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June 17, 1993

Maryanne Hruby
Legislative Commission to Review
Administrative Rules
Room 55 State Office Building
100 Constitution Avenue
St. Paul, Minnesota 55155-1201

Re: Proposed workers' compensation rules

Dear Ms. Hruby:

Yesterday we submitted Statements of Need and Reasonableness for the proposed workers' compensation rules.

Enclosed please find corrected Statements of Need and Reasonableness, dated June 17, 1993, for the proposed workers' compensation Medical Rules of Practice and Relative Value Fee Schedule. The witness list was inadvertently omitted from the Statement for the Medical Rules of Practice and has been revised in the Statement for the proposed fee schedule.

Sincerely,

Kathryn Berger

Kathryn Berger
Attorney
Department of Labor and Industry

KB/kh

Enclosures

6/21/93
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STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of Proposed Amendment
to the Rules Relating to Workers'
Compensation Medical Services
Parts 5221.0100 to 5221.0700

STATEMENT OF NEED
AND REASONABLENESS
(Medical Rules of Practice)

I. BACKGROUND

On October 7, 1983 the temporary rules governing reimbursement for workers' compensation medical services (4 MCAR 1.001 through 4 MCAR.1.0032) went into effect. These rules included the Medical Fee Schedule, which established maximum fees for medical services based on historic charge data. Also included were rules establishing authority, purpose, scope, definitions and guidelines for excessive services and charges, as well as payer's responsibilities, provider's responsibilities and procedures.

In October, 1984, the Department of Labor and Industry (DOLI) adopted the permanent rules. Since then there has been only one revision of the medical rules of practice, which was effective May 1, 1989. This revisions included additional definitions, clarification between excessive services and excessive charges, additions to payer's responsibilities, clarification of the provider's responsibilities, and updating of the dispute resolution process. This statement addresses changes to the medical rules of practice. A separate Statement of Need and Reasonableness addresses the adoption of the proposed Relative Value Fee Schedule, parts 5221.4000 to 5221.4070.

The statutory authority for the rules is discussed in detail in this statement under Part 5221.0200.

II. REASONS FOR REVISION AND NEW RULES

In the past several years, DOLI has received inquiries from health care providers, insurers, self-insurers, third-party payers, employers, qualified rehabilitation consultants, and even employees regarding disputed medical issues not addressed in the current rules. There have also been discussions with the Workers' Compensation Administrative Task Force and with the Workers' Compensation Advisory Council and the Medical Services Review Board (MSRB) about unresolved medical issues. The problems raised by these groups and individuals seem to focus on, but are not limited to, the following broad topics:

- Employers, insurers, and qualified rehabilitation consultants state they often do not receive adequate or timely information from health care providers that is necessary to evaluate claims, manage the medical aspects of a claim and promptly pay the bills.

- Employers and qualified rehabilitation consultants indicate that some health care providers do not adequately participate in return to work planning, causing delay in the employee's return to work.

- Employers, insurers and health care providers indicate that many disputes about compensability of services arise out of confusion over the various responsibilities of payers and providers with regard to billing and payment.

- Insurers, employers and health care providers, as well as DOLI request that the paperwork required in workers' compensation be limited, while still having available adequate, timely information on claims.

- Employers and insurers indicate that some employees engage in "doctor shopping" thus adding to medical costs and delaying return to work.

III. RULE DEVELOPMENT PROCESS

In 1990, in preparation for writing the rules, the MSRB in its advisory capacity to the Commissioner, conducted an internal survey about issues and problems that its members felt were critical to the workings of the system. The MSRB then formed subcommittees to address the following areas: access to medical data; communication between health care providers; treatment rules of practice; required forms; and cooperation with vocational rehabilitation.

The Rehabilitation Review Panel also participated in developing the rules for cooperation with vocational rehabilitation.

DOLI also contacted the American Guild of Patient Account Management (AGPAM), the Medical Account Managers Association (MAMA), the Minnesota Medical Group Management Association (MMGMA), and the Minnesota Medical Records Association (MMRA) for comments and guidance on these issues.

DOLI conducted a survey of insurers which was reported in The Medical Study Implementation Action Plan: A Report to the Legislature, published in February, 1991. This survey contained several questions about medical cost containment activities used by insurers, self-insurers and third-party administrators.

In addition, DOLI completed a survey of workers' compensation insurers, third-party administrators, and self-insured employers in Spring, 1991. The survey contained questions regarding use of the Physician's Report form by payers. A summary of the survey results was published in DOLI Compact (Nov. 1991).

Several drafts of the proposed rules were reviewed by the MSRB, outside health care providers, insurers, third-party payers, and self-insured employers. On February 26, 1992 a draft of the proposed rules was sent to approximately 25 different groups representing insurers, self-insured employers, rehabilitation providers, and professional organizations of medical doctors, chiropractors, nurses, and hospitals. The comments were incorporated in the final draft where appropriate.

IV. IMPACT ON SMALL BUSINESSES; EXPENDITURE OF PUBLIC MONIES

The rules are exempt from the requirements of Minnesota Statutes, section 14.115

because they regulate health care providers for standards and costs. The rules also affect self-insured employers and insurance companies, who are generally not small businesses. Nonetheless, the Department has considered methods for reducing the impact of the rule on small business health care providers. The MSRB, which includes small business health care providers, was consulted in development of the rules.

Part 5221.0410 requires reporting of medical information on the Health Care Provider Report form. It is not appropriate to modify these requirements for small health care providers because these rules already reduce the reporting burden from that required by the existing rules in that the rule combines two forms (Physician Report and Maximum Medical Improvement Report) into one form (Health Care Provider Report); the rule requires providers to report most information only upon request (mandatory reporting of maximum medical improvement and permanent partial disability is a requirement in the existing rules and therefore does not constitute an additional burden). The information on the form is the minimum necessary for the insurer and the Department to monitor the claim and ensure proper payment of benefits as required by Minnesota Statutes, section 176.231, subdivisions 3, 4 and 5.

The Report of Work Ability is a new form designed to provide the employer and other parties with the provider's most recent evaluation of the employee's ability to work. This information is critical to re-employing all employees, and therefore an exclusion for some providers would defeat the purpose of the requirement.

The rule incorporates flexibility into the system in that it permits providers to report the information in a narrative format instead of on the Health Care Provider Report or Report of Work Ability form if that is easier for the provider. Additionally, under the current rules, providers must already report the specific disability information that is unique to workers' compensation cases. The forms just specify information which is required.

Minnesota Rules Part 5221.0420 requires health care provider participation with return to work planning. This should not significantly impact small business health care providers either as it protects them from excessive requests for meetings from rehabilitation providers. Additionally, the provider is permitted to charge for the services provided under this section. Also, to exempt small business providers would defeat the purpose of the rule, namely, a coordinated effort focused on return to work for all injured workers.

Minnesota Rules Part 5221.0650 requires insurers, self-insurers, or third-party administrators to collect and retain data included on the required uniform billing forms and other claim data. No exception is appropriate since data collected by DOLI must be standardized to allow research into medical care and costs necessary for DOLI's monitoring function. Also, all payers must participate in order that data is representative of the workers' compensation population. Flexibility is built into the rule in that format is not mandated; the insurer may maintain paper copy, computerized records or in electronic format. The method of transfer of data will be agreed upon by the payer and DOLI. It is anticipated that many workers' compensation insurers will be moving toward more technologically advanced methods of handling data, much as health insurers have progressed already.

Minnesota Rules Part 5221.0700 requires a uniform billing form. This is required by

the 1992 Legislature, and therefore no exemption is appropriate. Minnesota Statutes, section 176.135, subdivision 7. The forms selected are the HCFA-1500 form, already in widespread use for federal programs, and the UB-92 (HCFA-1450). The UB-92 is an updated version of the UB-82 form currently in use by hospitals; and this new version will be required for federal programs in the fall 1993. It would be more burdensome to create a billing form specific to workers' compensation and require small businesses and hospitals to adapt their billing to yet another payer's requirements. The Department has consulted with health care providers, including small businesses, who have indicated it is feasible and preferable to use these forms which are already commonly used, for workers' compensation claims. Furthermore, MinnesotaCare's Health Care Commission is considering mandating the use of these standardized forms in Minnesota.

Fiscal note: It is not expected that implementation of the rules will require any local public body to spend more than $100,000 in either of the next two years. Therefore, a fiscal note is not necessary under Minnesota Statutes, section 14.11, subdivision 1. The rules do not adversely impact agricultural land and do not have their primary effect on Spanish speaking people.

V. Witnesses and Staff Presenters

Appearing at the public hearing to present the proposed workers' compensation medical rules of practice may be any of the following persons from the Department of Labor and Industry: Leo Eide, Assistant Commissioner; Sandra Keogh, Medical Policy Analyst, Rehabilitation and Medical Affairs; Monica Ryan, Medical Policy Analyst, Rehabilitation and Medical Affairs; Gloria Gebhard, Acting Director, Rehabilitation and Medical Affairs; William Lohman, M.D., medical consultant for the Department of Labor and Industry; and Kathryn Berger, Attorney, Legal Services. The Commissioner the right to appear or call upon any of his designees or other staff to appear in support of the rules.

VI. Overview of Proposed Revisions and New Rules in Medical Rules of Practice

There are seven major sections to be either revised or added as new rules.

1. 5221.0410 Required Reporting and Filing of Medical Information. This section replaces the Physician Report and the Maximum Medical Improvement Report required by Minnesota Rules Part 5220.2590 with a single revised Health Care Provider Report which provides basic information about the injury as well as maximum medical improvement and permanent partial impairment. This section describes considerations in determining maximum medical improvement generally, and limits the factors that may be considered when one year has elapsed from the date of a musculoskeletal injury. A new report is required, Report of Work Ability, which describes the worker's contemporaneous ability to work.

2. 5221.0420 Health Care Provider Participation in Return to Work Planning. This is a new section that addresses the provider's obligation to cooperate in planning an injured workers' return to employment whether or not a qualified rehabilitation consultant has been assigned to the case.

3. 5221.0430 Change of Health Care Provider. This new section addresses the requirement of Minnesota Statutes, section 176.135, subdivision 2 that the Commissioner adopt rules establishing standards and criteria to be used when the employee or employer requests a change of doctor.

4. 5221.0500 Excessive Charge; Limitation of Payer Liability. This section combines and revises 5221.0500 Excessive Charges and 5221.0550 Excessive Services and includes the 1992 legislative amendments (Minnesota Statutes, section 176.136, subdivisions 1, 1a, 1b and 2) regarding limits on an employer's liability for medical fees. A payer's liability for medical costs is clarified by pulling together into one section the information regarding what constitutes an excessive charge, and the payer's maximum liability in light of several statutory provisions.

5. 5221.0600 Payer Responsibilities. This section revises and adds language to be consistent with amendments in Minnesota Statutes, section 176.135, subdivision 6 and these proposed rules, 5221.0500. The rule clarifies the payer's responsibility to promptly review and pay medical bills and notify the provider and employee of their actions.

6. 5221.0650 Data Collection, Retention, and Reporting Requirements. This new section requires insurers and self-insurers to report medical and other data necessary for DOLI to monitor and evaluate treatment of work-related injuries.

7. 5221.0700 Provider Responsibilities. New language prohibits payment for services violating Medicare's antikickback statute consistent with the MinnesotaCare legislation in 1992. New wording also standardizes the billing process by requiring uniform billing forms for health care providers as mandated by the 1992 Legislature.

Each section will be reviewed separately in this Statement of Needs and Reasonableness and will include specific information on the problems addressed and the rationale for the changes or new rule.

VII. Content Review of Rules

Part 5221.0100 Definitions.

This part is amended to improve the accuracy of existing definitions and to add definitions for key terms and concepts which appear throughout the chapter.

Nature of Proposed Rule and Rationale:

Subp. 4. Code. The use of codes in the health care delivery system has increased dramatically in recent years, as a result of technological advances in the area of electronic data collection, storage and transmission. This subpart provides definitions of six different types of codes, all of which are required by various provisions in this chapter. Specifically, proposed Minnesota Rules Parts 5221.0410, 5221.0420, 5221.0500, and 5221.0700 require the health care provider to include specified codes in its billing and reporting documents; and proposed

Minnesota Rules Parts 5221.0600 and 5221.0650 require the payer to evaluate, collect and retain certain health care information, according to the specified codes. Services included in the Medicare Relative Value Fee Schedule are listed according to these specific codes. Thus, because our schedule incorporates the Medicare schedule, users must be familiar with these various types of codes and their application.

The codes required by this chapter and defined in this subpart are currently recognized and used not only by Medicare but also by health care providers and payers in most other sectors. These codes were also used in the current and past workers' compensation medical fee schedules. Thus, this rule reflects the Department's efforts to achieve the goal of uniformity in collection of health care data which is shared by both the private and public sector and which is mandated by the MinnesotaCare legislation.

Item A. Billing code. This item differentiates this term from other specific types of codes and establishes that its use is limited to billing purposes only. The billing code requirements are discussed in Part 5221.0700, subp. 3.

Item B. CPT code. This item explains the abbreviation "CPT" and clarifies that these codes are used to identify medical services, articles or supplies. This item also refers the user to Part 5221.0405, item D (proposed) which identifies the publisher of these codes and provides instructions for obtaining a manual containing the complete, current listing of codes.

Item C. HCPCS code. This item explains the abbreviation "HCPCS", describes the three different levels which comprise this coding system and clarifies that these codes are used to identify medical services, articles or supplies. It also refers the user to Part 5221.0405, items D and E (proposed), which identify the publishers of these codes and provides instructions for obtaining manuals containing complete, current listings of codes.

Item D. ICD-9-CM code. This item explains the abbreviation "ICD-9-CM" and clarifies that these codes are used to identify particular medical or chiropractic diagnoses. It also refers the user to Part 5221.0405, item A (proposed), which identifies the publisher of these codes and provides instructions for obtaining a manual containing complete, current listings of these codes.

Item E. Place of service code. This item differentiates this term from other specific types of codes and clarifies that it is used to identify the type of facility wherein the service was provided e.g., office, hospital inpatient, or outpatient, emergency room. It also refers the user to Minnesota Rules Part 5221.0405, items B and C (proposed), which references the prescribed billing claim forms on which this code is required.

Item F. Procedure code. This item differentiates this term from other specific types of codes in that it is a general term, intended to describe a health care procedure and may include several types of specific codes, as listed (e.g., CPT, HCPCS, chiropractic, prescription codes).

Subp. 6a. Conversion factor. This term is a key variable in the formula set forth in proposed Minnesota Rules Part 5221.4020, used to compute and determine maximum fees for services included in the proposed Relative Value Fee Schedule, Minnesota Rules Part 5221.4000

through Part 5221.4061. The use of the conversion factor is discussed in the statement of need for the proposed Relative Value Fee Schedule.

Subp. 6b. Division. This term is defined for ease and clarity and serves as an abbreviation for the more complete title of the relevant administrative body, the Workers' Compensation Division of the Department of Labor and Industry.

Subp. 10. Medical fee schedule. This part is amended only to reflect a change in numbering of the fee schedule portion of the rules.

Subp. 10a. Modifiers. Modifiers, like the codes defined in subpart 4, are currently recognized and used by providers and payers in all sectors. These modifiers are especially required in Minnesota Rules Parts 5221.0410, 5221.0420, 5221.0500, 5221.0600, 5221.0650 and 5221.0700 (proposed). The use of modifiers in this chapter allows more accurate description of the service actually provided. The code and modifier assist payers in determining correct maximum fees for services provided and ensures the compilation of uniform data which will ultimately provide the means for evaluating the efficacy of these rules and for studying health care delivery patterns and outcomes.

Subp. 11a. Physician. The two statutory definitions of this term are consolidated and included here to emphasize the limited application of this term and to distinguish physicians from other types of health care providers.

PART 5221.0200 AUTHORITY, and
PART 5221.0300 PURPOSE.

These sections are amended to reflect the expanded coverage of chapter 5221 and the statutory authority for rule-making is cited. The medical rules of practice previously and primarily governed payment for medical services. In response to escalating medical costs, the 1992 Legislature enacted a medical cost containment package. Changes are made to the rules in response to the legislation mandating a Relative Value Fee Schedule, a uniform billing form, limitations on payer liability, and permitting DOLI to collect medical data. Additional rules are intended to address problems identified with the workers' compensation system that interfere with the efficient delivery of quality medical care and communication between the health care provider and other parties in the system.

The statutory authority for these rules is as follows: Minnesota Statutes, section 175.171 provides the Department of Labor and Industry to adopt "reasonable and proper rules relative to the exercise of its powers and duties . . ." and "to collect, collate and publish statistical and other information relating to the work under its jurisdiction . . ."

Minnesota Statutes, section 176.101, subdivision 3e(f) authorizes the commissioner to monitor and adopt rules to assure the proper application of the provisions governing maximum medical improvement.

Minnesota Statutes, section 176.135, subdivision 2 and Minnesota Statutes, section 176.83, subdivision 8 requires the commissioner to adopt rules establishing standards and criteria

to be used when a dispute arises over selection or change of doctor.

Minnesota Statutes, section 176.135, subdivision 7 requires the commissioner to adopt a uniform billing form.

Minnesota Statutes, section 176.231, subdivisions 3, 4, 5, 6, and 7 and Minnesota Statutes, section 176.83, subdivision 15 authorizes the commissioner to develop forms and require reports from health care providers related to the nature and extent of the injury and disability.

Minnesota Statutes, section 176.83, subdivisions 1, 3, 4, 5, and 7 authorizes the commissioner to adopt rules to implement Chapter 176 and establish standards and procedures for evaluating the clinical consequences of services by health care providers and standards and procedures for determining whether charges and services are excessive and available to employees.

Minnesota Statutes, section 176.83, subdivision 5a authorizes the commissioner to adopt rules requiring insurers and others to reports medial and other data necessary to implement Chapter 176.

PART 5221.0400 SCOPE.

The scope of the rules is amended to reflect that employees have a responsibility to provide the Report of Work Ability form to the employer or insurer and qualified rehabilitation consultant under Part 5221.0410, subp. 6. Language is also added to reinforce that the provisions apply to all disputes in the workers' compensation system. This is necessary for consistency and predictability throughout the system, and is consistent with the statutory authority for the rules cited in part 5221.0200.

PART 5221.0405 INCORPORATION BY REFERENCE.

The documents identified in items A to D are incorporated by reference into chapter 5221. These are documents that are specifically referenced in the rules, and identifying information is therefore set forth as required by Minnesota Statutes, section 14.07.

PART 5221.0410 REQUIRED REPORTING AND FILING OF MEDICAL INFORMATION.

Minnesota Rules Part 5220.2590 is repealed and replaced with part 5221.0410 because the current rule no longer meets the information needs of the payer or DOLI.

Need for the Proposed Rule:

Inadequate, untimely medical information. Medical information is often needed early in the claim for an employer to determine liability for a claimed work injury; thereafter, regular communication with the health care provider facilitates medical management as well as return to work strategies. Requested information may not be received for many weeks and then may not be adequate to assist the payer in determining liability for the claimed condition, or the

compensability of the health care services billed. Furthermore, the payer needs to be informed of the worker's treatment and ability to work status so the case may be managed proactively to control medical costs and facilitate a prompt return to work.

Administrative burden. The current rule, Minnesota Rules Part 5220.2590, subp. 2 requires the health care provider to submit medical information routinely for every patient on the prescribed form to the insurer (if known) or to the division, if the insurer is not known. Workers' compensation claimants are a very small proportion of most health care providers' business and it is inefficient to require routine completion of the entire form on any patient that alleges to have a workers' compensation injury, whether or not the insurer needs the information to administer the claim. Further, payers have indicated that they prefer not to receive reports which have not been requested because of the resulting filing problems.

Many payers surveyed indicated a preference for narrative medical reports because more detailed information is included than is available from the currently prescribed forms, the Physician's Report and Report of Maximum Medical Improvement. Health care providers have complained that the forms ask questions requiring narrative responses yet provide inadequate space to reply. Further, health care providers on the MSRB indicate that the information required by the forms is generally contained in their narrative reports and it is a duplication of effort and an additional administrative cost to transfer the information from the narrative to the form. Redesigning a report form to include the information most needed by employers, insurers and DOLI, while making the form easier and faster for health care providers to complete, will facilitate rapid exchange of needed medical information. Also, by allowing a health care provider to submit a narrative report in lieu of completing a form, the information may be more complete and provided more quickly.

Charges for required medical reporting. Payers and health care providers are often confused about what reports must be completed without charge. This confusion has created ill will between providers and payers, and has added costs to the workers' compensation system by way of administrative costs and litigation costs. By clarifying in the rules what information is required to be reported by a health care provider and by prohibiting charging for this information (whether provided on a report form or in a narrative format) these disputes may be avoided.

Nature of Proposed Rules and Rationale:

Subpart 1. Scope. This subpart identifies the scope of the rule: the information the health care provider is required to submit to the employer and insurer or the Commissioner. The rule does not restrict an employer, insurer, or the Commissioner from requesting any additional information pursuant to Minnesota Statutes, section 176.231, subdivision 4.

Subp. 2. Health Care Provider Report. The Health Care Provider Report, a single form, replaces both the Physician's Report required by Minnesota Rules Part 5220.2590, subp. 2, and the Report of Maximum Medical Improvement, required by part 5220.2590, subp. 3. The name of the report was changed to Health Care Provider Report because not all treatment is directed by a medical doctor. This report is authorized by Minnesota Statutes, section 176.231, subdivisions 3, 4, 5, 6, and 7. A draft of the proposed form is attached.

This subpart identifies a time frame of 10 days within which a health care provider must respond to a request for required information. Ten days was considered a reasonable period for a health care provider to turn around a request for information and also meet a payer's need for prompt information. Further, a 10 day time limit is in accordance with penalty provisions of Minnesota Statutes, section 176.231, subdivision 10 and Part 5220.2830, subp. 1.

This subpart also attempts to reduce the paperwork burden within the system. Instead of requiring the health care provider to automatically report on every injured worker treated, the provider is only required to report when the employer, insurer or Commissioner requests information. This reduces the paperwork burden on the health care provider. It also reduces the paperwork received by the insurer and the Commissioner to that information which is necessary to properly manage and monitor claims. Use of one form reduces the administrative costs in that only one form would need to be stocked by the payers. It is also more efficient, where maximum medical improvement or permanent partial disability is determined early in the claim, to include all the information on one form.

This part allows the health care provider to respond to a request for required information on the Health Care Provider Report Form or with a narrative report which contains the same information. A health care provider is not required to provide the information in narrative form, but may do so if it meets the needs of the parties and the provider for prompt, meaningful information. This choice allows the health care providers to avoid duplicating information contained in narrative reports on a prescribed form. In some cases payers prefer narrative reports because the information is more extensive.

The Physician's Report and Maximum Medical Improvement Report forms may be used until January 1, 1994 in order to allow the payer and provider time to develop their procedures to implement the new communication requirements.

This rule specifies the prescribed form and the basic information that a health care provider is required to report upon request pursuant to Minnesota Statutes, section 176.231, subdivisions 3, 4, 5, 6, and 7. The information required by the rule is consistent with statutory requirements regarding reporting to DOLI the nature and extent of the injury and treatment to facilitate proper payment of compensation. Additionally, consideration was given to information most useful to payers. Table 1 outlines the required information on the Health Care Provider Report Form.

Table 1. Required Information on Health Care Provider Report Form

DATA ELEMENT	RATIONALE/USE
Information identifying the employee, employer, and insurer.	Information is necessary for all parties and DOLI to identify claimant.
Date of the first examination for the injury or disease by that health care provider.	Information assists in evaluating and managing the claim. Indicates whether the health care provider is a new provider to the case.
Diagnosis and ICD-9-CM Code	The medical diagnosis assists in evaluating the nature of the claim. The machine readable shorthand code for diagnosis (ICD-9-CM) can be used in data analysis and bill review. The ICD (International Classification of Diseases) coding system is widely used by providers and is accepted or required by payers of health care services.
History of the injury or disease as given by the employee.	Information is useful in determining compensability of a claim. It is used by DOLI to monitor denials of liability.
Relationship of the injury or disease to employment.	Information is necessary to evaluate compensability of the claim.
Information regarding any pre-existing or other conditions affecting the employee's disability.	Information is helpful in determining compensability of the claim and apportionment issues. DOLI monitoring unit also needs this information to evaluate whether a permanent partial disability payment is accurate.
Information about future treatment or referrals; surgery performed.	Information assists case management and also helps payers and DOLI evaluate the accuracy of the maximum medical improvement and permanent partial disability opinion rendered.
Information regarding the employee's ability to work; a copy of the most recent Report of Work Ability.	The insurer may require a copy of the most recent Report of Work Ability from a health care provider because the employee may not have submitted a Report of Work Ability for some time. This information is necessary to facilitate return to work.
Information regarding the employee's permanent partial disability rating.	Information is necessary for proper payment of benefits pursuant to Minnesota Statutes, sections 176.021, subdivision 3a, and 176.101.
Information regarding whether the employee is unable to return to former employment.	Information is necessary to determine eligibility for benefits pursuant to Minnesota Statutes, section 176.101, subdivision 3t(b).
Information regarding maximum medical improvement.	Information is required pursuant to Minnesota Statutes, section 176.101, subdivision 3e.
Signature, license or registration number and address of the health care provider.	Information identifies and authenticates the health care provider completing the report.

Subp. 3. Maximum medical improvement. Minnesota Rules Part 5220.2590, subp. 3 is repealed and replaced by this subpart. The information required by the proposed rule regarding maximum medical improvement and permanent partial disability are included in the Health Care Provider Report Form.

The maximum medical improvement section is intended to clarify for health care providers, employers and insurers what it is meant by "maximum medical improvement" as stated by the Minnesota Supreme Court. Maximum medical improvement is both a medical and legal concept. Hammer v. Mark Hager Plumbing & Heating, 435 N.W.2d 525 (Minn. 1988). The definition of "maximum medical improvement" from Minnesota Statutes, section 176.011, subdivision 25, is included on the form to assist portion in the accurate application of the law. The concept of maximum medical improvement was codified in Minnesota Statutes, section 176.101, subdivision 3e, effective for injuries on or after January 1, 1984. However, the health care provider may also be asked to report maximum medical improvement where an injury occurring before January 1, 1984 contributes to a subsequent injury. Hammer.

Although other questions of the Health Care Provider Report form need to be answered only upon request, a health care provider is required to report when an employee has reached maximum medical improvement. This requirement is the same as set forth in Minnesota Rules, Part 5220.2590 (repeal proposed). Because the date of maximum medical improvement is a controlling legal event, affecting entitlement to benefits under Minnesota Statutes, section 176.101, the health care provider must report maximum medical improvement as soon as it is determined. To require the insurer to estimate when maximum medical improvement has been reached, and to query all providers at various times, is not reasonable.

The Court referenced the factors to be considered by the health care provider in determining whether an employee has reached maximum medical improvement as set forth in the Department of Labor and Industry handbook, Health Care Provider's Guide to the Minnesota workers' compensation system. 11-12 (rev. ed. 1987) Hammer at 639. Because this handbook is out of date in other areas, due to recent legislation, and there has been much case law further refining the concept of maximum medical improvement, rules are appropriate. The rules set forth the basic principles discussed in the handbook and as applied in case law, including the history of improvement, current treatment, and proposed treatment. Although workers' compensation judges and providers will continue to make determinations on an individual basis, these rules are expected to provide general guidelines for providers to use in making determinations of maximum medical improvement.

Item A. The "employee's condition" and "functional status" are defined based on recommendations of the health care providers on the workers' compensation Medical Services Review Board and members of the Medical Committee of the International Association of Industrial Accident Boards and Commissions (IAIABC). These terms are used in the items which follow. This item defines the employee's "condition" to include signs, symptoms, findings and functional status that characterize the complaint, illness or injury. This is an appropriate definition, because all these factors constitute the nature of an injury, and may be relevant in determining whether maximum medical improvement has been reached.

Subitem 1 specifies the factors which indicate that maximum medical improvement has

been reached.

Unit (a) requires consideration of the history of treatment and proposed treatment. If neither of these indicate significant lasting improvement is likely, an employee may have reached maximum medical improvement. Because some providers expect that maximum medical improvement means full recovery, a clarification is added that maximum medical improvement may have been reached even if there is some ongoing minimal treatment for management of symptoms. See, Wittrock v. Bor Son Construction, 40 W.C.D. 395 (1987) (S. Aff'd. 11/2/87).

Unit (b) provides that maximum medical improvement may have been reached if all diagnostic evaluations and treatment options that may reasonably be expected to improve or stabilize the condition have been exhausted or declined by the employee. The concept of stabilization is one that has been reflected in several cases. See, Polski v. Consolidated Freightways, 39 W.C.D. 740 (1987); Peterson v. Mills Enterprises, 40 W.C.D. 963 (1987) (S.Aff'd. 4/87); Wilson v. Decker Lumber Co., 46 W.C.D. 319 (1991) (S. Aff'd. 3/25/92); Korthals v. McNeilus Truck Manufacturing, (WCCA 5/19/92). Additionally, if no further treatment is available, either because all options have been tried or because an employee declines further treatment, maximum medical improvement likely has been reached. An example is when an employee decides against surgery that might, if performed, further improve the employee's condition. A further evaluation that is likely to lead to treatment that will improve the employee's condition may mean the employee has not reached maximum medical improvement. Fontaine v. Johnson Bros. Corp., 45 W.C.D. 370 (S. Aff'd. 10/31/91); Decker, supra.

Units (c) and (d) reinforce that ongoing treatment does not necessarily mean the employee continues to improve. For instance, a person with a serious, permanent injury who is receiving treatment to prevent complications may have reached maximum medical improvement. Similarly, if treatment is designed to simply temporarily relieve symptoms or maintain the employee's condition without significant lasting improvement to the underlying condition, maximum medical improvement has likely been reached. Heiderscheit v. Sanborn Manufacturing, (WCCA 12/1/89).

Item 2 specifies that the converse of the factors set forth in item 1 may be an indication that maximum medical improvement has not been reached, for the reasons set forth above.

Item B. This item provides that when more than one year has elapsed since the date of a musculoskeletal injury, the relevant factors in determining maximum medical improvement (MMI) are whether a decrease is anticipated in the estimated permanent partial disability (PPD) rating or whether improvement is anticipated in the employee's work ability. This rule is necessary because, despite medical evidence that MMI is generally reached well within one year for these injuries, the workers' compensation system continues to receive disputes about MMI issues beyond this time period, resulting in unnecessary litigation and delay in benefit resolution.

The time period of one year is selected because, from a medical perspective, maximum improvement of a musculoskeletal injury is almost always reached sooner than one year. As noted above, attainment of MMI does not preclude further treatment, but rather is an indication that, even with additional treatment, "no further significant lasting improvement to a personal injury can reasonably be anticipated, based upon reasonable medical probability."

MMI is a legal, as well as medical, concept, and is significant in workers' compensation because it governs eligibility for certain benefits. Hammer, supra. Therefore, musculoskeletal injuries are not typically analyzed in the medical literature in terms of maximum medical improvement. However, medical literature does address expected treatment and disability periods for these injuries, which are indicative of whether further improvement can be anticipated based on reasonable medical probability.

The workers compensation treatment standards were adopted in May, 1993. Minnesota Rules, parts 5221.6010 to 5221.6500 [Emergency]. The treatment parameters as adopted were approved by the Minnesota Medical Association and the workers' compensation Medical Services Review Board. After extensive review and comment by medical specialists and others in the medical community familiar with workers' compensation injuries, the rules set forth parameters for appropriate treatment of the most common workers' compensation injuies, primarily low back and upper extremity disorders. Under these treatment parameters, initial non-surgical management for most upper extremity disorders and low back disorders is expected to end at 12 weeks; at that time, evaluation is made for chronic management or surgery. Chronic management and surgery are expected to be completed within 12 months under the rules. (Initital nonsurgical management for some upper extremity disorders can continue for up to 12 months, at which time surgery must be considered.)

Medical literature provides additional support for the one year time period. For instance, Presley Reed, M.D., in consultation with other medical experts, has developed guidelines for expected periods of disability for most musculoskeletal injuries.[1] He defines disability as "a state in which the individual is unable to perform his/her job at the same level and efficiency as before the illness or injury occurred."[2] No musculoskeletal injury is given an expected length of disability greater than 16 weeks for medium work activity. Although he does not establish expected periods of diability for heavy work activity or for severe injuries, he defines permanent disability as "a length of disability greater than 52 weeks."[3] This indicates that further improvement after 52 weeks is not likely.

Also supporting that treatment is likely to be completed for musculoskeletal injuries within one year are The Minnesota Chiropractic Association Standards of Practice.[4] These establish parameters for the treatment of many musculoskeletal injuries; none of the parameters indicate that chiropractic management beyond one year is expected for any of the

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[1] The Medical Disability Advisor; Workplace Guidelines for Disability Duration. Horsham, Penn: LRP Publications, 1991.]

[2] Id at xxvi

[3] Id. at xxvii

[4] Minnesota Chiropractic Association; Roseville, MN: 1991.

musculoskeletal injuries cited.[5]

The adopted workers' compensation treatment parameters and the medical community support that the expected treatment and disability for most musculoskeletal injuries is significantly less than one year. Therefore, where MMI has not been reached within that time, it is appropriate to evaluate these injuries more carefully.

The rule provides that the only relevant factors in determining MMI after one year are whether there is likely to be a decrease in the estimated PPD rating, or an improvement in work ability. These are factors which are an objective measurement of "significant and lasting" improvement after all reasonable treatment to improve the condition should have been exhausted, according to established medical standards of expected treatment and disability periods. Documenting objective improvement in these areas allows for individual determinations of MMI later than one year in medically unique or complicated cases, while removing other, less quantifiable factors that are difficult to measure and that, based on reasonable medical probability, are not likely to significantly change after a year of treatment.

The rule also provides that if there is not an improvement in the estimated PPD rating or work ability within any 3 month period following the injury, MMI is presumed, unless improvement in these areas is later established. This period is reasonable to avoid further delay in determining MMI where the improvement is merely speculative. The definition of MMI provides that it is reached where no significant, lasting improvement is reasonably anticipated, based upon reasonable medical probability. Where MMI has not been reached within one year, and there has been no further change in three months, it is reasonable to presume, consistent with the prevailing medical evidence, that further significant, lasting improvement is not likely.

The rule only applies to the musculoskeletal conditions listed in the workers' compensation permanent partial disability schedule because the schedule is comprehensive for almost all musculoskeletal injuries that occur in workers' compensation. This will promote consistency in determining whether an improvement in the employee's PPD rating is likely. Not all musculoskeletal injuries can be expected to maximally improve within the one year time period. For example, where surgery is necessary, the likely recovery period will be delayed. Additionally, for critical conditions such as head injuries and spinal cord injuries, the expected period of MMI is difficult to anticipate, and may extend beyond one year. Therefore, these are exceptions to the rule.

Item C. Notice to the employee of maximum medical improvement. The insurer is required to serve notice of maximum medical improvement on an employee under Minnesota Statutes, section 176.101, subdivision 3e. This item addresses the problem of notice to the employee when a narrative report indicating that maximum medical improvement has been

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[5] Other sources supporting that treatment is likely to be completed for musculoskeletal injuies well within one year include Clinical Policies, American Academy of Orthoepedic Surgeons, Park Ridge, Ill. 1991; and Richard Doyle, M.D., Healthcare Management Guidelines, Return to Work Planning, San Diego: Milliman and Robertson, 1991.

reached is served on the employee. The employee may not be aware of the significance of the maximum medical improvement report to his or her claim. The workers' compensation appellate courts have consistently held that timely, adequate notice to an employee of the significance of maximum medical improvement is crucial. Busso v. Transfleet Enterprises, 40 W.C.D. 19 (1987), Larsen v. Pace Dairy Foods, 41 W.C.D. 167 (1988). The prescribed Health Care Provider Report Form specified in subp. 1 will include instructions to the employee if maximum medical improvement is served using the form. Because a narrative report does not include information on the form, item C requires an insurer to send a cover letter notifying the employee of the significance of the narrative report of maximum medical improvement when the Health Care Provider Report form is not used, or when the Notice of Intention to Discontinue (which also provides additional information) or Petition to Discontinue is not served. The information required in the cover letter will inform the employee of the significance of the attached narrative report. By explaining the process and the significance of maximum medical improvement to the employee, prompt resolution of disputes may be facilitated. Table 2 indicates the information required in the cover letter and the rationale.

Table 2. **Required Information in the Cover Letter for the Maximum Medical Improvement Narrative Report.**

DATA ELEMENT	RATIONALE/USE
Information identifying the employee.	Information is necessary to identify the claimant and the workers' compensation case.
Information identifying the employer and insurer.	Information identifies the employer and the insurer who are serving the maximum medical improvement report on the employee.
The date the report was mailed to the employee.	The date is significant in that service of the report commences the 90 day time frame at the end of which temporary total disability benefits cease (Minnesota Statutes, section 176.101, subdivision 3e).
The statement that the attached report indicates that maximum medical improvement has been reached and specifies the date.	Statement informs that in the health care provider's opinion maximum medical improvement was reached as of a specific date. This information assists the employee in evaluating the appropriateness of the opinion.
The definition of maximum medical improvement.	Definition informs the employee of the statutory meaning of the term "maximum medical improvement."
Statement that there may be an impact on the employee's benefits and instructs the employee where they may have questions answered.	This informs the employee of the significance of the maximum medical improvement report in relation to temporary total benefits and informs the employee where questions may be answered. Facilities prompt resolution of disputes.

Subp. 4. Permanent Partial Impairment. Some health care providers are reported to routinely delay rating even minimal permanent partial disability until a year or so after an injury and this delays prompt payment of appropriate benefits. This subpart requires a health care provider to render an opinion on permanent partial disability when ascertainable but no later than the date of maximum medical improvement, at which time the rating should be ascertainable, because the employee's condition is not likely to further improve. Prompt reporting is facilitated by including permanent partial disability rating information with the maximum medical improvement information on the Health Care Provider Report form; this is consistent with the existing rule and form (see Minnesota Rules Part 5221.2590, subp. 3). Permanent partial disability information may be included in a provider's narrative report, for the reasons cited earlier.

Because there are several permanent partial disability schedules in effect based on the employee's date of injury, the health care provider is instructed that the rating must be based on a correct schedule and the appropriate category must be reported. The provider must also indicate ratings of zero since this informs the payers that permanent partial disability has been evaluated. Prompt reporting of a permanent partial disability rating will assist the payer in complying with statutory requirements for payment of permanent partial disability.

This section also addresses the situation where a primary provider may not feel capable of complicated determinations of permanent partial disability. The situations cited are typically where ratings may involve separate sections of the schedule, making a rating more difficult. Where only one section of the permanent partial disability schedule is involved, the health care provider should be able to accurately rate the condition. The section allows the provider to refer the employee to another provider for the purpose of determining a complicated rating, but the primary provider must be available to consult regarding the nature of the condition and must provide records at no charge. This will ensure referrals are made only when necessary, and will minimize the costs of such a referral while facilitating accurate ratings.

Subp. 5. Required reporting to Division. DOLI considered what information is necessary to perform its benefit monitoring function as required by Minnesota Statutes, sections 176.231, subdivision 6 and 176.251. The Department requires filing of permanent partial disability information because this is needed to properly monitor the closing of claims. Maximum medical improvement reports are required to be filed with the Division in accordance with Minnesota Statutes, section 176.101, subdivision 3e(c). Also, health care provider reports may be requested by the Commissioner at additional times to monitor compliance under Minnesota Statutes, section 176.231, subdivisions 3 and 4. The ICD-9-CM diagnostic code is required for DOLI to monitor trends in workers' compensation injuries and medical care in accordance with Minnesota Statutes, section 176.103, subdivisions 1 and 2.

Subp. 6. Report of Work Ability. Minnesota Statutes, section 176.231, subdivision 5 requires the Commissioner to prescribe forms for required information. Under Minnesota Statutes, section 176.231, subdivisions 3, 4, and 6 the health care provider is required to provide information about the nature and extent of an employee's injury or disability. The Report of Work Ability is a new requirement which is intended to properly communicate to employers and insurers the information necessary to plan return to work for an injured worker. A draft of the proposed form is attached to this statement.

This subpart identifies which health care providers must complete the work status report. By limiting the requirement to those health care providers independently directing and coordinating the course of treatment confusion over possibly differing opinions of providers may be reduced. For example, if an M.D. is directing treatment but a physical therapist is treating under that physician's referral only the M.D. would complete the Report of Work Ability.

Item A. This item identifies the required frequency of completing a Report of Work Ability. Here the rule is intended to reconcile the employer and insurer's need to know the employee's work status as soon as possible to promote a prompt return to work, with the health care provider's need to keep paperwork to a minimum. Beyond payer input, the frequency of reporting was determined through discussions with medical and chiropractic providers since these two groups have different practice patterns. Where an M.D. may see a patient every two weeks or every month, a chiropractor may initially provide treatment several times a week. Reporting work status several times per week when there is little or no change may be burdensome and unnecessary. The requirement to file a Work Ability Report at the prescribed frequency may be waived when restrictions are documented as permanent. Open-ended durations of disability are not allowed because constant monitoring of an employee's status is crucial to effective case management and return to work.

Item B. To accommodate the preferences and current practices of both providers and payers the health care provider may submit the required information either in a narrative report which may include the provider's own format, or on the Report of Work Ability, the form prescribed by the Commissioner. Many providers have developed reporting formats which describe restrictions and capabilities specific to the condition(s) they commonly treat, e.g., detailed hand function or back function. Therefore, flexibility is given to accommodate other formats which may be more useful and informative.

The work ability information required to be submitted was identified through discussions with the MSRB, the Workers' Compensation Administrative Task Force, and qualified rehabilitation consultants. The information required by the Report of Work Ability is identified in Table 3.

Table 3. Required Information on the Report of Work Ability

DATA ELEMENT	RATIONALE/USE
Information identifying the employee, employer, and insurer.	Information is necessary to properly identify the claim for the parties.
Date of most recent examination.	Information identifies the examination on which the report is based.
Information regarding whether the employee is able to work and any restrictions.	Information is necessary to determine if employee is disabled or able to return to work in some capacity.
Nature of restrictions.	Information is necessary to develop a job for an injured employee that is within physical restrictions.
Date any disability or restriction of work activity is to begin and the anticipated ending date.	Information identifies expected period of disability which will assist the employer and qualified rehabilitation consultant in planning a return to work for this employee. It will also help the payer to determine any benefits that may be due the employee.
Date of next scheduled visit.	Information assists in medical and vocational planning.
Signature, license or registration number and address of health care provider.	The information identifies and authenticates the health care provider completing the report.
Notice to the employee that the report must be provided to the employer, insurer and qualified rehabilitation consul	This statement is necessary to notify the employee that he/she is required to submit this report to the employer, or insurer, and qualified rehabilitation consultant. This encourages the employee to be an active participant in the return to work effort, and places responsibility on the employee to communicate about return to work with the necessary parties.

Item C. This section specifies that the Report of Work Ability must be based on the health care provider's most recent evaluation of the employee which will include the objective and subjective information considered by the health care provider in forming an opinion. An opinion should not be based solely on what would be expected in a typical patient with this condition, or solely on a patient's subjective statements.

Item D. In an effort to actively involve the employee in the return to work process and to maintain communication between the health care provider, employee and the employer, the employee is required to submit the Report of Work Ability to the employer or the insurer, and the qualified rehabilitation consultant. This minimizes the employee's experience as a passive participant, and the sense that others are controlling the process. This also removes from the health care provider the administrative task of conveying the return to work information. By requiring that the health care provider retain a copy of the Report of Work Ability in the medical records, the information is available to any other requesting party, including the Commissioner.

Subp. 7. Charge for required reports. This subpart continues the requirement of the existing rule, part 5221.2590, subp. 4 that prohibits a health care provider from charging for completing the Health Care Provider Report or the Report of Work Ability forms, or any narrative report prepared in lieu of these forms. Both payers and providers contacted agreed that there should be no charge for submitting the required information if these submission requirements could be filled via either the form or a narrative report. Further, since the information on the form is required by the insurer to administer the claims and by the Department to monitor claims there should be no charge for this reporting. On the other hand, the provider may charge a reasonable amount for reviewing medical records and preparing a report in response to a request for additional information (i.e., supplementary reports).

Subp. 8. Proper filing of documents with the division. Employers and insurers as well as DOLI have expressed interest in reducing the paper flow in the workers' compensation system. Many insurers and employers submit information by facsimile now and the Department is actively investigating electronic transmission of data. Since the Department's business hours are 8:00 a.m. to 4:30 p.m., facsimiles received after business hours are deemed received as of the next business day. If the electronically or faxed document is of poor quality, DOLI may require the original to be filed to ensure accurate information is filed and retained.

The rule requires that any narrative report filed with the Division identify the claim and the reason the report is filed. Such identification will facilitate proper, efficient handling of the more than 30,000 medical documents received by the Department annually. For instance, the law requires maximum medical improvement reports and permanent partial disability ratings to be filed. If DOLI received a lengthy report of several pages discussing many medical issues, it may not be apparent that maximum medical improvement has been filed.

PART 5221.0420 HEALTH CARE PROVIDER PARTICIPATION WITH RETURN TO WORK PLANNING.

This rule is intended to clarify the role of the health care provider in return to work planning and to improve communication regarding return to work issues between the health care provider, the employer, the insurer, and the qualified rehabilitation consultant.

Need for the Proposed Rule:

Health care providers need to fully participate in return to work planning. Some health care providers are not fully aware of their responsibility to facilitate a return to work for injured workers. Throughout their training health care providers traditionally focus on treatment and are less aware of the return to work component of workers' compensation. Thus they may not communicate medical information to the employers and insurers who are attempting to return the employee to work as soon as possible. Timely transmission of this return to work information is important so that a job may be offered as soon as possible in accordance with Minnesota Statutes, section 176.101 and the employer and insurer's liability for unnecessary benefits may be contained.

When a job has been developed for an employee, the insurer, employer or qualified rehabilitation consultant may need an opinion regarding whether a job offered to an employee is within the employee's physical restrictions. Since under Minnesota Statutes, section 176.101, subdivision 3e, the employer and insurer have only 90 days after maximum medical improvement to make a suitable job offer, it is critical that the health care provider gives the necessary input within a reasonable period of time.

Health care providers need to provide necessary information to qualified rehabilitation consultants. Qualified rehabilitation consultants complain that some health care providers refuse to meet or talk with them about their clients. This communication is required for a successful rehabilitation plan since the qualified rehabilitation consultant coordinates return to work efforts among the employee, the health care provider and the employer and insurer. The qualified rehabilitation consultant must have prompt, accurate information regarding the employee's ability to work and any restrictions in order to facilitate the return to work. On the other hand, health care providers have indicated that they do not have time to unnecessarily communicate with qualified rehabilitation consultants, and that the information is oftentimes already in their notes which the qualified rehabilitation consultant may have access to upon request. The Training Content Advisory Committee of Rehabilitation Professionals (a rehabilitation professional group that plans qualified rehabilitation consultant training programs with the Department of Labor and Industry) felt the issue was so important, they identified communication with health care providers regarding vocational management as a primary topic of concern to be addressed in training programs.

Some health care providers require payment in advance of scheduling a meeting with a qualified rehabilitation consultant. This policy creates barriers to effective and timely communication about rehabilitation and the employee's work status. Important information may be delayed for up to several weeks resulting in a delayed return to work. Furthermore, this policy creates cash flow problems for qualified rehabilitation consultants since the required prepayment sometimes exceeds $100. The qualified rehabilitation consultant must make the prepayment and then bill the charge back to the insurer, or, the qualified rehabilitation consultant may request an advance from the insurer. Either way, prepayment delays the meeting.

Nature of the Proposed Rules:

Subpart 1. Cooperation with vocational rehabilitation. This subpart identifies a

primary responsibility of health care providers working within the workers' compensation system to participate actively in the vocational rehabilitation process which has the goal of returning an employee to work.

Eighty-five percent of indemnity claims are managed by the employer and insurer without the assistance of a qualified rehabilitation consultant. This section requires the health care provider to respond within a 10 calendar day period to a request from an employer, insurer or employee regarding whether the physical requirements of a job offer are within the employee's medical restrictions given the importance of the provider's opinion to the return to work effort. The 10 day time frame is considered a reasonable time for a health care provider to respond to a request for input on a job offer and is consistent with other health care provider reporting obligations. Further, Minnesota Statutes, section 176.101, subdivision 3e(e) allows that an employee has 14 calendar days after receipt of a written description and offer to accept or reject a suitable job offer. The 10 day time frame will allow the employee an opportunity to discuss a job offer with a health care provider prior to making a decision about accepting or rejecting the job.

This subpart allows the provider flexibility in responding in person, in writing or by phone. A provider may wish to have a clearly documented description of a job so there is no misunderstanding of the requirements of the job being proposed. Disputes have often occurred where the job that a provider may have approved is not the job that was actually offered to an employee or actually assigned to that employee. To avoid this problem the health care provider may request a written description of the job or agree to view a videotape of the job prior to giving an opinion. The rule is flexible to allow the employer, insurer, employee and health care provider to determine the best avenue of communication.

Subp. 2. Communication with qualified rehabilitation consultant.

This subpart reconciles the need of the qualified rehabilitation consultant to meet with the health care provider to obtain information relative to vocational rehabilitation, with the health care provider's need to limit the qualified rehabilitation consultant's demand on the provider's time. The rule allows flexibility for the most appropriate communication between the provider and the qualified rehabilitation consultant. The rule specifies the times in vocational rehabilitation when the health care provider's input is critical to the success of a rehabilitation plan. These times were agreed upon by committees of the MSRB and rehabilitation professionals associated with the Rehabilitation Review Panel.

Item A: The doctor/patient relationship as well as patient right to privacy is protected by clearly requiring that the patient's authorization is necessary for a qualified rehabilitation consultant to obtain information from a health care provider. Minnesota Rules Part 5220.1802, subp. 5 prohibits a qualified rehabilitation consultant from communicating with a health care provider without written consent of the employee.

This section requires the health care provider to respond within ten calendar days of a request for communication from a qualified rehabilitation consultant when any of the circumstances listed in B occur. The ten days allows the health care provider a reasonable response time while minimizing the delay in developing a rehabilitation plan. The health care

provider is also given flexibility to choose the manner of response (meeting, phone or written). Where the issue is a job being proposed the health care provider may request documentation of the proposed job in written description or agree to view a videotape to reduce disputes.

Item B. This section identifies and limits the circumstances under which the health care provider must respond to a request for communication from the qualified rehabilitation consultant. These circumstances include:

- Upon initial assignment of a qualified rehabilitation consultant, the newly assigned qualified rehabilitation consultant may need medical information which is not in the record to develop a rehabilitation plan.

- After the initial communication the health care provider is not required to respond more often than once every 30 days. More frequent communication is unnecessary unless one of the following occur:

  (1) When an opinion is requested regarding whether the physical requirements of a proposed job are within the employee's physical restrictions, the qualified rehabilitation consultant needs a prompt response from the health care provider to facilitate prompt return to appropriate work.

  (2) An unanticipated or substantial change in the employee's condition will affect the rehabilitation plan and the qualified rehabilitation consultant is responsible for accommodating such changes.

  (3) When job search is initiated, prompt information from a health care provider is necessary regarding the employee's abilities in order that appropriate jobs may be targeted.

  (4) The provider's input is necessary when there has been a change in the employee's work status. For instance, if the restrictions need to be re-evaluated, the reasons for the change in work status or restrictions and any changes in the treatment plan should be communicated to the qualified rehabilitation consultant so that the rehabilitation plan may be modified appropriately. Further, this information is needed by the insurer so appropriate benefits may be paid.

Subp. 3. Reimbursement for services. This section addresses the problem of a few health care providers who require prepayment for conferences with the qualified rehabilitation consultant prior to scheduling the meeting. As stated earlier prepayment creates cash flow problems for the qualified rehabilitation consultant and delays necessary communication. Payers have indicated a preference for being billed directly by the health care provider for this service and the MSRB has expressed its opposition to the practice of prepayment and the resulting delay in furthering the vocational rehabilitation process. Appropriate procedure codes for this case management consulting service are identified to assist providers and payers with reimbursement.

5221.0430 CHANGE OF HEALTH CARE PROVIDER.

Minnesota Statutes, section 176.135, subdivision 2 requires rules to establish standards and criteria for determining a change of doctor. The previous Minnesota Rules Part 5220.2620, subp. 7, which broadly sets out the procedure and a "best interest of the parties" standard for change of doctor is repealed and replaced with more detailed information concerning the process to change providers and the criteria for approval in the event of a dispute. When an employee can change doctors is often the subject of litigation, and clear specific guidelines are necessary to identify for the parties when a doctor becomes a treating doctor and the circumstances under which a change is counterproductive or inappropriate.

Subp. 1. Primary health care provider. This subpart codifies current practice. In order to avoid conflicting decisions among judges and confusion among the parties, this paragraph sets out a description of the primary health care provider. For some time, workers' compensation parties have debated when a provider becomes the treating doctor, the primary health care provider. The rule indicates that when the employee returns for treatment the employee is choosing that health care provider as the primary provider. However, if the practitioner with whom the employee treats does not coordinate all of the employee's medical care for the injury, it would not be appropriate to refer to that individual as the primary health care provider. Since a duty of the primary provider is to coordinate the employee's care to avoid duplicate services and unnecessary or inappropriate services, the primary health care provider must be capable of doing so and willing to fulfill that function. Careful coordination of the employee's care promotes recovery, quality care, and cost-effective service. To avoid confusion concerning the selection of services and reimbursement of services, only one primary health care provider may be involved in a case at one time. Pursuant to Minnesota Statutes, sections 176.135, subdivision 1f and 176.1351, an employee covered by a certified managed care plan must receive care from plan providers. The employee's selection of a doctor under the managed care plan is governed by these statutes and Minnesota Rules, chapter 5218.

Subp. 2. Change of health care provider. As is the case with the employee's change of a rehabilitation provider, the employee has the option to freely change to another health care provider within the first 60 days of treatment. If the employer participates in a certified managed care health plan, that provider must be selected from participating providers in accordance with Minnesota Statutes, section 176.1351, subdivision 2 (11) and Minnesota Rules Chapter 5218. After one free choice is exercised, further changes of health care provider must be approved by either the managed care organization, the insurer, the Department or a compensation judge.

This section indicates what situations are not considered a change of provider. Consistent with the current practice, referral by the primary provider to another provider is not considered a change of provider, where the referral is the provider's decision. An example would be in a case where complications arise that the initial health care provider feels unable to treat. Likewise, the employee cannot reasonably be said to have exercised a choice for a change of doctor when other circumstances beyond the employee's control necessitate a change from one primary provider to another. As is the case with selection of a rehabilitation provider under Minnesota Statutes, section 176.102, subdivision 4, the selection of a health care provider after the first choice must be approved by the insurer or a decisionmaker in the workers'

compensation system. The rule reasonably balances the employee's right to select appropriate care personally and the employer and insurer's right to manage the workers' compensation claim.

Subp. 3. Unauthorized change; prohibited payment. This subpart sets out the sanction for failing to obtain approval for a change of doctor when required by subp. 2. In order to encourage employees and health care providers to obtain approval for the change in provider, the sanction is lack of payment to the health care provider for failing to do so. Of course, in an emergency situation such prior approval is not necessary. Many workers' compensation judges have historically approved medical treatment retroactively, even where a change of health care provider was not necessary or appropriate. To prevent such a result, the rule creates an incentive for the health care provider and the employee to seek approval of a change of primary health care provider before treatment expenses are incurred. This discourages an employee from seeking duplicative care or care similar to treatment rendered by a previous health care provider before the insurer is even aware that the employee is seeking additional treatment. While it is understandable that an employee may wish to seek treatment from another source where excellent results have not been obtained from the first provider, a change of provider is not always in the employee's best interest. Since rising medical costs are a significant portion of the workers' compensation dollar, an effort is made in these rules to contain unnecessary costs as directed by the 1992 Legislature.

Subp. 4. Change of primary provider not approved. This subpart lists the situations in which a change of primary health care provider should not be approved. A change of doctor is not in the parties' best interests where the employee is simply seeking to avoid appropriate treatment, is doing so at the request of an attorney or other professional as a litigation strategy instead of for medical reasons, or the treatment is at a great distance from the employee's residence and comparable treatment is available at a more reasonable location. Change of doctor requests are also appropriately denied where the desired provider lacks the expertise to treat the employee's injury or where the employee has been released from treatment and no further treatment is advisable. The sixth rule factor is the general test contained in existing rule that a change of doctor should not be allowed if it is not in the best interests of the parties. This list is not meant to be exhaustive. There may be other factors that are also significant; these reasons summarize the major bases upon which the decisionmaker should deny a request for a change of doctor. The basic principle is that the employee is entitled to treatment that is reasonably required for that employee's injury. This treatment may likely be obtained from a number of qualified providers. The above factors do not interfere with the employee's right to reasonably required treatment and therefore are not a basis to change doctors.

PART 5221.0500 EXCESSIVE CHARGES; LIMITATIONS OF PAYER LIABILITY.

Minnesota Rules Part 5221.0550 is repealed because the provisions on excessive services are incorporated into the amended rule on excessive charges. This single rule pulls together concepts of excessive charges from the previous provisions in part 5221.0500 and 5221.0550, as appropriate, with the excessive charge provisions in the 1992 amendments to Minnesota Statutes, section 176.136, subdivision 2, and proposed rules. Employer liability is distinguished from excessive charge rules based on amendments to Minnesota Statutes, section 176.136, subdivisions 1, 1a, 1b and 2. This part will clarify for payers and providers the liability

limitations for medical charges.

Nature of the Proposed Rule and Rationale:

Subp. 1. Excessive health care provider charges. This section identifies the conditions under which a billing charge is excessive and therefore for which a payer is not liable. An excessive charge is an inappropriate charge that the provider should not submit for payment. This is distinguished from the payers liability for the cost of treatment, which is established by Minnesota Statutes, section 176.136, and subp. 2.

Items A and B of the current rule are repealed. The provider should always submit his or her usual change, and Minnesota Statutes, section 176.135, subdivision 3 has been replaced by Minnesota Statutes, section 176.136, subdivision 1b(b).

A. This item indicates that charges for articles and supplies, as well as services, which duplicate other billing charges are excessive. Medical articles, supplies and services should be paid for only once.

B. This item clarifies that charges exceeding the provider's usual and customary charge as defined in subpart 2, item B are excessive. This requirement is found in Minnesota Statutes, section 176.136, subdivision 1b(b).

C. This item is renumbered from the existing rule.

D. This item replaces the current item E because it reflects the intent of the treatment parameters (Minnesota Rules [Emergency] part 5221.6010 to 5221.6500), in that services, articles and supplies which are outside the parameters are excessive. pursuant to Minnesota Statutes, section 176.136, subdivision 2.

E. This item refers to Minnesota Statutes, section 176.103 under which providers may be sanctioned by prohibiting them from receiving payment for services rendered for providing inappropriate, unnecessary, or excessive treatment, or any violation under Chapter 176 or rule adopted under this chapter. Minnesota Statutes, section 256B.0644 was enacted as part of the MinnesotaCare law which provides that health care providers must participate in the Medical Assistance program in order to receive payment under the workers' compensation system.

F. This item refers to Minnesota Statutes, section 176.135 and 176.136, subdivision 2 (1992) regarding the standards for determining whether a service is excessive.

G. If the provider violates antikickback statutes a workers' compensation payer should not be liable for those services either. This refers to proposed Minnesota Rules Part 5221.0700, subp. 1a, which reflects the provision in the MinnesotaCare law which adopts the federal Medicare antikickback regulations, and applies those standards to all Minnesota providers.

H. This item refers to proposed Minnesota Rules Part 5221.0430, subp. 3 which prohibits payment for treatment provided prior to authorization for change of provider.

I. This item adds language that indicates that treatment which is outside the scope of the provider or is not recognized as therapeutically valuable treatment, is excessive. The reader is referred to Minnesota Statutes, section 176.136, subdivision 2, clause (3).

Subp. 2. Limitation of payer liability. If charges are not excessive under subp. 1 a payer's liability for payment is limited as described in Minnesota Statutes, section 176.136, subdivisions 1a, 1b and 2. These provisions are included here to simplify payment decisions for the payers, to inform the health care provider, and to coordinate the various statutes and rules into one section.

A. For those services included in the workers' compensation medical fee schedule, payment liability is limited to the maximum allowed by the medical fee schedule or the actual fee whichever is lower. This refers to Minnesota Statutes, section 176.136, subdivision 2a.

B. Where the service is not included in the fee schedule, liability is limited according to the provisions of Minnesota Statutes, section 176.136, subdivisions 1b and c. The terms "usual and customary" and "prevailing charge" are defined for the purposes of workers' compensation in accordance with Minnesota Statutes, section 176.136, subdivision 1b(b). There has been significant confusion regarding these terms and therefore clarification is needed.

"Usual and customary" is defined as the amount actually billed by the health care provider to all payers, whether under workers' compensation or not, and regardless of the amount actually reimbursed. There are a variety of payment contracts for health care providers, and determining what is the usual and customary charge based on many different contacts would be difficult. This definition reflects the concept in Minnesota Statutes, section 176.136, subdivision 1b(b), that the usual and customary charge should not be different for workers' compensation patients than for anyone else. See also, Minnesota Rule part 5221.0700, subp. 1. It is not likely that the legislature intended the 15 percent reduction of usual and customary charges to be a further reduction from the amount reimbursed under a contract with another payer.

Many payers have applied their own database in determining a prevailing charge. Sometimes the database contains nationwide data, sometimes the database includes a variety of provider types. There are many disputes regarding an appropriate basis for prevailing charge determinations. Therefore, a standard is set forth to assist payers in evaluating data and to reduce disputes. This standard is based on the criteria set forth in Minnesota Statutes, section 176.136 for the data set used by the Department of Labor and Industry to develop its charge based fee schedule from 1983 to 1991. The maximum fees in the charged-based fee schedules were set at the 75th percentile. This is determined to be a reasonable basis for the prevailing charge as well. The other requirements adopted from the previous statutory criteria are to ensure statistical validity of the data. Distinctions based on inpatient and outpatient services, and on provider type, are appropriate because the fee schedule required to be adopted under Minnesota Statutes, section 176.136, subdivision 1a makes similar distinctions.

C. & D. The provisions of Minnesota Statutes, section 176.136, subdivision 1a and 1b for hospital charges and nursing home charges are included to reflect the requirements in Minnesota Statutes, section 176.136, subdivision 1b(a) and (b).

E. This item is new and addresses the disputes that have arisen regarding an employer's liability for payment of medical services, articles and supplies being limited to 85 percent under the broad language of Minnesota Statutes, section 176.136, subdivision 1b. This item specifically addresses payment for records and employee travel expenses for medical care. Payment for medical records is governed by chapter 5218 and should not be subject to the 85 percent payment. A reduced payment for records would invalidate the existing rule and discourage providers from submitting records to a payer as they are required to do. This dispute delays transfer of necessary information from the provider to the payer and can delay the employee's return to work.

Employee travel expenses for medical services should not be subject to an 85 percent reimbursement policy because it will leave the employee to absorb the additional 15 percent of the cost of travel, and Minnesota Statutes, section 176.136, subdivision 1b(b) only refers to a reduction of health care provider charges.

F. This item specifies that charges for supplementary reports and return to work services are not subject to the 85 percent reimbursement rule either. Distinguished from required reports in part 5221.0410, supplementary reports are not required, and reducing the charge for these would discourage providers from providing these reports. Such a reduced payment would be a significant obstacle in obtaining necessary health care provider input regarding an employee's condition and work status. Communication between the health care provider and the employer and insurer is essential to management of a claim.

Subp. 3. Collection of excessive charges. This subpart consolidates existing language of Minnesota Statutes, section 176.136, subdivision 2 and rule 5221.0700, subp. 5 (repeal proposed) so all information regarding excessive charges may be easily reviewed by payers and providers. This section also directs the health care provider to remove charges which were determined excessive by the payer from the billing unless a formal request for dispute resolution has been filed. The purpose is to clearly identify the correct balance due and not carry over excessive charges to new billings, which would be confusing to employees and payers.

PART 5221.0600 PAYER RESPONSIBILITIES

Subp. 2. Determination of Excessiveness. This subpart is amended to reflect the consolidation of the excessive charge, excessive service and payer liability rules under Part 5221.0500, consistent with the statutory amendments to Minnesota Statutes, section 176.136. This subpart also allows the payer to assign a correct code to a service if the payer determines the service was incorrectly coded. This is necessary because the payer must be able to interpret and apply the provisions of the fee schedule in order to administer the claim. Notice of any reduction in payment resulting from recoding must be given to the provider and employee under subpart 4, so the provider is able to review and discuss any coding issues with the payer.

Subp. 3. Determination of Charges. Amendments to this subpart are made to reflect the consolidation of the excessive charge, service and payer liability rules into Part 5221.0500, consistent with the statutory changes to Minnesota Statutes, section 176.136. The payer's right to deny a charge that is not submitted on a uniform billing form is necessary due to the addition of this requirement in Minnesota Statutes, section 176.135, subdivision 7. Item B is deleted

because the corresponding statutory provision, Minnesota Statutes, section 176.135, subdivision 3, was repealed.

Subp. 4. Notification. Amendments are made to items B and C for the reasons set forth for amendments to subparts 2 and 3 above. Language is added to item D, consistent with the statutory amendments to Minnesota Statutes, section 176.135, subdivision 6, which require the payer to reconsider charges within 30 days after the corrected submission.

PART 5221.0650 DATA COLLECTION, RETENTION, AND REPORTING REQUIREMENTS.

This part addresses DOLI's need for medical service and cost information for the purpose of monitoring care provided to injured workers and evaluating the medical cost containment program.

Need for the Rule:

Medical data is inadequate for DOLI to perform its monitoring function. DOLI has conducted several studies in the past few years on medical issues related to workers' compensation. The acquisition of accurate and complete medical data was difficult. Currently there is not a uniform method of collecting nor reporting medical data. This makes any type of comparison or analysis of medical information nearly impossible.

There has been no standardization of data elements or format that a health care provider must submit to a payer, nor standardization of data retained by a payer. This lack of standardization prevents aggregation of data across payers and makes any research activity very difficult.

This data is not only necessary for research purposes, it is necessary to implement the monitoring requirements in Minnesota Statutes, sections 175.17, 175.171, 176.103, 176.1351, 176.136, and 176.83. Under these statutes the Commissioner is required to monitor the medical and surgical treatment provided to injured workers. The monitoring shall include determinations concerning the appropriateness of the service, whether the treatment is necessary and effective, the proper cost of services, the quality of treatment, and the right of providers to receive payment for services rendered or payment for future services rendered under this chapter.

Due to these data problems, the Department and the MSRB are unable to fill their research roles with regard to utilization review, quality assurance, and evaluating the clinical consequences of the services provided (Minnesota Statutes, sections 176.103 and 176.83, subdivision 5).

Nature of the Proposed Rule and Rationale:

Subpart 1. Scope. This section identifies which parties are responsible for data collection. The insurers, self-insurers, group self-insurers, adjusters, and third-party administrators who act on behalf of an insurer, self-insurer, the assigned risk plan, and the Minnesota Insurance Guarantee Association are required to collect data because most of the needed data is available on the billing statements sent to the payer by the provider. The payer

generally reviews the bill for accuracy of information in the bill review process, thereby increasing the likelihood of valid information being collected and tracked with an individual claim.

Subp. 2. Purpose. This subpart establishes procedures and requirements for reporting medical and related data regarding treatment of workers' compensation injuries. This data is necessary for the Department to monitor and evaluate the effectiveness of medical and surgical treatment and the services of health care providers, including those providers providing services under the new Managed Care Plans for workers' compensation (chapter 5218) and subject to the newly promulgated treatment parameters (part 5221.6010 to 5221.6500 [Emergency]).

Subpart 3. Retention period. This part requires that specified data must be collected and stored for a period of ten years from the date the service or supply was provided to the employee. A ten year period is required because of the potential for long term case study. The most costly cases in workers' compensation are generally the longer term cases. With the ten year retention span, the Department would be able to follow cases for this extended period of time. The insurers and self-insurers would not be required to maintain the data on active file, but will be allowed to store the data on computer tape or in hard copy.

Subp. 4. Required data. Table 4 lists the data which must be collected from the uniform billing forms, and the rationale. Table 5 lists the data which must be collected and stored in addition to the data required on the uniform billing forms. The rationale for collecting this additional information is included.

This subpart provides that all the data required on the uniform billing forms must also be collected and retained by payers. The rationale is that DOLI must have ongoing claim level data in order to fulfill its statutory mandate to monitor treatment provided to injured workers. The 1992 amendments require the Commissioner to develop standards for treatment; data is needed to develop standards that reflect appropriate care for injured workers as well as to update standards as medical treatment changes.

Table 4. Data to be collected from uniform billing forms. Claim level data includes:

DATA ELEMENT	RATIONALE/USE
Diagnosis	To determine the condition being treated. Necessary to identify norms of treatment specific to a condition.
Date of injury	To determine timing of treatment. Was it provided in acute stage or much later.
Type of primary health care provider	Identify practice patterns of different types of providers. Recognize different scopes of practice.
Date of treatment	Frequency and length of treatment are critical factors in surveying appropriateness of care.
Treatment provided	Nature of service identified. Necessary in developing practice patterns.
Type of provider delivering the service	Some services may be delivered by a variety of providers, including licensed or registered professionals, office staff, or unregulated independent providers. Information helps clean up the data collected on practice patterns.
Place of service	Place of service, i.e., hospital, office, emergency room, can significantly impact cost of a service. Necessary in developing treatment standards.
Charge of each service	Necessary to evaluate the performance of a medical fee schedule.

Table 5. Data to be collected and retained in addition to data required on uniform billing forms.

DATA ELEMENT	RATIONALE/USE
Open or closed claim status.	Necessary to track which services are for which date of injury. Especially important where there are multiple injuries.
Was the employee incapacitated from work for more than three days.	Indicates if indemnity benefits paid. Significant in evaluating the outcome of treatment necessary to access claims with no lost time from work since these are not reported to DOLI.
Amount of payments for individual services, articles, supplies.[6]	Necessary to monitor trends in the charges for a service versus the amount actually paid. Allows evaluation of efforts to control cost per service.
Name of managed care plan if services were provided under such contract.	Necessary to evaluate cost of treatment through a managed care plan and compare with non-managed care plan.

[6] Only a required data element for professional services and supplies billed on uniform billing form HCFA-1500 as described in 5221.0700, subp. 2a. Payments for individual services may differ from the actual charge since the employer may reduce an individual charge for reason of excessiveness. Hospital charges, reported on the UB-92 form in subp. 2b, may be discounted a straight percentage of compensable charges so payment of individual services is not possible.

Subp. 5. Reporting Requirements. DOLI does not need and does not have the capacity to collect all medical data on all injured employees. For this reason, we are only requesting a sampling of data depending upon the research designs and monitoring needs of the Commissioner. These needs will change from year to year and it would not be appropriate to specify and require the reporting of all the potential data. Therefore, DOLI proposes to only require a portion of the data depending on the immediate needs. DOLI and the insurer, self-insurer, or third-party administrator will mutually agree on the standard of information exchange in order to minimize any administrative or technical problems and in an attempt to provide flexibility for the business needs of these entities. This exchange standard may include hard copy, computerized format, or electronic data interchange (a technology coming into widespread use in the insurance industry).

This section also provides that the data maintained by the payers must be reported to DOLI within 90 days of a request for data. Ninety days was discussed with insurers and was considered to be a reasonable time period for the payer to provide the data in the agreed upon format without significantly interfering with the payer's other business activities involving the information system.

This section further specifies that the data will be provided without charge to DOLI. There is no statutory provision for payment for this data under Minnesota Statutes, section 176.82, subdivision 5a.

Part 5221.0700 PROVIDER RESPONSIBILITIES.

The purpose of this rule is to implement federal antikickback regulations with workers' compensation and to mandate transfer of necessary medical information from the health care provider to the payer.

Nature of Proposed Rule and Rationale:

Subp. 1a. Conflicts of interest. The 1992 Legislature enacted, as part of the MinnesotaCare law, Minnesota Statutes, section 62J.23. This statute provides that all health care providers in Minnesota are subject to the Medicare "Antikickback" regulations for any service provided in Minnesota, whether under Medicare or not. These regulations prohibit certain health care provider referral of patients for treatment to facilities in which the health care provider has a financial interest. The concern addressed by that law is that the provider's financial interest results in unnecessary treatment or diagnostic testing. This provision in the MinnesotaCare law, applies to all treatment, including workers' compensation treatment, by Minnesota health care providers. This rule prohibits payment for workers' compensation services delivered in violation of this law. A workers' compensation insurer should not be liable for treatment that is prohibited by federal and state law.

Subp. 2. Submission of Information.

Minnesota Rules Part 5221.0700, subp. 2 is repealed, it is replaced with new wording which standardizes the billing process by requiring the use of two uniform billing forms. This subpart also clarifies when the appropriate record must be submitted.

Need for Subp. 2:

Medical records substantiating the services billed are not routinely submitted to the payer. While Minnesota Statutes, section 176.135, subdivision 7 (1992) requires that a health care provider submit to the payer medical records that substantiates the nature of the charge and the relationship to the work injury, there is confusion over when such records must be submitted.

Indirect billing for services. Some providers include on their billing statements, the services and charges provided by another health care provider under referral from the treating doctor. This combined billing creates difficulties for the payer in determining the reasonable payment for that outside service. For example, charges for a lumbar brace prescribed by the treating provider and ordered from a separate business entity may be billed by the ordering facility. The billed charge may include the cost of the brace to the provider, plus a mark-up of up to 40 percent.

Delayed billing. Bills are occasionally not submitted to a payer for several months during which time significant amounts of treatment may be provided without the payer's knowledge.

Nonstandard billing procedures. Minnesota Statutes, section 176.135, subdivision 5 (1992) requires the adoption of a uniform billing form. Historically, workers' compensation health care providers have been free to submit their bills in whatever format they chose. Given that there are over 8000 medical physicians alone in the state, this means that payers are subject to non-standard billing procedures. Added to the difficulty of processing different formats, billers give information that is inconsistent, incomplete or absent altogether, and unreliable from one health care provider to another. This somewhat erratic billing pattern increases costs and delays claims processing in the workers' compensation system because payers (a) take longer to find information on forms that are markedly different from each other; (b) must follow-up and correct incomplete or inconsistent data; and (c) cannot optically scan and electronically process bills. The result has been that payers complain of their added costs, while billers complain of the long lag time between services rendered and bills paid. Thus, neither the payer nor the biller can efficiently manage the cases.

Costs and treatment data invalid. Finally, given the inconsistent charge documentation procedures, the Department is hamstrung in its efforts to reliably compare cost and treatment data across health care providers to determine necessity, reasonableness and excessiveness. Additionally, workers' compensation billing procedures are inconsistent with other major billing systems, such as Medicare, making comparability of data invalid, if not outright impossible. The Department cannot meet its mandate to review services and charges (Minnesota Statutes, sections 176.103, 176.136 and 176.83).

Nature of Proposed Rule and Rationale:

Subp. 2. Submission of Information. This new language clarifies Minnesota Statutes, section 176.135, subdivision 7 which requires that health care providers submit an appropriate medical record that substantiates the nature of the charge and its relationship to the work injury.

The rule requires that health care providers, except hospitals, submit an appropriate record with the billing statement; hospitals must submit the records upon request of the payer. Documentation to support the change is required by Minnesota Statutes, section 176.135, subdivision 7.

Hospitals are distinguished from other medical services due to the nature of the services provided. The hospital services are often more numerous and of greater variety (e.g., surgery, laboratory, radiology, medication, supplies, therapy services are frequently billed in one hospital stay) than those provided in a clinic setting. The records for these hospital services are often voluminous and would be costly to routinely send with each bill. Furthermore, payers have indicated a preference for requesting specific records from a hospital for a review; or for reviewing records on site at the hospital. Under Minnesota Statutes, section 176.135, subdivision 7 and Minnesota Rules Chapter 5219 health care providers may charge for copies of existing records or reports related to a claim under chapter 176. Payers did not want to be required to pay for copies of extensive hospital records they did not request.

Health care providers other than hospitals are required to send a copy of the appropriate record with the bill. Disputes often arise over delayed payment of a bill where the problem is lack of records to support the services. A payer may deny payment where an appropriate record is not presented. In order to comply with timely payment of bills under Minnesota Statutes, section 176.135, subdivision 6, payers have indicated a preference for receiving an appropriate medical record with the bill from a clinic or other outpatient setting. Review of these records facilitates payment for services. The records also inform the payer of the medical status of the patient.

In this subpart, the Department is also prescribing the use of two uniform billing forms for all workers' compensation cases as required by Minnesota Statutes, section 176.136, subdivision 7, with the exception of dental charges, pharmacy charges and services in a veterans hospital. Dental and pharmacy services are unique and comprise only a small portion of workers' compensation charges. The uniform billing forms adopted by the Health Care Financing Administration would not be easily used for these services. Both dental and pharmacy services have standard forms in common use; it is unnecessary to mandate a uniform form at this time. Minnesota Statutes, section 176.135, subdivision 7 specifically exempts services in the veterans hospital from the billing form requirement.

Item A requires direct billing to the payer from the health care provider actually providing the services. Billing the payer directly allows the payer to review the charge for a service or supply and assess the reasonableness of the charge or compare the charge with other similar services. The problem of mark-up for services provided by another business entity but billed by the referring provider is avoided, thus reducing costs and minimizing disputes. Prompt payment is facilitated by direct billing because the bill is not sent first to another health care provider, or the employer or employee to be forwarded to the payer. This item applies, but is not limited to, charges for services, supplies or articles that are often referred out, including: diagnostic imaging, lab and pathology testing performed by other than the ordering health care provider; equipment, supplies, and medication not ordinarily kept in stock and ordered specifically for a patient from another entity.

This item also applies to services provided in a hospital by a provider with an independent practice who is not an employee of the hospital. Professional services are generally billed by the provider, separate from the facility bill. This procedure has been generally accepted by most payers and providers and is recommended by the administrative uniformity committee to the MinnesotaCare Health Care Commission.

Finally, the proposed rule specifies that pharmacies must bill outpatient medications directly to the payer. This protects the injured worker from paying in full for a medication, either under Part 5221.4070 or Minnesota Statutes, section 176.136, subdivision 1b(b), and then requesting reimbursement from the payer. If the payer determines the pharmacy charge is excessive the worker may have difficulty getting full reimbursement.

Item B requires that charges must be submitted to the payer within 60 days from the date the health care provider knew the treatment was for a condition claimed to be work related. Prompt billing informs the payer that the employee is treating with a provider and allows the payer to manage the claim. When a payer receives bills months after the service is rendered the opportunity to manage the claim and resolve issues related to treatment is severely compromised. Also, the health care provider is informed of the payer's position on a claim (acceptance or denial) early in the course of treatment, thus limiting the provider's exposure. Sixty days was specifically chosen as the limit, based on a recommendation passed by the MSRB at its February 19, 1992 meeting. In addition, the following groups were consulted and concur that the time is sufficient for bill processing: Minnesota Chiropractic Association; Minnesota Medical Association; and Minnesota Hospital Association.

Item C indicates this that part does not limit the collection of other information which may be required under state or federal jurisdiction. The workers' compensation law is only one law that payers and providers are governed by. The rules cannot limit the application of other jurisdictions.

Subp. 2a, 2b, 2c. Prescribed uniform billing forms. According to workers' compensation statutes, the employer must pay the charge for health care services or any portion of the charge which is not denied or stipulate the basis for denial, delay, or non-compensability (Minnesota Statutes, section 176.135, subdivision 6). Payers report that bills are often delayed due to inadequacy of billing information (Medical Study Implementation Action Plan, Chapter 5, "Survey of Utilization Review Services among Minnesota Insurers", February 1991). By specifying what information must be provided in this rule and specifying the time limit within which the billing form must be submitted to the payer, the Department anticipates a faster turn-around on bill processing and a decrease in number of disputes related to adequacy of billing information and excessive data demands on the part of the insurer.

Minnesota Statutes, section 176.135, subdivision 7 requires the Commissioner to prescribe a uniform billing form for submission of charges to an insurer. The forms adopted in subparts 2a and 2b by the Department are also required by the Health Care Financing Administration for all of its Title 18 and 19 claims processing under the federal entitlement programs. The forms are incorporated by reference in part 5221.0405, items B and C, and are attached to this statement. These forms have been under national review and used throughout the country, including here in Minnesota. By adoption of HCFA-1500 and UB-92 as the

Department-designated forms, the Department is consistent with other major health care payers and with MinnesotaCare efforts and recommendations to control medical administrative costs through standardization of billing. The standard billing forms and required data elements will be required as of January 1, 1994. This timeframe allows for anticipated modifications in provider's billing systems. Also, in January of 1994, the UB-92 form will replace the older UB-82 form in federal programs.

The Department has reduced the number of data elements required for workers' compensation so as to ease the data reporting burden on health care providers and to make the forms compatible with the needs of the workers' compensation system. Further, use of these forms will minimize the cost for small businesses, because it allows them to order worker compensation forms in bulk with their order of Medicare and Medicaid forms. Importantly, as well, commonly used forms will also facilitate treatment and cost comparisons of health care across populations.

Tables 6 through 9 identify the data elements required on each of the required billing forms and the rationale for inclusion.

Table 10 identifies the required information for pharmacy services and the rationale. A form is not prescribed for pharmacy services because standard billing forms are in use for pharmacy services which are specifically designed for these services. However, by rule the Department of Labor and Industry prescribed information which must be submitted to the payer to facilitate appropriate and timely payment.

Table 6. Required Information on the Uniform Billing Form, HCFA-1500.

DATA ELEMENT	RATIONALE/USE
Payer name, address	Identifies to whom bill is being/was sent.
Workers' compensation file number	Identifies the claimant; using DOLI filing system: the employee's social security number.
Employee's name, address, phone	Identifies claimant.
Claim number of insurer	Used to reference insurer records.
Name of certified managed care plan	Used to manage claim and determine excessiveness.
Date of Injury	To help establish compensability of the service.
Diagnosis or nature of illness (using ICD-9 codes)	Machine-readable shorthand code for a service; can be used in data analysis and bill review. ICD-9 coding system is commonly used by providers and payers.
Date of service	Helps establish compensability. Matches bill to medical records to substantiate claim.
Approved procedure codes and modifier for service	Identifies the service billed using standard shorthand code. Code is used in data analysis and conducting computerized bill reviews. Allows application of fee schedule where appropriate.
Charge for service	Identifies amount being billed/charged. Necessary to determine amount of payment.
Place of service	For data analysis purposes; documents location for those services for which reimbursement amount is dependent on location.
Units of service	Indicates the number of units of each service provided on that date and is used to establish total charge for that service.
Name of facility where service rendered	Identifies provider and location of service and location of records.
Health care provider's or supplier's name, address, phone	Documents biller and where payment is to be sent; phone number in the event of questions.
License or registration number of provider	Provider identification information.
Provider name and degree	Provider identification information.

Table 7. Required Information on the Uniform Billing Form, UB-92 (HCFA 1450).

(Tables 8 and 9 indicate the additional information required specific to outpatient or inpatient services.)

DATA ELEMENT	RATIONALE/USE
Name of the hospital and address	Documents the service provider and where payment is to be sent.
Patients unique control numbers	Identifies patient account and facilitates hospital's retrieval of financial records for a particular service period.
Type of bill	First two digits identify facility as hospital, surgical center, clinic, skilled nursing, emergency room and whether patient was inpatient/outpatient. Necessary for determining compensability and proper payment as well as Department monitoring of medical care. Third digit not required.
Service period included on bill	Facilitates accounting of bills paid or pending.
Patient's name, address	Identifies claimant.
Admission date for inpatient care	Facilitates payer's accounting and medical management.
Priority of care	Identifies emergency, urgent and elective care. Necessary to determine appropriateness of service.
Identification for work-related accident and date of injury	Assists payer identifying compensable services.
Name of workers' compensation payer	Identifies to whom bill is being/was sent.
Employee's workers' compensation file number	Identifies the claimant. Using DOLI's filing system: the employee's social security number.
Name of managed care plan involved	Necessary for payer to manage claim and determine excessiveness.
Diagnosis code	Necessary to determine compensability of services.
Principal procedure performed	Identifies for payer the primary reason for hospital's services. Assists case management.
Attending health care provider	Necessary for medical management, e.g., who is directing case.
Health care provider performing principal procedure	Necessary for payer's accounting and medical management.
Authorized signature	Necessary so an accounts manager acknowledges responsibility for accuracy in billing.

Table 8. **Outpatient services require the following itemization in addition to information from Table 7.**

DATA ELEMENT	RATIONALE/USE
Approved procedure codes and modifiers	Identifies the service billed using standard shorthand code. Code is used in data analysis and conducting computerized bill reviews. Necessary for application of fee schedule where appropriate.
Date of each service	Helps establish compensability. Matches bill to medical records to substantiate claim. Necessary to determine applicable statute and rules.
Units of service	Indicates the number of units of each service provided on that date and is used to established total charge for that service.
Total charge for each service.	Charges cross checked for accuracy. (Charge x units = total).
Sum of all charges	Cross check totals for accuracy.

Table 9. **Inpatient services require the following information in addition to information in Table 7.**

DATA ELEMENT	RATIONALE/USE
Revenue code and description of revenue category	A code designating a type of service, e.g., lab, radiology, physical therapy. Code summarizes the individual services by category.
Total charge for each category of service and the sum.	Gives payer a summary of charges for each category of service and the total of all categories. Cross check for accuracy.
Where a summary is used, an itemization of services and supplies must be submitted with the summary. Itemization must include:	
Approved procedure codes and modifiers, supply codes	Identifies the service billed using standard shorthand code. Code is used in data analysis and conducting computerized bill reviews. Allows application of fee schedule where appropriate.
Date of each service	Helps establish compensability. Matches bill to medical records to substantiate claim. Necessary to determine applicable statute and rules.
Units of service	Indicates the number of units of each service provided on that date and is used to establish total charge for that service.
Charge for each service	Identifies amount being billed/charged. Necessary to determine amount of payment.

Table 10. **Required information on pharmacy charges (including outpatient hospital pharmacy).**

DATA ELEMENT	RATIONALE/USE
Employees workers' compensation file number	Identifies claimant; using DOLI's filing system: the employee's social security number.
Employee's name and address	Identifies claimant.
Payer's name and address	Identifies the payer responsible and to whom bill was sent.
Date of injury.	Helps establish compensability of the service.
Name of HCP who ordered the medication	Facilitates medical management of claim.
Name of certified managed care plan.	Used to manage claim and determine excessiveness
Medication provided and procedure code.	Identify service being billed; necessary to determine amount of payment under Part 5221.4070.
Date medication provided	Establishes compensability. Matches bill to medical records to substantiate claim. Necessary to determine applicable statute and rules.
Total charge for each medication.	Necessary to determine amount of payment.
Name, address and phone number of pharmacy	Identifies the provider and where to send payment.

Subp. 3. Billing code. This part establishes that the provider is responsible for determining which code correctly describes the medical service rendered. New language is added to clarify that instructions and guidelines for determining correct codes are provided in this chapter and in the CPT and HCPCS manuals, incorporated by reference in Minnesota Rules 5221.0405. Because these manuals are updated at least annually, the manual in effect on the date this service was rendered is designated as the controlling document. This documentation is intended to prevent disputes arising from conflicting information and different versions of coding manuals and to maintain consistency and uniformity with other providers and payers.

Item A. This item limits the types of procedure codes that can be used by providers and requires that appropriate modifiers be included in billing codes. These requirements are intended to bring about uniformity in billing and record keeping which, as noted above, is required by MinnesotaCare legislation and which will assist all parties in administering and adjudicating claims and which will contribute to collection of reliable, valuable health care data. Language pertaining to the existing fee schedule is deleted for services after the effective date of the proposed fee schedule.

Item B. This item defines the term "modifier" and refers the user to the CPT and HCPCS manuals, incorporated by reference in Minnesota Rules Part 5221.0405, items D and E. These manuals are designated as the definitive source for the list of modifiers available for use in workers' compensation, in an effort to prevent disputes arising from disagreements related to the use or meaning of a particular modifier. These modifiers are in widespread use. Language pertaining primarily to the format and use of modifiers in the existing fee schedule is deleted, because it will be replaced by the proposed relative value fee schedule.

Item C. This item provides general guidelines related to provider group designations, defines and describes each provider group and directs the user to the specific rules which contain the lists of provider group services.

Subitem (1). Minnesota Statutes, section 176.136, subdivision 2, establishes that payers are not liable for excessive charges and that "a charge for a health service or medical service is excessive if it . . . (3) is for a service that is outside the scope of practice of the particular provider. . . ." The scope of practice for each type of provider is generally established by statute and is intended to ensure the delivery of appropriate health care and guard the public from harm caused by unsafe practices or unskilled providers. The reiteration of this restriction here is necessary because there is nothing in any procedure code which signifies the scope of practice limitations, since all services are coded using the HCPCS system.

The rule states that services delivered by assistants of a provider are coded as though delivered directly by the provider, reflects the fact that maximum fees for all services are calculated at the same rate, as long a licensed provider ordered or supervised the service. This is consistent with Medicare's payment methodology and with existing Minnesota fee schedule rules. It reflects the reality that, in practice, many services are provided by personnel working under the direction of a licensed provider. The fact that the licensed provider is ultimately responsible for these staff and liable for any damages caused by staff negligence serves to encourage prudent delegation by the licensed provider and obviates the need for oversight of such delegation by the Commissioner.

Specific reference of the application of the fee schedule to hospitals is made for clarity, as this area has been subject to litigation in the past and specific statutes and rules apply.

Subitems (2) - (6). These items identify the group of services and providers generally providing these services and directs the user to the portion of the medical fee schedule containing the list of actual services. A discussion of the four provider groups, and pharmacies, and corresponding services is found in the Statement of Need for the proposed Relative Value Fee Schedule, Parts 5221.4000 to 5221.4070.

REPEALERS

Part 5221.0100, subps. 7 and 8, the definitions of "excessive charge" and "excessive service" are repealed because they do not appear in the chapter other than in part 5221.0500.

Part 5221.0100, subps. 13 and 14 are repealed because the terms are not used in the chapter.

Parts 5221.0550 "Excessive Services, is repealed because the provisions on excessive services are incorporated into the amended part 5221.0500, governing excessive charges and services and employer liability. This is consistent with Minnesota Statutes, section 176.136, subdivision 3, which blurs the distinction between an excessive charge and an excessive service.

Part 5221.0700, subp. 5, "Collection of Excessive Charges" is repealed because it is incorporated into part 5221.0500.

Part 5221.0800, "Dispute Resolution" is repealed because Minnesota Statutes, section 176.136, subdivision 2 now permits a health care provider to file a medical request for an alleged excessive service as well as an excessive charge. This provision conflicted with the statute. Dispute resolution rules are now contained in Minnesota Rules, chapter 5220.

Part 5221.2620, subp. 7 is repealed because the broad procedures set forth a "best interest of the parties" standard which has not proved useful or effective in reducing disputes. It is replaced by proposed 5221.0430.

Parts 5221.1000 to 5221.3500 are repealed for services after the effective date of the proposed Relative Value Fee Schedule. The repealed sections are references to the existing fee schedule, which will be replaced by the Relative Value Fee Schedule.

Tables

APPENDIX

1. HCP Report

2. Report of Work Ability

3. HCFA-1500 claim form

4. UB-92 (HCFA 1450) claim form

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STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of Proposed Adoption of the Relative Value Medical Fee Schedule for Workers'Compensation, Parts 5221.4000 to 5221.4070

STATEMENT OF NEED AND REASONABLENESS (Relative Value Fee Schedule)

I. BACKGROUND AND STATUTORY AUTHORITY

The authority to regulate workers' compensation medical fees by rule was first established in 1979, through a general directive to "establish procedures for determining whether the charge for a health service is excessive." 1979 Minn. Laws Ex. Sess., ch. 3, § 45. In 1981, the legislature expanded upon this authority by adopting what is essentially now codified under Minn. Stat. § 176.136 and by giving the commissioner the authority to adopt temporary rules to implement new procedures. 1981 Minn. Laws ch. 346, § 87. In October, 1983 the temporary rules were adopted (4 MCAR 1.001 to 1.0032). In 1983, the authority to adopt rules was expanded to authorize standards and procedures "to determine what is necessary to encourage providers of health services and rehabilitation services to develop and deliver services for the rehabilitation of injured employees." 1983 Minn. Laws ch. 290, § 108, codified as Minn. Stat. § 176.83, subd. 4 (1990). The rules were also to insure that, "quality hospital, other health care, and rehabilitation is available and is provided to injured employees." Id. In October 1984 the Department of Labor and Industry promulgated the first permanent medical fee schedule, Parts 5221.1000 to 5221.3300. In 1985, subdivision 5 was added to Minn. Stat. § 176.136 to allow for annual updates to the permanent rules without formal rule-making. 1985 Minn. Laws ch. 234, § 11, codified as Minn. Stat. § 176.136, subd. 5 (1990). The purpose of subdivision 5 was to allow for annual updates to keep up with inflation, without going through a lengthy rule proceeding each year. There have been annual revisions of the maximum fees since 1984, based on the statistical criteria set forth in subd. 5.

In 1990, the Department initiated a series of studies designed to evaluate the ability of the existing Medical Fee Schedule to contain costs within the workers' compensation system and to assess the potential for increased cost savings through implementation of a Resource-Based Relative Value Fee Schedule.[1],[2] Under a Relative Value Fee Schedule, each service is assigned a numeric value, reflecting the worth of the service in comparison to a base service. This numeric value, referred to as the "Relative Value Unit" is then multiplied by a monetary conversion factor, to establish the maximum charge allowed for that service. This formula is explained in greater detail below in Section IV.

In 1992, the legislature, codified at Minnesota Statutes, section 176.136, subdivision 1a, directed the Department to implement a Relative Value Fee Schedule. The Commissioner was given authority to adopt by reference the Federal Medicare Relative Value Fee Schedule. The

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[1] Minnesota Department of Labor and Industry, Health Care Costs and Cost Containment In Minnesota Workers' Compensation: Report to the Legislature, St. Paul, MN, March, 1990.

[2] Minnesota Department of Labor and Industry, Medical Study Implementation Action Plan: Report to the Legislature, St. Paul, MN, February, 1991.

legislation also froze the 1991 Medical Fee Schedule until the new Relative Value Fee Schedule is adopted. This statement addresses the adoption of the proposed Relative Value Fee Schedule. A separate Statement of Need and Reasonableness addresses amendments to parts 5221.0100 to 5221.0700, the medical rules of practice.

II. SMALL BUSINESS CONSIDERATIONS; EXPENDITURE OF PUBLIC MONIES

The proposed workers' compensation relative value fee schedule regulates health care providers for standards and costs. Therefore, the requirements of Minnesota Statutes, statute 14.115 do not apply, pursuant to subdivision 5 of that law. Nonetheless, where appropriate, the proposed rules are modified from the Medicare fee schedule to facilitate ease in application for both health care providers and payers. The proposed rules do not require the expenditure of public monies by local public bodies, pursuant to Minnesota Statutes, section 14.11.

III. WITNESSES AND STAFF PRESENTERS

Appearing at the public hearing to present the proposed workers' compensation relative value fee schedule may be any of the following persons from the Department of Labor and Industry: Leo Eide, Assistant Commissioner for Workers' Compensation; Lisa Thornquist, Director, Research and Education; Patricia Kimpan, Researcher, Research and Education; Monica Ryan, Medical Policy Analyst, Rehabilitation and Medical Affairs; Gloria Gebhard, Acting Director, Rehabilitation and Medical Affairs; William Lohman, M.D., medical consultant for the Department of Labor and Industry; and Kathryn Berger, Attorney, Legal Services. The Commissioner reserves the right to appear or call upon any of his designees or other staff to appear in support of the rules. The Commissioner also reserves the right to call a health economist or actuary.

IV. COMPARISON OF THE EXISTING, CHARGE-BASED FEE SCHEDULE WITH THE PROPOSED RELATIVE VALUE FEE SCHEDULE

The statute requires the adoption of a Relative Value Fee Schedule. It is helpful as background, and for later reference in this statement, to discuss key distinctions between the current charge-based fee schedule and the proposed Relative Value Fee Schedule.

Current Charge-Based Medical Fee Schedule

Since 1983, the Minnesota Department of Labor and Industry has established maximum fees for workers' compensation medical services through a system based directly on historical fee-charging patterns by health care providers. Fee-charging patterns were established by using charges for provided services (not in the workers' compensation system), received by Blue Cross and Blue Shield of Minnesota during the previous calendar year. The Minnesota Fee Schedule was created by first refining this charge data to ensure that it reflected prevailing, usual and customary fees, as required by Minnesota Statutes, section 176.136, subdivision 5 (repealed by the 1992 legislation). Specifically, only those services which were billed more than 20 times, by at least three different, identifiable providers of the same provider type were included. Services were then included only if the standard deviation was less than, or equal to, 50 percent of the mean for the billings for each service in the data base or the charge at the 75th percentile

was not greater than or equal to three times the charge at the 25th percentile of the billings. Consequently, many services from the Blue Cross and Blue Shield charge-data were excluded from the Minnesota Fee Schedule data base. The maximum fee for services that met the criteria was set at the 75th percentile of the charges for each service; in other words, the fee was set at the point at which 75 percent of the actual fees charged were lower and 25 percent were higher than the maximum fee.

Problems with the Current Medical Fee Schedule

Service Coverage

In 1989, approximately 30 percent of the services provided to treat workers' compensation injuries were not included in the Medical Fee Schedule because they did not meet the statistical criteria described above. These services were provided with relative frequency and, in fact, accounted for almost half of the total charges for workers' compensation medical care.[3] This large volume of services was not subject to fee schedule limits, and the cost was controlled essentially by the providers themselves, since payers were required by Minnesota Statutes, section 176.135, subdivision 3 (repealed by 1992 legislation) to pay either the provider's usual and customary charge or the prevailing charge in the community for services not included in the fee schedule.

Effectiveness in Controlling Costs

Research supports the conclusion that the charge-based Medical Fee Schedule is not effective in controlling rising health care costs in workers' compensation.[4],[5] Because maximum fees are established under the charge-based fee schedule at rates directly related to actual fees charged, maximum fees have risen every year at a rate similar to that of the medical component of the Consumer Price Index (Medical CPI). The Medical CPI is increasing faster than both the overall CPI and the statewide average weekly wage. During the period 1983 through 1989, the Medical CPI averaged a 7.1 percent annual increase, compared with an average increase of 3.9 percent for overall Consumer Price Index and 4.5 percent for the statewide average weekly wage.[6] These comparisons support the conclusion that the current charge-based fee schedule does not reduce the total expenditure for workers' compensation medical costs, nor does it slow the growth of these medical costs.

Administrative Burdens

Determining maximum medical fees in a charge-based fee schedule required expenditure

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[3] Minnesota Department of Labor and Industry, supra note 2, at 10.

[4] Minnesota Department of Labor and Industry, supra note 1, at 74.

[5] Minnesota Department of Labor and Industry, supra note 2, at 10.

[6] Minnesota Department of Labor and Industry, supra note 2, at 11.

of considerable resources by both the Department and constituent groups. Annually, the Department of Labor and Industry purchased charge data from Blue Cross and Blue Shield, evaluated each service in the data in order to ensure statistical integrity and identified the 75th percentile charge for each service. The Department was also required to oversee publication and distribution of updated schedules every year. Constituents, in turn, were required to purchase updated schedules and modify their accounting systems to comply with all changes.

Resource-Based Relative Value Fee Schedule

A Resource-Based Relative Value Fee Schedule establishes maximum fees for medical services based on the value of the service in comparison to a standard or base service. The value of the service reflects the time and intensity of physician work expended in providing the service, as well as associated practice costs, such as overhead and malpractice expenses. The base service is assigned a relative value unit of 1.0. Services which require more medical resources than the base service are assigned higher relative value units such as 2.0, while services which require fewer resources are assigned lower relative value units, such as 0.50.

The maximum fee for a service listed in a Relative Value Fee Schedule is determined by multiplying the relative value unit for the service by a dollar amount, referred to as a conversion factor. For example, if the conversion factor is set at $50.00, then the maximum fee for a service whose relative value unit is 1.0, is $50.00, while that for a service whose relative value unit is 2.0, is $100.00. The relative value units assigned to a given service are intended to be permanent, because the amount of provider resources required for the service, as compared to other services, is generally consistent over time. The Medicare relative value units for services included in the Minnesota fee schedule are those which became effective January 1, 1993 and are not likely to change. See 57 FR 5914. By contrast, the conversion factor is intended to change over time. Because the conversion factor determines the maximum fee for scheduled services, adjustment of the conversion factor is the mechanism for controlling the rate of inflation of health care costs by a Relative Value Fee Schedule. Pursuant to Minnesota Statutes, section 176.136, subdivision 1a, the Commissioner must adjust the conversion factor on an annual basis, in an amount equivalent to the annual change in statewide average weekly wage. See also Minnesota Statutes, section 176.645, subdivision 1.

Benefits of a Resource-Based Relative Value Fee Schedule

Administrative Ease

As described above, decreased administrative costs are required to promulgate and maintain a Resource-Based Relative Value Fee Schedule because the annual fee schedule updates are accomplished by changing the conversion factor. Constituents are spared the expense of purchasing a new schedule every year and because payers in other areas utilize similar Resource-Based Relative Value Fee Schedules, providers will be familiar with associated methods of billing and payment amount determinations.

Comprehensiveness

The Resource-Based Relative Value Fee Schedule can establish maximum fees for many,

if not most, of the health care services provided for workers' compensation patients because the statistical criteria necessary for inclusion in the current charge-based schedule need not be met.

Effectiveness

The Resource-Based Relative Value Schedule is expected to be more effective in controlling health care costs because it includes more services and, thus, it is more comprehensive than the existing schedule. In addition, increases in maximum fees are not tied to the previous year's billing.

V. DEVELOPMENT OF THE MINNESOTA RESOURCE-BASED RELATIVE VALUE FEE SCHEDULE

Statutory Requirements

Minnesota Statutes, section 176.136, subdivision 1a requires the adoption of a Relative Value Fee Schedule. It gives the Commissioner specific authority to adopt the Resource-Based Relative Value Fee Schedule established for the Federal Medicare program. The Commissioner's authority to promulgate rules necessary to adopt, interpret and enforce a fee schedule for workers' compensation medical services is broad and exclusive. As noted recently by the Minnesota Supreme Court, ". . . [T]he legislature has entrusted the commissioner of the Department of Labor and Industry, . . . with the responsibility for promulgating the necessary rules." Boedingheimer v. Lake County Transportation, et al. 46 W.C.D. 646, 656, 485 N.W.2d 917, (Minn. 1992) The Court also noted that the promulgation of such rules ". . . are complex matters where the court ordinarily defers to agency expertise." Boedingheimer at 656 citing Manufactured Housing Institute v. Pettersen, 347 N.W.2d 238, 244 (Minn. 1984). Promulgating the Resource-Based Relative Value Fee schedule is indeed a complex matter and the Department has expended considerable time and resources to adopt the Federal Medicare Relative Value Fee Schedule in accordance with the requirements set forth in Minnesota Statutes, section 176.136. Consistent with the authorizing statute, the Medicare relative value units and corresponding rules have been incorporated into the proposed fee schedule to a large extent. Where the proposed fee schedule differs from the Medicare fee schedule, the difference is noted and discussed in this Statement. Some differences are for ease in application in a workers' compensation setting, while others are distinctions necessary to implement Minnesota law.

Minnesota Statutes, section 176.136, subdivision 1a establishes two general requirements for the adoption of the Medicare Relative Value Fee Schedule: (1) that the schedule contain reasonable classifications that differentiate among health care provider disciplines, and (2) that the conversion factors be set to reasonably reflect a 15 percent overall reduction from the Medical Fee Schedule most recently in effect, which is the 1991 Medical Fee Schedule. (Under that statute, the 1991 fee schedule remains in effect until adoption of the new Relative Value Fee Schedule.)

Adoption of the Medicare Resource-Based Relative Value Fee Schedule

The Medicare Fee Schedule contains relative value units for approximately 7,500 medical services. See 57 FR 55916. The total relative value unit for each service is the sum of three relative value units that reflect resources involved in furnishing three components of the service:

(1) practitioner work, (2) practice expense, and (3) malpractice insurance costs. The first, practitioner work relative value units, represent a combination of time, mental effort, stress due to risk, technical skill and physical effort associated with the provider service. Work relative value units were developed by a research team based at the Harvard School of Public Health, working in cooperation with researchers at the United States Department of Health and Human Services, Health Care Financing Administration. See 56 FR 59505 and 59508. The team developed a set of clinical vignettes for select services, which represented the typical medical practice of various subspecialities. Next, the team surveyed physicians asking them to estimate the amount of physician work, as described above, associated with each vignette. Initial recommendations were published in September 1988 in "*A National Study of Resource-Based Relative Value Scales for Physician Services.*"[7] At the time of publication of the Medicare Relative Value Fee Schedule in November, 1991, work values for 460 services had been obtained through this surveying process. See 56 FR 59526. Work values for approximately 3,500 additional services were extrapolated from the surveyed values by the Harvard team.[8] Since then, work values for additional services have been determined and existing work values have been analyzed and refined by panels of physicians convened by the Federal Health Care Financing Administration, through a process which incorporated group discussion and individual rating of services. 57 FR 55938. These panels assisted the Health Care Financing Administration in reviewing public comments received following publication of the final Medicare schedule in November of 1991.

The second component, practice expense relative value units, represent overhead costs, such as rent, staff salaries, equipment and supplies. The third component, malpractice relative value units, represents costs of professional liability or malpractice insurance. These values were computed by Medicare utilizing their historical charge data, as well as data from the American Medical Association's Socio-Economic Monitoring Survey for Physician Specialties. See 56 FR 59510 and 57 FR 55971.

The Department utilized the most current Medicare relative value units available; those which became effective on January 1, 1993. 57 FR 55997, Addendum B. These values are adjusted for the proposed workers' compensation fee schedule to accommodate the variance between national average physician costs per service, represented by the Medicare relative value units, and statewide average physician costs. (As a point of interest, Minnesota average costs are lower than nationwide average costs.) These adjustments were made by utilizing the same formulae and values utilized by Medicare to determine actual Minnesota payment amounts, set forth in 42 CFR 415.26, 56 FR 59626 and 59787 and 57 FR 55997, addendum B. The Department then simply added together the three geographically-adjusted relative value units (work value, practice expense value and malpractice value) to arrive at a total relative value unit for each included service. Only the total relative value unit for each service is listed in the

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[7] Hsaio, W.C., Braun, P., et al, A National Study of Resource-Based Relative Value Scales for Physician Services, Cambridge, MA, Harvard University Publishers, 1988.

[8] Kelly, N.L., Hsiao, W.C., et al, "Extrapolation of Measures of Work for Surveyed Services to Other Services," JAMA, Volume 26, Number 16, October 28, 1988. See also 56 FR 59526.

proposed relative value fee schedule because the proposed rules enable maximum fees to be calculated using only the total relative value unit. Thus, it was not necessary to list all three relative value units - work value, practice expense value and malpractice value for each service in the proposed schedule.

Provider Classifications

The proposed relative value fee schedule includes four provider groups. These are medical/surgical, pathology and laboratory, physical medicine and rehabilitation, and chiropractic. Services in the physical medicine and rehabilitation group include services which have been categorized as physical medicine services in the Physician's Current Procedural Terminology, or CPT system, which include CPT codes 97000 through 97799. (The CPT Manual, incorporated by reference in part 5221.0405, is published by the American Medical Association and lists codes for medical and surgical procedures.[9] CPT codes are universally used and recognized by health care providers and payers in all sectors). Also included in this group are services which have been categorized as physical therapy or occupational therapy in the Health Care Financing Administration Common Procedure Coding System, or, HCPCS and have been assigned alpha-numeric, HCPCS codes. (The HCPCS Manual, incorporated by reference in part 5221.0405, is published by the HCPCS subcommittee of Minnesota, under the authority of the Federal Health Care Financing Administration, and lists codes for medical services, articles and supplies for which no CPT code exists. HCPCS codes are recognized and used by Medicare, Medicaid and, increasingly, other payers). Services in the physical medicine and rehabilitation group are provided primarily by, or under the direction of the physical therapists and occupational therapists. Physical medicine services by physicians and osteopaths are also included in this group.

Services in the pathology and laboratory group include services which have been categorized as pathology and laboratory in the CPT system, which include CPT codes 80002 through 89399. These services are provided by a pathologist or by a technician working under the supervision of a physician.

Services in the medical and surgical group include all of the remaining services listed in the CPT system; in other words, all of the services in the CPT system except for physical medicine services and pathology and laboratory services. These services are provided primarily by or under the direction of physicians and surgeons. However, some services may also be provided by osteopathic physicians, podiatrists, dentists, oral and maxillofacial surgeons, optometrists, opticians, speech pathologists, licensed psychologists, social workers, nurse practitioners, clinic nurse specialists, and physician's assistants.

Services in the chiropractic group include services which are categorized as chiropractic services in the HCPCS system and which have been assigned alpha-numeric, HCPCS codes. Also included are some chiropractic radiology and laboratory services, listed by CPT codes. Services in this group are provided by or under the direction of a chiropractor.

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[9] American Medical Association, 1993 Physician's Current Procedural Terminology, Chicago, IL, 1992.

The selection and composition of each provider group were influenced by several factors. As noted above, the statute expressly requires that "The [workers' compensation] relative value fee schedule shall contain reasonable classifications including, but not limited to, classifications that differentiate among health care provider disciplines." The statute was silent as to the classifications to be used. However, the statute clearly differentiates between, among others, medical and chiropractic providers. See Minnesota Statutes, sections 176.136, subdivision 1(b).

These four groups reflect rational, historical distinctions. The primary type of provider in each group corresponds to a separate health care discipline, or group of related disciplines, with distinctive identifying features, such as education and licensure requirements, individual professional associations and unique statutory scopes of practice. Three of the four groups - physical and occupational therapists, chiropractors and physicians are presently listed as distinct provider groups in the existing fee schedule. Services by these providers constitute 97 percent of the workers' compensation nonhospital bills in the State Fund Data Base described below.

Other provider groups could also have been created. For example, podiatry is identified in Minnesota Statutes, section 176.136, subdivision 1(b) as a separate health care discipline and could have been included in the relative value fee schedule as another separate group. However, all other provider groups collectively account for less than 3 percent of bills. Moreover, administrative burdens associated with including additional provider groups for every possible profession, explained below in section VI, are extensive and outweigh any potential benefits to fee schedule users.

Certain limitations of the Medicare Resource-Based Relative Value Fee Schedule also influenced the selection of the types of provider groups. The Medicare schedule primarily includes relative value units only for those services provided by, or under the direction of medical doctors. Thus, no relative value units for chiropractic services, with one exception described below, are provided in the Medicare fee schedule. Medicare does not reimburse for any chiropractic service except for manipulation. 42 CFR § 410.22. The maximum fee for manipulation also includes an examination and x-rays. Similarly, the Medicare schedule includes relative value units for only a small portion of pathology/laboratory services, since Medicare pays for most pathology and laboratory services according to a separate, charge-based fee schedule. Thus, the Department was required to develop additional relative value units for chiropractic services and pathology/laboratory services. This process is discussed in detail in section VI. These factors further support the identification of separate provider groups for chiropractic services and pathology/laboratory services.

Fifteen Percent Reduction Applied to Each Provider Group

The selection of the four provider groups also reflects the Department's efforts to ensure that application of the fee schedule will not result in unfair revenue inequities on provider groups, a goal which reflects the statutory mandate to establish rules which "encourage providers to develop and deliver services for rehabilitation of injured workers." Minnesota Statutes, section 176.136, subdivision 1. As is described in greater detail in section VI, a target expenditure for each provider group was determined which reflected a 15 percent overall reduction from the 1991 fee schedule for that group. Although the 15 percent reduction mandated by statute need not be applied equally to all treatment or services," it is, nonetheless,

reasonable that the burden of this projected revenue decrease should be distributed between provider groups that provide the majority of workers' compensation services. Minnesota Statutes, section 176.136, subdivision 1a. Under the Medicare Relative Value Fee Schedule, this goal would not have been achieved without dividing the schedule into the four provider groups chosen. Thus, while services within each group of providers are not uniformally decreased 15 percent, no one group experiences fee increases at the expense of decreases in fees from another group of providers.

Although four separate conversion factors could have been developed, the proposed Relative Value Fee Schedule identifies only one conversion factor for calculation of maximum fees for all provider group services. This decision was made to achieve the goal of administrative ease in applying the fee schedule. As described below in the section entitled "Determination of Relative Value Units and Conversion Factors for Each Provider Group," in section VI, the relative value units were adjusted to accommodate a single conversion factor and achieve an overall decrease of 15 percent. This 15 percent goal or target total expenditure for each provider group, remains stable and, essentially, was mandated by statutory language. Thus, the same maximum fees would have occurred using one or several conversion factors.

In summary, the 1992 workers' compensation statute (Minnesota Statutes, section 176.136, subdivision 1a mandated that the conversion factor for the new resource-based relative value fee schedule accomplish a 15 percent overall reduction from the existing fee schedule. That statute provides that the 1991 fee schedule must remain in effect until the new relative value fee schedule is adopted. The statute also directed that the new fee schedule include classifications that distinguish between health care provider disciplines. As noted above, these classifications were determined to be medical/surgical, physical medicine, chiropractic and pathology/laboratory.

To accomplish the 15 percent reduction, three basic steps were taken: The total workers' compensation expenditures under the existing 1991 fee schedule were calculated for services in each provider group; relative values were assigned to services included in the database for each provider group; and the conversion factor, or dollar multiplier for the relative value units, was set so that payments under the new resource-based relative value fee schedule would be equal to 85 percent of expenditures under the 1991 fee schedule, for services common to both fee schedules. These three steps are explained in more detail for each provider group in sections VI.

State Fund Mutual Database

To calculate the expenditures for services in each provider group under the 1991 and proposed fee schedules, we applied the schedules to a large sample of Minnesota workers' compensation claims. This required a sufficiently large sample to ensure that the bills we used were representative of the types and numbers of services typically provided in workers' compensation. State Fund Mutual Insurance Company was able to provide such a sample.

State Fund Mutual was the largest insurer of Minnesota workers' compensation claims in 1991 and had available computerized data at the level of detail necessary for our analysis. As a competitive state fund, State Fund Mutual accounted for approximately eight percent of

Minnesota's insured workers' compensation market in 1991. All bills submitted to State Fund Mutual between January 1, 1991 and June 31, 1991 were obtained. These were the most recent data available at the time the calculations were begun. These bills numbered in the tens of thousands, from all areas of Minnesota, and included the numbers and types of services provided, the billed amount and the type of provider.

In calculating the 15 percent reduction it was necessary to apply the schedules to an actual sample of claims for several reasons. Simply reducing each maximum fee 15 percent is not possible because under a relative value fee schedule the relationship between the services changes. The expenditure amounts, based on the bills in the State Fund Mutual database, are reflective of the "real world" of payments under Minnesota's workers' compensation fee schedule for each provider group. The total expenditures under the fee schedule are the product of the price per service and the number of services performed, not just the sum of all maximum fees. Additionally, the current and proposed fee schedules contain services that are not typically performed in workers' compensation cases and are therefore not included in the data base. Including these services in calculating the 15 percent reduction would not have accurately reflected a 15 percent reduction in workers' compensation payments under the existing 1991 fee schedule. Finally, this mix of workers' compensation services was also necessary to accurately apply the multiple procedure and global surgical adjustments in the existing and proposed fee schedules, which are discussed more fully under each provider group.

Only services common to both fee schedules were included in calculating the 15 percent reduction. Minnesota Statutes, section 176.156, subdivision 1 requires that the initial relative value fee schedule reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in effect, which is the 1991 fee schedule. The proposed workers' compensation relative value fee schedule includes significantly more services for the medical/surgical provider group than the 1991 Minnesota fee schedule contains. Including these additional services in the total expenditure calculation would not accurately reflect a 15 percent reduction from the 1991 fee schedule. Providers of these services are now placed on an equal footing with chiropractors, pathology and laboratory and physical and occupational medicine providers, the majority of whose services were already limited by the 1991 fee schedule and are being reduced an additional 15 percent.

VI. Determination of Relative Value Units and the Conversion Factor for the Four Provider Groups

A. Medical/Surgical Services

Calculating Total Expenditures under Minnesota's 1991 Medical Fee Schedule

The State Fund Mutual database was used to determine a total expenditure amount for all medical/surgical services delivered by the providers in this group under the 1991 fee schedule. This was done by summing payments at either the billed amount or the maximum fee schedule amount, whichever was less, as required by Minnesota Statutes, section 176.136, subdivision 1 and in accordance with the 1991 fee schedule requirements. Nearly 38,000 bills for services included in both fee schedules were used for this analysis.

The 1991 fee schedule currently in effect contains some limitations on payments for some workers' compensation medical services. Under Minnesota Rules Part 5221.2250, subp. 2 for certain surgeries, normal, uncomplicated pre- and post-operative in-hospital care done in conjunction with the surgical procedure are already included in the reimbursement amount specified for that procedure, and are not individually reimbursed. Also, under Minnesota Rules Part 5221.2250, subp. 2, item F, concurrent surgical procedures, performed in addition to the primary surgical service performed at a single operation, are not reimbursable in full. These global surgical package and multiple procedure adjustment rules were applied to services in the database in calculating the total payments allowed under 1991 fee schedule. The expenditure total under the 1991 fee schedule, for medical/surgical services in the database, for the six month period under study, was $1,338,145.

Determination of Relative Value Units

The Medicare relative value fee schedule includes relative value units for all of the corresponding services in the workers' compensation medical/surgical database. Consistent with Minnesota Statutes, section 176.136, subdivision 1a, all of the most recent Medicare relative value units, adopted on January 1, 1993, are included in the proposed workers' compensation relative value fee schedule. 56 FR 59635; 57 FR 55997. Each of the three component parts of each total relative value unit was assigned a slight adjustment by Medicare to accommodate the relatively lower practice costs here in Minnesota compared with the nation's average. Medicare provides Geographic Practice Cost Indices (GPCIs) for Minnesota, according to the Medicare rules. 42 CFR 415.20; 415.26; and 56 FR 59514, 59629, Addendum A. The overall effect of the adjustment reduced each total relative value unit approximately two percent. This adjustment is already reflected in the relative value units as published in the proposed rules, which accounts for the slight difference between the proposed workers' compensation relative values and the values published by Medicare.

Target Expenditure Amount and the Conversion Factor

The conversion factor translates the relative value unit for particular services into dollar reimbursement (maximum fee) amounts. The relative value units are multiplied by the conversion factor to determine this dollar amount. As noted above, the total expenditure amount under the 1991 fee schedule for medical/surgical services was $1,338,145. A 15 percent reduction of this amount is $1,137,423. We assigned the appropriate geographically adjusted Medicare relative value units to all services included in the database common to both fee schedules, and calculated the conversion factor so that the total medical/surgical payments for those services under the relative value fee schedule equalled $1,137,423.

To calculate what total payments would be under the proposed workers' compensation relative value fee schedule, the Medicare "global surgery package" rule was applied to the services. 42 CFR 415.40; 56 FR 59513. This rule, continued in the proposed workers' compensation relative value fee schedule, excludes certain services from reimbursement when they occur within a certain length of time after a surgical procedure because these services are already included in the relative value for the surgery, see part 5221.4034, subp. 1. Medicare, and the proposed workers' compensation relative value fee schedule, also impose a "multiple procedure" adjustment factor which reduces reimbursement for certain procedures when

performed with other procedures. (42 CFR 415.40; 56 FR 59515; Minnesota Rules Part 5221.4034, subp. 3.) This multiple procedure adjustment was also applied to the services included in the database.

After assigning the Medicare geographically adjusted relative values to the workers compensation services in the database and applying the global surgery and multiple procedure adjustments, the conversion factor was determined to be $52.05. For medical/surgical services, the Medicare geographically adjusted relative value for a service, multiplied by the $52.05 conversion factor equals the reimbursement maximum for that service. For example, for repair of superficial wound(s), CPT code 12001, the maximum fee is determined as follows:

(Total RVU)	x	Conversion Factor	=	Maximum Reimbursement Amount
(2.30)	x	($52.05)	=	$119.72

B. **Physical Medicine and Rehabilitation/Occupational Therapy Services**

Calculating Total Expenditures under Minnesota's 1991 Medical Fee Schedule

A total expenditure amount for all physical therapy and occupational therapy services in the database "physical medicine" provided by any of the providers in this group identified on page 7, was determined in a similar manner as described for the medical/surgical services. All payments under the fee schedule were summed at either their billed or the maximum fee schedule amount, whichever was less, according to Minnesota Statutes, section 176.136, subdivision 1 and according to the 1991 fee schedule requirements. The physical medicine database contained nearly 16,000 bills for services common to both fee schedules.

As with the medical/surgical analysis, those physical medicine services that are not limited by the 1991 fee schedule did not contribute to the total expenditure calculation. Accordingly, all physical medicine services billed by a hospital were excluded from the total expenditure calculation, as those services are not subject to the 1991 fee schedule, pursuant to Minnesota Rules Part 5221.2800, subp. 1 and Boedingheimer v. Lake Country Transport, 485 N.W.2d 917 (1982). However, outpatient hospital physical therapy clinic changes that were billed by the clinic were included in calculating the total expenditures under the 1991 fee schedule.

For physical medicine and occupational therapy services, the expenditure total under the 1991 fee schedule, for services in the database in the six month period under study, was $345,466.

Determination of Relative Value Units

Medicare has established relative value units for all of the services in the physical medicine database. All Medicare relative value units adopted on January 1, 1993, are included in the proposed relative value fee schedule. 56 CFR 59635; 57 CFR 55997. Each of the three component parts of the Medicare relative values were adjusted slightly to accommodate the relatively lower practice costs here in Minnesota compared with the nation's average. Medicare provides Geographic Practice Cost Indices (GPCI) for Minnesota, according to the Medicare

rules. 42 CFR 415.20; 415.26 and 56 FR 59629, 59514, Addendum A. The overall effect of the adjustment reduced each relative value unit approximately two percent, which is why the proposed relative value units are slightly different than the relative value units published by Medicare. The relative values were further adjusted to accommodate a single conversion factor, as explained below.

Target Expenditure Amount and the Conversion Factor

The total expenditure amount under the 1991 fee schedule for physical medicine services in the database was $345,466. Eighty-five percent of this amount is $293,646. As noted earlier, a single conversion factor of $52.05 is proposed for all provider groups. Therefore, the relative value units are adjusted instead of conversion factor for this group. We assigned Medicare geographically adjusted relative value units to all services included in the database for the physical medicine providers and calculated a relative value adjustment factor so that the total physical medicine payments for those services under the workers' compensation relative value fee schedule, with a conversion factor of $52.02, equalled $293,646. This adjustment factor was 0.81. Each relative value unit for physical medicine services were multiplied by this amount. This adjustment does not change the relative value relationship between individual services within the provider group, and the maximum fees remain the same as if a separate conversion factor was used.

To calculate what total payments would be under the proposed workers' compensation relative value fee schedule, the multiple procedure adjustment rule in Minnesota Rules Part 5221.4051, was applied to the services. This rule decreases reimbursement to 75 percent of the fee schedule amount, for additional modalities provided to a patient on the same day. This adjustment does not affect the expenditure target amount of $293,646, but rather the distribution of fees within the provider group.

For physical medicine services, the Medicare geographically adjusted relative value unit for a service, multiplied by the 0.81 adjustment to accommodate one conversion factor, multiplied by the $52.05 conversion factor equals the maximum fee for that service. For example, for 30 minutes of therapeutic exercise, or CPT code 97110:

(Total RVU)	x	(PT Adjustment)]	x	(Conversion Factor)	=	Maximum Reimbursement Amount
[(0.51)	x	(0.81)]	x	($52.05)	=	$21.34
or (0.41)			x	($52.05)	=	$21.34

For administrative ease, the physical medicine total relative value units in the new proposed relative value fee schedule have already been geographically adjusted, and adjusted to accommodate the single conversion factor, which is why the relative values differ from those published by Medicare. This means that the values in the fee schedule can be multiplied by the $52.05 conversion factor to calculate the maximum reimbursable amount.

C. Chiropractic Services

Calculating Total Expenditures under Minnesota's 1991 Medical Fee Schedule

A total expenditure amount for all chiropractic services was determined in a similar manner as described for the provider groups. All payments under the 1991 workers' compensation fee schedule were summed at either their billed or fee schedule amount, whichever was less, according to Minnesota Statutes, section 176.136. The chiropractic database contained nearly 30,000 bills for services included in both fee schedules.

All services in the database were provided by chiropractors. Any services not included in Minnesota's current fee schedule did not contribute to the total expenditure calculation. The total expenditure amount under the 1991 fee schedule was then reduced by 15 percent to become our target expenditure amount under the proposed relative value fee schedule, or the amount on which to base our conversion factor calculations. For chiropractic services, the expenditure total under the 1991 fee schedule, for the six month period under study, was $467,831.

Determination of Relative Value Units

Medicare established a relative value unit for only one chiropractic service, code A2000, a manipulation of the spine. As noted earlier, Medicare does not reimburse for other chiropractic services. The three components of this relative value were adjusted slightly to accommodate the relatively lower Geographic Practice Cost Indices (GPCI) in Minnesota, in accordance with the Medicare adjustment rule. 42 CFR 415.20; 415.26; and 56 FR 59626; 59514, Addendum A. The overall effect of the adjustment reduced the Medicare relative value unit approximately two percent. This and the other proposed relative value units were also adjusted for a single conversion factor, as noted below.

Since the Medicare Fee Schedule provides a relative value for only one chiropractic service, relative values were calculated for all other services in the proposed workers' compensation relative value fee schedule. Charge data from the chiropractic State Fund database were used to determine the relative value units for the other services. These services are represented frequently enough in the State Fund Mutual database to provide an adequate sample with which to calculate relative value units. These additional relative values were calculated in the same way that Medicare calculated relative values for the medical/surgical services it did not individually survey.[10] Under this methodology, the median charge (50th percentile) for each service in the database was divided by the median charge for the anchor, or base service. In this case, the anchor service was A2000. The result was then multiplied by the total relative value for the anchor service. This produced a relative value unit for all chiropractic services included in the proposed workers' compensation relative value fee schedule.

Target Expenditure Amount and the Conversion Factor

The total expenditure amount under the 1991 fee schedule for chiropractic services in the State Fund database was $467,831. Eighty-five percent of this amount is $397,656. As noted earlier, a single conversion factor or $52.05 is proposed which requires an adjustment of the relative value units. We assigned the geographically adjusted Medicare and other calculated relative values to all services included in the database. The relative values were then adjusted

[10] See Kelly, supra note 4.

so that the payments for the services, if paid under the relative value fee schedule with a conversion factor of $52.05, equalled $397,656. This adjustment factor was 0.572. Each of the relative values were multiplied by this amount. This adjustment did not change the relative value relationship between individual services within the group, and the maximum fees remain the same as if a separate conversion factor was used.

To calculate what total payments would be under the proposed workers' compensation relative value fee schedule, the multiple procedure adjustment rule set forth in part 5221.4061, was applied to the services in the database. This rule decreases reimbursement to 75 percent of the fee schedule amount, for additional modalities given to a patient on the same day. This adjustment does not affect the expenditure target amount under the proposed relative value schedule of $397,656, but rather the distribution of fees within the group.

For chiropractic services, the geographically adjusted relative value unit for the service, multiplied by the 0.572 chiropractic single conversion factor adjustment, multiplied by the $52.05 conversion factor equals the maximum fee for that service. For example, for manipulation of spine, code A2000:

[(Total RVU) x (CH Adjustment)]	x	(Conversion Factor)	=	Maximum Reimbursement Amount
[(0.75) x (0.572)]	x	($52.05)	=	$22.38
or (0.43)	x	($52.05)	=	$22.38

For administrative ease, the chiropractic total relative value units in the new Minnesota RBRVS have already been multiplied by the geographic and single conversion factor adjustments. This means that the values in the fee schedule can be multiplied by the $52.05 conversion factor to calculate the maximum reimbursable amount.

D. Pathology/Laboratory Services

Calculating Total Expenditures under Minnesota's 1991 Medical Fee Schedule

A total expenditure amount for all pathology and laboratory services in the database was determined in a similar manner as described for the other provider groups. All payments under the 1991 fee schedule were summed at either their billed or fee schedule amount, whichever was less, in accordance with Minnesota Statutes, section 176.136, subdivision 1. The pathology/laboratory database contained more than 600 bills for services common to both fee schedules.

As with the other provider groups, services in the database that were not limited by the 1991 fee schedule did not contribute to the total expenditure calculation. This total was then reduced by 15 percent to become our target expenditure, or the amount on which to base our conversion factor calculations. For pathology/laboratory services, the expenditure total under the 1991 fee schedule, for services in the database in the six month period under study, was $7,432.

Determination of Relative Value Units

The Medicare fee schedule did not establish relative value units for most pathology/laboratory services that are included in Minnesota's 1991 fee schedule. For those services with no available Medicare values, relative values were calculated using charge data in the State Fund Mutual pathology/laboratory database and the methodology used by Medicare for calculating relative values for services which were not individually surveyed.[11] For those services used frequently enough in the State Fund Mutual database to provide an adequate sample with which to calculate relative value units according to Medicare, relative value units were calculated. In this case, the base service was CPT code 88300 (surgical pathology; gross examination). The median charge (50th percentile) for each service was divided by the median charge for the anchor, or base service. This was the service which had a Medicare relative value assigned and which occurred with the most frequency and distribution in the database. The result was then multiplied by the total relative value for the anchor service. This method produced a relative value unit for all pathology/laboratory services in the proposed workers' compensation relative value fee schedule.

Target Expenditure Amount and the Conversion Factor

The total expenditure amount under the 1991 fee schedule for pathology/laboratory services in the database was $7,432. Eighty-five percent of this amount is $6,317. As noted earlier, a single conversion factor of $52.05 is proposed, which requires adjustment of the relative values instead. We assigned the geographically adjusted Medicare and other calculated relative values to all services included in the database. Each of the relative values were then adjusted so that the payments for the services, if paid under the relative value fee schedule with a conversion factor of $52.05, equalled $6,317. This adjustment factor was 0.572. Each of the relative values was multiplied by this amount. This adjustment did not change the relative value relationship between individual services within the group, and the maximum fees remain the same as if a separate conversion factor was used.

For pathology/laboratory services, the geographically adjusted relative value unit for the service, multiplied by the 0.835 pathology/laboratory single conversion factor adjustment, multiplied by the $52.05 conversion factor equals the reimbursement maximum for that service. For example, for seven clinical chemistry tests, code 80007:

[(Total RVU)	x	(PL Adjustment)]	x	(Conversion Factor)	=	Maximum Reimbursement Amount
[(0.94)	x	(0.835)]	x	($52.05)	=	$40.56
or (0.78)			x	($52.05)	=	$40.56

For administrative ease, the pathology/laboratory total relative value units in the new Minnesota RBRVS have already been multiplied by the geographic and pathology/laboratory single conversion factor adjustment. This means that the values in the fee schedule can be multiplied by the $52.05 conversion factor to calculate the maximum reimbursable amount.

VII. Content Review of Rules

[11] Kelly, Supra, note 4.

Part 5221.4000 APPLICATION OF THE FEE SCHEDULE; INSTRUCTIONS.

Minnesota Rules Part 5221.1000, which includes the instructions for the 1991 fee schedule, is replaced with Minnesota Rules Part 5221.4000 which explains the contents of the Relative Value Fee Schedule and identifies which types of health care charges are governed by fee schedule limits. The instructions in the 1991 fee schedule are specific to the present charge-based fee schedule. The proposed workers' compensation relative value fee schedule differs substantially from the existing schedule in both content and format; thus, the new instructional language in this part is required.

Subpart 1. Contents. This subpart describes the contents of the rule and lists the components which make up the fee schedule.

Subpart 2. Revisions. This subpart verifies that the current medical fee schedule is effective until the annual revisions required by Minnesota Statutes, section 176.136, subdivision 1a, are adopted but recognizes that the Commissioner may revise the schedule at any time. Possible reasons that may require revision for an accurate, fair effective fee schedule are listed.

Subpart 3. Applicability. This subpart lists the general criteria for applicability of the fee schedule and allows the user to determine if a charge for a particular health care service is governed by fee schedule limits. This is one of the threshold questions asked by providers and payers when billing or adjudicating claims for health care services because, if the charge is not subject to fee schedule limits, then other statutory limits may apply; specifically, those set forth in Minnesota Statutes, section 176.136, subdivision 1(b).

Part 5221.4010 EMPLOYER'S LIABILITY FOR SERVICES UNDER THE MEDICAL FEE SCHEDULE.

This part gives the user an overview of employer liability under the medical fee schedule consistent with Minnesota Statutes, section 176.136. Although this concept is included in the statute and also in the proposed amendments to part 5221.0500, it is important to make the instructions as user-friendly and conclusive as possible. This establishes the rule that the employer's liability for included services is 100 percent of the calculated fee or the provider's usual and customary fee for their service, whichever is lower. "Usual and customary" is defined in Minnesota Rules Part 5221.0500, subp. 2. The definition clarifies and is consistent with the meaning of the phrase "usual and customary" set forth in Minnesota Statutes, section 176.136, subdivision 1b(b): ". . . charges for similar treatment, articles and supplies furnished to an injured person when paid for by the injured person. . ."

Although the statute uses the term "actual" fee, in Minnesota Statutes, section 176.136, subdivision 1, it is determined that this is not really a different concept than the provider's "usual and customary" fee, used elsewhere in that statute. A health care provider should always bill the provider's usual and customary fee, which then may be reduced by the payer consistent with the fee schedule. The term "actual" fee can be interpreted to mean that a provider may bill something other than the usual and customary fee for the service, thus receiving higher reimbursement than in non-workers' compensation cases. This is prohibited by the above statutory provision and Minnesota Rules Part 5221.0700, subp. 1.

Part 5221.4020 FORMULA FOR DETERMINING FEE SCHEDULE PAYMENT LIMITS; CONVERSION FACTOR.

This part provides the user the arithmetic formula needed to calculate maximum fees for services included in the fee schedule.

Subpart 1. Formula. The arithmetic formula for calculating maximum fees in most situations is presented in this subpart. This formula is essentially the same as that used by the Health Care Financing Administration in determining reimbursement amounts for Medicare services, set forth in 42 CFR § 415.20, 56 FR 59625 and further explained at 56 FR 59508. The difference is that, where the Medicare fee is arrived at by multiplying and adding numerous variables, the Minnesota fee can be obtained by multiplying only two variables. Specifically, the Medicare formula requires three steps. First, the relative value units for each three components of the service are multiplied by the specific geographic practice cost indices for the area where the service was delivered. Next, these three geographically adjusted relative value units are added together to obtain a total relative value unit and, third the total relative value unit is multiplied by the conversion factor to determine the payment amount.

In other words Medicare payment = [(Work Relative Value Unit x Geographic Practice Cost Index, work) + (Practice Expense Relative Value Unit x Geographic Practice Cost Index, practice expenses) + (Malpractice Relative Value Unit x Geographic Practice Cost Index, malpractice)] x Conversion Factor. 56 FR 59508. These calculations could not be further simplified in the Medicare fee schedule because the three geographic practice cost indices are different for each geographic area. See 56 FR 59785, Addendum C.

In the Minnesota fee schedule however, further simplification was possible because Medicare has calculated only one set of geographic practice cost indices for the State of Minnesota. Thus, as described above on page 6, it was possible to adjust the Medicare relative value units for each three components of all services by the appropriate geographic practice cost index for Minnesota and add all of these together to obtain the total relative value units for all services. Because only total relative value units are required to determine maximum fees under the proposed fee schedule, only these values are listed. These differences reflect the department's efforts to simplify application of the schedule for the user wherever possible.

In some situations, adjustments of this base formula are necessary. This subpart alerts the user that a different formula may be required to calculate charges for some medical services and lists the parts which identify these situations. This subpart also identifies the specific parts containing the relative value units, which are listed in the schedule by provider group. Selection of the four provider groups was discussed in section V of this statement.

Subpart 2. Conversion factor. The actual dollar amount for the conversion factor is presented in this subpart. Also noted is the fact that the conversion factor will be updated annually, according to methods set forth in Minnesota Statutes, section 176.136, subdivision 1a. The conversion factor was calculated to bring about the 15 percent reduction from the 1991 fee schedule mandated by Minnesota Statutes, section 176.136, subdivision 1. The calculations employed to arrive at the conversion factor are described above in section VI entitled "Determination of Relative Value Units and Conversion Factors for Each Provider Group".

A sample calculation is included in this subpart to clearly illustrate how actual relative value units are multiplied by the conversion factor, to arrive at the maximum fee allowed for a given service.

Part 5221.4030 MEDICAL/SURGICAL PROCEDURE CODES.

This part provides relative value units and other items of information for services included in this provider group. Services and providers subject to these maximum fees are specified in part 5221.0700, subp. 3, item C, and are also discussed in section V. Relative value units and other items of information presented in this part are needed to calculate maximum fees for services using the basic formula set forth in Minnesota Rules Part 5221.4020.

Subpart 1. Key to Abbreviations and terms. This subpart explains the format of the list of medical/surgical procedure codes, which appears in subpart 2. This list is comprised of six columns and, in this subpart, the heading for each column is identified and explained and the type of information contained in each column is described.

Item A. All services included in the medical/surgical group are listed by procedure code, in ascending order. Procedure codes are the same codes used and recognized by Medicare and by virtually all other payers and providers. This coding system is referred to as the Health Care Financing Administration's Common Procedure Coding System, or "HCPCS." 42 CFR § 415.40 and 56 FR 59513. The HCPCS coding system is incorporated by reference in part 5221.0405, item E, and contains three levels of codes, identified and described in Minnesota Rules Part 5221.0100, subp. 4.

Item B. The breakdown of a service into professional and technical components may affect payment amounts. The professional component of a service represents the cost of the care rendered by the physician or primary provider while the technical component of the service represents all other costs, such as use of equipment and services of technicians. This item explains that services for which such a breakdown is appropriate are identified in the list by modifiers appearing in this column, aptly labeled "Technical/Professional MOD". Rules for determining payment amounts for affected services appear in part 5221.4032. All services identified by Medicare as having separate professional and technical components are assigned modifiers in this listing. 42 CFR § 415.40. See also 57 FR 55995, Addendum B, and 56 FR 59514.

Item C. Every service has been assigned by Medicare one of five different symbols, specified in subitems 1 through 5. Each of these symbols represent a specific rule regarding payment for the service; in other words, each service has been assigned a particular payment status. This item lists the symbol for each payment status, referred to as status indicators, and explains the rule for each. Status indicators and associated payment rules included here are identical to those created for Medicare. 57 FR 55995, Addendum B. Medicare also used other status indicators but these are omitted from the proposed Minnesota schedule, because these represent unique Medicare rules not applicable to our schedule. Those codes in the Medicare fee schedule which were assigned any of these omitted status indicators, listed and described below, were not included in the proposed Minnesota fee schedule and therefore liability for these

services is controlled by Minnesota Statutes, section 176.136, subdivision 1b. The omitted status indicators are:

C = Carriers price the code. Under the Medicare fee schedule, carriers establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation such as an operative report.

D = Deleted codes. These codes were deleted from the Medicare schedule effective with the beginning of calendar year 1993.

E = Excluded from the Medicare physician fee schedule by federal regulation. These codes are for items or services that HCFA chose to exclude from the physician fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the physician fee schedule for these codes.

N = Noncovered service. These codes are noncovered services. Payment may not be made for these codes under Medicare.

R = Restricted coverage. Special coverage instructions apply. Under Medicare, if covered, the service is carrier-priced.

X = Exclusion by law. These codes represent an item or service that is not within the definition of "physician services" for Medicare physician fee schedule payment purposes. No RVUs or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. [Examples are ambulance services and clinical diagnostic laboratory services].

The Medicare status codes that are included in the proposed Minnesota fee schedule are listed in subitems 1 through 5, followed by definitions and associated payment rules. 57 FR 559915, Addendum B.

Subitem (1). Active codes ("A") are those which have distinct relative value units, and which are paid pursuant to the general rules, in amounts calculated according to the formula set forth in part 5221.4020.

Subitem (2). Bundled codes ("B") are those services or supplies that are normally provided in conjunction with another "primary" service. The relative value units for the "primary" service include the costs of these bundled services or supplies, thus; no relative value units have been assigned and no separate payment is made for these bundled services.

Subitem (3). Services assigned a "P" code are ones that may or may not be separately payable, as described below. These are generally limited to articles or supplies.

Our proposed rule for payment of "P" coded services is identical to Medicare's rule; that is, if the service was provided incident to the services of a licensed provider, on the same day as the licensed provider service, payment of the "P" coded service is bundled into the "primary" service and no separate payment is made. This rule reflects the fact described above in subitem

(2), that the relative value units for the "primary" service include the costs of the bundled service.

If the service is not provided incident to the services of a licensed provider, it is excluded from the fee schedule and, as with Medicare, liability for the service is limited by other statutory provisions; namely, Minnesota Statutes, section 176.136, subdivision 1(b). This subitem includes an illustrative example for clarity. Specifically, it is noted that an elastic bandage, procedure code number A4202 is a "P" code. If a provider furnished an employee an elastic bandage while treating the employee for a tibia fracture, the cost of the elastic bandage is included in the cost of the treatment, procedure code number 27750. No separate payment for the bandage is allowed. On the other hand, if the bandage is not provided in conjunction with another service, it is excluded from the schedule and the maximum fee is limited by Minnesota Statutes, section 176.136, subdivision 1(b).

Subitem (4). "T" indicates injections and the corresponding rule for payment is identical to that for Medicare. That is, if the "T" service was provided incident to the services of a licensed provider, on the same day as the licensed provider service, then the "T" service is bundled into the costs of the "primary" service and no separate payment is made. If the "T" service was not provided incident to the services of a licensed provider, then separate payment is made and the maximum fee for the "T" service is calculated using the relative value units listed for the service and the formula in part 5221.4020. This distinction addresses those situations in which the only service the patient receives on a given day is an injection.

Subitem (5). "Z" codes are electrocardiograms and the rule for payment is identical to that for Medicare, which, in turn is identical to the rule for payment of injections, outlined above in subitem (4).

Item D. These descriptions, which are contractions of the CPT/HCPCS definitions, are identical to the brief procedure code descriptions which appear in the Medicare fee schedule. 42 CFR § 415.40. See also 56 FR 59513 and 57 FR 55995. The user is referred to the CPT and HCPCS manuals for more complete descriptions, because the description of the procedure code which appears in the CPT or HCPCS manual on the date the service was rendered is controlling. This reflects the fact that the CPT and HCPCS codes and their accompanying descriptions are updated by their publishers on an annual basis. This rule makes it unnecessary to print the entire description for each code, and reprint these descriptions annually. Not only would that result in an unreasonably large and unwieldy fee schedule, it would also require reprinting and distributing a new schedule on an annual basis. This is unnecessary, because virtually all providers and payers have access to the most current CPT and HCPCS manuals, either in their own offices or through the minitex interlibrary loan system. This rule is intended to prevent disputes which arise from ambiguous or imprecise code descriptions.

Item E. Column 5 contains the total relative value units for each service. As noted in section V, the total relative value unit is the sum of the Medicare relative value units for the three components of each service (the physician work component, the practice expense component and the malpractice component) adjusted by the Medicare Geographic Practice Cost Indices for Minnesota. 42 CFR § 415.22, 56 FR 59625. See also 57 FR 55995, 57 FR 55997, Addendum B and 56 FR 59785, Addendum C.

In the Medicare fee schedule, the relative value units for all three components are listed, in addition to the total relative value unit. This is necessary because payment amounts for some services under Medicare are calculated by adjusting individual components and because, as noted in section V, each individual component for a given service must be multiplied by the specific geographic practice cost index for the area. Since none of the payment calculations set out in our fee schedule require application of any individual components and because the Minnesota geographic practice cost indices were incorporated into the total relative value unit for each service, it was unnecessary to list the individual components.

Item F. Relative value units for certain operative-type procedures represent the resources expanded by the physician in providing not only the procedure but also the normal pre- and post-operative care. The normal amounts of post-operative care for effected procedures have been quantified in terms of numbers of days. For example, Medicare has determined that the normal amount of care provided by the surgeon following a skin graft procedure, code 15200, will be completed within 90 days of the procedure. This concept is referred to variously by Medicare and providers as the "global surgery package", "global surgery fee" or "global period." The result of this rule is that the surgeon is paid a flat rate for the procedure, as well as all related care provided through the end of the global period. This item explains that the symbols in column five indicate the extent to which this global surgery rule applies to the corresponding service and refers the user to the instructions for payment determination in part 5221.4034, subp. 3. The global fee periods contained in our schedule are the same as those assigned by Medicare, in policies issued pursuant to 42 CFR § 415.40. 56 FR 59627 and 59513, 57 FR 55995 and 55997, Addendum B.

Subpart 2. List of medical/surgical procedure codes. This is the list described in subp. 1, items A through F. The listed services, relative value units, and global periods apply to medical and surgical services performed by the health care providers specified in part 5221.0700, subp. 3, item C, discussed in section V of this statement.

Part 5221.4032 PROFESSIONAL/TECHNICAL COMPONENTS FOR MEDICAL/SURGICAL SERVICES.

This rule provides instructions for calculating maximum fees payable for medical/surgical services identified as having a professional and technical component. The professional component of a service represents the cost of the care rendered by the physician or primary provider while the technical component of the service represents all other costs, such as use of equipment and services of technicians. In practice, the professional component of the service may be performed by one individual or entity and the technical component may be performed by a different, separate individual or entity. The payer may or may not receive separate invoices for each portion of the service. This rule provides guidelines for payment of all possible scenarios for these services. The proposed rules set forth in subparts 1 through 3 are identical to those created for Medicare reimbursement. 42 CFR § 415.40, 56 FR 59627. See also 56 FR 59514. These rules are intended to prevent double payment to any provider.

Subpart 1. General. This subpart explains the general distinction between the professional and technical components, identifies the modifiers used for each component (TC for technical component and 26 for professional component) and establishes that the maximum fee for either component is calculated using the relative value units listed for the component and

the formula set forth in part 5221.4020.

Subpart 2. Separate Billing for Each Component. This establishes a maximum fee limit for a service which has been "split" into professional and technical components. When this occurs and each component of the service has been billed separately, the maximum fee for both cannot exceed the maximum fee allowed for the complete service. This is identical to Medicare's payment policy.

Subpart 3. One Billing for Both Components. This subpart notifies the user that, if the same provider renders both components of the service, the maximum fee is calculated for the complete service, by using the relative value units listed without a modifier and the formula set forth in part 5221.4020. The effect of this rule is to simplify the determination of a maximum fee by replacing two calculations - one for the professional component and one for the technical component - with one calculation, one for the complete service.

Part 5221.4033 OUTPATIENT LIMITATION FOR MEDICAL/SURGICAL SERVICES.

This rule identifies those services which are predominantly performed in a physician's office and which normally do not require hospital admission. When a physician performs a procedure in a setting other than his or her office, such as an outpatient setting, additional expenses are generated. These are often referred to as "facility fees." This rule provides payers assistance in determining when payment of a facility fee is or is not required. This rule contains the same and most current list of procedures which Medicare has determined should generally be performed in office settings, effective January 1, 1993. 57 FR 56157, Addendum D.

This part stipulates that additional facility fees charged in conjunction with any of the procedures listed will only be paid if it was medically necessary to perform the procedure in a non-office setting. This is a departure from the rule adopted by Medicare, set forth in 42 CFR § 415.32, 56 FR 59626. The Medicare rule, which addresses only the physician's fees, reduces the physician's fee for the service when performed in an outpatient setting, in an amount equal to 50 percent of the practice expense portion of the relative value unit for service. This reduction reflects the fact that the supplies, equipment and other practice expenses normally furnished by the physician, when the service is provided in the physician's office, have not been provided by the physician but have instead been provided by the outpatient facility. Medicare pays the associated facility fee charged by the outpatient hospital, pursuant to 42 CFR § 416.

The proposed Minnesota Rule does not provide for a reduction in physician fees for applicable services. Such a reduction would only be made on the rare occasion when one of the specified procedures is performed in a non-office setting. An analysis of six procedures revealed that adopting the Medicare rule for reducing physician fees in these situations would lower payments to physicians by $7.30 to $25.50, depending upon the procedure. Applying this reduction would have required listing the practice expense relative value units for all procedures in the fee schedule, thus expanding the volume of the fee schedule and complicating its application for a relatively few situations. For payers, this rule would have required analyzing each outpatient surgery bill, to determine if the rule applied, learning the formula for fee determination and calculating the maximum fee. The proposed rule for the workers' compensation fee schedule discourages the unnecessary use of facilities, such as hospital

emergency rooms, by placing responsibility on the facility. The responsibility of determining the appropriate use of outpatient facilities rests not only with the ordering physician but also with the facility. Facilities need to be aware of the procedures being performed and should communicate with health care providers as necessary to determine appropriate utilization.

Part 5221.4034 FEE ADJUSTMENTS FOR MEDICAL/SURGICAL SERVICES.

This part identifies those services and situations for which the general formula for fee calculations set out in Minnesota Rules Part 5221.4020 does not apply and provides alternative methods for determining correct maximum fees. These fee adjustments discussed in detail below are essentially the same adjustments made in the Medicare fee schedule.

Subpart 1. Global Surgery Fee. This subpart defines the global surgery concept; that is, that codes for surgical procedures, and the maximum fees calculated for those codes, include all services normally furnished by the surgeon before, during and after the procedure, within a predetermined post-operative period, measured in days. This concept, and associated rules for payment, discussed below, are based on Medicare global surgery payment policies established pursuant to 42 CFR § 415.40, 56 FR 59627. See also 56 FR 59513. This subpart also lists, for clarity, the specific services normally included in the pre-operative, intra-operative and post-operative phases of the global period. As discussed above in relation to Minnesota Rules Part 5221.4030, subp. 1, item F, the global fee periods contained in our schedule are the same as those assigned by Medicare, see 57 FR 55995 and 55997, Addendum B. This part notes that each procedure has been placed into a specific surgical category, each with different global fee periods and explains how to determine the global fee period and payment rules for specific procedures. The different category symbols are listed and described. All of the categories listed are categories defined and assigned by Medicare. One category included in the Medicare schedule was omitted from our schedule, category "YYY," which signifies that the global period for the procedure is to be set by the Medicare carrier. Since these codes are not assigned Medicare relative value units, they were not included in our schedule and, hence, the global surgery policy does not apply. Reimbursement for these services is governed by Minnesota Statutes, section 176.136, subdivision 1(b).

Subpart 2. Exclusions from global surgery fee. This part identifies which services, articles or supplies are not included in the global surgery fee, provides instructions for coding and billing for these services and explains methods of determining correct maximum fees.

Item A. This item clarifies that, for purposes of the global surgery fee, pre-operative care does not include any care administered by the surgeon before it is determined that surgery is required, nor does it include the initial evaluation or consultation by the surgeon during which the decision to have surgery is made (referred to by some as the "decision encounter.") These visits are paid separately. This rule is identical to Medicare's policy. 56 FR 59513. This item also confirms that maximum fees for these visits are calculated according to the standard formula in part 5221.4020, using the RVUs for the "decision encounter" service.

Item B. Because the relative value units for global surgery periods are intended only to cover services provided in a normal, uncomplicated surgical case, additional payment is generally allowed for unusual, additional services provided by the surgeon during the global

period. These additional services fall into four categories and this item provides coding and billing instructions for each category. These instructions, with one exception, explained below, are identical to those adopted by Medicare and include definitions for CPT modifiers which are universally agreed upon and recognized by providers and payers. See 56 FR 59513 and 59516. Two of these categories address the provision of additional evaluation and management services during the global period. Evaluation and management services include office visits, hospital visits and other cognitive-type services and have been assigned CPT procedure codes 99201 through 99499. The remaining two categories address the provision of additional surgeries or procedures, during the global period. Although Medicare's payment policy for both categories of services is the same, providers are required to distinguish between the two by including the correct modifier in the billing code, so that Medicare will be able ". . . to analyze the frequency with which we could expect to pay for these service and therefore set a standard for future payment based on actual experience," and to "conduct post-payment monitoring on the use of modifiers to identify potential abusers." 56 FR 59517. We have adopted this requirement for consistency.

The coding and billing instructions contained in subitems (1) through (4) are identical to those for Medicare, with one exception. In the case of a re-operation, provided to deal with complications of the original surgery, (subitem 3), identified by Modifier 78, Medicare sets its payments on a case-by-case basis, in an amount not to exceed 50 percent of the value of the intra-operative services originally performed. This calculation is possible because Medicare has determined intra- and post-operative percentages of the global surgery fee for families of procedures. See Appendix I. The intra-operative percentage of services include the services normally provided by the surgeon from the time of admission to the hospital for surgery, the surgery proper and the post-operative care through hospital discharge. The post-operative percentage of services include the normal, post-operative follow-up care, provided after discharge from hospital, through the end of the global period. Medicare's rule that re-operations are paid at a fee which does not exceed 50 percent of the value of the inter-operative services for the original procedure, reflects Medicare's assumption that in these instances, even though two surgeries were performed, only one "set" of pre-operative and post-operative services were provided, thus the surgeon should not be paid the entire global fee for the re-operation.

The corresponding rule in the Minnesota fee schedule is that the maximum fee for a re-operation, identified by Modifier 78 is calculated according to the following formula: Maximum fee = .43 x (total RVU for original procedure x CF) This rule was drafted to simplify application of the fee schedule. The formula is a simplification of Medicare's formula. It was determined in the following manner: Because the most frequent types of surgery performed in workers' compensation, namely, low back disc surgery, #63030 and carpal tunnel surgery, #64721, fall into the nervous system category, the intra-operative percentage assigned to the nervous system category by Medicare was used as the standard, that is, 86 percent. See Appendices I and II. Applying the Medicare formula, using the 86 percent value, results in the following formula: Maximum payment for re-operation = .50 x .86 x (total RVU for original procedure x CF). This may be simplified to .43 x (total RVU for original procedure x CF). The difference in payment amounts for re-operations, calculated using both methods is slight, as illustrated in Appendix III. Thus, the administrative burdens associated with adopting Medicare's payment strategy for re-operations (e.g., listing intra- and post-operative percentages for all surgical procedures, etc.) outweighed the potential benefits of doing so.

Item C. Because relative value units for global surgery packages in the Minnesota fee schedule are from the Medicare schedule, they do not account for medical resources expended for services specifically related to return-to-work planning. Examples of such services which the surgeon may provide during the global period include assessment of the employee's ability to return-to-work, review of specific job descriptions, communication with the employee's qualified rehabilitation consultant or employer and preparation of supplementary related reports. As these services are not included in the global surgery fee, this item refers the user to the parts which govern payment amounts and procedures.

Item D. This item clarifies that the cost of certain services generally provided in conjunction with organ transplant surgeries are not included in the global fee for the surgery. These are the same services Medicare excludes from global surgery fees for transplant surgeries, by policies issued pursuant to 42 CFR § 415.40 or law. See 56 FR 59546 and 59547.

Item E. This item, consistent with Medicare, clarifies that the costs of physical and occupational therapy services are not included in the global surgery fee. This rule is identical to Medicare's relevant policy issued pursuant to 42 CFR § 415.40, 56 FR 59627. This item also confirms that separate billing and payment for these services is allowed at fees calculated according to the basic formula in part 5221.4020.

Subpart 3. Multiple surgery fee reduction. This subpart reflects the fact that, in general, fewer medical resources are expended for multiple surgical procedures performed by the same surgeon on the same day, than would be expended if each procedure was performed separately. As noted by the Health Care Financing Administration in its rules for Medicare, the concept of reduced billing for multiple surgeries has been an accepted practice by physicians for many years. 56 FR 59601. The rules in this subpart are identical to Medicare's policy, enacted pursuant to 42 CFR § 415.20, 56 FR 59627 and 59515. The specific reduction amounts for each successive procedure reflect suggestions made in 1974 in the context of a study published by the California Medical Society, as well as similar rules in relative value scales of many other states and national specialty organizations. See 56 FR 59601.

Item A. This item sets out the rates of reduction for each successive multiple procedure and provides instructions for coding which are identical to Medicare's policy. 56 FR 59515. An illustrative example is included for clarification.

Item B. Some procedures have been exempted from the multiple surgery reduction in the Medicare schedule, because these procedures require the same amount of resources, regardless of whether they are performed separately or in combination with another procedure. 56 FR 59601. The list presented in this item includes the same procedures that Medicare exempts from multiple surgery reductions. The statement that maximum fees for these procedures are calculated according to the standard formula is included for clarification.

Subpart 4. Bilateral procedures. This rule is identical to Medicare's policy for payment for bilateral procedures. 42 CFR § 415.20, 56 FR 59516. It reflects the same general principles of the multiple procedure reduction; that is, that fewer medical resources are expended in one surgical session than would be in two separate sessions. The rule provides that the maximum amount paid to the surgeon for the complete bilateral procedure is 150 percent of the

global fee for one procedure. This is actually the same amount of reduction called for by the multiple surgery reduction rule, because here the surgeon will be paid 100 percent of the global fee for one side and 50 percent of the global fee for the other side. Modifier 50 is required in the billing code to inform the payer that the surgery was performed bilaterally.

Surgeries that normally are performed bilaterally have been assigned specific CPT codes, and their corresponding relative value units are intended to represent the amount of resources required for the complete bilateral procedure. Consequently, no reduction is made, and the 50 modifier must not be included in the billing code. This is also the case with Medicare. 56 FR 59516.

Subpart 5. Co-surgeons. This rule is identical to Medicare's policy for calculating the amount of payment to be made for one surgical procedure when performed by two physicians acting as co-surgeons. 56 FR 59516. The definition of co-surgeon, as one who performed a discrete function during the operative session, is included to distinguish a co-surgeon from an assistant-at-surgery. Assistants-at-surgery are paid pursuant to different calculations, outlined below in subpart 6. As noted in the Medicare rules, this is the current predominant carrier practice for payment for co-surgeons and reflects the fact that more resources are expended in performing the operation and follow-up care, when co-surgeons are required, than would be the case when only one surgeon is involved. The amount paid is 125 percent of the global fee, divided equally between the two surgeons.

The proposed Minnesota rules, unlike those for Medicare, will allow different payment distributions because it is recognize that the actual distribution of care between co-surgeons may not be equal. For example, the surgeons may not contribute the same amount of time or effort during the operation proper or only one surgeon may provide all of the follow-up care. A different payment distribution to co-surgeons is allowed only if the co-surgeons specify and explain the agreed upon distribution to the payer, in a writing included on the bills for the procedure, and if such distribution does not violate the state statute prohibiting fee-splitting, Minnesota Statutes, section 147.091, subdivision 1, paragraph (p).

As is the case with Medicare, Modifier 62 is required on each physician's billing, to notify the payer that the procedure was performed by co-surgeons.

Subpart 6. Assistant-at-surgery. Our rules for payment for the services of an assistant-at-surgery are the same as those for Medicare, which are established by statute, in section 1848 (1)(2) of title XVIII of the Social Security Act. 56 FR 59516 and 59603.

Item A. This rule recognizes and allows for payment of the services of an assistant-at-surgery, at the same percentage allowed for by Medicare. The term assistant-at-surgery is defined as one who does not perform a discrete function but merely assists the primary surgeon, to distinguish an assistant-at-surgery from a co-surgeon, discussed above in subp. 5. A modifier is required on the billing by the assistant surgeon to inform the payer that the surgeon functioned only as an assistant-at-surgery. The CPT system contains three assistants-at-surgery modifiers, each of which signifies a unique circumstance. Although the amount paid to the assistant surgeon is the same in both our schedules and Medicare's schedule, regardless of which of the three modifiers is used, we included all three in the rules because providers currently bill using

all three modifiers and payers will likely see all of them on bills received.

Item B. The Social Security Act, as cited above, requires that Medicare make no payment for an assistant-at-surgery in cases that national data show use of an assistant occurs less than 5 percent of the time. 56 FR 59603. The list included in this part is identical to the most current Medicare list. Our rule varies from Medicare's rule and allows payment for the services of an assistant-at-surgery, when documentation confirms that these services were required, because it is recognized that there may be circumstances unique to an individual patient, which justify these additional services.

Subpart 7. Multiple surgeons. This part provides instructions for distribution of the global fee in cases in which multiple physicians care for the patient during the global fee period. The most common of these is the case in which the surgeon performs only the operation and the referring primary physician provides the follow-up post operative care. These rules are a variation of those for Medicare, as described below.

Items A, B, D & E. These items specify the distribution of the global surgery fee between two physicians in the standard case described above. Under the proposed Minnesota fee schedule, the surgeon who performs the surgery and provides care only through hospital discharge, is paid 86 percent of the global fee for the surgery. The physician who assumes post-discharge follow-up care is paid the remaining 14 percent of the global fee. This "86-14" breakdown is a simplification of the Medicare Rules for payments of multiple physicians.

As noted earlier, Medicare has determined specific intra- and post-operative percentages for families of procedures. See Appendix I. The intra-operative percentages range from 93 percent of the global fee payment to the surgeon for the mediastinum category, which includes such procedures as repair of laceration of diaphragm, to 78 percent of the fee to the surgeon for the maternity category. Medicare's policy for payment of the global fee when intra- and post-operative care is performed by different physicians is to pay each physician the percent of the global fee which corresponds to the intra- and post-operative percentages listed. For example, the surgeon who cares for a patient with a musculoskeletal condition from time of hospital admission through time of hospital discharge is paid 79 percent of the global fee for the procedure and the physician who cares for the patient post-operatively from the time the patient is discharged through the end of the global period is paid 21 percent of the global fee for the procedure.

Our rule simplifies these calculations in an effort to make the fee schedule as user-friendly as possible. The 86/14 percent breakdown was chosen because the Medicare percentages for the nervous system category of surgeries is 86 percent intra-operative and 14 percent post-operative. Nervous system surgeries are the most frequent type of surgery occurring in workers' compensation. See Appendices I and II.

This departure from the Medicare rules will not only make the schedule more user-friendly, it also will save the administrative costs associated with including one or two more columns of information for each listed service, specifically, intra- and post-operative percentages, and corresponding instructional rules. Furthermore, if in specific instances, the physicians are dissatisfied with this distribution, a different fee distribution is allowed, as long

as the physicians specify and explain the agreed upon alternative fee distribution to the payer, in a writing included with the bills and if such distribution does not violate the state statute prohibiting fee-splitting, Minnesota Statutes, section 147.091, subdivision 1, paragraph (p). This alternative is set forth in Item D of this subpart. An alternative distribution of the global surgery fee should not work a hardship on payers because, as provided in Item E, the sum of the fees allowed for all practitioners providing care included in a global surgery package shall not exceed the amount of the global fee calculated for a single practitioner. The rule in Item E is identical to Medicare's policy in these situations, established pursuant to 42 CFR § 415.40, 56 FR 59627. See also 56 FR 59516. Modifiers are required, as described.

Item C. This item provides a method for calculating further distributions of the global surgery fee, when several practitioners furnish post-operative care. This method is identical to the Medicare policy for these circumstances. See 56 FR 59602. The limitation provided in Item E, that is, that the sum of fees provided to all practitioners must not exceed the fee that would have been paid to one practitioner, providing the global surgery services, applies to these situations, also.

Part 5221.4040 PATHOLOGY AND LABORATORY PROCEDURE CODES.

This part provides relative value units for services included in this provider group. Relative value units are needed to calculate maximum fees for these services, using the basic formula set forth in Minnesota Rules Part 5221.4020.

Subpart 1. Key to abbreviations and terms. This subpart explains the format of the list of pathology and laboratory procedure codes, which appears in subpart 2. The list is comprised of three columns, and, in this subpart, the heading for each column is identified and explained and the type of information contained in each column is described.

Item A. All services included in the pathology and laboratory group are listed by procedure code. Procedure codes are the same codes used and recognized by Medicare and by virtually all other payers and providers. This coding system, referred to as the Health Care Financing Administration's Common Procedural Coding System or "HCPCS" is described in Minnesota Rules 5221.0100, subp. 4.

Item B. These descriptions which are contractions of the CPT/HCPCS definitions, are identical to the brief procedure code descriptions which appear in the Medicare fee schedule. The user is referred to the CPT and HCPCS manuals for more complete descriptions because the CPT/HCPCS code description in effect on the date the service was rendered is controlling.

Item C. The development of the relative value units for pathology/laboratory services is discussed in section VI of this statement.

Subpart 2. Pathology and laboratory procedure codes and values. This is the list described in subpart 1, items A through C. The listed procedure codes, descriptions and relative value units apply to pathology and laboratory services performed by the health care providers specified in part 5221.0700, subp. 3, item C, discussed in section V of the statement.

Part 5221.4041 FEE ADJUSTMENTS FOR PROFESSIONAL/TECHNICAL COMPONENTS FOR PATHOLOGY/LABORATORY SERVICES.

This part provides instructions for calculating maximum fees for the professional and technical components of pathology and laboratory services. In practice, the professional component of this service may be performed by one individual or entity and the technical component by a different, separate individual or entity. The payer may or may not receive separate invoices for each portion of the service. This part provides payment guidelines for various scenarios which may arise.

Subpart 1. General. This rule is patterned after Medicare's policy for payment of professional and technical components for physician services, adopted by Minnesota Rules Part 5221.4032. Because the distribution of professional and technical resources for most pathology and laboratory services is fairly consistent, separate relative value units for each component were not calculated. Rather, maximum fees for each were set at a standard percentage of the total relative value unit for the service. Specifically, the maximum fee for the professional component is 25 percent of the total fee and the maximum fee for the technical component is 75 percent. These amounts were determined in the following manner: Medicare provided relative value units for the technical and professional components for 59 pathology and laboratory services. 56 FR 59510, 57 FR 55997, Addendum B. The Medicare relative value units for the technical component of these services was, on average, 75 percent of the total relative value units for the services, and the Medicare relative value units for the professional component of these services was, on average, 25 percent of the total relative value units for the services. Modifiers are required to explain to the payer which component of the service was provided.

Subpart 2. Services Provided to Hospital Inpatients. This rule provides instructions for billing and paying for a service when a physician provides the professional component of the service and an inpatient hospital provides the technical component. This rule is not included in Medicare, and is necessary because, under Minnesota Statute, section 176.136, subdivision 1, charges for inpatient hospital services are not subject to fee schedule limits but, rather, are limited by Minnesota Statutes, section 176.136, subdivision 1b. Therefore, the physician continues to receive the maximum fee calculated for the professional component of the service, while the technical component of the service, performed by the hospital, is payable according to Minnesota Statutes, section 176.136, subdivision 1(b).

Subpart 3. Separate Billing for Each Component. This rule establishes that the total cost for both components of a procedure, provided by two separate individuals or entities, shall not exceed the maximum fee allowed if the complete procedure had been provided by one entity. This rule is patterned after Medicare's corresponding rule for physician services. Exceptions are allowed, because unique, individual circumstances may require additional, necessary services.

Subpart 4. One Billing for Both Components. This subpart provides instructions for calculating the maximum fee for a pathology/laboratory service when the same provider furnishes both the professional and technical components of the procedure. The fee in these situations is simply calculated using the total relative value units listed for the service and the formula set forth in Minnesota Rules Part 5221.4020.

Subpart 5. Services Performed in an Independent Laboratory. This rule is applicable in those instances in which a physician orders a pathology or laboratory test but the test is performed in an independent laboratory. Traditionally, some physicians and independent laboratories arranged collaborative practices, whereby the laboratory billed the physician for tests performed, the physician paid the laboratory and, in turn, billed the patient for the test, perhaps at a fee higher than that paid to the laboratory by the physician. Tests performed in this fashion are sometimes referred to as "purchased diagnostic tests." Medicare has expressly prohibited physician markups for purchased diagnostic tests, in accordance with section 1842 (n)(1) of title XVIII of the Social Security Act. See 56 FR 59515.

The rule in this part is patterned after the above-described Medicare rule and is consistent with Minnesota Rule Part 5221.0700, subp. 2, which requires separate billing directly to the payer, by the provider actually furnishing the service. This rule does not require that the ordering physician's assessment of the test results go uncompensated, because those services are accounted for by the physician when billing for the related evaluation and management services, such as office and hospital visits.

Part 5221.4050 PHYSICAL MEDICINE AND REHABILITATION PROCEDURE CODES.

This part provides relative value units for the services included in this provider group. Relative value units are needed to calculate maximum fees for these services, using the basic formula set forth in Minnesota Rules Part 5221.4020.

Subpart 1. Key to abbreviations and terms. This subpart explains the format of the list of physical medicine and rehabilitation procedure codes, which appears in subpart 2. The list is comprised of three columns and, in this subpart the heading for each column is identified and explained and the type of information contained in each column is described.

Item A. All services included in physical medicine and rehabilitation group are listed by procedure code in ascending order. Procedure codes are the same codes used and recognized by Medicare and by virtually all other payers and providers. This code and system, referred to as the Health Care Financing Administration's Common Procedural Coding System or "HCPCS" is described in Minnesota Rules Part 5221.0100, subp. 4.

Item B. These descriptions, which are contractions of the CPT/HCPCS definitions, are identical to the brief procedure code descriptions which appear in the Medicare fee schedule. The user is referred to the CPT and HCPCS manuals for more complete descriptions, because the CPT/HCPCS code description in effect on the date the service was rendered is controlling.

Item C. The development of relative value units for listed services is discussed in section VI of this statement.

Subpart 2. List of physical medicine and rehabilitation procedure codes. This is the list described in subp. 1, items A through C. The listed procedure codes, descriptions and relative value units apply to physical medicine and rehabilitation services performed by the health care providers specified in part 5221.0700, subp. 3, item C, discussed in section V of this statement.

Part 5221.4051 FEE ADJUSTMENTS FOR PHYSICAL MEDICINE AND REHABILITATION SERVICES.

This rule provides instructions for calculating fees for multiple physical medicine and rehabilitation modalities provided to the same patient on the same day. Although the Medicare fee schedule does not include this adjustment, it is patterned after the multiple surgery reduction rule established for Medicare and adopted here at part 5221.4034, subp. 1. This rule reflects the presumption that fewer resources are expended in providing multiple modalities to the same patient, during the same clinic appointment, then would be expended if each modality was provided at separate appointments. It provides that the most expensive modality, in other words, the modality with the highest relative value, is paid at 100 percent of the amount calculated according to the formula in part 5221.4020 and all additional services provided are paid at 75 percent of the fee calculated according to the formula in part 5221.4020. The amount of fee reduction, 25 percent for all services provided after the most expensive service, represents the Department's estimation of the amount of health care resources that would be expended had the individual service been provided to the patient at a separate appointment and is the same amount provided in the current charge-based schedule for multiple surgeries, with separate incisions or separate body parts. Minnesota Rules Part 5221.2250, subp. 2, item F, subitems 2 and 3. The CPT Modifier 51 is required in the billing code to alert the payer to the fact that multiple modalities were provided to the patient on the same day.

Part 5221.4060 CHIROPRACTIC PROCEDURE CODES.

This rule provides relative value units for services included in this provider group. Relative value units are needed to calculate maximum fees for these services, using the basic formula set forth in Minnesota Rules Part 5221.4020.

Subpart 1. Key to abbreviations and terms. This subpart explains the format of the list of chiropractic procedure codes which appears in subpart 2. This list is comprised of three columns, and, in this part, the heading for each column is identified and explained and the type of information contained in each column is described.

Item A. All services included in the chiropractic procedure group are listed by procedure code in ascending order. Procedure codes are the same codes used and recognized by Medicare and by virtually all other payers and providers. This coding system, referred to as the Health Care Financing Administration's Common Procedure Coding System or "HCPCS" is described in Minnesota Rules Part 5221.0100, subp. 4.

Item B. These are brief descriptions of each procedure code. More complete descriptions of these procedures are provided either in subpart 3 or in the CPT and HCPCS manual. The user is referred to these manuals because the CPT or HCPCS code descriptions in effect on the date the service was rendered is controlling.

Item C. Medicare provided relative value units for only one chiropractic service, A2000, office visit with manipulation. The development of the additional relative value units listed here is discussed in section VI.

Subpart 2. List of chiropractic procedure codes. This is the list described in subp. 1,

items A through C. The listed procedure codes, descriptions and relative value units apply to chiropractic services performed by the health care providers specified in part 5221.0700, subp. 3, item C, discussed in section V.

Subpart 3. Select chiropractic procedure code descriptions. The three code descriptions presented here do not appear in either the CPT or HCPCS manuals. The codes and their descriptions are required to facilitate billing by chiropractic providers for services specifically related to vocational rehabilitation and return to work efforts. Instructions for the use of these codes and determination of corresponding maximum fees are provided in parts 5221.0410, subp. 7, 5221.0420, subp. 3 and 5221.0500, subp. 2, item F.

Part 5221.4061 FEE ADJUSTMENTS FOR CHIROPRACTIC SERVICES.

This rule provides instructions for calculating fees for multiple chiropractic modalities provided to the same patient on the same day. It is unique to the workers' compensation fee schedule, and is patterned after the multiple surgery reduction rule established for Medicare and adopted herein at part 5221.4034, subp. 1. This rule reflects the presumption that fewer resources are expended in providing multiple modalities to the same patient, during the same clinic appointment than would be expended if each modality was provided at separate appointments. It provides that the most expensive modality is paid at 100 percent of the amount calculated according to the formula in part 5221.4020 and all additional modalities provided are calculated at 75 percent of the fee calculated according to the formula in part 5221.4020. The amount of fee reduction, 25 percent of all services provided after the most expensive procedure, represents the Department's estimation of the amount of health care resources that would be expended had the individual service been provided to the patient at a separate appointment and is the same reduction provided in the current charge-based schedule for multiple surgeries, with separate incisions or separate body parts. Minnesota Rules Part 5221.2250, subp. 2, item F. The CPT Modifier 51 is required in the billing code to alert the payer to the fact that multiple modalities were provided to the patient on the same day.

Part 5221.4070 PHARMACY.

This rule provides instructions for billing and for determining maximum fees owed for medications. Minnesota Statutes, section 176.136, subdivision 1(b) requires the commissioner to develop procedures limiting fees that are designed to "encourage providers to develop and deliver services for the rehabilitation of injured workers." These reimbursement limitations are not established by use of relative values, because that mechanism is not easily applied to supplies such as medications. Given the commissioner's general authority to limit fees under Minnesota Statutes, section 176.136, subdivision 1, and 176.83, subdivision 5, it is not likely that the legislature intended that only services for which a relative value could be established can be included in the fee schedule. Because pharmacy services were not included in the 1991 medical fee schedule, the services have been subject to payment limitations imposed by the 1992 legislation, codified at Minnesota Statutes, section 176.136, subdivision 1b(b), which provides that services, articles and supplies not included in the fee schedule are reimbursed at 85 percent of the usual and customary or prevailing charge. In the fall and winter of 1992, when payers began applying this discount to bills received, providers of pharmacy services contacted the Department and described the hardships these discounts worked on their operations. Because

the profit margin for pharmacies is typically small, representatives for pharmacists affected by this statute stated that they were delivering pharmacy services to workers' compensation recipients at a loss. Thus, the absence of a rule providing fee limits for pharmacy services was, in effect, serving to discourage providers of pharmacy services from treating individuals who had been injured on the job. The reasonable cost of pharmacy services is easily determined, based on a study done by the Pharmaceutical Economics Research Center at Purdue University. Accordingly, reasonable limitations of pharmacy charges can be included in the fee schedule.

Subpart 1. Substitution of generically equivalent drugs. This subpart is patterned after a similar rule promulgated by the Minnesota Department of Human Services for provision of health care under its medical assistance program. Minnesota Rules Part 9505.0340, subp. 3, item H. The rule requires the health care provider to substitute a generically equivalent drug for the drug ordered by the physician, if the following conditions are met:

(1) The generically equivalent drug is approved by the United States Food and Drug Administration and is also determined as therapeutically equivalent by the United States Food and Drug Administration; and

(2) in the professional judgment of the dispensing health care provider, the substituted drug is therapeutically equivalent to the ordered drug; and

(3) the charge for the substituted generically equivalent drug does not exceed the charge for the drug originally ordered.

These conditions are identical to those set out in the rule promulgated by the Department of Human Services, cited above. In recognition of the obligation of the ordering physician to evaluate and treat each patient on an individualized, case-by-case basis, an "override" mechanism is included in this part. That is, the ordering physician may prevent the substitution of a generally equivalent drug by writing the words "dispense as written" or "DAW" on the prescription. This mechanism is provided in the Minnesota Drug Selection Act, Minnesota Statutes, section 151.21 and is widely recognized by health care providers who order and dispense medications.

The requirement that the dispensing provider notify both the recipient and the payer is similar to the notice requirement included in the Department of Human Services rule cited above, and is necessary for the determination of the correct maximum fees for medications, as provided for in subp. 3.

Subpart 2. Procedure code. This subpart defines acceptable codes to be used when a procedure code is required for medications. Certain medications have been assigned HCPCS codes and these are listed in the HCPCS manual. The number of HCPCS codes for medications is limited, however. Thus, the prescription number is listed as an acceptable procedure code, to use if required. This subpart is provided to assist with the interpretation and application of other rules which refer to procedure codes for services.

Subpart 3. Maximum fees.

Item A. The formula for calculating the maximum fee for outpatient prescription medications is the average wholesale price for the medication, plus a dispensing fee of $5.14. Average wholesale prices for medications are listed in several commercially produced guides, available to all payers and providers. Such listings are updated regularly for accuracy. The dispensing fee amount is based on findings of a study performed by the Pharmaceutical Economics Research Center, School of Pharmacy and Pharmacal Sciences at Purdue University. (4). Generally, this study revealed that the national average cost of dispensing a third-party prescription, in other words, a prescription provided to a patient but billed to a third party, was $6.39, while the national average cost of dispensing and receiving payment directly from the patient was $5.14. To reflect the limitation of maximum fees anticipated by Minnesota Statutes, section 176.136, subdivisions 1a and 1b, the lower of the two dispensing costs described above is allowed.

Item B. The same formula as described above is intended for use with non-prescription medications also. However, this item recognizes that the actual price of a non-prescription medication may be lower than that amount calculated according to the formula, and, therefore, sets the maximum fee for the non-prescription medication as the lower of the two.

APPENDIX I

Intra- and Post-Operative Percentages
By Families of Procedures

Family	Procedure codes	Intra-operative percentage	Post-operative percentage
Integumentary	10000 - 19499	79	21
Musculoskeletal	20000 - 29909	79	21
Respiratory	30000 - 32999	87	13
Cardiovascular	33010 - 37799	92	8
Hemic and Lymphatic	38100 - 38999	84	16
Mediastinum	39000 - 39599	93	7
Digestive	40490 - 49999	88	12
Urinary	50010 - 53899	83	17
Male Genital	54000 - 55980	85	15
Female Genital	56000 - 58999	85	15
Maternity	59000 - 59899	78	22
Endocrine	60000 - 60699	91	9
Nervous	61000 - 64999	86	14
Eye	65091 - 68899	80	20
Auditory	69000 - 69979	92	8

Source: 56 FR 59516

APPENDIX II

Workers' Compensation Services
with Highest Total Cost

Code	Physician Services
99213	office/outpatient visit estab
99070	special supplies
72148	MRI - lumbar spine
72131	cat scan of lower spine
99214	office/outpatient visit estab
72141	MRI - neck spine
64721	carpal tunnel surgery
99203	office/outpatient visit, new
63030	lumbar laminotomy
12001	repair superficial wound(s)
29881	knee arthroscopy/surgery
73221	MRI - joint of arm
99202	office/outpatient visit, new
99212	office/outpatient visit, estab
99215	office/outpatient visit, estab

Source: Minnesota Department of Labor and Industry, Research and Education Division

APPENDIX III

Comparison of Maximum Fees for Re-operations when calculated According to Medicare Formula and Proposed Minnesota Fee Schedule Formula

Representative Sample Procedure	Procedure Code	Maximum Fee per Medicare Formula	Maximum Fee per Minnesota Formula	Dollar Difference
Repair of Nail Bed	11760	52.63	57.30	$ +4.67
Repair achilles tendon	27650	396.80	431.96	+35.16
Repair of wind pipe	31750	428.61	423.68	-4.93
Repair lip	40650	199.25	194.72	-4.53
Neck disc surgery	63040	1,004.26	1,004.26	0.00
Repair of eye wound	65270	64.75	69.61	+4.86
Repair of ear drum	69610	131.21	122.68	+8.53

Source: Minnesota Department of Labor and Industry

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