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STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Permanent Rules Relating to Managed Care Plans for Workers' Compensation
Minnesota Rules, Parts 5218.0010 to 5218.0900

STATEMENT OF NEED AND REASONABLENESS

I. OVERVIEW AND STATUTORY AUTHORITY

The statutory authority for these rules is found in Minnesota Statutes, section 176.1351, subd. 6. Minnesota Statutes, section 176.135, subdivision 1(f) states that as of October 1, 1992, an employer may require that the treatment and supplies required by Minnesota Statutes, Chapter 176 be provided in whole or in part by a certified managed care plan. Minnesota Statutes, section 176.1351 specifies the criteria for a managed care plan and in subd. 2 (12) and subd. 6 authorizes the Department of Labor and Industry to promulgate emergency and permanent rules necessary to implement that statute and rules necessary to provide quality medical services and healthcare to injured workers.

The Department of Labor and Industry published the proposed emergency rules in the *Minnesota State Register* on July 27, 1992. Following review by the Attorney General, the emergency rules were approved and went into effect on October 19, 1992. On April 12, 1993, the rules were extended for an additional 180 days. Notice of the extension and solicitation of opinion for the permanent rules was mailed to the people on the Departments workers' compensation rule mailing list on April 5, 1993, and the notices were published in the *Minnesota State Register* on April 12, 1993.

The Department has received comments on the proposed rules from managed care plan administrators, health care providers, insurers, employees, employers, and other parties within the workers' compensation system. The Department has also solicited information and comments from the following workers' compensation advisory boards: Medical Services Review Board; Rehabilitation Review Panel; Workers' Compensation Administrative Task Force; and the Workers' Compensation Advisory Council.

The 1992 Minnesota Legislature attempted to reduce workers' compensation costs by 16 percent. In order to reduce medical costs, the Legislature introduced several programs. The managed care plans are only one part of an overall program to address the increasing costs of medical services in workers' compensation. Other portions of the program to control medical costs include establishing treatment standards for health care providers, implementing a resource based relative value medical fee schedule with a 15 percent overall reduction from the fee schedule most recently in effect, and development of medical administrative rules. The purpose of all of these programs is to assure cost effective medical treatment for injured employees with return to work as soon as possible.

In adopting managed care for workers' compensation the legislature stated:

> "It is the intent of the legislature that the commissioner of labor and industry proceed with certifying managed care organizations as expeditiously as possible. Any rules or procedures the commissioner adopts must be designed to assist in the formation of managed care organizations while ensuring quality managed care to injured employees." 1992 Laws of Minn, Ch. 510, Art. 4, sec. 25.

As evident in the managed care legislation, workers' compensation cost containment must not only deal with the medical costs, it must also consider the indemnity or wage loss benefits. If an employee is injured on the job, the health care provider must not only treat the employee's medical condition but must also be aware of the impact on the employee's ability to work. The health care provider is called upon to make decisions on the employee's ability to return to work and other medical determinations that affect the employee's entitlement for workers' compensation benefits, and must communicate about these matters with the employer, insurer and assigned qualified rehabilitation consultants.

Because of the differences in the health care environment between general health care and workers' compensation, the managed care plans for workers' compensation have special requirements that they must meet in order to be certified. To succeed in providing quality care and a prompt return to work, a managed care plan must emphasize:

- prompt evaluation and provision of quality cost effective treatment by the health care provider
- communication between the health care provider and the employer to promote prompt return to work with appropriate job modifications and job restrictions, if necessary
- health care provider education on workers' compensation and return to work issues

Under the emergency rules for managed care, 11 plans have been certified. Six months of experience in certifying managed care plans under the emergency rules led to several changes in the proposed permanent rules. Some of the primary changes or clarifications are in the following areas:

- the types of providers and services that must be included in the plan are specified;
- annual reporting requirements are specified;
- education of the medical director of the plan and participating providers is required;
- clarification of medical case management, peer review and utilization review procedures is made;
- employer notice to an employee of enrollment in a managed care plan is required.
- the rules specify that a workers' compensation insurer cannot own, form or operate a managed care plan, and set forth factors suggesting insurer ownership;

For additional background on managed care in workers' compensation, the Department's Interim Report of Emergency Rule for workers' compensation managed care plans, and a list of certified managed care plans as of May 10, 1993, are available from the agency.

II. WITNESSES AND STAFF PRESENTERS

Appearing at the public hearing to present the proposed permanent rules for workers' compensation managed care will be: Gloria Gebhard, Acting Director Rehabilitation and Medical Affairs Unit, Department of Labor and Industry; Leo Eide, Assistant Commissioner, Workers' Compensation Division, Department of Labor and Industry; and Kathryn Berger, Legal Services, Department of Labor and Industry. The Commissioner reserves the right to appear or call upon or any of his designees in support of these rules.

III. SMALL BUSINESS CONSIDERATIONS

Because managed care plans are service industries regulated for standards and costs, the requirements of Minnesota Statutes, section 14.115 do not apply, pursuant to subdivision 7(c) of that statute. Nonetheless, the principles articulated in that statute are recognized as important to all entities regulated by the agency. Careful consideration has been given to imposing only those requirements that are critical to the operation of quality, effective managed care plans. Throughout the rules an attempt has been made to maintain flexibility to accommodate all types and sizes of plans.

IV. OTHER CONSIDERATIONS

The proposed rule amendments do not require the expenditure of public moneys by local public bodies, pursuant to Minnesota Statutes § 14.11 do not adversely impact agricultural land, and do not have their primary effect on Spanish speaking people.

V. NEED AND REASONABLENESS OF THE PROPOSED PERMANENT RULES

Part 5218.0010 DEFINITIONS.

Subpart 1. Scope. The terms used in Chapter 5218 are defined as follows:

Subpart 2. Commissioner. This definition indicates that the commissioner means the Commissioner of the Department of Labor and Industry or a designee. The designee characterization is necessary because the commissioner may delegate some of the functions to Department staff.

Subpart 3. Emergency care. This definition is derived from Minnesota Statutes, section 256B.0625, subdivision 4. The definition reflects that emergency care should be treatment which is immediately necessary for a condition that, if not immediately treated, could lead to

serious physical or mental disability or death. Emergency care is also appropriate if immediately necessary to alleviate severe pain. This will permit employees and managed care plans to more accurately determine when emergency care outside of the managed care network is appropriate.

The second part of the definition is intended to acknowledge that health care providers make good faith decisions based on symptoms presented at the time of the emergency treatment. This is based on comment received that a retrospective review might well determine that an emergency did not actually exist. However, the information may not have been available to the physician who made the original decision on emergency treatment and who was motivated by welfare of the patient. For instance, for a patient presenting with chest pain, treatment might be required to determine if an acute heart attack is occurring. At the time of the admission the tests immediately available may not be able to clearly distinguish whether or not the patient is actually having a heart attack. At the conclusion of the admission to the hospital, further extensive and time consuming testing may have determined that in fact the patient was not having a heart attack. From this point of view admission to the hospital for treatment of a heart attack was not necessary because the patient did not have a heart attack. However, this information was not available to the admitting physician and prudent medical care requires that in cases of possible heart attack the patient should be in the controlled environment of a hospital for further evaluation and proper treatment based upon that evaluation. Therefore, the rule provides that the evaluation of emergency treatment must be based on the symptoms at the time that the emergency treatment is given.

Subpart 4. Employee. This defines an employee as a person entitled to treatment for a personal injury under Chapter 176, the workers' compensation statutes. Minnesota Statutes, section 176.135 is the provision that sets forth the standard for compensable medical treatment to an employee with a workers' compensation injury.

Subpart 5. Health care provider. This part refers to the definition of the health care provider listed in the workers' compensation statutes 176.011, subdivision 24. This is necessary so the rules are consistent with the applicable statutory definition.

Subpart 6. Insurer. This subpart refers to the definition of the workers' compensation insurer found in Chapter 176 but also includes in the definition of the insurer a self-insured employer and a third party payer who is administering the workers' compensation claim for an employer or insurer. A third-party payer is added because it acts in place of an insurer, has the same interest as an insurer, and performs the same duties as an insurer; therefore third party payers are governed by the rules in the same manner as insurers.

Subpart 7. Managed care plan. This part indicates that in this chapter, a managed care plan means a plan that has been certified by the commissioner. This distinguishes it from other entities which may provide treatment to an employee, but who are not certified workers' compensation managed care plans.

Subpart 8. Participating health care provider. This definition reflects that a health care

provider can be an individual, a company, a organization or professional corporation with which the managed care plan contracts or refers patients to for delivery of medical services. Health care providers include individual doctors and other entities, such as hospitals, clinics, diagnostic imaging centers or diagnostic laboratories. Any entity with which the managed care plan has a contract arrangement to deliver medical services or supplies to an injured employee will be considered a participating provider for purposes of the rules, and is subject to monitoring by the plan.

Subpart 9. Payer. This subpart refers to the entity who is responsible for the payment of workers' compensation benefits. This generic term is used because the payer may be a self-insured employer, insurer or third party administrator.

Subpart 10. Primary treating health care provider. The definition in this part coordinates with the definition in part 5218.0100, item F, subitem 3, which provides that a physician, chiropractor, osteopath, podiatrist or dentist may direct and coordinate the medical care for an injured employee. These categories are selected because their statutory scopes of practice permit independent diagnosis of injuries and coordination of treatment. While other health care providers deliver treatment to employees, such as occupational and physical therapists, nurses, hospitals and diagnostic centers, these services are typically delivered in response to a directive from a physician or doctor. Allied health care providers do not typically diagnose conditions or coordinate or direct all the treatment that may be necessary in a case.

Subpart 11. Revocation. This definition identifies when a managed care plan is no longer allowed to continue to operate under this rule. This requires a new application for certification, as specified in part 5218.0900.

Subpart 12. Suspension. Suspension occurs where the Commissioner does not allow new or amended contracts between the managed care plan and an insurer. The plan can continue to operate and remains certified, but may not expand until the problems are corrected. The effect of this definition is discussed more fully in part 5218.0900.

Part 5218.0020 AUTHORITY.

This section refers to the statutory authority under which the Commissioner is promulgating permanent rules that are necessary to implement workers' compensation managed care, Minnesota Statutes, section 176.1351, subdivision 6. As noted on page 2, the legislature also required that rules and procedures must be designed to assist in the formation of managed care organizations while ensuring quality managed care to injured employees.

Part 5218.0030 PURPOSE AND SCOPE.

This part indicates that the rules must establish and report procedures and requirements for certification as a managed care plan, consistent with the statutory requirements and this chapter. Because Minnesota Statutes, section 176.1351 provides that an employee may only be

required to receive services under a certified managed care plan, the rule specifies that no other entity that delivers services to an injured employee which Chapter 176 may be referred to as "managed care." This is necessary to avoid confusion among parties, particularly employees, in the workers' compensation system about the nature of an entity providing medical services, and to prevent an employee from misunderstanding that he or she is required to receive services under a provider network that is not certified pursuant to Minnesota Statutes, section 176.135, subdivision 1f.

Part 5218.0040 PROVISIONAL CERTIFICATION.

This part provides that a managed care plan provisionally certified under the emergency rules may continue to operate as a certified managed care plan, if it submits a new application for certification under the permanent rules within 60 days after the effective date of the permanent rules. This is necessary to ensure a smooth transition period from the emergency rules to the permanent rules because a plan certified under the emergency rules will have to be recertified under the permanent rules. There have been significant changes from the emergency rules to the permanent rules. In some instances the plans will have to submit more information and in other areas information will no longer be required. In some areas minimum standards are specified or further clarification of an emergency rule is made. Therefore, the plans certified under the emergency rules can not automatically be certified under the permanent rules.

In order to maintain the certification under the permanent rule, the managed care plan must submit an annual report as specified under 5218.0300, subpart 2. The requirements for that report are listed in that section.

Part 5218.0100 APPLICATION FOR CERTIFICATION.

Subpart 1. Certification. In general, this subpart specifies the information that the managed care plan must submit to the Department for certification. The subpart states that any person or entity may make written application to the commissioner to provide managed care to injured employees for injuries and diseases compensable under Minnesota Statutes Chapter 176. There is an exception noted in part 5218.0200, subpart 4 which indicates that a workers' compensation insurer cannot establish a managed care plan, discussed further in that part.

This part also indicates that an application must be submitted on a form provided by the Commissioner. Under the emergency rules, a specific form was not required. Each submitted plan followed an individual format and determining compliance with the rules was complicated in some instances. A uniform application form will simplify the administrative procedures of the Department and also will clearly specify the requirements to the applicant managed care plan.

Subp. 1, item A This item requires the applicant managed care plan to submit two copies, an original plus one identical copy. This will ease the administrative burden on the Department. The Department must have a public file available for anyone who wishes to see it. The copy

submitted by the managed care plan would be used for this public file following removal of any data classified as a trade secret. The copy will also be used during the certification process, to the extent review is necessary by more than one person.

This part also indicates that any information believed to be a trade secret by the potential managed care plan must be clearly marked, separated and justified in accordance with 5218.0800, subpart 2, item B. Since the Department must have a public copy of the managed care plan, it is very important that any portion covered by the trade secret protection be clearly identified and distinguished from the rest of the application.

Subpart 1, item B. This part of the plan states seven items which must be submitted by the managed care plan. They include the following:

1. The names of all directors and officers of the managed care plan.

2. The title and name of the person to be the day to day administrator of the managed care plan.

3. The title and name of the person to be the administrator of the financial affairs of the managed care plan.

4. The name and medical specialty of the medical director.

5. The name and address and telephone number of the communication liaison for the Department, insurer, employer and employee.

6. The nature of any affiliation between an employer or insurer and the managed care plan or its parent or subsidy or other related organization specified under part 5218.0200, subp. 4.

7. The name of any entity other than an individual health care provider with whom the managed care plan has had a joint venture or other agreement to perform any of the functions of the managed care plan.

Subitems 1, 2 and 3 require the identification of those who operate the plan. This is appropriate information that must be available for review and accountability purposes.

Subitem 4 requires the managed care plan to give the name of their medical director and any medical specialty if applicable. The medical director of a Plan will likely have a great deal of influence on the basic philosophy and operation of the plan. Therefore this person's name and specialty, if any, should be disclosed.

Subitem 5 requires the name of the communication liaison. This person is critical to facilitate communication between the Department, the insurer, the employer and the employee.

Since communication of information on managed care to parties throughout the system is important, this person should be clearly designated. Requiring disclosure of this person requires the plan to specifically designate a person whose function is to answer questions about the plan from any interested person.

Subitem 6 is necessary to determine whether or not there is any relationship between the persons or entity owning, operating and forming the managed care plan and a workers' compensation insurer or employer. Minnesota Statutes, section 176.1351, subdivision 1, provides that a workers' compensation insurer or employer cannot apply to become a certified managed care plan. These provisions require the managed care plan to disclose any type of a relationship that may conflict with this statute. This issue is discussed more fully in part 5218.0200, subp. 4.

Subitem 7 requires the plan to identify any other entity with whom the plan has an agreement to perform some of the functions for the reasons set forth in subitem 6 and also because entities may create a joint venture to form a plan; this information is necessary for the Department to review the underlying structure and design of the plan.

Subpart 1, item C. This section specifies the fee to the managed care plan for applying for initial certification and for certification under the permanent rules following certification under the emergency rules. Minnesota Statutes, section 176.1351, subdivision 1 allows the Commissioner to charge a reasonable fee for the certification process.

The rule states that for a potential plan that has never been certified, the application fee is $1,500. This includes Department professional, technical and clerical costs of reviewing and processing the application, as well as other miscellaneous costs to the Department, such as supplies, electronic data processing, and mailing costs.

The rule indicates that if a Plan has been provisionally certified under the emergency rules and reapplies under the permanent rules, the fee for certification is $600. The justification for the reduced fee is that the plan has been reviewed extensively at the time of provisional certification. The plan would need minimal review in the areas that have been unchanged from the emergency rule and more extensive review in the areas where there were changes in the rules. The approval from the Commissioner of Finance for the fees is attached.

Subpart 1, item D. This section states, as required by Minnesota Statutes, section 176.1351, subdivision 2(1), that the managed care plan must ensure provision of all quality services necessary under Chapter 176 that meet the treatment standards adopted by emergency and permanent rule by the Department. Minnesota Rules Part 5221.6010 to 5221.6500 [Emergency]. Application of adopted treatment standards in managed care is further discussed under part 5218.0100, subpart 1, item M.

Subpart 1, item E. This section states that the plan must describe the services under the plan, and how it will ensure that an adequate number of accessible health care providers in each

category is available to employees. This is a requirement set forth in Minnesota Statutes, section 176.1351, subdivision 2(10). The rule allows each plan flexibility to develop a system that works within a given geographic area, while ensuring that the plan has given thought to the statutory requirements for access to all types of treatment.

In subitem 1 of this section, the types of providers and services that must be included in the plan if they are available in the community are as follows:

1. Medical doctors, which include the following specialties:

   - Specialists in either family practice, internal medicine, occupational medicine or emergency medicine
   - Orthopedic surgeons including specialists in hand and upper extremity surgery
   - Neurologists and neurosurgeon
   - General surgeons

   Specialists in family practice, internal medicine, occupational medicine or emergency medicine are often the first line of treatment. While some work injuries may eventually require the services of a specialist, this is not true in the majority of cases. These are typically primary care givers, who typically can offer more cost effective and holistic treatment than specialists. Orthopedic and neurology specialists and general surgeons are required because employees with complicated back and extremity and other traumatic injuries, which are frequent workers' compensation injuries, may need this specialized treatment.

2. Doctors of chiropractic. Doctors of chiropractic are specifically referenced in Minnesota Statutes, section 176.135. These are also primary care providers who often treat back injuries, which are typical workers' compensation injuries. There is not a shortage of these professionals in this state, so it is reasonable to include them in the plan.

3. Doctors of podiatry. Doctors of podiatry are specifically referenced in Minnesota Statutes, section 176.135. However, because there are less than 100 practicing podiatrists in the state, it may not be possible for a plan to include them in every part of the state.

4. Doctors of osteopathy. Doctors of osteopathy are also specifically referenced in Minnesota Statutes, section 176.135. These doctors have the scope of practice of medical doctors, but specialize in structural abnormalities, including without limitation treatment and manipulation of the spine. Again, however, because the number of these providers is limited this care may not be available in all parts of the state.

5. Physical and occupational therapy services. These services are often provided to employees with musculoskeletal injuries, and are therefore reasonably required under the plan.

6. Psychological and psychiatric services. Although psychological injuries are not compensable in and of themselves under Minnesota law, psychological treatment necessary to treat a compensable injury may be required. Because these tend to be complex cases, it is important for the managed care plan to include these services, to promote appropriate management.

7. Diagnostic pathology, laboratory and radiology services are required in many cases, to assist the health care provider in making a diagnosis. Because these services are so frequently required, a plan should have specific arrangements for the services.

8. Hospital, out-patient surgery, and urgent care services. Surgery may be required for musculoskeletal injuries. In addition, because there is a requirement that employees receive treatment under the plan within 24 hours, and some conditions may require treatment even earlier for urgent or emergency conditions, these services must also be available.

The above types of providers and services are the minimum required for certification. These will likely be sufficient for the majority of workers' compensation injuries. However, it is recognized that all of these providers and services may not be available within the mileage parameters set forth in item F (7) in all parts of the state, particularly in rural areas. Therefore, if the plan can provide evidence that a particular service or type of provider is not available in the community, the provider does not have to be included in the plan. For example, doctors of podiatry and osteopathy, and orthopedic surgeons who are specialists in hand and upper extremity surgery may not be available in every community. Because they are not available to employees for non-workers' compensation injuries a plan is not required to include them in every location. The plan cannot be expected to provide greater specialization than is available within the community. However, the burden is on the plan to demonstrate in its application that these services are not available.

The managed care plan must disclose the nature of its relationship to the provider or the business entity providing the services to the employee under the plan and must include copies of all agreements with participating providers, so the Department can ensure the contracts are consistent with these rules and Minnesota Statutes, section 176.1351. The managed care plan must also attach a list of the names of the providers and the type of license and specialty so the Department can determine compliance with this provision and provide the public with information about plan membership. The plan must also supply a name and address of all participating clinics. In order to assure that employees receive care from qualified licensed providers, the plan must also submit a statement that all licensing requirements for the providers are current and the providers are in good standing in Minnesota or in the state in which the

provider is practicing. This is necessary to ensure that the plan has appropriately screened and communicated with providers about the nature of services to be provided.

Subitem 2. This section acknowledges that every type of specialized health service cannot be included in a managed care plan. Only the most common services were listed out specifically in subitem 1. Therefore, all other specialized services (i.e. burn specialists, ophthalmology surgeons, etc.) must be provided for through referral. The managed care plan must have a procedure for referral to any specialist that is not included in its primary plan, to document that provision will be made for care in unique cases.

This subitem also indicates that the insurer remains liable for any health service ordered by the managed care plan even though it is not provided by the managed care plan. Therefore, if a managed care plan does not provide a needed service the employee may obtain care from any health care provider who is able to give the service, and the employer/insurer remain liable for the treatment. This is consistent with Minnesota Statutes, section 176.135, subdivision 1 which requires an employer to "furnish any . . . treatment . . . as may be required at the time of injury and any time thereafter to cure and relieve from the effects of the injury."

Subpart 1, item F. This section includes seven specific procedures that the managed care plan must implement in order to be certified as a managed care plan.

Subitem (1). This section indicates that the employees must receive the initial evaluation by a participating licensed health care provider within 24 hours of the employee's request for treatment, following a work injury. The initial evaluation may be performed by any licensed participating health care provider. Licensure is required to ensure a minimum level of competence to evaluate an injury. Provider distinctions are eliminated from the rule in this instance, and are left to the discretion of the managed care plan.

It has been alleged that this violates Minnesota Statutes, section 176.1351, subdivision 4. That provision provides that the Commissioner "may" refuse to certify a plan if direct access to all categories of health care providers is unfairly restricted. Under the statute, direct access is unfairly denied only if the treatment is within the provider's scope of practice and appropriate for the condition.

Allowing the managed care plan to distinguish between health care providers at the time of an initial evaluation does not constitute discrimination or a denial of equal access for treatment. The statute does not require unlimited direct access to all types of health care providers, but specifically identifies the provider's scope of practice and treatment standards as factors to be considered in providing access. Providers have differing scopes of practice and are found in varying concentrations throughout the state. Employees suffer from different types of injuries. The statute cannot reasonably be interpreted to expand any health care providers scope of practice, or legislate the best treatment for any employee. The term "managed care" requires decisions to be made regarding the appropriateness of treatment for a given condition for an employee. The rules are intended to provide the managed care plan with flexibility to

design the most effective system, unique to the employees served, the injuries sustained in terms of the types of injuries they are permitted by law to diagnose and treat, and the type of providers available. Medical doctors and osteopaths have an essentially unlimited scope of practice. See Minnesota Statutes Chapter 147. Chiropractors, podiatrists, psychologists and others have limited scopes of practice. See Minnesota Statutes Chapter 148. Many injuries such as fractures, burns, lacerations and heart conditions cannot be legally diagnosed and treated by limited practice practitioners. By allowing the employee direct access to all kinds of providers at the initial evaluation in the first 24 hours would require the plan to have all disciplines, including limited license practitioners and arguably even medical specialists, "on call," to be seen at the employee's option, regardless of the nature of the injury or the availability of the specialist. The rules do not prohibit any class of health care provider from being an evaluating provider or even require an evaluating provider, but allow the plan flexibility in this area, depending on the needs of the managed care plan and the employees served.

It is important to note that the employee must be given the opportunity to receive ongoing treatment with any type of provider. This issue is discussed further in subitem (3). Additionally, the plan may not exclude any type of provider from participation in the plan under Minnesota Statutes, section 176.1351, subdivision 2(10) and part 5218.0100, subpart 1, items E and F(3).

The requirement that the employee be seen within 24 hours of the request for treatment is necessary because prompt evaluation of an injury will often prevent complications. Additionally, prompt evaluation is important because a determination must be made as to whether the employee can return to work or if, upon return to work, any restrictions or modifications are necessary. It is inappropriate for an employee to be off of work due solely to the inability to see a health care provider. Often employers do not want an employee to return to work following a reported injury until they have seen a health care provider, fearing reinjury. Under non-workers' compensation managed care a patient might not be seen for some conditions, such as a back injury, until a certain period of time has passed, because a certain number of these people will recover with time and the cost of treatment is therefore minimized. However, during this period, employees may be losing time from work. Delaying treatment or evaluation for several days or weeks can result in unnecessary payment of workers' compensation wage loss benefits. Therefore, prompt evaluation and aggressive treatment designed to minimize lost time from work is important in workers' compensation managed care.

Subitem (2). This section deals with employees who have been receiving medical services from a health care provider outside of the managed care plan, if the employee requests a change of doctor or has been referred to a provider within the managed care plan. In either of these situations, the employee must be seen by the managed care plan provider within five working days. Since the employee has already been seen by a health care provider outside the plan and has had at least an initial evaluation and treatment from that provider, the 24 hour restriction noted in item (1) has been extended to five working days. It is still important that the employee be seen promptly by a participating provider and a minimum time period of five days will promote continuity of treatment and appropriate case management.

Subitem (3). This section states that following the initial evaluation by a licensed participating health care provider, the employee must be allowed to choose the type of primary treating provider from one of the following disciplines: doctors of medicine, chiropractic, podiatry, osteopathy or dentistry. In accordance with Minnesota Statutes, section 176.1351, subdivision 2(10) and subdivision 4, the treatment must be necessary under M.S. 176.135, appropriate for the employee's condition under the applicable treatment standards and within the provider's scope of practice. The employee must be given the opportunity to receive care from any participating health care provider under the plan if the type of provider is available in the community and the treatment is necessary and appropriate for the injury. It is expected that the plan has screened and educated all of its participating providers in workers' compensation, so no other limitation on employee choice should be necessary. Any provider who is a participating provider should deliver quality, cost effective care.

It is important to note again that under Minnesota Statutes, section 176.1351, the employee may treat with any type of provider. The managed care plan is prohibited from unlawfully discriminating against any provider group requested by the employee, for reasons other than those based on the appropriateness of the treatment and the scope of practice. Part 5218.0250, Notice to Employee by Employer, states that the employer must give the employee specific notice regarding the different types of services that are available to the employee.

To the extent an employee is denied access to appropriate care from any given provider group, the employee may obtain authorization directly from the insurer or may proceed with the dispute resolution mechanisms under the plan and Chapter 176. The workers' compensation insurer remains liable for any necessary treatment, and a managed care plan's certification may be suspended or revoked for unlawful discrimination.

The rule permits an evaluating provider to be offered as a treating provider, in response to questions raised about the relationship between the provisions.

Subitem (4). This section states that all treatment tests or specialty service must be timely, effective and convenient for the employee. Since workers' compensation encompasses all types of injuries, it would be impossible to make more specific requirements for treatment or service guidelines. Complaints of untimely service or lack of service will be explored on a case by case basis, depending on the type and severity of the injury. This rule references the corresponding statutory requirements in Minnesota Statutes, section 176.1351, subdivision 2, clauses 1 and 2, and 10.

Subitem (5). This section states that the employee must be allowed to change primary treating providers within the managed care plan at least once without proceeding through the managed care plan's dispute resolution process. This is consistent with Minnesota Statutes, section 176.1351, subdivision 2, clause 11. The rule also states that a change of provider from the evaluating health care provider to a primary treating doctor for ongoing treatment is not considered a change of doctor, unless employee has received treatment from the evaluating health care provider more than once. This complies with the direct access directive in the

statute; the employee has not selected a treating doctor unless the employee returns to the evaluating provider for additional treatment.

This rule correlates with the proposed rule in part 5221.0430, regarding change of doctor. That rule proposes that the health care provider becomes the primary treating doctor if the employee returns to that health care provider for additional treatment.

Subitem (6). This section states that an employee should be able to receive information about the managed care plan and the availability of necessary services on a 24 hour basis. The information may be through a recorded telephone message after normal working hours. The message must include information on how the employee can obtain information on emergency services or urgently needed care and how the employee can obtain an evaluation within 24 hours of the notice of injury.

For quality and effective service, an employee should be able to speak to an individual during normal working hours about the services provided by the managed care plan. However, after normal working hours this basic information should also be able to be obtained. It is reasonable that this information be available through a recorded message, which will notify the employee how to receive any immediately needed care, and who to contact during working hours. It is critical that this information be available on a 24 hour basis because the employee may be injured on other shifts or may only realize that they need to see a health care provider after leaving the work site.

Subitem (7). This section contains the mileage requirement stating that the employee must have access to an evaluating and primary treating health care provider within a specified distance of either the employee's place of employment or residence. The rule further states that if the employee's residence or place of employment is within the seven county metro (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties) the allowable distance is 30 miles.

This mileage restriction is reasonable within the seven county metro area due to the dense population and availability of health care services. This is similar to the requirement for Health Maintenance Organizations. Minnesota Rules Part 4685.1010, subd. 3(C). There are concerns specifically about rural areas where it may be more difficult to provide all necessary treatment required by Chapter 176 within 30 miles, and the mileage limitations are therefore extended to 50 miles in rural counties. It is not reasonable to require that managed care plans provide significantly greater accessibility than exists naturally in the community. An exception to the mileage rule is made for specialized services which are not available in the community within the 30 or 50 mile limitation. The employee would not be expected to exceed these limitations for an initial evaluation or the primary treating doctor. However, they may be exceeded for specialty service which may not be available within the stated mileage requirements.

Subpart 1, item G. This section requires the managed care plan to state how an employee is to obtain services from outside the managed care plan. Detailed requirements for

this section are discussed in part 5218.0500. The plan must provide this information in its application as is required by Minnesota Statutes, section 176.1351, subdivision 2, clause 8.

Subpart 1, item H. This section requires the managed care plan to include a procedure for peer review and utilization review, as required by Minnesota Statutes, section 176.1351, subdivision 2, clause 4. This is further specified in part 5218.0750.

Subpart 1, item I. This section states that a managed care plan must provide a method of dispute referral as required by Minnesota Statutes, section 176.1351, subdivision 2, clause 4. Detailed requirements for this section are in part 5218.0700.

Subpart 1, item J. This section requires the plan to specify how the managed care plan is going to convey information to employers and insurer which will be passed onto the employees concerning the choices of medical service providers within the plan and how the employee can gain access to those types of providers.

Since the needs of the employers, insurers and employees will vary depending upon the size of the managed care plan and the size and type of the employer's business, it is difficult to list specific requirements. However, the managed care plan can supply to the Department examples of material to be given to employees. The Department will screen the information for accuracy and consistency with the law. The information to be included for employee notification is further specified in part 5218.0250.

This information must be supplied to the employee at the time the plan is presented to all the employees and must be offered again at the time of injury. Information may be in the form of a card or other written document given to the employee, or through verbal information. To provide maximum flexibility in unique situations, the plan, the insurer and the employer may determine how the employee can be best notified regarding the managed care plan services. It must be noted, however, that it is the responsibility of the employer to notify the employee of the managed care plan. If this notice is not given, the employee is not required to receive treatment under the managed care plan. For this reason, it is to the employer's advantage to give the employee the most accurate and thorough information possible.

Subpart 1, item K. This section states that the managed care must provide aggressive case management for injured employees and a program for early return to work, as required by Minnesota Statutes, section 176.1351, subdivision 2(6). This requirement is further described in part 5218.0760.

Subpart 1, item L. This section states that the managed care plan must make available to participating health care providers information on the following subjects

- treatment parameters adopted by the Commissioner
- maximum medical improvement
- permanent partial disability ratings

- return to work and disability management
- health care provider obligations in the workers' compensation system
- any other topic that the managed care plan may feel is necessary to obtain cost effective medical treatment and appropriate return to work for an injured employee.

It is important that the participating health care providers understand the workers' compensation system, which is complicated. Every primary treating health care provider must make determinations in each of these areas. Accurate determinations, consistent with the workers' compensation law and rules, are critical to appropriate management of a workers' compensation injury.

As noted earlier, all health care providers are governed by the adopted treatment parameters (Minnesota Rules Part 5221.6010 to 5221.6500 [Emergency]). In every case of more than three days of lost time, the health care provider may be asked to render an opinion of maximum medical improvement under Minnesota Statutes, section 176.101, subdivision 3e. Permanent partial disability ratings are also required under that section for many injuries. Return to work and disability management considerations by the health care provider are paramount. Additionally, the workers' compensation medical rules of practice require providers to file forms about the employee's condition, maximum medical improvement, permanent partial disability and work ability. Health care providers are also subject to rules regarding communication with parties. Knowing and understanding these requirements is absolutely necessary for the effective care of an employee with a workers' compensation injury under a workers' compensation managed care plan. See, Minnesota Rules, chapter 5221 (proposed and existing).

This item requires that the managed care plan make available to the health care providers information in these critical areas, again without specifying the precise mechanism for sharing the information to provide maximum flexibility for unique circumstances under each plan. Some of the more aggressive managed care plans may actually require the health care provider to attend seminars or other educational activities to learn about these areas. The managed care plans with superior health care provider education will likely have greater success in managing the care.

This item also states that the medical director or designee of the medical director must have a minimum of 12 hours of education the first year, and four hours per year thereafter, covering the topics listed above. For the first year, this is typically two (six hour) days of continuing education, which is the amount determined necessary to cover reasonably well all the above topics. Four hours per year thereafter should be sufficient for the director to maintain reasonably current about developments in the workers' compensation system. The medical director of the managed care plan should have an in-depth understanding of the system. The Department will not be requiring that the verification of this education be submitted on an annual basis, but it must be available for audit. The rule also states that the medical director or the designee must be available as a consultant on these subjects to any of the health care providers

delivering services under the managed care plan. It is important that participating providers have a resource, with a thorough knowledge of the workers' compensation rules and laws available to answer questions as they arise.

Subpart 1, item M. Minnesota Statutes, section 176.1351, subdivision 2(1) and 176.83, subdivision 5 provide that treatment standards adopted by the commissioner apply to managed care as well. This section deals with treatment standards developed by the Department and treatment standards developed by the managed care plan that are reasonably likely to be used in the treatment of workers' compensation injuries. This section states that the managed care plan is subject to all treatment standards developed by the Department, pursuant to Minnesota Statutes, section 176.83, subdivision 5, and that the managed care plan may not prescribe treatment standards that disallow treatment that is permitted by the Commissioner's standards. This is in response to concerns expressed by some groups that plans may impose standards that are more restrictive. However, as stated in the treatment standards, all treatment given must be medically necessary and effective. Minnesota Rules Part 5221.6010, subp. 1. Unnecessary treatment should not be provided just because the maximum treatment under the standard has not been given.

Consistent with the above referenced statutes, the treatment standards were developed to cover all injured employees, not just those covered by a managed care plan. It would be inappropriate, and difficult for providers to comply, if each managed care plan had a different standard of care for the most common types of injuries. The treatment standards were developed in consultation with a large number of health care providers and are felt to be appropriate for all injured employees. Nonetheless, it should be noted that the rules do not prohibit standards where the Department standards are silent on a matter. If a plan has developed its own standards, they must be reported, and must be made available for review should circumstances arise which require review for compliance with the workers' compensation law or rules.

Subpart 1, item N. This section states that the managed care plan must provide other information as the commissioner deems necessary to determine compliance with this chapter. Department staff are becoming more experienced in dealing with managed care plans. However, it is impossible anticipate every situation that may arise. Therefore, as business arrangements, medical science, and the workers' compensation law changes, it will be necessary to, on a case by case basis, ask and receive information from the managed care plans.

Subpart 2. Notification; approval or denial. This section determines timelines for notifying an applicant for certification of the commissioner's actions. The rule states that within 30 days of an application, the commissioner must notify the applicant whether any additional information is required or any modifications that must be made. The rule requires the commissioner to respond within 30 days of the receipt of the additional information as to whether or not the plan has been certified or denied. It also states that the commissioner must notify the applicant in writing of the reasons for the denial.

Under the emergency rules, there were no timelines set for the Department to initially respond to the plans. Under the provisional rules, 30 days might not have been enough time because it was in some cases difficult to determine whether or not the plan had fulfilled all of the criteria. However, if applications are submitted on a form provided by the commissioner, and with experience, it should be easier to determine whether or not the necessary information has been submitted. Therefore, the timeline of 30 days for the commissioner to initially request more information, and 30 days to approve or deny after receipt of the additional information is appropriate. It is also appropriate that any reasons for denial be in writing so that the plan may respond or make changes if considering reapplication. These timelines are shorter than the 90 day review timeline for health maintenance organizations under Minnesota Statutes, section 62E.04, subdivision 2.

Subpart 3. Review of decision. This part states that if there is a denial of certification, the managed care plan may, within 30 days of the date of denial, initiate a contested case proceeding under Minnesota Statutes, Chapter 14. The rule indicates that following receipt of the administrative law judge's findings and recommendations, the commissioner shall issue a final decision in accordance with Minnesota Statutes, section 14.62. This is consistent with Minnesota Statutes, section 176.1351, subdivision 5, which authorizes the commissioner to make decisions regarding certification of managed care plans. If the managed care plan is not in agreement with the commissioner, it may appeal to the Workers' Compensation Court of Appeals in accordance with Minnesota Statutes, section 176.442.

The authorizing statute, Minnesota Statutes, section 176.1351, is silent as to the mechanism for challenging the commissioner's determination. This rule is consistent with the Administrative Procedures Act, Minnesota Statutes, section 14.57 which provides that "an agency shall initiate a contested case proceeding when one is required by law. Unless otherwise provided by law, an agency shall decide a contested case only in accordance with the contested case procedures of the administrative procedure act." A contested case proceeding will allow for a proceeding at which all parties may present their information and positions to an experienced presiding administrative law judge; due process requirements for a hearing on the issues are preserved. After the hearing, the Commissioner will make the final decision after reviewing the report of the Administrative Law Judge.

Part 5218.0200 COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN.

Subpart 1. Scope. This subpart states that a managed care plan must provide comprehensive medical services according to the rules regarding certification and and all other applicable workers' compensation statutes and rules. Simply stated, the managed care plan must provide all reasonable and necessary medical services under the workers' compensation statute, and in accordance with the procedures set forth in its application for certification. This is required by Minnesota Statutes, section 176.1351.

Subpart 2. Contracts and Coverage. This part states that a managed care plan must actually have a contract with the workers' compensation insurer who is liable for the medical

coverage of injured employees. It sets forth the contract provisions that are required by part 5218.0300, subpart 1 and also the conditions of coverage under subpart 3 through 6 of this subpart.

This subpart states that the managed care plan must contract with the insurer liable under Chapter 176 to provide services for a particular employee. The requirement of a contract between the managed care plan and the insurer, rather than the employer, provides workers' compensation insurers and self-insured employers with a mechanism to monitor the effectiveness of the plan in managing increasing medical and indemnity costs associated with workers' compensation injuries. Requiring the contract with insurers permits the insurers and self-insured employers, who are ultimately responsible for payment of the medical costs, to contract with the managed care plan that will be most effective in achieving the statutory goals. Employers are required to obtain authority to self-insure from the Department of Commerce under Minnesota Statutes, section 176.181. To the extent an employer obtains this authority, it may contract with the managed care plan as a self-insured employer. The insurer is the entity responsible for administering the claim, pursuant to the contract between the employer and insurer. By contracting with the insurer, the employer has authorized the insurer to act in its behalf in providing workers' compensation coverage. Minnesota Statutes, section 176.253. An employer may contract with the insurer to pay a deductible amount for workers' compensation coverage. Even that law however, requires the insurer to continue to administer the claim, pay the benefits and seek reimbursement from the employer for the deductible amount. Minnesota Statutes, section 79.081, subds. 1 and 2. For maximum effectiveness and efficiency the managed care plan should contract with the entity responsible for actually administrating the claims.

Subpart 3. Multiple Plans. This provision covers the situation where an employer or insurer contracts with more than one managed care plan. It states that the employee has the initial choice within a reasonable time designated by the employer and insurer to select which managed care plan, within the applicable mileage parameters, that will cover the employee's personal injury. Employers may have worksites available in other parts of the state, and may wish to offer different plans for each site. It would not be appropriate for an employee in St. Paul to select a plan located in Duluth.

This provision requires an employee to select from a certified plan with which the insurer has a contract. In the contract between the employer and insurer and the managed care plan, provisions for payment of services must be made and monitoring the effectiveness of the plan is important. If the employee is allowed to chose from a certified plan with whom the insurer does not have a contract, the insurers would have no administratively feasible way to monitor the effectiveness of a plan, except on a case by case basis. Only by requiring employees to receive care under a plan who has a contract with the insurer can the effectiveness of each plan be monitored. Insurers, who are ultimately responsible for payment of medical and indemnity costs must be able to cooperatively work with a plan to achieve the statutory goals. Furthermore, Minnesota Statutes, section 176.135, subdivision 1f provides that an employer may require an employee to receive services from "a" certified managed care plan, not "any" managed care plan.

Subpart 4. Restrictions on Employer or Insurer Forming Plans.

Item A. This item states that the workers' compensation insurer may not own, form or operate a certified managed care plan as specified in Minnesota Statutes, section 176.1351, subdivision 1. There has been much discussion about the meaning of the first two sentences of Minnesota Statutes, section 176.1351, subdivision 1. Although the first sentence prohibits a workers' compensation insurer from applying for certification as a managed care plan, the second sentence states that "without limitation a health maintenance organization (HMO) or preferred provider organization (PPO) may form a managed care plan." These provisions could reasonably be interpreted more than one way. One interpretation, reflected in the emergency managed care rules, is that any entity who forms a health maintenance organization or preferred provider organization, which is not defined, may apply for certification, but may not require a covered employee to receive services under the plan. A more narrow reading of the statutory language would preclude a health maintenance organization from providing services to its own employees under the plan, and would also preclude a self-insured HMO or PPO from applying for certification. The likely intent of the statute is to prevent the employee from being required to receive treatment from what is perceived to be a "company doctor," because the doctor is required to make many decisions that affect the employee's entitlement to benefits under the workers' compensation law.

Interpretation of this statutory language has been the subject of discussion and litigation. In a Ramsey County District Court action in which this provision was one of the issues, the judge determined that ". . . the statutory prohibitions or restriction that are expressly articulated in the statute with respect to an insurer apply with equal force to the [Assigned Risk] Plan and the Plan's third party administrators - neither is eligible for have a managed care plan certified for this purpose under Minnesota Statutes, section 176.1351." (Finding #40, Berkley Administrators vs. Minnesota Workers' Compensation Assigned Risk Plan, Minnesota Second Judicial District, File Nos. C4-93-1051 and C2-93-1100) (currently on appeal)

In light of the apparent majority view that the statute should be read more restrictively, the proposed permanent rules prohibit a workers' compensation insurer from forming, owning or operating a managed care plan. It is crucial to promote managed care plans within the workers' compensation system. Allowing certification by insurers, or attempting to promulgate a rule permitting insurers to form managed care plans could result in extended litigation, in individual cases and also over the rules. This would interfere with the establishment of an effective managed care system. Accordingly, the proposed permanent rules prohibit a workers' compensation insurer from forming, owning or operating a managed care plan.

Minnesota Statutes, section 176.1351, subdivision 1 does not preclude employers from forming a managed care plan, because every managed care plan has employees itself. Although these employees may not be required to receive services under the plan, it is not reasonable to assume that if an employee of a certified plan (such as an HMO) wants to receive services under the plan he or she may not do so. However, the employee may not be required to receive services under the plan. In the same vein, an established health maintenance organization or

preferred provider organization should not be precluded from certification simply because it is self-insured for workers' compensation. A self-insured employer whose primary business is the provision of health services through managed care is not functionally equivalent to a workers' compensation insurer whose business is not primarily to provide health care. Accordingly, the rule permits a self-insured employer, who is primarily in the business of managed health care as an established HMO or preferred provider organization, to apply for certification, although attendance under the plan is voluntary for the plan's employees.

In summary, to reconcile the statutory language in Minnesota Statutes, section 176.1351, subdivision 1, the rules prohibit a workers' compensation insurer from forming, owning or operating a managed care plan, but permit a self-insured HMO or PPO to apply for certification, so long as its employees are not required to receive care under the plan.

Subpart 4, item B. This section defines factors to be considered on a case by case basis in determining whether or not a managed care plan is controlled by an insurer or employer. The existence of one factor alone may not indicate that a workers' compensation insurer has owned, operated or formed the plan. However, a number of factors, taken together, or one strong factor in a particular case, may indicate insurer operation. The factors are as follows:

- If the insurer or employer or any member of its staff directly participate in the formation or certification of the plan. This factor addresses the first sentence of Minnesota Statutes, section 176.1351, subdivision 1, as discussed above.

- When an insurer or employer or any member of its staff assumes a position as a director or other governing member officer or agent of the plan. This factor indicates the plan may control the plan operation. Although it is not likely that one shared person constitutes control, a number of common employees and directors may indicate insurer operation.

- When an insurer or employer or any member of its staff has an ownership interest or similar financial or investment interest in a managed care plan. Again, while an employee who has a minor interest in the plan may not indicate ownership, a block of ownership may be cause for concern.

- When an insurer or employer or member of its staff enters into a contract with the plan that limits the ability of the plan to accept business from any other insurer or any other source. This suggests that the plan may be so dependent on the insurer for its existence that the insurer effectively operates the plan. This would result from the plan having an identity of interest that is indistinguishable from the insurer's interest.

The above definitions attempt to set the parameters to more clearly define what it means to own, operate or form a managed care plan. The business arrangements of a plan are often very complicated and the actual ownership or operation of the plan may not always be evident

by disclosure of the names of the directors and administrators. These provisions are an attempt to specify information that the plans must disclose so that the commissioner can make an informed decision in individual cases about insurer ownership or operation of a plan.

Subpart 4, item C. This item defines the words "staff" and "insurer" used in item B. The word "staff" means any person who is a regular employee of an insurer or other employer or someone who is a regular employee of any parent or subsidiary entity of an insurer or employer. The word "insurer" includes any subsidiary, parent or other related entity affiliated with the insurer, including a third party administrator. These definitions are appropriate because ownership of a subsidiary must still be considered ownership by the workers' compensation insurer. To the extent that Minnesota Statutes, section 176.1351 prohibits a workers' compensation insurer from forming a managed care plan, the insurer cannont avoid the prohibition simply by forming a subsidiary or contracting with a third party administrator who has formed a plan. This is consistent with the findings by Judge Campbell in the Berkley Administrators case noted above.

Subpart 5. Coverage. Item A. This subpart requires the employee to receive services from the managed care plan with whom the insurer liable for the injury has a contract. For the reasons discussed in subparts 2 and 3 of this statement, cooperation and coordination between the managed care plan, employer, insurer, and employee is necessary to accomplish the goals set forth in Minnesota Statutes, section 176.1351. Minnesota Statutes, section 176.135, subdivision 1f permits the employer to require the employee to receive care from a managed care plan certified by the commissioner. The employer has contracted with the insurer to administer the claim. For effective administration of the claim the employer must contract with the managed care organization through the insurer.

This subpart also states that an employee is not required to receive medical services under the managed care plan until the employee has been notified of enrollment in the plan according to part 5218.0250. This item is consistent with Minnesota Statutes, section 176.1351, subdivision 1f, which provides that an employer may require the employee to receive treatment under a certified managed care plan. This item reinforces that the employee cannot be deemed to have been "required" to receive services under the plan until the employee has been notified of enrollment with a plan. This subpart also provides that an employee who gives notice of an injury after the effective date of the managed care plan is covered by the plan. The agency has received inquires about cases where the employee has received treatment for an injury before giving notice to an employer. Without this rule, an employee could avoid coverage under the plan simply by delaying notice to the employer until after treatment by a non-plan provider.

Subpart 5, item B. This part states that an employee is not subject to the managed care statute and rules if notice of the injury is given prior to the date of the managed care plan contract with the insurer contract until the employee requests a change of doctor. The rule indicates that at the time of the request for change of doctor, the employee must change to a health care provider within the managed care plan.

Since an employee who has been injured prior to the contract has established a plan of care with a health care provider, and has received services in accordance with 5218.0500, that employee cannot be required to receive services under the managed care plan. However, when the employee requests a change of treating doctor, it is appropriate to change to a treating doctor within the managed care plan. This is not a substantive change in the law such that only employees with dates of injury after the effective date of Minnesota Statutes, section 176.1351 are covered. The substantive law regarding medical treatment of an employee remains unchanged: The employee remains entitled to all treatment under Minnesota Statutes, section 176.135, subdivision 1 that is reasonably required to cure or relieve the employee of the effects of the injury. Minnesota Statutes, section 176.135, subdivision 1f specifically provides that the medical benefits under workers' compensation may be provided by a certified managed care organization. The managed care law is not unlike Minnesota Statutes, section 176.135, subdivision 2, which provides that rules may be promulgated that govern an employee's choice of doctor. Managed care is simply a mechanism by which an employee is to receive all reasonably required treatment for the injury. The medical benefit has not been expanded or limited; only the manner in which the medical benefit is delivered is changed. See, Tri-State Ins. Co. v. Bouma, 306 N.W.2d 564 (Minn. 1983); Sherman v. Whirlpool, 386 N.W.2d 221, (Minn. 1986); and Nelson v. Mid-Minnesota Women's Center, 40 W.C.D. 580 (WCCA 1988).

Subpart 5, item C. This part states that employer may elect to require an employee who has notified the employer of a claimed workers' compensation injury to receive treatment from a certified managed care plan before the employer accepts or denies liability for the injury. It also states that the employer is liable for the cost of that treatment even if the injury is not found to be work related. The rule states that the employer cannot claim reimbursement from the employee for the services. However, it does not limit the employer's right to obtain reimbursement from other sources.

This item is designed to address the problem of where an employee should receive treatment before liability for a workers' compensation personal injury is admitted. Many employees are limited to a provider network by their personal health insurance plan. To require employees to go to a workers' compensation managed care plan after a claimed injury, without providing for payment, could result in the personal health plan also denying payment if liability for the work injury is denied. However, it is reasonable that if the employee the benefits of the workers' compensation law, the employee should be subject to the managed care provision of the law. Therefore, the rule provides that the employer may initially determine whether the employee must receive treatment from a workers' compensation managed care plan after receiving notice of a claimed injury. If acceptance of liability for the work injury is likely, the employer can require treatment from the workers' compensation managed care plan to ensure the most effective management. If the employer questions liability, the employer may permit the employee to seek treatment from the personal health insurance plan. Minnesota Statutes, section 176.191, subdivision 3 requires a workers' compensation insurer to reimburse the personal health carrier if liability for the work injury is later determined.

If the injury is found not to be work related and the employer has required the employee

to receive services from a provider not in the employee's personal health insurance plan, the rule allows the employer to seek reimbursement from the employee's personal health insurance plan or other insurer, but not the employee. This does not extend the rights of the workers' compensation employer or insurer, or impose an obligation on any other entity; it merely acknowledges that there may be other rights under the law that are not specifically addressed in the rule.

Subpart 5, item D. The general topic of this provision involves when an employee may be required to receive treatment from the workers' compensation managed care plan after a denial of liability or after an employee has given notice of a claimed injury to the employer, and the employer does not require the employee to receive treatment from the workers' compensation managed care plan. If the injury is then found to be compensable, the employer is responsible under the workers' compensation law for all reasonable and necessary medical treatment received by the employee. The rule further makes a distinction between acceptance or denial of liability before or after 14 days following the notice of injury. If there is an acceptance of liability prior to the 14 day limit, the employee must switch to a provider within the managed care plan unless the employee has established a relationship with a health care provider prior to the injury. If the acceptance of liability comes after the 14 day time period, the employee is allowed to continue treating with a health care provider if the health care provider agrees to the provisions of the managed care plan in accordance with part 5218.0500, subpart 2.

This rule is an attempt to reconcile the statutory provisions that require an employee to receive treatment from the managed care plan but also require the recognition of the importance of the pre-existing relationship with a provider outside of the plan. This item reflects the possibility that it may take weeks or months before liability is established if, for instance, litigation is pending. It would be unfair to require an employee, who has established a lengthy treating relationship with a provider, to receive further treatment from the managed care plan, when liability has initially been denied by the insurer. However, the rule anticipates that if liability is accepted within 14 days, the time frame given to the insurer for accepting or denying reportable workers' compensation claims under Minnesota Statutes, section 176.231, subdivision 1, the employee may be required to receive further treatment under the managed care plan.

Subpart 6. Termination of Coverage. This subpart ensures the continuity of care with a specific health care provider if for some reason that health care provider leaves the managed care plan. It permits the employee to stay with that health care provider if so desired and if the provider agrees to restrictions under 5218.0500.

This is consistent with the general concept expressed in the statute that recognizes the importance of the relationship between a provider and patient. When a contract between either the health care provider and managed care plan or an insurer and the managed care plan terminates, the employee has the right to continue treating with the same health care provider, for consistency of treatment and in deference to the relationship.

Part 5218.0250 NOTICE TO EMPLOYEE BY EMPLOYER.

In general, this part specifies what an employer must tell the employee about the managed care plan before the employee can be required to receive services under the plan. The notice from the employer to the employee must be given at enrollment and offered again at the time of injury. There are five items the employer must tell the employee:

A. That the employer has enrolled in a managed care plan on a specified date. This is basic, essential information that an employee must know before the employee can be required to receive care under the plan pursuant to Minnesota Statutes, section 176.135, subdivision 1f. An employee who has not been fully informed about rights and obligations under managed care cannot be said to have been required to receive the care under that provision.

B. The name and telephone number of a contact person who can answer questions about the managed care plan. The employee may have questions about operation of the plan and coverage issues. The employee should be able to receive this information from the plan liaison or the employer.

C. Notification that the employee may receive treatment from a medical doctor, chiropractor, podiatrist, osteopath or dentist. Minnesota Statutes, section 176.1351 and these rules clearly require that an employee must have direct access to all types of health care providers. Because the evaluating provider may not necessarily be one of these categories, it is important that employees receive notice of this right.

D. Information about how the employee can obtain care under the managed care plan and a 24 hour telephone number of the managed care which informs the employee of the available services. This is critical information that an employee will need to access care after an injury, since prompt treatment (within 24 hours) is required and injuries may occur after normal business hours.

E. Notification to the employee that they are not required to receive services under the managed care plan if any of the following circumstances prevail:

- If the employee has established a relationship with a health care provider who is able to treat the injury and has treated the employee at least twice within the previous two years before the injury under part 5218.0500, subp. 1.
- In the case of an emergency
- If the employee lives or works more than 30 or 50 mileage parameters under part 5218.0100, subp. 1F(7), whichever is applicable

These exceptions are provided by statute or rule and employees should be notified accordingly.

F. The telephone number of the Department of Labor and Industry. This number is important so that an employee may receive answers to their questions about the law, benefits and responsibilities. In addition, the Department will be able to obtain information about employee perceptions about workers' compensation managed care.

The employee must be notified of the enrollment in the managed care plan before he or she can be expected to receive services from the plan. Notice at the time of enrollment is reasonable because, at the time of injury, the employee may not be in the best position to understand his or her rights and obligations. This information may be conveyed to the employee in any way, such as by meetings with representatives from the managed care plans and employers, or written notification by the employer. The exact manner of communication is not specified to allow employers maximum flexibility to give notice in accordance with the needs of the employees. A posted notice is required so that employees have access to the information at all times. The information must be again offered at the time of injury so the employee is able to again review information necessary to make informed decisions and take the appropriate steps to receive compensable medical treatment.

This notice provision was not included in the emergency rules for managed care plans. The Department has had to subsequently mediate several disputes following an employee's visit to a non-participating health care provider where the employee reported that he or she did not know about the managed care plan. This resulted in a great deal of confusion as to who is responsible for the medical treatment. In order for a managed care system to effectively function, employees must have accurate, timely notice of their rights and responsibilities.

Part 5218.0300 REPORTING REQUIREMENTS FOR CERTIFIED MANAGED CARE PLANS.

Subpart 1. Contracts; Modifications. This section specifies three types of contracts to be reported to the commissioner:

1. The commissioner must be notified within 30 days of any contract signed between the managed care plan and any insurer or self-insured employer. The rule allows a standard contract to be submitted instead of individual contracts if no modifications are made. These standard contracts must contain a list of signatories plus a listing of all the employers covered by each contract. It must also include all the employers names, the unemployment insurance identification number, the estimated number of employees governed by the managed care plan contract. The contract must also specify the billing and payment procedures and how the medical case management and return to work functions will be coordinated between the insurer, employer and managed care plan. The rule also requires any additions or addendum to the contracts to be submitted within 30 days.

2. The plan must submit any new types of agreements between participating health

care providers and the managed care plan.

3. The plan must submit contracts between the managed care plan and entity other than the individual participating providers that perform some of the functions of the managed care plan.

The Department must be notified of any contract between the managed care plan and insurer and self-insured employer. It is also important to obtain the specific information about enrolled employers and employees. The Department is often asked questions by employees and employers about coverage. The Department will computerize this information and have it available to the public. It is also important to know the number of employees enrolled in a managed care plan, to evaluate on a broad basis whether the plan will be able to fulfill its responsibility to provide needed treatment consistent with Chapter 176 and in accordance with these rules.

The contracts between the plan and the insurer must specify the billing and payment procedures and the medical case management because these are critical aspects of the plan and are open to negotiation between the insurer and the managed care plan. The insurer may retain some of the case management and payment activities, subject to the requirements of part 5218.0760. The Department must carefully review the contracts and confirm that the negotiations and arrangements are within the spirit and letter of the law for managed care plans. The second and third types of contracts are necessary to confirm that any type of arrangements made by the managed care plan and health care provider conform with the rules and regulations of managed care plans. In reviewing the contracts submitted under the emergency rules, several contracts were not consistent with the workers' compensation law and rules, and had to be revised accordingly. Because the workers' compensation system is complex, it is appropriate for educational and compliance reasons to review contracts.

Subpart 2. Annual Reporting. The managed care plans will not be required to "recertify" each year. However, they will be required to submit an annual report in order to maintain their certification. The rule requires that the annual report be submitted on the first working day following the anniversary of the certification. The rule specifies the following items to be submitted along with a non-refundable fee of $400.

- A listing of all health care providers including any changes from previous lists. This is necessary so the Department has an accurate listing of health care providers under each managed care plan.

- A summary of any sanctions or punitive actions taken by the managed care plan against its participating providers. This is important information for the Department to measure compliance with peer review requirements and also to monitor the appropriateness of treatment under Minnesota Statutes, section 176.103.

- A report that summarizes peer review, utilization review, report of complaints and dispute resolution procedures showing cases reviewed, issues involved and any actions taken. This is necessary to determine compliance and effectiveness of these procedures and treatment required by Minnesota Statutes, section 176.1351.

- A report of the educational opportunities offered to participating providers and a summary of attendance of the providers at those opportunities. This is necessary to evaluate the nature and effectiveness of educational opportunities provided, as education of health care providers is critical to the success of workers' compensation managed care. The managed care plans are not specifically required to educate their health care providers about workers' compensation issues, except for the medical director or their designee. However, it is hoped that the managed care plans will participate in educational activities for their health care providers. By listing the specific activities undertaken, employers and insurers can better compare the plans on how the providers are educated in workers' compensation issues.

The fee of $400 is required because of the amount of professional, technical and clerical staff needed to review the reports and the possibility of on-site visits to the managed care plan to verify or gather additional information, and miscellaneous costs. The analysis of fees and approval by the Commissioner of Finance for these fees is attached.

Subpart 3. Plan Amendments. If the managed care plan makes any of the following changes to the plan as certified, they must be reported to the Department before they can be implemented. The change(s) must also be accompanied by a non-refundable fee of $150.

- Amendments to any contract with the participating health care provider. The Department must be able to review contracts for consistency with Minnesota Statutes, section 176.1351 and these rules.

- Amendments to any contracts between the managed care plan and other business entity. Again, the Department must be able to determine consistency with the applicable law, and must be able to determine the organizational structure of the plan.

- Any changes in the managed care plan ownership, organizational status, or affiliation with an insurer, employer or third party administrator. The Department must be able to review the new relationship for compliance with Minnesota Rules Part 5218.0220, subpart 4 and Minnesota Statutes, section 176.1351, subdivision 1.

A fee is charged because of the time for professional, technical and clerical staff time review plus other miscellaneous expenses such as materials, supplies and mailing costs. See the

attached analysis of fees and approval by the Commissioner of Finance.

Subpart 4. Insurers; Data. This section requires the managed care plan to use the uniform billing forms proposed in Minnesota Rules Part 5221.0700, subdivisions 2a, 2b and 2c. All health care providers will be required to submit information on the uniform billing forms, following adoption and implementation of these rules. The managed care plans will not be exempt from this rule. The Department needs to collect billing and treatment data from all health care providers pursuant to Minnesota Rules part 5221.0650 and Minnesota Statutes, section 176.83, subdivision 5a to research and monitor the effectiveness of workers' compensation treatment and cost containment programs.

Subpart 5. Monitoring. This section allows the commissioner to ask for any other information that may be necessary or relevant to determining if the managed care plan is in compliance with the statute or rules. It would be impossible to ascertain in advance every circumstance in which the Department may need to make an inquiry or request data from a managed care plan.

Part 5218.0400 COMMENCEMENT AND TERMINATION OF CONTRACT WITH PARTICIPATING PROVIDERS.

Subpart 1. Commencement. This part states that the prospective health care provider must submit an application to the managed care plan to become a participating health care provider. The managed care plan decides whether or not this person meets the plan requirements and has the responsibility of determining whether this person meets all licensing, registration, and certification requirements.

Subpart 2. Termination. This subpart indicates that the managed care plan may terminate participation of a health care provider in the plan. If this occurs, the plan must make arrangements for continued medical services for the injured employee.

These two subparts essentially state that the managed care plan has control over which health care providers are in the managed care system. The managed care plan cannot be forced by the Department or any other group or individual to accept anyone who applies. It is up to the managed care plan to determine which providers are best able to provide the quality, cost-effective treatment. This selection process anticipated by Minnesota Statutes, section 176.1351, subdivision 1, clause 1 and subdivision 2, clause 4.

Part 5218.0500 HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subpart 1. Authorized Services. This part specifies under what circumstances an employee may receive services outside of the managed care plan. The rule also states that the employer/insurer must notify the managed care plan of such treatment and that the managed care plan employer or insurer must then initiate contact with the non-participating provider. A non-

participating provider may deliver services under the following circumstances:

- if that health care provider maintains the employee's medical records, has a documented history of treatment of that employee at least twice in the two years before the date of injury, whether it is work related or not. The rule states that a documented history of treatment does not include evaluations for no or minimal compensation or treatment for an injury before notice of the injury is given to the employer. The rule further states that the employee must promptly provide the insurer with copies of the medical records documenting the previous treatment. The insurer must treat these medical records as private data.
- in cases of emergency treatment
- when the employee is referred to the provider by the managed care plan
- if the employer has denied liability for the injury more than 14 days after the employer has received notice of such injury

Minnesota Statutes, section 176.1351, subdivision 2 states that an employee may receive compensable treatment from a health care provider who is not a member of the managed care plan if that provider maintains the employee's medical records and has a documented history of treatment with that employee before the employer receives notice of the injury. Because the employee is claiming the prior relationship, it is the employee's responsibility to document the relationship with medical records. As discussed earlier, a prior relationship cannot be established before the employer is given notice of an injury; the Department has received comments that employees have delayed giving notice of an injury for several days simply to establish a treating relationship with a non-plan provider. This is clearly contrary to the intent of the statute.

The statute and rule allow an employee to continue to treat with a provider with whom the employee has established a previous relationship prior to the injury. This may be a family doctor who has seen the employee for non-work related conditions, or for a prior work related condition. There is no requirement that the employee be seen for a specific type of injury. For instance, an employee may see his or her family doctor for an upper respiratory infection on one visit and for a sprained ankle on another visit. This does not preclude the employee from seeing this health care provider for a work related carpal tunnel syndrome. However, the relationships anticipated by the statute should not be a casual relationship, for instance after only one visit or after free screening for potential problems. The rules specify that the employee should have been seen by the health care provider at least twice in those two years. While an employee may have received treatment from a provider over a longer period of time, if the employee has not seen the provider twice in the past two years, the relationship is remote enough that the provider will not have current knowledge of employee's medical status, and the relationship is not likely of a nature that the employee would benefit from care with that provider more than care with a medical provider who specializes in workers' compensation treatment. This rule attempts to balance competing benefits, but some limitation is necessary. While the statute is not specific as to what constitutes a previous treating provider, it cannot be read to qualify any previous health care provider, because everyone has seen a health care provider at some point in time.

In cases where emergency treatment is required, the employee may see any appropriate health care provider or go to any facility that is appropriate.

Minnesota Rule 5218.0200, subpart 5 discusses in detail the rationale for allowing an employee to continue seeing a provider with whom the employee consulted after the insurer has denied liability for the injury.

Subpart 2. Requirements. This section states what a non-participating health care provider must agree to in order to treat an employee outside of a managed care plan.

- The provider must agree to comply with the treatment standards, utilization review, peer review, dispute resolution and billing and reporting requirements of the managed care plan.

- The provider must agree to refer the employee to the managed care plan for specialized services including physical therapy and diagnostic testing. It allows the health care provider to do minor diagnostic testing in the office. If the non-participating provider refers to the employee to services in the managed care plan, that non-participating provider can continue to act as the primary treating provider.

Essentially, this subpart requires that the non-participating provider must comply with all the same requirements that participating health care providers must comply with. The employee's treatment should be managed the same inside the plan as outside the plan. This is required by Minnesota Statutes, section 176.1351, subdivision 2, clause 8.

If an employee requires specialized services such as physical therapy or diagnostic testing, the managed care plan is required to provide for these types of specialized services and may be able to provide them on a more cost effective basis. The non-participating health care provider may do minor diagnostic testing within his or her office, such as plain x-rays and minor laboratory work because referral back to the plan for these services would not be cost effective. If the non-participating provider refers the employee to any services inside of the managed care plan, that provider does not give up the right to be the primary treating provider.

Subpart 3. Disputes. This section states that any disputes related to the nonparticipating provider must be resolved under the managed care plans dispute resolution procedure. This is consistent with Minnesota Statutes, section 176.1351, subdivision 3, which requires an employee to exhaust the dispute resolution process under the plan. It also states that a health care provider who has been informed that the employee is covered by a managed care plan but does not comply with the requirements in subpart 2 is subject to denial of the payment for the services and potential sanctions under Minnesota Statutes, section 176.103. If a health care provider has received notice that an employee is enrolled in managed care, the provider delivers unauthorized services at his or her own risk.

Part 5218.0600 CHARGES AND FEES.

This part indicates that a managed care plan provider must be reimbursed in the same manner as a non-certified provider. The rule further states that the managed care plan may not require a health care provider to accept a lesser payment or pay a fee as a condition of receiving referrals from or becoming a participating provider in the plan.

This rule requires that the health care providers in the plan be reimbursed in the same manner as provides outside of a plan. They are to be reimbursed in a manner and in amounts set forth in Minnesota Statutes, section 176.136, subdivision 1a and 1b. This statute specifies how health care providers are to be reimbursed: Subdivision 1a provides that for services governed by the fee schedule, either the maximum amount in the fee schedule applies, or the provider's actual fee, if it is lower than the fee schedule amount.

Minnesota Statutes, section 176.83, subdivision 4 authorizes the commissioner to develop rules which "encourage providers of health services . . . to develop and deliver services for the rehabilitation of injured employees." A similar provision is found in Minnesota Statutes, section 176.136, subdivision 1, which governs the establishment of a workers' compensation medical fee schedule. It is with this principle in mind that these rules have been developed. It has been suggested that managed care organizations should be allowed to negotiate rates lower than the provider's usual and customary charge, actual charge or fee schedule amount. This issue has been carefully considered.

The 1992 Legislature required a relative value fee schedule to be adopted on October 1, 1993, to reflect a 15 percent overall reduction from the 1991 medical fee schedule. Subdivision 1(b) provides that, except for small hospitals, services that are not included in the fee schedule are reimbursed at 85 percent of the provider's usual and customary charge. Accordingly, the 1992 legislation already provides for significant reductions in reimbursement to the health care providers, not only in the fee schedule maximum rate but also for charges that are not included in the fee schedule.

As noted on page 2, the legislature required that "Any rules adopted must be designed to assist in the formation of managed care organizations while ensuring quality managed care to injured employees."

It is determined that to permit further reduction of reimbursement to providers could compromise the delivery of medical services and possibly limit the number of quality providers available to participate in managed care. Managed care plans are designed to promote quality, cost-effective treatment and promote an early return to work. The savings in the workers' compensation system are designed to come from these areas. See, Minnesota Statutes, section 176.1351, subdivision 2. Cost savings that result from simply reducing reimbursement to providers could very well compromise these goals. The costs of administering the plan should be a matter of contract between the insurer and the managed care plan; the providers should not be required to subsidize administrative costs as a condition of treating injured workers under the

plan. The statutory reference to "financial incentives" to reduce costs and utilization without compromising patient care can be accomplished by adjusting the number of referrals or terminating the contract with the health care provider, or even by providing bonuses for quality care.

The fees in the medical fee schedule are reasonable and established by the legislature. The problem in the workers' compensation system is not so much the individual cost of any given service but the utilization of services. By "managing the care" of the injured employee, the managed care plans should reduce the overall costs in the workers' compensation system by reducing the utilization of inappropriate services, and unnecessary delay in return to work.

Part 5218.0700 DISPUTE RESOLUTION.

This section states that if an employee has a dispute with the managed care plan regarding the medical services, the dispute must be taken through the internal dispute resolution procedure of the managed care plan. The dispute must be processed within 30 days. If there are problems following this procedure, any of the parties may come to the Department for further dispute resolution. The rule also states that there can be no charge by the managed care plan to the employee for this service because Minnesota Statutes, section 176.1351, subdivision 3 requires the employee to exhaust the plan's dispute resolution mechanism prior to proceeding with an administrative action under Chapter 176. Thirty days is a reasonable period of time for the plan to resolve issues, because medical issues are of paramount importance to the employee, and more complicated issues may still need to proceed through the workers' compensation system, which may result in further delay. The 30 days time period is consistent with the dispute resolution requirement for health maintenance organizations. See Minnesota Rules Part 4685.1500, subpart 1(B). The plan's dispute resolution process is not intended to address non-medical disputes. Disputes about entitlement to wage loss benefits, or whether an injury has occurred, will still be initially addressed through the workers' compensation dispute resolution system.

Part 5218.0750 UTILIZATION REVIEW AND PEER REVIEW.

This part requires the managed care plan to develop utilization review and peer review programs to maintain the quality of care for injured employees. These procedures are required by Minnesota Statutes, section 176.1351, subdivision 2(4).

The peer review program must be designed to evaluate the quality of care given by the health care providers in the plan to the employee. The plan must describe how the providers are selected for review, who will be doing the review, the nature of the review and how the results will be applied to improve patient care and increase cost effectiveness. The peer review program is essential to maintain quality standards for health care providers. The peer review must include at least one provider in the same profession, to ensure that the profession's scope of practice and standard of care is represented in the process.

The application must describe how the plan will perform utilization review, including collecting, reviewing, and analyzing group data to improve overall quality of care and efficient use of resources. This program must focus on outcomes for patients collectively, through review of individual outcomes and treatment.

The specific manner of performing utilization and peer review is not specified, because better methods of collecting and analyzing data are evolving with advances in medical treatment and computer technology. Accordingly, the plan must report a program with stated procedures and goals, but the details are deliberately left open to allow for flexibility to develop a system unique to the needs of each plan.

Part 5218.0760 MEDICAL CASE MANAGEMENT.

This part specifies the role of the medical care manager and the qualifications for the medical case manager. The medical case manager must monitor, evaluate, and coordinate the deliver of quality, cost effective medical treatment and other health services needed by the injured employee. Medical case management focuses on maximizing quality treatment for individual employees. The medical case manager must also facilitate a prompt and appropriate return to work for the injured employee. The managed care plan must describe who will be doing the medical case management and how employees are selected. The rule also states that a medical case manager must be a licensed or registered health care professional with at least one year experience in workers' compensation case management.

Minnesota Statutes, section 176.1351, subdivision 2(6) requires that a plan must provide "aggressive case management for injured workers." In some cases, the medical case manager will be one of the most important persons in the workers' compensation managed care system. This person will coordinate the medical treatment and facilitate the employee's return to work. The medical case manager will keep open the lines of communication between the employee, the health care provider, the employer, and the insurer.

Since the role of the medical case manager is so critical, it should be entrusted to someone who is knowledgeable about injuries and medical treatment and has had at least one year's experience in an area of workers' compensation. This may include a variety of experiences, such as treating injured employees or workers' compensation case management.

Not all injured employees require extensive medical case management. This will vary greatly depending upon the type of injury, work considerations, and the employee's response to the injury. The managed care plan must specify in its application which employees will receive what level of medical case management.

Because each case is unique, some of the case management functions may be coordinated between and performed by the health care provider, the plan, the employer, and the insurer. Each of these entities may be uniquely situated in any given case to provide one or more of the components of case management. However, the managed care plan must offer case management

services in all cases, and the person performing the function must meet the requirements of this rule in every case.

Part 5218.0800 MONITORING RECORDS.

Subpart 1. Audit. This section states that the commissioner must monitor and conduct periodic audits and special examinations of the plan to ensure that they are in compliance with the certification and any other performance requirements.

Since the employee will be required to receive care under the managed care plan, the Department has a responsibility to ensure that the managed care plans are in compliance with the certification requirements and any other rules or regulations required by the workers' compensation statute and rules.

Subpart 2. Records. The rule states that the records of the managed care plan must be disclosed within a reasonable time upon request of the commissioner for purposes of determining compliance with this rule. Specific timelines are not specified because the records may take a number of forms and will vary in content. This is an area in which the agency must be flexible and work cooperatively with the plan. The rule also states the obvious, that the records must be legible and not kept in a coded or semi-coded manner unless the code is explained. In order for the commissioner to conduct periodic audits, the commissioner must have access to the medical records of the managed care plan. The records must be in a condition so that they can be easily read or interpreted.

The rule states that the managed care plan must clearly identify portions of its application which are identified as being protected under the trade secret statutes. The plan must submit a written opinion why the material should be considered a trade secret and not be made part of the public record.

All of the materials submitted in the application by a managed care plan that has been certified is considered to be public information under Minnesota Statutes, section 13.03, subdivision 1, except that which is classified as a trade secret under Minnesota Statutes, section 13.37, subdivision 2. Since the entire record is considered to be public information, the managed care plan must establish the trade secret nature of any of the information. If the managed care plan meets the statutory criteria for keeping the information a trade secret, this information will not be released to the public. Because trade secret protection is a complicated area of the law, it is determined that if an attorney submits an opinion the Department will presume the trade secret characterization is consistent with the statutory definition. Although the Department will of course consider an analysis and opinion from non-attorneys, the rule simply acknowledges that this is a complex legal issue in an area which requires an in-depth analysis of the managed care plan's development process. The Department will presume the statutory trade secret criteria have been met only when supported by an opinion from the plan's attorney.

Part 5218.0900 SUSPENSION; REVOCATION.

This part states that if after receipt of a written complaint and investigation, the commissioner has reasonable cause to believe the managed care plan is in violation of the certification, he may initiate a contested case hearing under the Administrative Procedures Act (APA), Minnesota Statutes, Chapter 14. Under Minnesota Statutes, section 176.1351, subdivision 5, the commissioner is authorized to make the final decision on certification. The provisions governing contested case hearings under the APA are consistent with this authorizations. Under the APA, an administrative law judge conducts the hearing and makes recommendations to the commissioner. This procedure is also utilized under Minnesota Statutes, section 176.102 and 176.103 for discipline of health care and rehabilitation providers.

The reasons for suspension or revocation are as follows:

- if services are not being provided according to the terms of the certified plan
- if services are not being delivered according to the managed care rules
- if the plan or participating provider submits any false or misleading information
- if a health care provider whose license, or registration, or certification has been invoked and continues to provide services under the plan
- if the managed care plan is found to be formed, owned or operated by an insurer

These are essential requirements for certification. To the extent these failures occur, the plan's operation must be restricted, depending on the nature of the violation.

The rule states that if a certification is revoked, the employee is no longer required to attend because the plan is no longer a certified plan under Minnesota Statutes, section 176.1351, subdivision 1f. If the plan is suspended, the employee may continue to receive services under the plan, but new contracts may not be entered into until the suspension is lifted.

This section has been added in the remote possibility that a managed care plan does not comply with the terms of the certified plan or follow the requirements stated in Minnesota Statutes and Rules. The Department hopes to avoid this drastic possibility through active monitoring and review of the annual reports and communication with all parties. However, it is critical to have a procedure in place in case suspension or revocation is necessary.

MN DEPARTMENT OF FINANCE
Fi-00395-01

Exhibit B:
Workers' Compensation - Managed Care
1994-95 DEPARTMENTAL EARNINGS REPORT

Collecting Agency Name: Department of Labor and Industry	Sec./Seq.: 573	Earnings Group: Workers' Compensation Managed Care
Brief Description of Item or Group of Items Reported Below: Revenue shown here is paid by the managed care organizations who wish to be certified for the provision of services to individuals who were injured on the job and are receiving workers' compensation benefits.		
Fee set by Statute ____ or Agency __X__	Legal Citation: M.S. 176.1351	Date Prepared: 30-Apr-93
Purpose: The purpose of these fees is to cover the costs of providing the certification which assures that managed care organizations have agreed to abide by the fee structure and other service guidelines as specified in the workers' compensation law.		
____ Dedicated or __X__ Non-dedicated	APID: 21400:99-10 Labor and Industry Receipts	Revenue Code(s): 310

Fiscal Information Section

($1,000,000 = 1,000)

	ACT. 1991	ACT. 1992	EST. 1993	Current Law EST. 1994	Current Law EST. 1995	Agency Plan EST. 1994	Agency Plan EST. 1995	Recommended EST. 1994	Recommended EST. 1995
Actual and Estimated Resources									
Accumulated balance forward	0	0	0	1	1	1	1		
Type of Departmental Income									
1. User/Service Charge	0	0	0	0	0	0	0		
2. Occupational Licensure Charges	0	0	0	0	0	0	0		
3. Business/Industrial Regulatory Charges	0	0	17	16	8	16	8		
4. Special Taxes and Assessments	0	0	0	0	0	0	0		
5. Other (Specify)	0	0	0	0	0	0	0		
Less Refunds:	0	0	0	0	0	0	0		
Plus Earnings transferred from Other APIDs	0	0	0	0	0	0	0		
Total Resources Available	0	0	17	16	8	16	8		
Transfers Out:	0	0	0	0	0	0	0		
Actual and Est. Expenditures (Specify APID)									
21491:01-32 Workers' Comp. Reg. & Enf.									
Direct Expenditure	0	0	14	15	7	15	7		
Indirect Expenditure	0	0	2	1	1	1	1		
Total Expenditures:	0	0	16	16	8	16	8		
Current Difference:	0	0	1	0	0	0	0		
Accumulated Ending Balance	0	0	1	1	1	1	1		

MN DEPARTMENT OF FINANCE
Fi-00395-01

Exhibit B:
Workers' Compens[illegible]n - Managed Care
1994-95 DEPARTMENTAL EARNINGS REPORT

Collecting Agency Name: Department of Labor and Industry	Sec./Seq.: 573	Earnings Group: Workers' Compensation Managed Care

Agency Remarks (including explanation of agency plan):

These permanent fees replace those which were mandated for certification only under the emergency rules which have been in effect during F.Y. 1993. These permanent fees anticipate a one-time recertification of all organizations certified under the emergency rules as well as a few additional organizations applying for initial certification during F.Y. 1994. By F.Y. 1995, the majority of the revenue will be generated only by the annual report fee and changes to plans which have already certified. There may be an occasional initial certification application, but this would remain a very small and undetermined source of revenue. All revenues generated by this activity are deposited in the General Fund, and agency operations are supported by a direct appropriation from the Workers' Compensation Special Fund.

Department of Finance Comments:

(Agencies are to make no entries in this space.)

STATE OF MINNESOTA

Department: of Finance

Office Memorandum

Date: May 10, 1993

To: Kate Berger, Attorney
Legal Services
Department of Labor and Industry

From: Bruce J. Reddemann, Director BJR
Budget Operations

Phone: 296-5188

Subject: Proposed Workers' Compensation Managed Care rules (fees)

The fees submitted as part of the proposed Workers' Compensation Managed Care rules draft dated May 3, 1993 and the Departmental Earnings report have been reviewed and are hereby approved per M.S. 16A.128.

This approval includes the following fees and is consistent with the Governor's 1994-95 biennial budget:

A. Initial certification	$1,500.00
B. Recertification of provisionally certified plans..	600.00
C. Annual report fee.....	400.00
D. Plan amendments.....	150.00

cc: Jim King
Charlie Bieleck
Anina Bearrood