STATE OF MINNESOTA
DEPARTMENT OR LABOR AND INDUSTRY

In the Matter of the Proposed Amendment of Rules of the Minnesota Department of Labor and Industry, Workers' Compensation Division, Governing Medical Charges and Reimbursement

STATEMENT OF NEED AND REASONABLENESS

Part 5221.0100 Definitions

Subpart 3. Charge.

The proposed amendment deletes the word "fee" to clarify and simplify the language. The word "charge" is used throughout the rules in reference to the provider's billing, while the word "fee" only occurs in the context of the Medical Fee Schedule. Accordingly, the use of the word "fee" as synonymous with "charge" may be misleading.

Subpart 4. Code

The proposed amendment deletes the reference to the maximum fee schedule because proposed Rule 5221.0700, Subp. 3(a) requires providers to bill using approved codes, including codes not listed in the fee schedule. This provides payers with accurate information about the nature of the service and helps prevent confusion caused by the use of provider generated codes for internal office use. The proposed rule also clarifies and simplifies language.

Subpart 6. Compensable Injury.

This amendment deletes language which defines compensability only in reference to liability for a service, and clarifies the definition of a compensability injury to mean that it is the injury or condition, rather that the service, for which the payer is liable under Chapter 176. This is necessary because rules referencing excessive service and excessive charges limit the use of those terms to injuries or conditions for which liability has been accepted or established under Chapter 176. The addition of the word "condition" clarifies that the term "excessiveness" does not apply to a service for treatment of a condition which has not been causally related to an admitted or established work injury.

Subpart 7. Excessive Charge.

These changes clarify that the use of the term "excessive charge" applies only to charges for treatment once it has been established that a work injury has occurred for which liability has been established under Chapter 176 because an excessive workers' compensation charge cannot be collected form an employee. Other changes simplify or clarify existing language. The word "conditions" replaces "standards" to provide consistency with the use of that word in part 5221.0500.

Subpart 8. Excessive Services.

This definition is added to distinguish excessive services from excessive charges. A separate definition is necessary because a charge can be excessive when a service is not, and a service can be excessive even though the charge is reasonable. Also, under M.S. 176.136, subd. (2) a provider can request a determination from the Commissioner only as to whether a charge is excessive, not a service. Therefore, a separate rule, Part 5221.0550, setting forth the conditions of an excessive service has been proposed. This proposed rule presumes that a service can only be excessive if it has been established that the injury or condition is compensable under Chapter 176.

Subpart 10. Medical Fee Schedule.

This definition clarifies the statutory authority for establishing the Medical Fee Schedule and changes the rule citation to conform with the revised re-numbering. The term "Maximum Fee Schedule" is changed to "Medical Fee Schedule" because that is the term commonly used by providers and payers. The "75th percentile" is deleted because that standard is set by statute and it is more useful to reflect the dollar amount and specific rule citation.

Subpart 11. Payer.

The changes in this subpart simplify the language to provide for ease in understanding. The changes are not intended as a substantive change in meaning. The word "medical" is eliminated as unnecessary. The itemization of insurers is also deleted as unnecessary, because all deleted entities are payers within the revised definition.

Subpart 13. Reasonable Charge.

The changes simplify language and clarify that a charge cannot be defined as reasonable unless liability for the injury or condition has been admitted or established under Chapter 176 and the charge is not excessive. The additional language provides consistency with other definitional changes proposed.

Subpart 14. Reasonable Service.

This definition is added to distinguish between a reasonable charge and a reasonable service. This is necessary to ensure that the term reasonable service is not confused with reasonable charge, as previous definitions and later rules distinguish between the terms "charge" and "service". The definition also clarifies that a service cannot be defined as reasonable unless the service is not excessive and was rendered for treatment of an admitted or established work injury or condition pursuant to Chapter 176, because there is no rulemaking authority to define services for treatment of non-work related conditions as reasonable or unreasonable.

Subpart 15. Service or Treatment.

The phrase "curing and relieving" is changed to "curing or relieving" to reflect caselaw which establishes that treatment may be compensable if it cures or if it relieves the effects of an injury. The word "compensable" is added to clarify that unless the rules indicate otherwise, the use of term "service" relates to a service provided to treat an injury or condition for which liability under Chapter 176 has been established or admitted.

Subpart 16. Appropriate Record.

This subpart defines "appropriate record" according to the type of provider. M.S. 176.135, Subd. (7) requires that substantiating information accompany a bill. This subpart establishes what type of record satisfies this requirement. The definition varies by provider to reflect the varying nature of services and type of record typically generated for each.

After the proposed rules were submitted to the State Register for publication the Minnesota Hospital Association proposed the elimination of Item "B", a separate section for hospitals. Because hospitals need not supply an appropriate record under M.S. 176.135, subd. 7, to document a bill, unless one is requested, and the existing language could suggest that submission by hospitals of an appropriate

record is required with the bill, the Department agrees with this change. Item C, defining an appropriate record for chiropractors, is proposed to be merged with Item A at the request of the Minnesota Chiropractic Association. Initially, that group had requested a separate provision due to the differing nature of the services provided. These proposed modifications will be submitted to the Attorney General or Administrative Law Judge for approval.

Part 5221.0300. Purpose.

Without intending to change the substantive meaning of the rule, the amendments clarify that the rules do not apply to services for treatment of conditions that are not compensable as work-related under Chapter 176. Such charges are beyond the scope of these rules and the workers' compensation act. The term compensable is used for consistency with that term as defined in Part 5221.0100. The changes also reflect the distinction in other proposed amendments between excessive charges and services.

Part 5221.0400. Scope.

Again, the proposed changes clarify for consistency that the rules apply to compensable injuries as defined in Part 5221.0100. The substance of the rule is unaffected.

Part 5221.0500. Excessive charges.

This rule sets the conditions under which a charge may be determined to be excessive. The deleted language in reference to services is necessary because a new rule, 5221.0550, sets the conditions for an excessive service.

Item A. The changes do not substantively alter the meaning, but merely simplify the language and reflect the more common usage of the term "medical fee schedule."

Item B. Clarifies that when a service is not included in the medical fee schedule, the charge for the service is excessive if it exceeds the charge that prevails in the community for services provided under similar circumstances. This rule is necessary to eliminate confusion as to the extent of the payer's liability when a service is not included in the Medical Fee Schedule. The community charge standard applied is found in Minn. Stat. 176.135, subd. 3.

Item E. The deletions concerning standards of appropriateness, quality and coordination of treatment under M.S. 176.83 are necessary because these are standards of excessive service and not standards of excessive charges. A similar provision is now found in Part 5221.0550 (A), the rule on excessive services.

Item F. Previous language, deleted as it refers to an excessive service and not an excessive charge, has been moved to the new rule setting forth the conditions of an excessive service.

Item G. This item has been deleted because it concerns services and not excessive charges, and because Minn. Stat. 176.135, subd. 1a does not provide a basis for denial of payment for failure to obtain a second surgical opinion.

Item H. This item has been deleted because it concerns excessive services, not excessive charges, and because caselaw does not support a denial of payment soley on the grounds that procedural requirements for change of physician have not been met.

Item I. This item has been deleted as not an excessive charge, and moved to the rule setting forth the conditions of an excessive service. The new language provides that an incorrect charge or billing code for the service is an excessive charge. This may occur, for example, when there is a dispute as to which code under the fee schedule applies or whether a fee schedule code applies at all. It is characterized as an excessive charge because the underlying dispute concerns the amount for which the insurer is liable under the medical fee schedule.

Part 5221.0550. Excessive Services.

This is a new proposed rule, created to distinguish between excessive services and charges under Part 5221.0500. This distinction is necessary because a service can be excessive even though the charge is not, and a charge for a reasonable service can be excessive. Further, when the insurer has determined that a charge is excessive, M.S. 176.136 permits the provider to initiate an action to resolve the dispute. When the insurer determines that a service is excessive, only the employee, employer or insurer, may file the claim.

Item A. Identifies an excessive service as one which does not comply with requirements adopted pursuant to M.S. 176.83 concerning the reasonableness and necessity, quality coordination and frequency of services. A similar provision was included in the former rule on excessiveness. The rule will apply to any standards that are adopted pursuant to M.S. 176.83, subd. 5. The rule is necessary because the statute provides that services that do not comply with adopted standards should not be compensable. This assures appropriate treatment is provided.

Item B, previously included under the general excessiveness rule, is now more appropriately classified an excessive service. This condition refers to services provided by health care providers whom the Medical Services Review Board has determined have consistently performed procedures or provided services at an excessive level or cost in the past under M.S. 176.83.

Item C identifies as excessive those services that have been determined to be not reasonably required for the cure or relief of a work-related injury by the insurer, commissioner or compensation judge under M.S. 176.135. This is necessarily defined as an excessive service because under Minn. Stat. 176.135 and caselaw, the payer is not liable for services that are not reasonably required.

Part 5221.0600. Payer Responsibilities.

Subpart 1. Compensability.

These changes clarify that the rules do not require a payer to pay a charge for a service that is for the treatment of an injury or condition which is not work-related under Chapter 176. This is necessary to provide consistency with the definitions and because a workers' compensation insurer is not required to pay for services that are for the treatment of an injury or condition for which it is not liable under Chapter 176.

Subpart 2. Determination of Excessiveness.

The subparts have been restructured so that payers' responsibilities are set forth chronologically for ease in following. Subpart 2 provides that the initial payer responsibility is to evaluate whether any service or charge is excessive under the conditions of excessiveness in Parts 5221.0500 and 5221.0550. Deleted language concerning determination of excessiveness is revised and restated for clarity. Other deleted portions have been moved to later subparts for a more chronological progression.

Subpart 3. Determination of Charges.

This subpart deletes language in the first paragraph, now found as modified in subpart 2, regarding a determination of excessiveness. The subpart now identifies the payer's responsibilities for payment of charges.

Item A reflects the statutory requirement in M.S. 176.136, subd. 6, that the payer must pay or deny the bill or request additional information within 30 calendar days after receiving the bill. Where an appropriate record or additional information is needed to make a determination, 3A (3) requires the payer to respond within 30 days of receipt of the information. This rule is necessary to ensure that payers make timely and prompt determinations.

Item B. The changes in this item clarify and expand on the former Item C. Where the service is not included in the Medical Fee Schedule, the payer may pay no less than the provider's charge, as long as the charge does not exceed the charge that prevails in the same geographic community for similar services. Where the provider's charge exceeds the prevailing charge in the community, the payer must pay the prevailing charge. This is necessary because there has been confusion among payers concerning whether the payer need only pay 75% of the provider's charges. Because this interpretation is inconsistent with Minn. Stat. 176.135, subd. 3, the rule clarifies that the 75th percentile applies only to services included in the medical fee schedule.

In what was formerly Item B, language is deleted requiring the payer to consider the professional judgment and standards of the healing arts in determining excessiveness. This language is deleted because it is impractical to enforce. The deletion of this language is not intended to suggest that payers may no longer consider professional judgment and standards in making a payment determination; such consideration is encouraged and expected. The deletions are simply a recognition that enforcing the rule is difficult, impractical and unnecessary; whether the payer's denial of a claim is based on a reasonable medical standard is most appropriately determined by the commissioner or compensation judge if the denial is contested.

Subpart 4. Notification.

This rule requires the payer to notify the employee and provider in writing of the basis for and amounts of charges denied. The rule also requires notification of any specific additional information requested. This subpart is necessary to ensure that the employee and provider are informed of the amounts and bases of denial as required by M.S. 176.135, subd. 6. This allows the provider to re-evaluate the service and charges and encourages early resolution of disputes. The rule also ensures that employees are kept informed of information the payer is requesting from the provider.

Subpart 5. Penalties.

Formerly included in subpart 2, this provision is renumbered to provide for a more chronological structure. This subpart identifies the statutory penalties to which a payer may be subjected, and adds for completeness the prohibited practices penalties enacted by the 1987 legislature.

Subpart 6. Collection of Excessive Payment.

The changes clarify that a payer, who has determined that payment previously made to a provider was for an excessive charge or service, must demand reimbursement from the provider within one year of the payment. This change is necessary so that the provider, not the employee, is initially notified of the demand for reimbursement.

Part 5221.0700. Provider Responsibilities.

Subpart 2. Submission of Information.

The changes in this subpart clarify that the provider must supply the tax identification number, not social security number, because it is the tax identification number by which providers are generally professionally identified.

The rule also requires providers to supply a copy of an appropriate record to substantiate the bill. This ensures that payers have adequate information by which to determine the compensability of the charge or services.

Language referring to the use of codes found in the Medical Fee Schedule has been deleted because providers are required to use codes on all billings, not just those where the service is included in the medical fee schedule. This is so payers can accurately determine the nature of the service in all billings.

Subpart 3. Billing Code

Item A of this subpart sets out a list of approved billing code schedules. The use of billing codes is necessary so that payers can accurately determine the nature of the service even when the service is not included in the fee schedule. The schedules in Item A are familiar to and typically used by providers, and cover virtually all medical services by provider group.

Item B clarifies a CPT Coding procedure when the code refers back to a common procedure. The example is given to assist payers and providers determine how the fee schedule code and description should be read, or identified on a bill, to provide the most information efficiently.

Item C will list the code modifiers now listed as amended in Part 5221.1000, Subpart 7, items A-T. This is being re-numbered because the code modifiers are to be used along with the general approved codes in all billings, not just for those services found in the medical fee schedule. The modifiers are more appropriately listed under the general code rule.

Subpart 4. Cooperation with Payer.

This subpart has been renumbered from Subpart 3 to Subpart 4 to provide a more chronological structure.

The proposed changes clarify that providers must comply within seven working days with payer's requests for copies of existing medical data. These changes are needed to comply with M.S. 176.138. The deletions are necessary to simplify the language for clarity and consistency with changes in the definitions. The prohibition against prepayment for costs of copies of existing medical records is necessary to prevent delay in processing charges.

Subpart 5. Collection of Excessive Charges.

Formerly Subpart 4, re-numbered to provide for a more chronological structure, this provision prohibits the provider from attempting to collect from the employee or any other insurer or governmental entity when the payer has determined that a charge is excessive. This change is necessary to conform to Minn. Stat. 176.136, Subd. 2. Providers are not without a remedy if they disagree with a payer's determination because under M.S. 176.136, Subd. 2, the payer may initiate an action for a determination by the commissioner or compensation judge as to whether a charge is excessive. This subpart is limited to collection of excessive charges. (The employee or payer must file a claim for excessive services.) Prior to a determination by the commissioner or compensation judge, this provision does not prohibit a provider from attempting to collect from the employee for <u>services</u> which the payer has determined are excessive.

This subpart also requires that a charge which the payer has determined is excessive must be removed from the provider's billing statement if a claim is not filed with the commissioner or if it is determined excessive by the commissioner, compensation judge or on appeal. This is added to ensure that injured workers are not unnecessarily brought into a dispute regarding the reasonable amount of a charge, a dispute which the provider has standing to initiate pursuant to M.S. 176.136, subd. 2.

Part 5221.0800. Dispute Resolution.

The new language identifies the statutory authority and the procedure for requesting a determination as to whether a charge or service is excessive. The changes reflect statutory changes made since the rules were initially promulgated; M.S. 176.106 governing dispute resolution procedures, and 176.136, subd. 2, of the provider's right to initiate a proceeding. Again, a distinction is made between excessive service and excessive charge disputes. The rule clarifies that at any time an employee, employer or insurer may request a determination regarding whether a charge or service is reasonable, while under M.S. 176.136, subd. 2, the provider has statutory standing only to request a determination of whether a charge is reasonable. The rule also identifies the procedure to request a formal hearing when there is a disagreement with the initial commissioner's or compensation judge's determination. Language regarding appeals to the Medical Services Review Board is deleted as the Board no longer adjudicates disputes.

Part 5221.0900. Maximum Fee Schedule.

Subparts 1 and 2 of this part have been renumbered as Part 5221.1000, Subparts 1 and 2, with no language changes. This renumbering was done to consolidate the general fee schedule provisions under one heading for ease in referencing. See below for a discussion of standards used in the proposed fee schedule.

Part 5221.1000. Instructions for Application of the Medical Fee Schedule for Reimbursement of Workers' Compensation Medical Charges.

(Subpart 1, Contents, and Subpart 2, Revisions, have been renumbered from Part 5221.0900, Subparts 1 & 2 - see above).

Standards for Inclusion and Exclusion of Service in the Proposed (1989) Medical Fee Schedule

Minn. Stat. 176.136, subd. 5 provides that where the data base for the Workers' Compensation Medical Fee Schedule meets certain criteria, the fee schedule can be updated simply by publication in the State Register. The criteria are:

(a) The data base includes at least three different providers of the service.

(b) The data base contains at least 20 billings for the service.

(c) The standard deviation as a percentage of the mean of billings for the service is 50 percent or less.

(d) The means of the Blue Cross and Blue Shield data base and of the department of human services data base for the service are within 20 percent of each other.

(e) The data is taken from the data base of Blue Cross and Blue Shield or the department of human services.

However, when the data base for the fee schedule does not meet all of the above statutory criteria, the fee schedule must be adopted by following the rulemaking procedures set forth in the Administrative Procedures Act. Because the data base for the proposed fee schedule does not meet all the statutory criteria, the fee schedule is published as a proposed rule and is being taken through the rulemaking process.

The data base differs from the statutory criteria in three ways. First, the data is taken exclusively from Blue Cross, Blue Shield of Minnesota.

The task force on the Medical Fee Schedule set up by the Medical Services Review Board recommended that the data base from Blue Cross/Blue Shield be used exclusively for the information compiled for the specific fees for the Minnesota Workers' Compensation Fee Schedule. The committee heard presentations from Blue Cross/Blue Shield and the Department of Human Services concerning the source of their data and the way it is presented.

After hearing presentations from Blue Cross/Blue Shield and Human Services, the committee recommended that the Department use only the data base of Blue Cross/Blue Shield for the following reasons:

1. Blue Cross/Blue Shield data offered the widest possible source of data which was representative of statewide providers. It was pointed out that the Department of Human Services restricts access to certain providers and requires their recipients of medical care to go to designated providers. It was also pointed out that St. Paul Ramsey Hospital and Hennepin County Medical Center were often designated providers and it has been shown that their rates are higher than others.

2. The committee felt that the demographics of the Blue Cross/Blue Shield data were less skewed than those of the Department of Human Services. The Department of Human Services data contain a greater proportion of Medicaid and Medicare charges and a large population of children. The committee felt that the group that we are primarily interested in, the working population, was not proportionally included in this data. There was also a concern that the Twin City area was more heavily represented than the outstate Minnesota area.

3. There was also concern that the Human Services data would reflect either much higher or much lower costs for certain services. Specifically, the concern expressed was that since Human Services data contained a large number of elderly and nursing home patients, the physical therapy services conducted in a nursing home would be billed at a higher rate than the same codes as those conducted for the more mobile, healthier working age person. There was also a concern that Human Services Department did not correct unusually high fees, for instance, due to input errors or inappropriate charges, in their report to the Department of Labor and Industry.

In summary, it was felt that the Blue Cross/Blue Shield data gave a more representative, broader and compatible data base and that at this time, it should be the primary source of data for the Medical Fee Schedule.

Second, the comparison between BCBSM and Department of Human Services data is not a criteria because only BCBSM data is used.

The third manner in which the data base differs from the statutory criteria is that an additional formula was utilized to determine whether the charges included in the data base approximate a normal distribution of charges. This formula, developed by the Research and Education Unit of the Department, minimizes the effects of a few unusually high or low charges and permits the inclusion of more services. This formula was used in addition to the statutory formula for comparing the distribution of charges. Both formulas are more fully explained in number 2.A. below (under "Utilization").

The following standards, when analyzed as a whole, determine whether or not a service was included in the medical fee schedule. Our goal was to create a fee schedule that was both comprehensive and fair. The data set used to derive the 1989 fee schedule was purchased from Blue Cross Blue Shield of Minnesota (BCBSM) and contains 1987 charges for each service (procedural code) and provider type. The fee schedule sets the maximum charge at the 75th percentile of the BCBSM data. All charges, up to and including the rate of the 75th percentile, will be paid in full. The remaining charges, which exceed the 75th percentile, will be reduced.

A procedural code was included in the fee schedule if it met two sets of criteria which were based on utilization and the distribution of charges. The following are the criteria for a code's inclusion in the fee schedule:

Utilization

1. The service had at least 3 unique providers and occurred at least 20 times in the BCBSM data set.

2. The distribution of charges for each procedural code had to meet either one of two statistical criteria:

A. The standard deviation of the distribution of charges was less than one half of the average (mean) value (the statutory formula). For example, a code with a mean value of $100 needed a standard deviation of $50 or less to meet this criterion. This criterion led to inclusion of a code in the fee schedule when most of the charges were clustered around the mean and the variation in charges was due to the value of the extreme charges. It excluded the code if there was considerable variation in the distribution of charges. A few extreme cases with higher or lower values can exclude a code from the schedule.

B. The value of the 75th percentile charge was less than or equal to three times the value of the 25th percentile charge regardless of the standard deviation of the distribution (the formula developed by the Research and Education Unit). For example, a code with a 25th percentile charge of $50 needed a 75th percentile charge of $150 or less to meet this criterion. This criterion led to inclusion of a code in the fee schedule when the majority of charges clustered around the median (50th percentile) and the variation in charges was due to the number of extreme charges. It excluded the code if the range of values between the 25th and 75th percentiles is too great. A few extreme cases with much higher or lower values would not exclude the code from the schedule.

In the special case where a surgical procedure was performed on both an out-patient and in-patient basis, the following criteria were used to determine the maximum allowable fee:

A. If either the in-patient or out-patient surgical charges accounted for at least 75 percent of the services performed in that category and it met the two criteria above, it was included in the fee schedule.

B. If neither the in-patient or out-patient surgical charges accounted for 75 percent of the services then:

(a) the code with the higher charge at the 75th percentile was tested to meet the two criteria. If the criteria were met, the service was included in the fee schedule.

(b) if the code with the higher charge did not meet the two criteria, then the service with the lower charge was tested against the two criteria. If the criteria were met, the service was included in the fee schedule.

Subpart 4. Applicability of the Fee Schedule.

This subpart clarifies that the Medical Fee Schedule applies when an approved code under 5221.0700, Subp. 3(A) is included in the fee schedule for the appropriate provider group. This change is reasonable because the codes in the fee schedule are taken from the list of approved code schedules in 5221.0700 3(A). The references to charges are added because the charge for a service is what is affected by the fee schedule.

This subpart also explains the payer's payment responsibilities when a service is not included in the medical fee schedule. This is the same language found in 5221.0600, subp. 3 (B) and is included again for easy accessibility to payers and providers; it can reasonably be looked for as a "payers" responsibility" under 5221.0600 3(B) or this Part.

Subpart 5. Coding.

The new language in this subpart clarifies the payer's obligation to evaluate whether a code has been correctly assigned and is subject to the fee schedule. This subpart also prohibits providers or payers from dividing a broad inclusive service into component services if the broad service is subject to the fee schedule, but permits division if the broad service is not subject to the fee schedule and the component services are. The proposed changes are reasonable to help ensure that the services subject to the fee schedule are reimbursed accordingly and to discourage coding a service in such a way that the provider receives a greater or lesser fee than allowed under the schedule.

Subpart 6. Ambiguity.

The changes in this subpart require the parties to first try to resolve disputes over the applicability of the fee schedule themselves to decrease litigation. Because unresolved disputes concern whether a charge is excessive under the fee schedule, either the payer or provider may file a request with the commissioner for a determination. These changes reflect M.S. 176.135, subd. 2, which permits a provider to file a request for a determination on cases of excessive charges.

Subpart 7. Code Modifiers.

The proposed amendments move this subpart to 5221.0700, subp. 3C, as the modifiers are required for services even not included in the fee schedule and are more appropriately described with the rule that requires the use of approved codes. (See Part 5221. 0700, subp. 3C above). In addition to changes which clarify and simplify the language and reflect the common use of the term "medical" fee schedule, the amendments propose the following changes:

Item A (to be renumbered as 5221.0700 3C (1)). Modifier 20. Language is modified to conform to the definition of modifier 20 in the current edition of the CPT manual.

Item D (to be renumbered as 5221.0700 3C (4)), Modifier 26. This modifier is used only when the professional component is reported separately. The previous language could be interpreted as allowing the use of the modifier whenever a service includes both a professional and technical component, whether or not the components are billed separately. See also discussion of Part 5221.2300, subpart 1 A.

Item F & G (to be renumbered as 5221.0700 3C (6 & 7). Modifiers 50 and 51, Bilateral and Multiple Procedures. Both bilateral and multiple procedures were included under Modifier 50 in the previous fee schedule, leading to uncertainty as to when the modifier applies. Distinguishing and expanding the descriptions will enable providers to more accurately describe the services performed. See also, discussion of Part 5221.2250, subp. 2F. Since the rule was sent to the State Register the Department has discovered that language about the applicability of the maximum fee should have been deleted from the provision on code modifier 50. This language may conflict with, and at a minimum is confusing when compared to the additional modifier language proposed in Part 5221.2250, subp. 2F. This proposed modification will be submitted to the Attorney General or Chief Administrative Law Judge.

Item T (to be renumbered as 5221.0700 3C (20)). Modifier TC - Technical Component. This modifier is added for those services that include both a technical and professional component, where the technical component is reported separately. This is necessary because several types of services such as x-ray, include both professional and technical components, yet are often reported separately. This modifier permits an accurate description of the service being reported. See also discussion of Part 5221.2300, subp. 1A.

CATEGORY HEADINGS AND DESCRIPTIONS

The following new category descriptions in the fee schedule are added to correspond to new or existing codes for that category. The descriptive language corresponds for consistency to language in the Common Procedural Terminology manual. Discussion of changes in other headings or descriptive language can be found under the respective parts in this statement.

5221.1100, Subp. 3a Home Services

Subp. 5 Skilled nursing, intermediate care and long-term care facilities

Subp. 6 Nursing home, boarding home, domiciliary or custodial care medical services.

Subp. 7 Emergency department services (portion pertaining to physician directed emergency care only.)

5221.1200, Subp. 2, item B Follow-up consultation
Subp. 2, item C Confirmatory (additional opinion) consultation

5221.1210 Immunization Injections

5221.1600 Otorhinolaryngologic Services

5221.1950 Allergy and Clinical Immunology

5221.2070, Subp. 2 Dermatological Procedures, Services

Part 5221.1100. Physician Services.

Subpart. 1. Scope.

This subpart adds language which ensures that services performed by or under the direct supervision of the physician are physician services. This is necessary because there has been confusion as to whether services performed under the direct supervision of a physician are physician services. For example, where a physician's assistant provides a service in the office under the supervision of the physician, that service is considered a physician service. To characterize the service otherwise would unnecessarily result in a severely limited fee schedule. These services are reported to Blue Cross and analyzed in the data base as physician services and the fee in the medical fee schedule is therefore appropriate.

Subpart 2. Definitions.

Item A. New Patient. This item identifies a new patient as one whose records for a work injury need to be established. This includes a known patient with a new work injury because it is not necessarily less work for a physician to initially evaluate a patient with a new work injury simply because the patient was previously seen for a different condition. In either case, the physician's efforts in evaluating and establishing new workers' compensation records may be the same.

Item B. Established Patient. The changes reflect that an established patient is one for whom the workers' compensation records are available to the physician. This further clarifies the distinction between a new patient and an established patient.

Item C. Level of Services. Language is added requiring the preparation of an appropriate record to document the level of service. This reflects that the level of service provided is an element which needs the same documentation as any other service in the fee schedule.

Item M. Referral. This new item defines a referral as distinguished from a consultation. When a referral is made, the new physician assumes part or total care of the patient. When there is no transfer of care, the service is characterized as a consultation and must be billed as such. This differentiation is necessary because the terms have been a source of confusion, which results in inaccurate application of the relevant fee schedule codes.

Item N. Hospital Discharge Day Management. This is the standard Common Procedural Terminology definition for Hospital Discharge Day Management and is included because the corresponding code is included in the fee schedule.

Subpart 3. Office Services.

Language recommended by the Medical Services Review Board is added establishing that non-emergency services provided in an outpatient hospital clinic setting are considered office services. This is reasonable because it is a more accurate characterization of the business practice of a patient and physician meeting at a hospital rather than the clinic where it is more convenient for the patient or physician, yet is not an emergency.

Subpart 3a. Home Services, and

Subpart 5. Skilled Nursing, Intermediate Care and Long-term Care Facilities, and

Subpart 6. Nursing Home, Boarding Home Domiciliary or Custodial Care Medical Services.

....See Category Headings, p. 16 of this statement.

Subpart 7. Emergency Department Services

As with subpart 3 (office services) this subpart clarifies that the emergency service codes do not apply when an emergency room is used as a substitute for office services. This change, recommended by the Medical Services Review Board, reflects the practice of patients and physician meeting at a hospital rather than a clinic for convenience. Because the nature of the service is more similar to an office service than an emergency service it is inappropriate to use the emergency codes. For discussion of the language pertaining to physician directed emergency care, see Category Headings, p. 16 of this statement.

Part 5221.1200 Consultations

Subpart 2, Item A.

The amendments to this item reflect the requirement of preparing an appropriate record, consistent with the definition of that term and provider responsibilities under Part 5221.0700. Language regarding referral is deleted because a similar definition of referral is established in Part 5221.1100, subp. 2.

Items B and C, Follow-up and Confirmatory Consultation, see Category Headings, p. 16 of this statement.

Part 5221.1210 Immunization Injections. See Category Headings, p. 16 of this statement.

Part 5221.1300 Psychiatry and Psychiatric Therapy

Language is added directing non-physician providers of psychiatric services to the appropriate section of the fee schedule, to avoid confusion and provide assistance to providers not covered by this section.

Part 5221.1400 Biofeedback

The Department has determined that this part is erroneously repealed. The codes and amounts for biofeedback services by a physician are erroneously placed in Part 5221.3170. Modifications to correct the error will be submitted for approval to the Attorney General or Administrative Law Judge.

Part 5221.1500 Ophthalmological Services, Subp. 2(B). Definitions, Level of Service.

The additional language clarifies, to avoid confusion, that items C and D are exceptions to the level of service descriptions in Part 5221.1100.

Part 5221.1600 Otorhinolaryngologic Services, See Category Headings, p. 16 of this statement.

Part 5221.1700 Audiologic Tests

Due to an error, this Part should have been repealed because these services are performed by an audiologist, not a physician. Since these services are provided by audiologists, it is more appropriate to include the services under Part 5221.2700. Repeal of Part 5221.1700 will be added as a proposed modification, and submitted to the Attorney General or Administrative Law Judge for approval.

Part 5221.1950 Allergy and Clinical Immunology. See Category Headings, p. 16 of this statement.

Part 5221.2050 Chemotherapy Injections

Data for this part was requested from BCBSM. These codes were not previously included because the services were thought unlikely to be provided in workers' compensation cases. However, these services may be provided in workers' compensation cases and inclusion is therefore appropriate. For instance, exposure to asbestos may cause a condition for which chemotherapy is necessary.

Part 5221.2070, Subp. 2 Dermatological Procedures, Services. See Category Headings, p. 16 of this statement.

Part 5221.2100 Physical Medicine

Physical therapy and occupational therapy language and codes are eliminated from this part and are now found in the section on Physical and Occupational Therapy in Part 5221.2800. This change is reasonable because the previous fee schedule distinguishes between services provided by a physical therapist in a clinic associated with a physician and an independent physical therapy clinic. There is no reasonable basis for this distinction.

Part 5221.2200 Special Services and Reports

The description of the critical care services category is moved from the beginning to the end of the part (between miscellaneous services and other services). This change is necessary to eliminate confusion because some payers have refused to pay the maximum fee for miscellaneous services unless provided in a critical care setting. Introductory language on the application of these codes corresponds to language in the CPT manual for the category.

Part 5221.2250 Physician Services, Surgery

Subpart 2. Instructions

Item A. The changes clarify that the follow-up care mentioned in the rule is in-hospital follow-up care, and clarifies that if an assistant surgeon assists during surgery, the primary surgeon is responsible for reimbursing the assistant surgeon out of the maximum fee received for the procedure under the fee schedule. These changes are in response to conflict among payers and providers as to the interpretation of this item. The changes are reasonable to resolve the confusion and to prevent reimbursement in excess of the medical fee schedule.

Item F. Special Situations. This item clarifies reimbursement for services corresponding to certain modifiers for multiple and bilateral procedures. This is in response to confusion as to how the fee schedule is applied in these circumstances. The billing instructions and reimbursement percentages represent standard billing practice by surgeons for these procedures. The Minnesota Medical Association task force on workers' compensation approved the descriptions and percentages, except that its recommendation for reimbursement, under 2(b) (multiple procedures/single operative session/different incisions, billing for the secondary procedure) is 75 percent rather than 65 percent. The Department agrees and modification will be proposed to the Attorney General or Administrative Law Judge in accordance with the MMA recommendation.

Subparts 3-15.

Specific subpart headings have been added to make this part easier to use. Subpart 10, Reproductive System, should be numbered Subpart 11, and will be modified accordingly.

Part 5221.2300 Physicians Services, Radiology

Subpart 1. General

The changes clarify that this rule applies to physicians and technicians under a physician's supervision, and specify that where the charge for a radiologic procedure is broken down into a professional and technical component the maximum fee for the procedure is divided accordingly. This is necessary because often charges for the technical and professional components of a radiological procedure are submitted separately. This rule ensures that the maximum

fee is fairly and accurately applied when the components are billed separately. To arrive at the 60/40 percent division as a fair proportion of the maximum fee, other states workers' compensation fee schedules were reviewed as to how the technical and professional components are generally proportioned.

Part 5221.2600 Optometrists

The amendments limit the application of this part to optometrists because they are licensed to prescribe eyeglasses and treat some eye conditions, while opticians, certified nationally rather than licensed in Minnesota, grind lenses and fit eyeglasses. Therefore, it is more appropriate to separate the codes for each provider group. The level of service descriptions correspond to those of the Minnesota Chapter of American Optometric Association. Line 8, Code 92285-00 should read "External" instead of "Extended". A modification to correct this error will be proposed.

Part 5221.2650 Opticians

As above, optician services are moved to a separate section because the services provided are different than those provided by optometrists.

Part 5221.2700 Audiologists

Part 5221.2750 Speech Pathologists.

Previously these two provider groups were included in the same part. Separate parts now reflect the different services provided by each. Part 5221.1700 pertaining to physician services, audiologic tests, should have been repealed as these services, now in Part 5221.2700, are performed by audiologists, not physicians. Line 7 on page 107 of the rules (audiology code 06045-00) was erroneously included and should have been deleted. A modification to delete this code will be submitted to the Attorney General or Administrative Law Judge, as that code no longer exists.

Part 5221.2800 Physical Therapist and Occupational Therapists

Physical therapy and occupational therapy codes are now included in one section. Previously, some physical and occupational therapy codes were found under physician services. They are consolidated in this part to eliminate confusion resulting from an artificial distinction between therapists in physician owned clinics and independent clinics. This part has always included occupational therapists but that group was erroneously omitted from the heading.

Subpart 1. Scope.

This subpart specifies that the codes and fee schedule apply only to therapists and assistants who possess the proper professional credentials.

Subpart 2. Definitions.

These definitions clarify terminology used in the codes in response to confusion over application of the various codes utilizing these terms. These definitions have been approved by the Minnesota Chapter of the American Physical Therapy Association (including occupational therapy representatives).

Subpart 3. Physical and Occupational Therapy Instructions.

Item A. This item requires the treatment plan to be in writing to document services so payers can adequately evaluate the service. No separate fee is allowed for preparation of the plan. This is reasonable as consistent with Minn. Stat. 176.135, subd. 7, which requires supporting documentation to be submitted with the bill.

Item B. This item requires the therapist to supply the license number on request. This is in response to concern expressed by payers and physical therapists that non-licensed persons have been billing under these codes.

Subpart 4. Scope.

This subpart clarifies the facilities that are covered by this section to ensure that comparable services and facilities are reimbursed comparatively. This has specifically been agreed to by the Minnesota Hospital Association. The heading should read "Physical Therapy and Occupational Therapy. Services," and will be changed accordingly.

Part 5221.2900 Chiropractors

Subpart 1a. Definitions.

These definitions are added to clarify the terms used in the code service descriptions, which have been a source of confusion. The language corresponds to the BCBSM definitions published in Provider Bulletin no. P-3-87 February 1987. Additionally, the Minnesota Chiropractic Association and the Minnesota Board of Chiropractic Examiners were consulted in drafting the language.

Subpart 1b. Chiropractor Instructions.

This language clarifies application of codes pertaining to additional manipulation and conjunctive therapy in response to confusion as to the application of these codes. The language is similar to language used by BCBSM Specialty Clinic Schedules.

Part 5221.3000 Podiatrists

Subpart 2. Ancillary Services.

Language is added clarifying that ancillary services provided by podiatric assistants must be under the direct on-site supervision of a physician. This is necessary to help ensure that services provided are appropriate and clarify that such services are reimbursable under the appropriate code.

Part 5221.3100 Psychologists and Rule 29 Facilities

Part 5221.3150 Licensed Consulting Psychologists and Rule 29 Facilities

Language is added to these two parts about Rule 29 Facilities because that is how the Department of Human Services characterizes them and the BCBSM data base is taken from these facilities. The language about the Minnesota Board of Psychology is added in each part because that is the licensing board for both groups of providers. Licensed Consulting Psychologists are given a separate section and separate codes because there are separate professional practice and licensure requirements for each.

Part 5221.3160 Social Workers

Social workers are given a separate section because they are a different profession, licensed by a different board than psychologists.

Part 5221.3170 Biofeedback

Biofeedback - Part 5221.3170 is inappropriately added, as the codes and amounts from the BCBSM data base are for physician services, and should be found in Part 5221.1700. Modifications to correct this error will be proposed and submitted to the Attorney General or Chief Administrative Law Judge for approval.

Part 5221.3310 Effective Date

This is added to reflect the statutory guidelines of the Administrative Procedures Act. Under that statute, unless otherwise provided in the rule, rules are effective 5 days after publication of the Notice of Adoption in the State Register.

These rules are not made retroactive because services may have already been paid for under two previous fee schedules. The effective date of these rules cannot reasonably be made retroactive.

5221.3400 (Previous effective date provision)

The repealing language for this provision was erroneously omitted. If not repealed, it would cause confusion as to the application of these rules. A modification to repeal this provision will be proposed and submitted to the Attorney General or Administrative Law Judge for approval.

Repealer:

Minnesota Rules Part 5221.1400 (Physician Services, Biofeedback) was erroneously repealed. A proposal to repeal Parts 5221.1700, (Physician Services, Audiologic Tests) and 5221.3400 will be submitted to the Attorney General or Administrative Law Judge as proposed modifications. Please see the discussion for these parts in this Statement of Need and Reasonableness.

Impact on Small Business:

Minn. Stat. sec. 14.115, subd. 7(c) provides that agencies must consider the impact of proposed rules on small business, unless the rules impact "Service businesses regulated by government bodies, for standards and costs, such as nursing homes long-term care facilities, hospitals, and providers of medical care...."

Because these rules affect workers' compensation insurers (generally not small businesses) and the above service business, such as health care providers, the impact on small business need not be considered.

Nonetheless, the Department has generally considered the potential impact on small businesses and has concluded that the impact is minimal.

In addition to modifications to the fee schedule, the amendments could affect small business providers of health care in two ways. First, they require submission of an appropriate record to substantiate the medical bills. Second, the rules require providers to use approved codes in submitting bills. The first requirement is already required by statute and should therefore require no additional financial expenditure. The rules simply clarify the providers' responsibilities under the statute. The second requirement should have minimal impact as providers are generally familiar with these codes and this rule in most cases reflects current practice.

The medical fee schedule assists small business by limiting medical costs and therefore contributing to lower workers' compensation premiums.

In addition to updating the fee schedule, the rules are designed to resolve problems brought to the Department's attention by payers and providers, and to encourage prompt handling and payment of reasonable charges and services with a minimum of litigation. To limit the application of the rules to only certain providers would be unfair and would defeat the general purpose.

FISCAL IMPACT ON LOCAL PUBLIC BODIES

The rules have an impact on municipalities who are self-insured for workers' compensation claims and on county hospitals, such as Hennepin and Ramsey County Hospitals. These rules do not require significant expenditure of money by local public bodies. Self-insured municipalities generally benefit by the limit on medical fees.

Administratively the rules require payers to respond to medical claims within 30 days and provide written notification of a denial or request for information. These changes were made to bring the rules into compliance with existing statutory provisions. Therefore, to the extent these are considered an increased level of service under M.S. 3.981, they are not new requirements. Furthermore, to the extent there is concern that any other provision may increase administrative costs, it should be noted that these rules are designed to streamline the processing of bills by both payers and providers. Any potentially increased administrative costs due to increased payer responsibilities should be offset by savings as a result of increased provider responsibilities. The same analysis would apply to a provider's claim of increased administrative costs.