer shall pay the costs of obtaining the second opinion. Except in cases of emergency surgery, the employer or insurer may require the employee to obtain a

second opinion on the necessity of the surgery, at the expense of the employer, before the employee undergoes surgery. Failure to obtain a second surgical opinion shall not be reason for nonpayment of the charges for the surgery. The employer is required to pay the reasonable value of the surgery unless the commissioner or compensation judge determines that the surgery is not reasonably required.

Subd. 1b**. Complementary and alternative health care providers.** Any service, article, or supply provided by an unlicensed complementary and alternative health care practitioner as defined in section 146A.01, subdivision 6, is not compensable under this chapter.

Subd. 2. **Change of physicians, podiatrists, or chiropractors.** The commissioner shall adopt rules establishing standards and criteria to be used when a dispute arises over a change of physicians, podiatrists, or chiropractors in the case that either the employee or the employer desire a change. If a change is agreed upon or ordered, the medical expenses shall be borne by the employer upon the same terms and conditions as provided in subdivision 1.

Subd. 2a. **Definitions.** For the purposes of this section, the word "physicians" shall include persons holding the degree M. D. (Doctor of Medicine) and persons holding the degree D. O. (Doctor of Osteopathic Medicine); and the terms "medical, surgical and hospital treatment" shall include professional services rendered by licensed persons who have earned the degree M. D. or the degree D. O.

Subd. 3. [Repealed, 1992 c 510 art 4 s 26]

Subd. 4. **Christian Science treatment.** Any employee electing to receive Christian Science treatment as provided in subdivision 1 shall notify the

employer in writing of the election within 30 days after July 1, 1953, and any person hereafter accepting employment shall give such notice at the time of accepting employment. Any employer may elect not to be subject to the provisions for Christian Science treatment provided for in this section by filing a written notice of such election with the commissioner of the Department of Labor and Industry, in which event the election of the employee shall have no force or effect whatsoever.

Subd. 5. **Occupational disease medical eligibility.** Notwithstanding section 176.66, an employee who has contracted an occupational disease is eligible to receive compensation under this section even if the employee is not disabled from earning full wages at the work at which the employee was last employed.

Payment of compensation under this section shall be made by the employer and insurer on the date of the employee's last exposure to the hazard of the occupational disease. Reimbursement for medical benefits paid under this subdivision or subdivision 1a is allowed from the employer and insurer liable under section 176.66, subdivision 10, only in the case of disablement.

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,

subdivision 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.** (a) Health care providers shall submit to the insurer an itemized statement of charges in the standard electronic transaction format when required by section 62J.536 or, if there is no prescribed standard electronic transaction format, on a billing form prescribed by the commissioner. 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.

(b) For medical services provided under this section, the codes from the International Classification of Diseases, Tenth Edition, Clinical Modification/ Procedure Coding System (ICD-10), must be used to report medical diagnoses and hospital inpatient procedures when required by the United States Department of Health and Human Services for federal programs. The commissioner must replace the codes from the International Classification of Diseases, Ninth Edition, Clinical Modification/Procedure Coding System (ICD-9), with equivalent ICD-10 codes wherever the ICD-9 codes appear in rules adopted under this chapter. The commissioner must use the General Equivalence Mappings established by the Centers for Medicare and Medicaid Services to replace the ICD-9 diagnostic codes with ICD-10 codes in the rules.

(c) The commissioner shall amend rules adopted under this chapter as necessary to implement the ICD-10 coding system in paragraph (b). The amendments shall be adopted by giving notice in the State Register according to the procedures in section 14.386, paragraph (a). The amended rules are not subject to expiration under section 14.386, paragraph (b).

Subd. 7a. **Electronic transactions.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "workers' compensation payer" means a workers' compensation insurer and an employer, or group of employers, that is self-insured for workers' compensation;

(2) "clearinghouse" has the meaning given in section 62J.51, subdivision 11a; and

(3) "electronic transactions" means the health care administrative transactions described in section 62J.536.

(b) In addition to the requirements of section 62J.536, workers' compensation payers and health care providers must comply with the requirements in paragraphs (c) to (e).

(c) No later than January 1, 2016, each workers' compensation payer must place the following information in a prominent location on its website or otherwise provide the information to health care providers:

(1) the name of each clearinghouse with which the workers' compensation payer has an agreement to exchange or transmit electronic transactions, along with the identification number each clearinghouse has assigned to the payer in order to route electronic transactions through intermediaries or other clearinghouses to the payer;

(2) information about how a health care provider can obtain the claim number assigned by the workers' compensation payer for an employee's claim and how the provider should submit the claim number in the appropriate field on the electronic bill to the payer; and

(3) the name, phone number, and e-mail address of contact persons who can answer questions related to electronic transactions on behalf of the workers' compensation payer and the clearinghouses with which the payer has agreements.

(d) No later than January 1, 2017:

(1) health care providers must electronically submit copies of medical records or reports that substantiate the nature of the charge and its relationship to the work injury using the ASC X12N 5010 version of the ASC X12N 275 transaction ("Additional Information to Support Health Care Claim or Encounter"), according to the requirements in the corresponding implementation guide. The ASC X12N 275 transaction is the only one that shall be used to electronically submit attachments unless a national standard is adopted by federal law or rule. If a new version of the attachment transaction is approved, it must be used one year after the approval date;

(2) workers' compensation payers and all clearinghouses receiving or transmitting workers' compensation bills must accept attachments using the ASC X12N 275 transaction and must respond with the ASC X12N 5010 version of the ASC X12 electronic acknowledgment for the attachment transaction. If a new version of the acknowledgment transaction is approved, it must be used one year after the approval date; and

(3) if a different national claims attachment or acknowledgment requirement is adopted by federal law or rule, it will replace the ASC X12N 275 transaction, and the new standard must be used on the date that it is required by the federal law or rule.

(e) No later than September 1, 2015, workers' compensation payers must provide the patient's name and patient control number on or with all payments made to a provider under this chapter, whether payment is made by check or electronic funds transfer. The information provided on or with the payment must be sufficient to allow providers to match the

payment to specific bills. If a bulk payment is made to a provider for more than one patient, the check or electronic funds transfer statement must also specify the amount being paid for each patient. For purposes of this paragraph, the patient control number is located on the electronic health care claim 837 transaction, loop 2300, segment CLM01, and on the electronic health care claim payment/advice 835 transaction, loop 2100, CLP01.

(f) The commissioner may assess a monetary penalty of $500 for each violation of this section, not to exceed $25,000 for identical violations during a calendar year. Before issuing a penalty for a first violation of this section, the commissioner must provide written notice to the noncompliant payer, clearinghouse, or provider that a penalty may be issued if the violation is not corrected within 30 days. Penalties under this paragraph are payable to the commissioner for deposit in the assigned risk safety account.

Subd. 8. **Data.** Each self-insured employer and insurer shall retain or arrange for the retention of (1) all billing data electronically transmitted by health care providers for payment for the treatment of workers' compensation; and (2) the employer or insurer's electronically transmitted payment remittance advice. The self-insured employer or insurer shall ensure that the data in clauses (1) and (2) shall be retained for seven years in the standard electronic transaction 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 transaction format to the commissioner 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.

Subd. 9. **Designated contact person and required training related to submission and payment of medical bills.** (a) For purposes of this subdivision:

(1) "clearinghouse" means a health care clearinghouse as defined in section 62J.51, subdivision 11a, that receives or transmits workers' compensation electronic transactions as described in section 62J.536;

(2) "department" means the Department of Labor and Industry;

(3) "hospital" means a hospital licensed in this state;

(4) "payer" means:

(i) a workers' compensation insurer;

(ii) an employer, or group of employers, authorized to self-insure for workers' compensation liability; and

(iii) a third-party administrator licensed by the Department of Commerce under section 60A.23, subdivision 8, to pay or review workers' compensation medical bills under this chapter; and

(5) "submission or payment of medical bills" includes the submission, transmission, receipt, acceptance, response, adjustment, and payment of medical bills under this chapter.

(b) Effective November 1, 2017, each payer, hospital, and clearinghouse must provide the department with the name and contact information of a desig-

nated employee to answer inquiries related to the submission or payment of medical bills. Payers, hospitals, and clearinghouses must provide the department with the name of a new designated employee within 14 days after the previously designated employee is no longer employed or becomes unavailable for more than 30 days. The name and contact information of the designated employee must be provided on forms and at intervals prescribed by the department. The department must post a directory of the designated employees on the department's website.

(c) The designated employee under paragraph (b) must:

(1) complete training, provided by the department, about submission or payment of medical bills; and

(2) respond within 30 days to written department inquiries related to submission or payment of medical bills.

The training requirement in clause (1) does not apply to a payer that has not received any workers' compensation medical bills in the 12 months before the training becomes available.

(d) The commissioner may assess penalties, payable to the assigned risk safety account, against payers, hospitals, and clearinghouses for violation of this subdivision as provided in clauses (1) to (3):

(1) for failure to comply with the requirements in paragraph (b), the commissioner may assess a penalty of $50 for each day of noncompliance after the department has provided the noncompliant payer, clearinghouse, or hospital with a 30-day written warning;

(2) for failure of the designated employee to complete training under paragraph (c), clause (1),

within 90 days after the department has notified a payer, clearinghouse, or hospital's designated employee that required training is available, the commissioner may assess a penalty of $3,000;

(3) for failure to respond within 30 days to a department inquiry related to submission or payment of medical bills under paragraph (c), clause (2), the commissioner may assess a penalty of $3,000. The commissioner shall not assess a penalty under both this clause and section 176.194, subdivision 3, clause (6), for failure to respond to the same department inquiry.