

Section 3

Medical Benefits

The Minnesota workers' compensation statutes entitle an employee to reasonable and necessary medical treatment or supplies to cure or relieve the effects of the work injury. The employer is required to furnish medical treatment as described by Minnesota Statutes §176.135, Subd. 1 including, but not limited to, psychological, chiropractic, podiatric, surgical, and hospital treatment.

Choice of Health Care Provider

Employees may choose their health care provider for treatment of a work-related injury. An employer may **require** an employee to see a designated health care provider only in the following circumstances:

- An employer may require an employee to receive treatment and supplies from a managed care plan certified under Minnesota Statutes §176.1351 except as otherwise provided by that law and corresponding rules (Minnesota Rules Chapter 5218).
- An employer who is part of a collective bargaining agreement, recognized and on file with the department, may include a provision specifying a list of health care providers that may be the exclusive providers of medical and related treatment and independent medical examinations (Minnesota Statutes §176.1812).
- An employer may request an employee to be examined by an employer's doctor, referred to as an independent medical examination (IME). IMEs are for evaluation purposes only, not for treatment (Minnesota Statutes §176.155).
- An employer may require an employee to obtain outpatient prescription and non-prescription medications from a pharmacy or network of pharmacies as long as it is within 15 miles of the employee's residence [Minnesota Statutes §176.135, Subd. 1(g)].

Change of Health Care Provider

(Minnesota Rules Part 5221.0430)

The primary health care provider directs and coordinates care of the employee. An employee may have only one primary health care provider at a time. The selection of a primary health care provider by an employee covered by a certified managed care plan is governed by the certified plan and Minnesota Rules Chapter 5218.

The employee is allowed to change their primary health care provider once within 60 days of initiating treatment without approval from the insurer, commissioner, or a workers' compensation judge. After the first 60 days of treatment, any changes of primary health care provider must be approved by the insurer, commissioner, or a workers' compensation judge.

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If the employee or health care provider initiates treatment without the required approval of a change of health care provider, the insurer may not be liable for treatment rendered prior to approval.

No prior approval is required if a change of primary provider is due to conditions beyond the employee's control, such as referral from a primary provider, or retirement or death of the primary provider.

Access to Medical Data

Federal Law

Federal laws impact access to personal health information held by health care providers, health plans, and some other entities. The "Health Insurance Portability and Accountability Act" (HIPAA), enacted in 1996, established among other things, a national standard for privacy of personal health information. Health care providers are required to develop procedures to ensure the privacy and security of employees' personal health information. Violations of the federal law may subject the provider to significant penalties.

HIPAA recognizes the legitimate need of insurers and other entities in the workers' compensation system to have access to an individual's health information as authorized by state or other laws. Thus, HIPAA permits a health care provider to disclose personal health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation. However, HIPAA requires a health care provider to limit the amount of health information that is not required by law to the minimum necessary to accomplish the workers' compensation purpose.

Minnesota Workers' Compensation Law

Communication between the insurer or employer and the employee's health care provider is necessary to manage a claim. The employee must be kept informed of all communications, written and non-written (discussions), that occur between the insurer or employer, and the employee's health care provider. Minnesota Statutes §176.138 regulates access to personal health information, or medical data, in workers' compensation.

Medical data includes medical office notes, reports, hospital records, medical bills, in-person and telephone discussion, and faxed information. In Minnesota, medical data related to a current claim for compensation may be released in specific situations. A current claim for compensation is defined under Minnesota Rules Part 5220.2810, Subp. 2 as one in which benefits are being paid to or claimed by an employee, whether or not a claim petition has been filed.

Medical data related to a current claim for compensation in Minnesota may be released to the employee, insurer or employer (who are parties to the claim), or department without authorization of the employee.

The employee's written authorization is required for:

- release of medical data that is not related to a current claim for compensation
- release of medical data related to a current claim for workers' compensation to any person or entity not listed above

A valid authorization to release medical information must include the elements required by HIPAA. When requesting existing written medical data the requester must do all of the following:

- make the request in writing to the person or organization possessing the data
- identify the requester by name, organization, and relationship to the claim, e.g., the employee, insurer, or employer who are parties to the claim
- specify the data being requested
- send written notification of the request to the employee (and attorney) at the time the request is made
- treat the data as private data
- provide the employee or attorney with copies of all data requested or received

The health care provider must provide existing medical data within seven working days of receiving the request. Failure to release the data in a timely manner may result in penalties of up to \$600.00.

Non-written data (discussions) may, but is not required to be, provided by the health care provider. When requesting non-written medical data, the requester must do all of the following:

- confirm in writing the date of the scheduled discussion with the provider participating in the discussion
- send the employee (and attorney) a written notice of the request for discussion with the provider at the same time the request is made, or a written confirmation of the discussion
- treat the data as private data
- provide the employee or attorney with copies of all data requested or received

Failing to comply with the requirements of Minnesota Statutes §176.138 to keep the employee informed of all communication concerning medical information and failing to inform the employee's attorney of such communication, may result in exclusion of the medical data from evidence in workers' compensation hearings (Olson v. Quality Pork Processors, WCCA 11/21/96). A party that does not treat the medical data as private is guilty of a misdemeanor.

Payment for Copies of Medical Records

(Minnesota Rules Part 5219.0300)

A health care provider may charge up to \$0.75 per page for the first copy of the “appropriate record” when provided to the payer to substantiate a service being billed. This amount applies whether the record is provided with the bill, sent separately, or in response to a request from the payer for an appropriate record.

An “appropriate record” is a legible medical record or report which substantiates the nature and necessity of a service being billed and its relationship to the work injury.

For all other copies of records, the health care provider may charge a \$10.00 retrieval fee and \$0.75 per page. The health care provider may also charge actual postage, any Minnesota sales tax, and notary fees. Reimbursement to the health care provider must be made within 30 days of receipt of the copies.

Medical Reports

(Minnesota Rules Part 5221.0410)

Required Reports

The primary health care provider must provide information critical to administering a workers’ compensation claim promptly to the employer, insurer, or department. A health care provider is not reimbursed for providing information from a required form, but the provider may itemize this service on a bill using CPT code 99080. Two forms are used to request required information from a health care provider:

1. The Health Care Provider Report (HCPR) identifies the following required information:
 - date of first exam
 - diagnosis
 - history of the injury as given by the employee
 - relationship of the injury to employment
 - any pre-existing or other conditions affecting the injury
 - any future treatment
 - any surgery
 - the employee’s ability to work
 - any permanent partial disability (PPD) rating
 - whether the employee has reached maximum medical improvement (MMI)

The insurer should complete the top of the form and specify which questions are to be answered. The HCPR is commonly used to request the health care provider's opinion on MMI and PPD.

2. The Report of Work Ability (RWA) identifies the following required information:

- date of most recent exam
- employee's ability to return to work with or without restrictions
- work restrictions described in functional terms
- date restricted work activity begins
- end or review date of restricted work activity
- date of next scheduled visit

The primary health care provider must provide a RWA to the employee at the following intervals:

- every visit if visits are less frequent than once every two weeks; or
- every two weeks if visits are more frequent than once every two weeks, unless restrictions change sooner; or
- at expiration of the end date or review date specified in previous RWA.

The employee must promptly submit the RWA to the employer or insurer and the assigned rehabilitation provider (QRC).

The primary health care provider must respond within 10 days of receipt of a request for information on a required report (HCPR or RWA). The provider may respond on the form or in a narrative report. Failure to respond to the department's request for information on a required form may result in penalties.

Supplementary Reports

The employer, insurer, employee, or department may request information about the nature and extent of an injury without using the HCPR or RWA. A written response to requests for information not required on the HCPR or RWA from the health care provider is considered a supplementary report. A health care provider is not required to respond to a request for supplementary information nor is there a time limit for a response. The health care provider may charge a reasonable fee for providing supplementary information. The charge for the supplementary report is listed using CPT code 99199 on an itemized bill and is not subject to a fee reduction.

Return to Work Planning

(Minnesota Rules Part 5221.0420)

In addition to completing the required RWA, a health care provider must participate in return to work planning by communicating with the employee, employer, insurer, QRC, and department. A health care provider must respond within 10 days to a request from the employee, employer, insurer, or QRC regarding whether the physical requirements of a proposed job are within the employee's medical restrictions or whether more information is necessary to make that determination. Minnesota Rules Part 5221.0420, Subp. 2B describes other situations in which the health care provider must communicate with the assigned QRC.

A QRC must provide a signed authorization from the employee to the health care provider prior to discussing the employee's case or requesting medical information.

A health care provider may not require prepayment for communication concerning return to work planning, but may bill a reasonable fee for communication with any party to the claim except the employee. The health care provider may charge an insurer for communication for return to work planning using code 99199 on an itemized bill. The fee is not subject to a fee reduction. Counseling the employee about return to work is considered part of an office visit charge.

Billing and Payment Responsibilities

Health Care Provider Responsibilities

(Minnesota Rules Part 5221.0700)

When billing for medical services, a health care provider must:

- charge the workers' compensation payer the same amount other payers are billed for the same service (usual and customary)
- itemize services and use appropriate billing codes on prescribed electronic forms; ASC X12N 837P for professional services and clinics, ASC X12N 837I for hospitals, NCPDP for pharmacy, and ASC X12N 837D for dental
 - Payers and providers must submit bills and remit payments electronically pursuant to the requirements of Minnesota Statutes §62J.536
- submit the bill to the payer within 60 days of the provider knowing the condition is claimed by the employee as work related
 - If not submitted within six months, the payer can deny payment under Minnesota Statutes §62Q.75, Subd. 3.
- send an appropriate record with the bill. A hospital must send an appropriate record only upon request.

Payer Responsibilities

(Minnesota Rules Part 5221.0600)

Within 30 days of receipt of a bill from a health care provider, a payer must:

- pay all or any portion of a charge; and/or
- deny all or any portion of a charge, giving the specific reason and citing the rule, part, and subpart supporting the denial; and/or
- request the appropriate record or additional specific information

Interest and penalties may be assessed for a late response. The payer must notify, in writing, the provider and the employee that payment is denied. Within 30 days of receipt of requested information the payer must reconsider the charges.

Excessive Charges

(Minnesota Rules Part 5221.0500)

A payer is not liable for charges from a health care provider that are excessive. A charge is considered excessive if **any** of the following conditions apply:

- the charge duplicates another charge for the same service, article, or supply
- the charge exceeds the provider's current usual and customary charge
- the charge is described by a billing code that does not reflect the actual service provided
- the service does not comply with treatment parameters rules
- the provider is prohibited from receiving reimbursement under chapter 176
- the service is not usual, customary, and reasonably required, or is provided at a level, duration, or frequency that is excessive
- the service, article, or supply was delivered in violation of Medicare anti-kickback regulations
- where a change of health care provider has not been approved, if required under Minnesota Rules Part 5221.0430
- the service is outside the provider's scope of practice or is not recognized to be of therapeutic value

If the payer determines that a service or charge is excessive, the health care provider may not collect from the employee or any other source unless payment is ordered by the commissioner or a workers' compensation judge. The health care provider must remove the charges from the bill. If a dispute exists about whether the employee's

injury is compensable under workers' compensation and the employee has general health insurance, the provider may bill the health carrier under Minnesota Statutes §176.191, Subd. 3.

Certified Managed Care Organizations (CMCO)

(Minnesota Statutes §176.1351 and Minnesota Rules Parts 5218.0010 – 5218.0900)

Under Minnesota workers' compensation law there are limited circumstances under which an employer may require an employee to receive medical treatment from a designated provider. Minnesota Statutes §176.135, Subd. 1(f) provides that an employer may require that treatment and supplies for a work-related injury be received from a managed care organization certified by the department.

To be certified by the department, an entity must meet statutory requirements to ensure the delivery and management of quality medical treatment of employees through a network of health care providers. The CMCO network of providers must be geographically accessible to employees and allow an employee a choice of a provider. Employees must have access to information regarding the availability of medical services within the CMCO on a twenty-four hour basis.

A CMCO must also provide the following services:

- utilization review
- peer review
- dispute resolution
- medical case management

Insurers can not be a CMCO. A CMCO contracts with an insurer to provide certified managed care services to covered employers.

Employee Notice

(Minnesota Rules Part 5218.0250)

An employer can not require an employee to treat under a CMCO until the employee receives notice of CMCO coverage. An employer must give this information to an employee when the employer enrolls in the CMCO and when the employer receives notice of injury. In addition, the employer must post the notice of CMCO coverage on the premises. The posted and individual notices must include all of the information outlined in Minnesota Rules Part 5218.0250.

Requiring Treatment with a Participating Provider

(Minnesota Rules Part 5218.0200)

Generally, an employee covered by a CMCO must treat with a participating provider. An employer may direct an employee to a specific participating provider for the initial evaluation if the certified plan allows the employer to select a designated

clinic/provider and the information is given to the employee in the notices specified above. An employee is entitled to an initial evaluation with a participating provider within twenty-four hours of requesting treatment.

Following an initial evaluation from the employer's designated clinic, an employee may choose any participating provider to act as their primary health care provider. A primary health care provider is a medical doctor, chiropractor, osteopath, podiatrist, or dentist directing and coordinating the course of medical care to the employee. To be considered a primary health care provider, the treatment for the injury must be within the primary health care provider's scope of practice.

An employer may require an employee to treat with a participating provider before accepting or denying liability for the injury. However, if primary liability is subsequently denied, the employer is liable for the cost of any treatment received from the participating provider before notice of primary denial of liability is given to the employee.

Allowing Treatment with a Non-Participating Provider

(Minnesota Rules Part 5221.0500, Subp. 1)

There are several exceptions to the requirement that an employee treat with a participating provider.

The first exception allows an employee to see a health care provider outside the CMCO network if **all** of the following apply:

- the treatment is within the provider's scope of practice
- the provider maintains the employee's medical records
- the provider has a documented history of treatment with the employee before the date of injury

A documented treatment history is deemed established if the employee had at least two visits with the provider within the two years preceding the date of the injury. However, employees with a history of treatment that does not meet this standard may request approval of treatment from a non-participating provider from the CMCO or insurer. An employee must provide to the CMCO or insurer copies of medical records or a letter from the health care provider documenting dates of previous treatment. A documented treatment history does not include evaluations for little or no compensation or treatment of the work injury before the employee gives notice of the injury to the employer.

A second exception allows an employee to see a primary health care provider of his choice if no primary health care provider is within certain mileage requirements. In the seven county metro area, the provider must be within 30 miles of the employee's home or job. In out-state Minnesota, the provider must be within 50 miles of the employee's home or job. If an employee needs specialty services, the CMCO may refer the employee to a participating provider located beyond the mileage requirements. However, if the employee in need of specialty services is medically

unable to travel, the CMCO must refer the employee to a non-participating provider located within the mileage requirements.

In addition, a non-participating provider may deliver services to an employee in the following situations:

- in cases of an emergency
- where the CMCO refers the employee to the provider
- where the employee is injured before the effective date of CMCO coverage
- where the employer does not give the employee notice of CMCO coverage
- where the insurer denies primary liability
- where the employer does not require the employee to treat with a participating provider before accepting liability (If the employer accepts liability within fourteen days of notice of injury, the employer can then require the employee to treat with a participating provider. If liability is accepted later than fourteen days of notice of injury, the employee is not required to treat with a participating provider.)

Requirements for Non-Participating Providers

(Minnesota Rules Part 5218.0500, Subp. 2)

As outlined above, there are situations where an employee may treat with a non-participating provider. In those situations, the non-participating provider must agree to comply with the CMCO treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures. The provider must also agree to refer the employee to a participating provider if specialty services are needed. A non-participating provider who does not follow these rules may be subject to denial of payment. A non-participating provider must resolve disputes involving treatment or compliance with CMCO procedures through the CMCO dispute resolution process.

Change of Health Care Provider

(Minnesota Rules 5218.0100)

Employees may change primary health care providers at least once without going through CMCO dispute resolution. However, the employee must make the request to the CMCO. Changing from an evaluating health care provider to a primary health care provider is not considered a change unless the employee has received treatment from the evaluating provider more than once for the injury. A referral to a specialist is not considered a change of health care provider. All other changes of health care provider must be approved by the CMCO.

Where an employee has treated with a non-participating provider, if the employee wishes to change providers, the employee must change to a participating provider.

Medical Case Management

(Minnesota Rules Part 5218.0760)

CMCOs are required to provide medical case management by licensed health care professionals. The medical case manager must monitor, evaluate, and coordinate the delivery of quality, cost effective medical treatment, and must promote an appropriate, prompt return to work. The medical case manager must facilitate communication among the employee, health care provider, insurer, employer, and QRC.

Dispute Resolution

(Minnesota Rules Part 5218.0700)

An employee or health care provider who has an issue related to a certified managed care plan must first try to resolve the issue through the CMCO dispute resolution process. The CMCO can not charge for hearing the dispute. A CMCO must resolve the dispute within thirty days of receiving written request for dispute resolution. After exhausting the dispute resolution process of the CMCO, if the employee or health care provider is not satisfied with the result, they may file a Medical Request with the department.

Issues that are subject to CMCO dispute resolution include, but are not limited to:

- changes of health care provider
- documented treatment history or treatment by a non-participating provider
- treatment plan concerns
- medical case management concerns
- medical provider compliance with treatment parameters or CMCO standards
- permanent partial disability ratings

Issues that are not subject to the CMCO dispute resolution process include, but are not limited to:

- compensability of the workers' compensation claim
- wage loss benefits
- vocational rehabilitation and QRC issues

Non-Certified Managed Care and Provider Networks

Managed care is a commonly used term in the insurance industry. Many insurers contract with entities that offer "managed care services". Such entities may offer a variety services including a network of health care providers, medical bill review, or

case management.. However, no entity may hold itself out to be a workers' compensation managed care organization unless it is a managed care plan certified by the department. Non-certified entities differ from certified organizations in that non-certified entities:

- can not require an employee to see a health care provider designated by the employer or insurer.
- can not require parties to use an internal dispute resolution process. Employees and health care providers may bring their disputes directly to the department.
- may discount fees through contracts with individual health care providers.
- are not required to provide peer review, utilization review, dispute resolution, or medical case management.
- are not reviewed or approved by the department. The insurer is responsible for actions of non-certified entities.

Certified Managed Care Organization – Exercise 3A

1. An employer is covered by a CMCO. What are the three ways that the employer must notify an employee of CMCO coverage?
2. Three years ago, Ralph treated with a chiropractor, Dr. Jones, for several visits over a period of two months for a neck injury resulting from a motor vehicle accident. Ralph injured his low back at work and wants to treat with Dr. Jones. If Dr. Jones is not a participating provider, can Ralph see him? Why?
3. Dr. Jones recommends that Ralph have a CT scan. What must Dr. Jones do?
4. The CT scan is denied. What course of action may be taken to resolve the issue?

Treatment Parameters

The treatment parameters for workers' compensation are found in Minnesota Rules Parts 5221.6010 through 5221.6600.¹

The purpose of the rules is to establish guidelines for reasonable treatment of employees with compensable injuries and to facilitate communication between the health care provider and the insurer. The parameters assist insurers and health care providers in identifying services that are performed at a level or frequency that is excessive, unnecessary, or inappropriate based on accepted medical standards for quality health care.

The rules apply to all dates of injury and all health care providers. The rules do not affect determinations of liability for an injury. The parameters do not apply to treatment of an injury or condition for which the insurer has denied liability. If the insurer reverses a denial, the parameters apply to all treatment after the claim has been accepted. The rules are not intended to expand or restrict a health care provider's scope of practice under any other statutes.

Guidelines have been established for some common work-related injuries; low back pain, neck pain, thoracic back pain, upper extremity disorders, and reflex sympathetic dystrophy.

General Parameters

(Minnesota Rules Part 5221.6050)

The general parameters include broad guidelines that reflect good medical practice which apply to all injuries. They do not require or permit any more frequent examinations than would normally be required for the condition being treated. They require ongoing evaluations of the employee that is medically necessary and consistent with accepted medical practice. For the specific parameters listed, the health care provider must evaluate at each visit whether initial nonsurgical treatment is effective including:

- the employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms

¹ This guide contains only a summary overview of some of the treatment parameter rules. You should read each rule before applying it. Specific information regarding parameters for each phase of treatment is divided according to the area of injury, and is located within the following sections:

5221.6050 General Treatment Parameters
5221.6100 Parameters for Medical Imaging
5221.6105 Medications
5221.6200 Low Back Pain
5221.6205 Neck Pain
5221.6210 Thoracic Back Pain
5221.6300 Upper Extremity Disorders
5221.6305 Reflex Sympathetic Dystrophy of the Upper and Lower Extremity
5221.6400 Inpatient Hospitalization Parameters
5221.6500 Parameters for Surgical Procedures
5221.6600 Chronic Management

- the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury
- the employee's functional status, especially vocational activities, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity

The health care provider must use the least intensive setting appropriate and must assist the employee in becoming independent in the employee's own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

They require that all health care providers maintain an appropriate record of any treatment provided.

As part of these standards, a course of treatment must include an initial trial of non-operative treatment, except in cases where immediate surgical intervention is indicated or when surgery is the standard treatment for the injury.

The parameters also describe procedural obligations to facilitate communication between the insurer and the health care provider.

Another component of the general parameters is the expeditious transfer of information when an employee is referred for consultation with or care is transferred to another health care provider. This transfer of information is important because a health care provider must consider all prior care when developing an appropriate treatment plan. The requirements include:

- the primary health care provider shall make timely and appropriate referrals for consultation or transfer of when necessary
- a consulting health care provider must coordinate further referral with the primary health care provider
- except in cases of emergency, the referring health care provider shall, with employee authorization, summarize for the consultant the conditions of injury, the working diagnosis, the treatment to date, the employee's response to treatment, all relevant laboratory and medical imaging studies, return to work considerations, and any other information relevant to the consultation.
- the referring health care provider shall make available to the consultant, with employee authorization, a copy of all medical records relevant to the employee's injury
- when accepting for treatment an employee with a workers' compensation injury, the health care provider shall ask the employee if treatment has been previously given for the injury by another health care provider.

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- when the employee has been previously given for the injury by another health care provider unless the medical records for the injury have already been transferred, the new health care provider shall request authorization, from the employee, and obtain relevant medical records from the previous health care providers.
- upon receipt of the request for medical records and employee authorization, the previous health care providers shall provide the records within seven working days to the new health care provider
- where a previous health care provider has performed diagnostic imaging, a health care provider may not repeat the imaging or perform alternate diagnostic imaging for the same condition except as permitted under 5221.6100
- when a therapeutic modality employed by a health care provider was no longer improving the employee's condition or has been used for the maximum duration, another health care provider may not employ the same modality at any time thereafter to treat the same injury except if one of the departures applies, after surgery, or for treatment of reflex sympathetic dystrophy
- it is also inappropriate for two health care providers to use the same treatment modality concurrently
- an employee's refusal to provide authorization for release of medical records does not justify repeat treatment or diagnostic testing

Determinations of Excessive Treatment

(Minnesota Rules Part 5221.6050, Subp. 7)

If payment for treatment that departs from the parameters is denied, the insurer must notify the employee in writing and the health care provider in writing or electronically using electronic form ANSI ASC X12N 835 of the reason for the denial. The notice must cite the specific rule part and subpart that supports the denial (as required under Minnesota Rules Part 5221.0600, Subp. 4). The notice must also include a statement that the parameters permit departure in specified circumstances (see Departures below).

If the insurer denies authorization or payment, the health care provider or the employee may request a determination from the commissioner or a compensation judge by filing a Medical Request form. The Medical Request may not be filed prior to completion of the certified managed care plan's dispute resolution process, if applicable.

Departures

(Minnesota Rules Part 5221.6050, Subp. 8)

While the parameters describe a community standard of reasonable and necessary care, treatment can be modified to accommodate employees whose care does not

follow the normal course. A departure from a parameter that limits the duration or type of treatment may be appropriate in any of the following circumstances:

- a documented medical complication
- previous treatment did not meet the accepted standard of practice
- Treatment is necessary to assist the employee in the initial return to work where the employee's work activities place stress on the part of the body affected by the work injury. In this case, the health care provider must document the specific work activities that place stress on the affected body part, a detailed treatment plan, treatment given at each visit, employee's response to each treatment, and efforts to promote employee independence from clinical care.
- where treatment continues to meet two of the three criteria for progressive improvement
- an incapacitating exacerbation

The health care provider must provide prior notification of treatment that departs from a parameter.

Prior Notification

(Minnesota Rules Part 5221.6050, Subp. 9)

Provider Request

The provider must notify the insurer, in writing or verbally, of proposed treatment at least seven working days prior to the initiation of the following treatments:

- certain chronic pain modalities
- some durable medical equipment
- non-emergency inpatient hospitalization or surgery
- treatment that departs from a parameter that limits the duration or type of treatment

If the provider initiates a treatment that departs from a parameter due to an incapacitating exacerbation or an emergency, the provider must notify the insurer within two business days of the treatment being initiated and provide specific information about the employee's diagnosis and the treatment plan.

Insurer Response

Within seven working days of receipt of the provider's prior notification the insurer must respond orally or in writing. If the provider does not receive a response within

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seven working days, authorization for the proposed treatment is deemed to have been given. The insurer's response will do one of the following:

- approve treatment
- deny treatment
- request additional information from the provider;
- request the employee obtain a second opinion; or
- request an IME.

If authorization for treatment is denied, the insurer must notify the employee and health care provider of the reason the information given by the health care provider does not support the proposed treatment. The written explanation must also notify the provider and employee of the right to a review of the denial by an appropriate licensed health care professional.

The insurer may delegate responsibility for notices and responses to a certified managed care organization. Alternatively, the CMCO may act as the intermediary between the health care provider and the insurer.

They also establish guidelines for specific interventions including:

- medical imaging (includes a section specific to low back pain)
- hospitalization
- surgical procedures
- chronic management

Medical Imaging

(Minnesota Rules Part 5221.6100)

Except for emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the employee's condition, before ordering any imaging study.

Effective Imaging

A health care provider should initially order the single most effective imaging study for diagnosing the suspected etiology of an employee's condition. No concurrent or additional imaging studies should be ordered until the results of the first study are known and reviewed by the treating health care provider. If the first imaging study is negative, no additional imaging is indicated except for repeat and alternative imaging.

Appropriate Imaging

Imaging solely to rule out a diagnosis not seriously being considered as the etiology of the employee's condition is not indicated.

Routine Imaging

Imaging on a routine basis is not indicated unless the information from the study is necessary to develop a treatment plan.

Repeat Imaging

Repeat imaging of the same views of the same body part with the same imaging modality is not indicated except as follows:

- diagnose a suspected fracture or suspected dislocation
- monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment; repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment
- follow up a surgical procedure
- diagnose a change in the employee's condition marked by new or altered physical findings
- evaluate a new episode of injury or exacerbation which in itself would warrant an imaging study
- when the treating health care provider and a radiologist from a different practice have reviewed a previous imaging study and agree that it is a technically inadequate study

Alternative Imaging

Persistence of an employee's subjective complaint or failure of the condition to respond to treatment are not legitimate indications for repeat imaging. In this instance an alternative imaging study may be indicated if another etiology of the employee's condition is suspected because of the failure of the condition to improve.

Alternative imaging is not allowed to follow up negative findings unless there has been a change in the suspected etiology and the first imaging study is not an appropriate evaluation for the suspected etiology.

Alternative imaging is allowed to follow up abnormal but inconclusive findings in another imaging study. An inconclusive finding is one that does not provide an adequate basis for accurate diagnosis.

Specific Imaging Procedures for Low Back Pain

Except for the emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the employee's condition, before ordering any imaging study of the low back.

Except for the following conditions, computed tomography (CT) scanning is not indicated in the first eight weeks after an injury. CT scanning is indicated any time that one of the following conditions is met:

- when cauda equina syndrome is suspected
- for evaluation of progressive neurologic deficit
- when bony lesion is suspected on the basis of other tests or imaging procedures.

CT scanning is indicated after eight weeks if the employee continues with symptoms and physical findings after the course of initial nonsurgical care and if the employee's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

Except for the following conditions, magnetic resonance imaging (MRI) scanning is not indicated in the first eight weeks after an injury. MRI scanning is indicated any time that one of the following conditions is met:

- when cauda equina syndrome is suspected
- for evaluation of progressive neurologic deficit
- when previous spinal surgery has been performed and there is a need to differentiate scar due to previous surgery from disc herniation, tumor, or hemorrhage
- suspected discitis

MRI scanning is indicated after eight weeks if the employee continues with symptoms and physical findings after the course of initial nonsurgical care and if the employee's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

Myelography is indicated in the following circumstances:

- may be substituted for otherwise indicated CT or MRI scanning, if those imaging modalities are not locally available
- in addition to CT or MRI scanning, if there are progressive neurologic deficits or changes and CT scanning or MRI scanning has been negative

- for preoperative evaluation in cases of surgical intervention, but only if CT or MRI scanning have failed to provide a definite preoperative diagnosis

Computed tomography myelography is indicated in the following circumstances:

- the employee's condition is predominantly sciatica, there has been previous spinal surgery, and a tumor is suspected
- the employee's condition is predominantly sciatica, there has been previous spinal surgery, and MRI scanning is equivocal
- when spinal stenosis is suspected and the CT or MRI scanning is equivocal
- in addition to CT or MRI scanning, if there are progressive neurologic symptoms or changes and CT or MRI scanning has been negative
- for preoperative evaluation in cases of surgical intervention, but only if CT or MRI scanning have failed to provide a definite preoperative diagnosis

Intravenous enhanced CT scanning is indicated only if there has been previous spinal surgery and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor, but only if intrathecal contrast for CT-myelography is contraindicated and MRI scanning is not available or is also contraindicated.

Gadolinium enhanced MRI scanning is indicated in the following circumstances:

- there has been previous spinal surgery and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor
- hemorrhage is suspected
- tumor or vascular malformation is suspected
- infection or inflammatory disease is suspected
- unenhanced MRI scanning was equivocal

Discography is indicated in the following circumstances:

- when back pain is the predominant complaint, the employee has failed to improve with initial nonsurgical management, other imaging has not established a diagnosis, and lumbar fusion surgery is being considered as a therapy
- there has been previous spinal surgery, and pseudoarthrosis, recurrent disc herniation, annular tear, or internal disc disruption is suspected

Computed tomography discography is indicated in the following circumstances:

- sciatica is the predominant complaint and lateral disc herniation is suspected
- if appropriately performed discography is equivocal or paradoxical, with a normal x-ray pattern but a positive pain response, and an annular tear or intra-annular injection is suspected

Anterior-posterior (AP) and lateral x-rays of the lumbosacral spine are indicated in the following circumstances:

- when there is a history of significant acute trauma as the precipitating event of the employee's condition, and fracture, dislocation, or fracture dislocation is suspected
- when the history, signs, symptoms, or laboratory studies indicate possible tumor, infection, or inflammatory lesion
- for postoperative follow-up of lumbar fusion surgery
- when the employee is more than 50 years of age
- before beginning a course of treatment with spinal adjustment or manipulation
- eight weeks after an injury if the employee continues with symptoms and physical findings after the course of initial nonsurgical care and if the employee's condition prevents the resumption of the regular activities of daily life including regular vocational activities

Anterior-posterior (AP) and lateral x-rays of the lumbosacral spine are not indicated in the following circumstances:

- to verify progress during initial nonsurgical treatment
- to evaluate a successful initial nonsurgical treatment program

Oblique x-rays of the lumbosacral spine are indicated in the following circumstances:

- to follow up abnormalities detected on anterior-posterior or lateral x-ray
- for postoperative follow-up of lumbar fusion surgery
- to follow up spondylolysis or spondylolisthesis not adequately diagnosed by other indicated imaging procedures

Oblique x-rays of the lumbosacral spine are not indicated as part of a package of x-rays including anterior-posterior and lateral x-rays of the lumbosacral spine.

Nuclear isotope imaging (including technicium, indium, and gallium scans) are not indicated unless tumor, stress fracture, infection, avascular necrosis, or inflammatory lesion is suspected on the basis of history, physical examination findings, laboratory studies, or the results of other imaging studies.

Thermography is not indicated for the diagnosis of any of the clinical categories of low back conditions in Minnesota Rules Part 5221.6200, Subp. 1A.

Electronic x-ray analysis of plain radiographs and diagnostic ultrasound of the lumbar spine are not indicated for diagnosis of any of the low back conditions in Minnesota Rules Part 5221.6200, Subp. 1A.

Medications

(Minnesota Rules Part 5221.6105)

Treatment with non-narcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the employee's condition and the most cost-effective regimen is used.

Minnesota Rules Part 5221.6105 provides guidelines for use of medication in an outpatient setting. It does not require a health care provider to prescribe any class of drugs in the treatment of any employee.

NSAIDs

Nonsteroidal anti-inflammatory drugs (NSAIDs) are drugs with analgesic, antipyretic, and anti-inflammatory effects. The term "nonsteroidal" is used to distinguish these drugs from steroids. NSAIDs act as inhibitors of the enzyme cyclooxygenase. NSAIDs include diflunisal but not other salicylates or acetaminophen. NSAIDs can be divided into two groups, nonselective NSAIDs and COX-2 inhibitors. Examples of nonselective NSAIDs include diclofenac, diflunisal, etodolac, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketorolac, meclofenamate, mefenamic acid, meloxicam, nabumetone, naproxen, oxaprozin, piroxicam, sulindac, and tolmetin. An example of a COX-2 inhibitor is celecoxib.

NSAIDs are indicated for the symptomatic relief of acute and chronic musculoskeletal pain. NSAIDs must be prescribed at the lowest clinically effective dose, as determined by the prescribing health care provider, but not to exceed the manufacturer's maximum daily dosage.

A COX-2 inhibitor may be indicated instead of a nonselective NSAID for:

- employees over 60 years of age;
- employees with a history of gastrointestinal bleeding or peptic ulcer disease; or
- employees with a history of gastrointestinal side effects with nonselective NSAID use.

However, for any employee meeting any of these criteria who is taking aspirin or who

is at an increased risk of cardiovascular disease, a COX-2 inhibitor is not indicated and a nonselective NSAID is indicated as allowed, together with gastroprotective medication.

When treating musculoskeletal pain, a generic nonselective NSAID is indicated unless a COX-2 inhibitor is indicated as specified above.

- When a nonselective NSAID is used, treatment must begin with generic ibuprofen or generic naproxen. If there is a medical contraindication documented by the prescribing health care provider to each of the medications in this item, then treatment may begin with any other generic nonselective NSAID.
- Other generic nonselective NSAIDs are not indicated unless one-week trials of each of ibuprofen and naproxen have been ineffective in reducing the employee's pain by at least 50 percent as determined by the prescribing health care provider.
- Nonselective NSAIDs that are not available as generics are not indicated.

NSAIDs are indicated only for the shortest duration needed as determined by the prescribing health care provider and with the following restrictions:

- NSAIDs prescribed within the first four weeks after the injury are limited to no more than two weeks of medication per prescription or refill.
- NSAIDs prescribed more than four weeks after the injury may not be for more than one month of medication per prescription or refill.
- NSAIDs prescribed more than 12 months after the injury may not be for more than three months of medication per prescription or refill.

Opioid Analgesics

An opioid is any agent that binds to opioid receptors. There are three broad classes of opioids: opium alkaloids, such as morphine and codeine; semisynthetic opioids such as heroin and oxycodone; and fully synthetic opioids such as meperidine and methadone. Opioid analgesics include codeine, hydrocodone, levorphanol, methadone, morphine, hydromorphone, and oxycodone.

Opioid analgesics are indicated for the symptomatic relief of acute and chronic pain that has been inadequately relieved by nonopioid medications. Opioid analgesics must be prescribed at the lowest clinically effective dose, as determined by the prescribing health care provider.

When treating pain, a generic oral opioid analgesic is indicated.

- When an oral opioid analgesic is used for the symptomatic relief of acute or chronic pain, treatment must begin with one of the following: generic codeine, generic hydrocodone, generic oxycodone, or generic morphine, unless there is

a medical contraindication documented by the prescribing health care provider. If there is a medical contraindication documented by the prescribing health care provider to each of the listed medications, then treatment may begin with any other generic oral opioid analgesic.

- Other generic opioid analgesics are not indicated for oral use for the symptomatic relief of acute or chronic pain unless one-week trials of each of hydrocodone, oxycodone, and morphine have been ineffective in reducing the employee's pain by at least 50 percent as determined by the prescribing health care provider.
- Generically available combinations of an oral opioid and a nonopioid analgesic may be prescribed instead of that opioid analgesic as otherwise allowed above.
- Oral opioid analgesics that are not available as generics and combinations of an oral opioid analgesic and a nonopioid analgesic that are not available as generics are not indicated.

A course of oral opioid analgesics or combination of an oral opioid and a nonopioid analgesic is limited as follows:

- Oral opioid analgesics prescribed within the first four weeks after the injury are limited to no more than two weeks of medication per prescription.
- Oral opioid analgesics prescribed more than four weeks after the injury may not be for more than one month of medication per prescription.
- Oral opioid analgesics prescribed more than 12 weeks after the injury may be for more than one month of medication per prescription if there has been a clinical evaluation to confirm the need for an efficacy of the prescription and a clinical evaluation at least every six months thereafter during continued use of opiate analgesics.

Meperidine is not indicated in the treatment of acute or chronic pain.

Transcutaneous opioid analgesics are only indicated for employees with a documented disorder that prevents adequate oral dosing.

Oral transmucosal and buccal preparations are only indicated for the treatment of breakthrough pain and only for employees with a documented disorder that prevents adequate dosing with swallowed medications.

Muscle Relaxants

A muscle relaxant is a drug which decreases the tone of a muscle. For the purposes of these rules, muscle relaxants include carisoprodol, chlorzoxazone, cyclobenzaprine, metaxalone, methocarbamol, orphenadrine, and tizanidine. It does not limit the use of medications that may be used to treat spasticity.

Muscle relaxants are indicated for the symptomatic relief of acute and chronic musculoskeletal pain. Muscle relaxants must be prescribed at the lowest clinically

effective dose, as determined by the prescribing health care provider, but not to exceed the manufacturer's maximum daily dosage.

When treating musculoskeletal pain, a generic muscle relaxant is indicated.

- When a muscle relaxant is used, treatment must begin with one of the following: generic carisoprodol, generic chlorzoxazone, generic cyclobenzaprine, generic methocarbamol, or generic tizanide. If there is a medical contraindication documented by the prescribing health care provider to each of the medications in this item, then treatment may begin with any other generic muscle relaxant.
- Metaxolone and orphenadrine are not indicated unless one-week trials of each of carisoprodol, chlorzoxazone, cyclobenzaprine, methocarbamol, and tizanide have been ineffective in reducing the employee's pain by at least 50 percent as determined by the prescribing health care provider.
- Generically available combinations of a muscle relaxant and an analgesic may be prescribed instead of that muscle relaxant as otherwise allowed above.
- Muscle relaxants that are not available as generics, and combinations of a muscle relaxant and an analgesic that are not available as generics, are not indicated.

A course of muscle relaxants or combination of a muscle relaxant and an analgesic is limited as follows:

- Muscle relaxants prescribed within the first four weeks after the injury are limited to no more than two weeks of medication per prescription or refill.
- Muscle relaxants prescribed more than four weeks after the injury are limited to no more than one month's worth of medication per prescription or refill.
- Treatment with muscle relaxants for more than three consecutive months is not indicated.

Benzodiazepines are not indicated as muscle relaxants for the symptomatic relief of acute and chronic musculoskeletal pain.

Long Term Use of Opioids

New rules are effective July 31, 2015.

- Applies to opioid medication prescribed for more than 90 days.
- Pain assessments and patient criteria must be met.
- Written treatment contract between prescriber and employee.
- Prescriber must monitor treatment including:

- Regular follow-up visits.
- Review patient's history in the Minnesota Prescription Drug Monitoring Program.
- Urine analysis for over 120 morphine equivalents or at prescribers discretion.
- Patients currently receiving treatment have 3 months after notification to meet requirements of the rule.

Condition Specific Parameters

In addition to the general parameters applying to all injuries, parameters have been established that provide guidelines for reasonable treatment for some common work-related injuries, including:

- 5221.6200 Low Back Pain
- 5221.6205 Neck Pain
- 5221.6210 Thoracic Back Pain
- 5221.6300 Upper Extremity Disorders
- 5221.6305 Reflex Sympathetic Dystrophy of the Upper and Lower Extremity

The rules for each of these specific conditions describe reasonable medical services from all health care providers for the entire course of treatment of the compensable injury. The course of care by all health care providers over time for an injury is an episode of care.

The rules require a health care provider to assign the employee to a clinical category based on the evaluation, diagnosis, and clinical signs and symptoms. The clinical categories are listed in the treatment parameters and vary according to the area of the body that is injured. For example, an employee with low back pain must be placed in one of the following categories identified in Minnesota Rules Part 5221.6200, Subp. 1:

- regional low back pain
- radicular pain with static or no neurologic deficits
- radicular pain with progressive neurologic deficits
- cauda equina syndrome

Each condition specific parameter is organized in a manner that encompasses the treatment options during an episode of care for a given injury:

diagnostic procedures → **parameters for passive and active treatment; therapeutic injections; surgery; DMEs; and medications for the specific condition** → **specific parameters based on clinical category**

Based upon the applicable condition and the assigned clinical category, the rules outline the health care provider's choices for reasonable diagnostic tests and treatment options. The majority of diagnostic tests and treatments are optional at the provider's discretion, however the rules limit the number, frequency, and duration of a service. In certain circumstances, specific diagnostic or treatment procedures may be proscribed.

In general, a course of treatment is divided into three phases:

- initial non-surgical management
- surgical evaluation
- chronic management

Not every injury will require each phase. For instance, only non-surgical management may be necessary for a minor injury. Additionally, surgery may be indicated for a particular injury, but if the employee refuses surgery, treatment may move directly to the chronic management phase.

Phase 1 – Initial Non-Surgical Management

A period of conservative, non-invasive care begins with the first treatment. Depending on the nature of the condition and the assigned category, the health care provider's plan of treatment may include passive care, active care, therapeutic injections, and medication. The parameters provide specific guidelines as to the frequency and duration allowed for each type of passive treatment modality.

Passive Treatment

During the initial non-surgical management and surgical evaluation phases, passive treatment modalities are allowed. The parameters identify nine types of passive treatment modalities:

- bed rest
- thermal treatment
- traction
- acupuncture
- electric muscle stimulation

- braces
- manual and mechanical therapy
- massage
- adjustments

In general, the frequency with which a passive modality is used is expected to decrease after the first one to three weeks. The use of all passive treatment modalities is limited to 12 calendar weeks after the first passive treatment modality is initiated with some exceptions:

1. Passive treatment modalities may be used for an additional 12 visits over 12 months without prior notification if **all** of the requirements listed below are met:
 - the employee is released to work or is permanently totally disabled and the additional passive treatment results in progressive improvement in, or maintenance of, the functional status achieved during the initial 12 weeks of passive care
 - the treatment is not given on a regularly scheduled basis
 - a plan to encourage the employee's independence and decreased reliance on health care providers is documented in the medical record
 - the management of the employee's condition includes active treatment modalities
 - the required surgical or chronic pain evaluation is not delayed by the additional 12 visits for passive treatment
 - the employee does not have chronic pain syndrome
2. Passive treatment may continue beyond the additional 12 visits if approved by the insurer, commissioner, or a compensation judge.
3. At any time, passive treatment is allowed when a departure applies under Minnesota Rules Part 5221.6050, Subp. 8.

Active Treatment

Active treatment modalities must be included in the treatment of an employee's condition during the initial non-surgical management phase. Active treatment modalities are limited to a specified number of treatments, but may extend beyond the 12 week limit placed on passive treatment modalities. The parameters define active treatment as education, posture and work method training, worksite analysis and modification, and supervised and unsupervised exercise. Home exercises performed independently by the employee are not limited in frequency nor duration.

Injections

The types of injections allowed varies according to the area of the body that is injured. The types of injections might include:

- trigger point injections
- sacroiliac joint injections
- facet joint or nerve injections
- nerve root blocks
- epidural injections

Prolotherapy and botulinum toxin injections are not indicated in treatment and are not reimbursable.

Progressive Improvement

The health care provider must evaluate at each visit whether initial non-surgical treatment for low back, cervical, thoracic, and upper extremity conditions is resulting in progressive improvement. Progressive improvement must be documented in the medical record and is defined in Minnesota Rules Part 5221.6050, Subp. 1 as **at least two of the following** occurring as a result of the treatment rendered:

- decreased distribution, frequency, or intensity of pain symptoms as described by the employee
- improvement of objectively measured physical signs of injury
- improvement of functional status/vocational activities evidenced by less restrictive limitations on activity

If progressive improvement is not apparent by the anticipated treatment response time, the treatment plan must be re-evaluated and/or the diagnosis reconsidered.

Phase 2 – Surgical Evaluation

Employees who have persistent symptoms after a period of non-surgical management must be evaluated for surgical intervention. The parameters provide guidelines for diagnostic tests and surgical procedures appropriate for a condition specified in the rules.

Any employee who has had surgery may require postoperative therapy which includes active and passive treatment modalities. This therapy may be in addition to any received during the period of initial non-surgical management.

Spinal Cord Stimulators

Spinal cord stimulators have very limited application and are indicated only for employees with intractable pain, are not a candidate for another surgical therapy and have no untreatable major psychological or psychiatric comorbidity that prevents the employee from benefitting from the treatment.

Before a trial screening is conducted, a second opinion from a provider outside of the treating provider's practice must confirm that the required conditions are met and the employee has no contraindications to a spinal cord stimulator.

Long term use of a spinal cord stimulator is indicated if the treating health care provider documents that there has been at least a 50% improvement in pain during the screening period of at least 3 days, compared to the employee's pain level immediately preceding the trial screening period.

Intrathecal Drug Delivery Systems

Intrathecal drug delivery systems have very limited application and are indicated only for employees with intractable pain, are not a candidate for another surgical therapy and has no untreatable major psychological or psychiatric comorbidity that prevents the employee from benefitting from the treatment.

Before a trial screening is conducted, a second opinion from a provider outside of the treating provider's practice must confirm that the required conditions are met and the employee has no contraindications to an intrathecal drug delivery system.

Long term use of an intrathecal drug delivery system is indicated if the treating health care provider documents that there has been at least a 50% improvement in pain during the screening period of at least 24 hours, compared to the employee's pain level immediately preceding the trial screening period.

Phase 3 – Chronic Management

For those employees who are not candidates or refuse surgery or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Minnesota Rules Part 5221.6600 applies to all types of injuries, even if the condition is not specified in the rules.

The purpose of chronic management is twofold:

- the employee should be made independent of health care providers for ongoing care of a chronic condition
- the employee should be returned to the highest functional status reasonably possible

Chronic management treatment may include; home-based exercise programs, health club memberships, computerized exercise programs, work-conditioning or work-hardening programs, chronic pain management programs, and individual or group psychological or psychiatric counseling. Prior notification is required for all chronic management modalities except home-based exercise.

Medical Fee Schedule

Once a health care provider submits charges for medical services, the insurer must determine whether the service, article or supply is compensable, then determine how much the provider will be paid for the services. The liability of the employer for services, articles, and supplies claimed under Minnesota Statutes §176.135 is limited to the maximum fee allowed by the fee schedule in effect on the date of service, or the provider's actual fee, whichever is lower.

Reference Materials

The department did not create the coding systems and claim forms used by health care providers when billing for their services. Manuals offering more detailed instructions must be used as reference in order to determine if the charges of the provider have been submitted using the correct codes for all services. The following coding manuals and claim forms have been incorporated by reference, as their use is essential to the correct assignment of billing codes and appropriate use of the claim forms:

- ICD-9-CM manual (The International Classification of Diseases, Clinical Modification, 9th revision). A numeric system used to identify a medical or chiropractic diagnosis.
- The uniform billing and coding standards and requirements as referenced in Minnesota Statute 62J, including the accompanying rules, manuals, and guides.
- CPT manual (The Physician's Current Procedural Terminology). A directory of numeric codes used to identify a specific service. This manual is updated annually.
- HCPCS manual (The Health Care Procedural Coding System). A directory of alphanumeric or numeric codes used to describe a service, article, or supply.

General Concepts of the Medical Fee Schedule

The fee schedule is based on Medicare's resource-based relative value system. Minnesota adopted the resource-based system because it was familiar to most health care providers and payers, promoting consistency within the health care system. In this system, a base service is assigned a value of 1.0. Values are then assigned to other services, indicating the resources required to provide the service when compared to the base service. The value assigned to a service is called its Relative Value Unit (RVU). In order to determine the maximum reimbursement assigned to a service under the fee schedule, the RVU for that service must be multiplied by a Conversion Factor (CF) to convert it into an actual dollar amount.

$$\text{RVU} \times \text{CF} = \text{maximum reimbursement}$$

For example, the maximum reimbursement according to the fee schedule and

conversion factor, effective on January 1, 2003, for a level 2 office visit for an established employee (CPT code 99212) provided by a physician in an office setting would be:

$$0.73 \times \$75.18 = \$54.88$$

The conversion factor is adjusted annually on October 1st. The conversion factors since 1993 are listed in Minnesota Rules Part 5221.4020.

For services on or after October 1, 2005, all scaling factors were removed from the RVUs and four separate CFs are calculated for the following provider groups; medical/surgical, pathology/laboratory, physical medicine and rehabilitation, and chiropractic. Below are CFs for these groups for dates of service from October 1, 2008 through September 30, 2009:

- medical/surgical: \$80.74
- pathology/laboratory: \$67.43
- physical medicine and rehabilitation: \$70.00
- chiropractic: \$58.78

The formula used to determine payment is the same, but the new list of RVUs and the CFs that corresponds to the provider rendering the service must be used.

Limitation of Payer Liability

(Minnesota Rules Part 5221.0500)

The maximum amount of reimbursement for a health care service is determined by the fee schedule in effect on the date the service was provided. The current fee schedule determines the maximum reimbursement for services rendered on or after January 1, 2001. Where the service was provided is another important consideration. Different payment standards are applied to inpatient services of large hospitals and to all services of small hospitals in accordance with Minnesota Statutes §176.136, Subd. 1b.

Determining Maximum Reimbursement

(including outpatient services at large hospitals)

The payment methods described below apply to all health care services except those provided by a small hospital or to an employee who is an inpatient at a large hospital. The maximum payment allowed will be a set dollar amount derived from the fee schedule, a percentage of the health care provider's usual and customary fee, or a percentage of a prevailing charge appropriately established by the payer.

If the billing code is listed in the fee schedule in effect on the date of service, the payer's liability is the maximum reimbursement under the fee schedule or the provider's usual and customary fee, whichever is lower. Maximum reimbursement under the fee schedule is ascertained by multiplying the RVU for the service by the CF in effect on the date of service. If the billing code is listed, but no RVU has been

assigned (RVU = 0.00), the status of the code (listed in column three) may indicate that payment is still required. If payment is required, the amount is determined in the same manner as when a code is not listed in the fee schedule, which is outlined below.

If the billing code is not listed in the fee schedule in effect on the date of service, the payer's liability is the lower of 85 percent of the provider's usual and customary fee or 85 percent of an appropriately established prevailing charge. The criteria for establishing a prevailing charge are outlined under Minnesota Rules Part 5221.0500, Subp. 2B(2) and Minnesota Statutes §176.136, Subd. 1b.

Payment for Services Provided by a Small Hospital

All services provided by small hospitals, whether the employee is an inpatient or outpatient, are reimbursed at 100 percent of the hospital's usual and customary fee. Payment can only be less if the charge is determined to be unreasonably excessive by the commissioner or a compensation judge. A small hospital is defined as one which has 100 or fewer licensed beds.

Payment for Services Provided by a Large Hospital

All services provided to an employee who is an inpatient at a large hospital are reimbursed at 85 percent of the hospital's usual and customary fee or 85 percent of an appropriately established prevailing charge, whichever is lower. A large hospital is defined as one that has more than 100 licensed beds.

Maximum reimbursement for outpatient services of a large hospital is determined in the same manner as non-hospital services as described above (see Determining Maximum Reimbursement).

Payment for Services Provided by a Nursing Home

Services provided to an employee by a nursing home that participates in the medical assistance program are paid at the rate established by the Commissioner of Human Services. Fee information and other questions should be directed to the Minnesota Department of Human Services.

Reimbursement for Travel Expenses

Travel expenses incurred by the employee related to compensable medical services are not subject to 85% limit and are paid at the lower of:

- the rate paid by the employer for ordinary business travel expenses, or
- the rate paid by the State of Minnesota under the Commissioner's Plan for employment-related travel

When the Fee Schedule Applies

Once a health care provider submits charges for medical services, it must be determined how much the provider will be paid for the services. Many health care services defined by the standard coding systems (CPT/HCPCS), are listed in the fee schedule according to their billing codes and within the provider group designation which normally supplies that service. The reimbursement limits set by the fee schedule only apply if **all** of the following occur:

- the medical service is compensable
- the services were not provided by a small hospital
- the services were not provided to an employee while an inpatient at a large hospital
- the billing code is listed in the current coding manual
- the billing code is listed in the schedule in effect on the date of service under the appropriate provider group designation

Provider Group Designations

The fee schedule is divided into five sections, each representing a different group of providers. Minnesota Rules Part 5221.0700, Subp. 3C identifies the types of providers included within each provider group.

- medical/surgical
- pathology/laboratory
- physical medicine and rehabilitation
- chiropractic
- pharmacy

Each section includes a list of services normally performed by those providers with corresponding billing codes. In order to determine payment, the insurer must first determine the group to which that provider belongs and the billing code that identifies the service(s) performed.

Applying the Fee Schedule

(Minnesota Rules Part 5221.4020)

The fee schedule contains twelve columns of information for each billing code including; providing a description of the service, indicators for payment determination, values for payment calculation, and instructions for payment adjustments. Each column has its own set of indicators, unique to that column.

Description of the Service

The billing code describing a particular service, article, or supply is listed in column 1 of the fee schedule. If a service can be broken down into a technical and professional component, the billing code may be listed three times. The first listing will indicate the information for the complete service, used when both components are performed by the same provider. The next two listings will provide information relative to each component identified in column 2 by an indicator of 26 to indicate only the professional component of the service and TC to indicate only the technical component of the service. The same indicators listed in column 2 are added as modifiers to the billing code by the provider to indicate which component they performed.

An abbreviated narrative description of the service corresponding to that billing code is located in column 4. Complete descriptions of the services are provided in the coding manuals, and are often required in order to determine precisely what service is being billed.

Payment Determination

Determination of payment is guided primarily by the information listed in column 3 (status). A billing code will be assigned one of thirteen possible alphabetical characters to indicate the code's payment status. The status indicators have been created by Medicare, but payment determination under workers' compensation is not always consistent with Medicare guidelines. The status determines if payment is allowed for that particular service. In some cases, the specific circumstances under which that service, article, or supply was provided is necessary to determine if payment is allowed. Guidelines for payment determination based on status include:

- Codes assigned a status of D, G, H, or I can not be used and therefore no payment is allowed. Another code must be assigned.
- Codes assigned a B status indicate a bundled code. No separate payment is allowed.
- Codes assigned a status of A, C, E, N, R, or X are all paid according to the formula (CF x RVU) if an RVU greater than zero is listed under columns 5 and 6. If the RVU listed is 0.00, payment is 85 percent of the usual and customary charge or 85 percent of a prevailing charge.
- A status of P indicates that payment for the service may be bundled, depending on the circumstances. If the item or service is covered as incident to another service of the provider received on the same day, payment is bundled into the service to which it was deemed incident. If the item or service is not incident to any other service, payment is determined by the formula if an RVU greater than 0.00 is listed, or the 85 percent payment standards.
- A code assigned a T status indicates an injection. If any other compensable services are billed that day by the provider, payment for the injection is bundled into the other service(s). If no other compensable services were billed that day

by the same provider, the injection service is paid. Payment for the injected material is separate from the injection service and is paid in both circumstances.

Once it is determined that the status of a billing code and the circumstances under which the service was provided allows for payment of that service, the remaining columns supply information on the maximum payment. If the status of a code and/or conditions of delivery of a service indicate no payment is allowed, it is not necessary to retrieve information from the remaining columns for that service, and the rationale justifying denial of payment for the service is included in the explanation of payment to the provider.

Values for Payment Calculation

Columns 5 and 6 contain the office and facility RVUs, respectively. The setting in which the service was performed determines which RVU is used in the formula to calculate the maximum liability for a professional service. The office RVU includes overhead costs and is used when the service was provided in a practitioner's office. If the professional service was provided in a facility, such as a hospital, ambulatory surgery center, or nursing home, the facility RVU which has the overhead factored out is used. In these cases, the facility will typically submit a bill for the facility fee separate from the bill for professional service charges. The facility fee seeks reimbursement for the overhead, staffing, services, and equipment related to the procedure which were provided by the facility.

Instructions for Payment Adjustments

Columns 7 through 12 all contain information which is specific to payment of surgical procedures and the application of the global surgery package. The global surgery package is governed by Minnesota Rules Part 5221.4035. In addition to information for surgical procedures, columns 8 and 9 also contain additional information.

- Column 8 (multiple procedure) also identifies when multiple modality payment adjustments can be applied to physical medicine and chiropractic services. These services will have an indicator of "4" in column 8.
- Column 9 (bilateral procedure) also identifies when additional payment for a bilateral procedure is allowed. These services will have an indicator of "1" in column 9, and payment is 150 percent of the RVU when the service is performed bilaterally.

Separate Payment for Supplies

Charges for the following supplies provided during an evaluation and management service may be billed separately and paid:

- some surgical trays (for procedures listed in Minnesota Rules Part 5221.4035, Subp. 3I)

Medical Benefits

- injectable drugs and antigens
- splints, casts, and other devices for treatment of fracture or dislocation
- take home supplies
- orthotic devices
- prosthetic devices

Medical/Surgical Services

The majority of the tables in the fee schedule are located in Minnesota Rules Part 5221.4030 and consist of billing codes for medical/surgical services.

Payment of Facility Fees

(Minnesota Rules Part 5221.4033)

The fee schedule contains a long list of medical/surgical services which are typically performed in an outpatient setting. No facility fee should be billed in conjunction with the delivery of the listed services in most cases. However, in cases of emergency or the medical condition of the employee necessitates performance of the procedure in a non-office setting or after normal office hours, payment of a facility fee is allowed.

The following are considered components of a facility fee, therefore, no separate payment is allowed for:

- nursing and technician services
- use of facilities
- drugs, biologicals, dressings, supplies, splints, casts, and equipment directly related to the surgical procedure
- diagnostic services related to a procedure
- administrative and housekeeping services
- intraocular (IOL) lenses
- supervision of an anesthetist by the operating surgeon

The following are not considered part of a facility fee and separate payment is allowed for:

- physician service
- lab services and x-rays not directly related to the surgical procedure

- prosthetic devices (except IOLs)
- ambulance services
- braces and artificial limbs
- durable medical equipment or take-home supplies
- anesthetist services

Pathology and Laboratory Services

(Minnesota Rules Part 5221.4040)

Services listed under this provider group may be divided into professional and technical components for billing purposes, if separate providers performed each component. Although the billing codes are not subdivided to indicate reimbursement for the individual components, separate payment can be made to each provider. The professional component represents the care involved to examine the employee, perform and supervise the procedure, and consult with other practitioners. A modifier 26 is added to the billing code for the professional service and the maximum fee is calculated using 75 percent of the total RVU listed in the schedule. The technical component represents all other costs associated with the service, such as cost of equipment, salaries of technicians, and supplies. A TC modifier is added to the billing code, and the maximum fee is calculated using 25 percent of the total RVU listed.

If the pathology or laboratory service was rendered while the employee was an inpatient at a hospital, the maximum fee paid to the health care provider rendering the service would be the calculated value of the professional component only. Payment for the technical component included in the hospital's charges would be according to the payment rates for inpatient services of large and small hospitals.

Physical Medicine and Rehabilitation Services

(Minnesota Rules Part 5221.4050)

Services under this provider group are divided into three categories:

- supervised modalities
- constant attendance modalities
- therapeutic procedures

Each category is followed by additional payment instructions to assist providers in proper assignment of the billing codes within the category. Payment adjustments are allowed when more than one modality is provided to the same employee on the same day. The list of billing codes located in Minnesota Rules Part 5221.4051, to which the payment adjustment can be applied, includes the supervised and constant attendance modalities. These services will also have an indicator of "4" in column eight. If more than one modality on the list is provided to the employee on the same

day, payment is 100 percent of the calculated fee for the service with the highest RVU and 75 percent of the calculated fee for each additional modality on the list. A modifier 51 is added to the billing code of all modalities except the first modality with the highest RVU.

Chiropractic Services

(Minnesota Rules Part 5221.4060)

Services listed for the chiropractic provider group include the same three categories of services as were identified in the physical medicine section. Application of payment adjustments for modalities is also identical to the physical medicine section, however, additional instructions are included to reduce payment for extraspinal manipulation (98943) by 50 percent if any of the spinal chiropractic manipulative treatment codes (98940-98942) are billed on the same day, and to allow no payment for manual therapy treatment (97140) when it is reported with any chiropractic or osteopathic manipulation codes for the same body regions on the same day. It is important to note that although many of the services listed are the same as the physical medicine services, the RVUs used to calculate the maximum fees are different.

Additional services are listed in the chiropractic section that are not included in the physical medicine and rehabilitation provider group, including chiropractic manipulation, x-rays and evaluation and management (E/M) services. Because the chiropractic manipulation services involve an assessment component, billing and payment for E/M services separate from the manipulative therapy services provided on the same day is only allowed if the employee's condition requires a significant, separately identifiable E/M service.

A separate E/M service is appropriate when any of the following occur:

- a new injury
- an exacerbation of a previous injury
- an unanticipated change in condition

A separate E/M service may be appropriate under any of the following conditions:

- in preparation for a requested report other than the report of work ability
- if requested to render an opinion about a job offer
- when a job search is initiated
- to review the employee's condition after a period of treatment by another health care provider
- to evaluate the employee's condition in anticipation of a change in the plan

Pharmacy Services

(Minnesota Rules Part 5221.4070)

Application

The provisions and requirements of Minnesota Rules Part 5221.4070 apply to pharmacy services and drugs dispensed for outpatient use by a:

- large hospital pharmacy
- practitioner authorized to dispense drugs
- community/retail pharmacy

If the medication is provided for inpatient use at a large hospital, payment is 85 percent of the usual and customary charge or 85 percent of a prevailing charge. Small hospitals receive 100 percent of usual and customary, whether for inpatient or outpatient use.

Generic Substitution

Pharmacy providers must comply with the mandatory generic substitution and exceptions requirements of Minnesota Statutes §151.21.

Submission of Charges

For drugs dispensed from a community/retail pharmacy, the procedure code is the applicable code in the National Drug Code (NDC) Directory. Procedure codes are not required for over-the-counter drugs.

An entity designated by the pharmacy or practitioner to submit its charges to a workers' compensation payer can not submit a charge that is more than the pharmacy or practitioner's usual and customary charge for the drug at the time it is dispensed.

Maximum Payment

The maximum payment for drugs dispensed for outpatient use is lower when the pharmacy or practitioner has electronically requested and received authorization to dispense the drug or fails to do so after being properly notified by the payer. Payment for an over-the-counter drug is the amount derived using the applicable calculation below, or the actual retail price, whichever is lower.

Maximum Fee for Electronic Transactions

In order for this provision to apply, **either of these two** circumstances must be met:

1. The pharmacy or practitioner electronically requests authorization for payment of the drug from the workers' compensation payer in accordance with the standards adopted under the federal HIPAA legislation.

AND

The workers' compensation payer electronically, and in real time, authorizes payment for the drug (in accordance with HIPAA standards). Once the payer has authorized the drug to be dispensed, they can not later deny payment.

2. If the pharmacy or practitioner does not request electronic authorization in the manner above from the workers' compensation payer, but does request authorization in such a manner from other paying entities, such as health insurers.

AND

The workers' compensation payer has given the pharmacy or practitioner 30 days notice of their ability to provide electronic authorization and either:

- The employee has notified the pharmacy or practitioner at the time of dispensing that the charges should be submitted to the WC payer; or
- The WC payer has notified the pharmacy prior to dispensing that it had accepted liability for the employee's claim.

AND

The workers' compensation payer pays for the drug within 30 days after the pharmacy or practitioner submits its charges.

Maximum payment in either of the above circumstances is the lower of (on the date the drug was dispensed):

- the average wholesale price (AWP) minus 12 percent plus a \$3.65 dispensing fee;
- the maximum allowable cost (MAC) as determined by the Minnesota Department of Human Services plus a \$3.65 dispensing fee; or
- the pharmacy or practitioner's usual and customary charge.

Maximum Fee when Electronic Transaction Rates do not Apply

If the pharmacy or practitioner does not have the capability to submit its charges electronically or the requirements above are not satisfied, a different formula is used to calculate the maximum fee. Maximum payment is the sum of the average wholesale price (AWP) of the medication on the date it was dispensed and a dispensing fee of \$5.14 per medication, or the usual and customary charge, whichever is lower.

Medical Fee Schedule – Exercise 3B

You will need to refer to the CPT Manual and Medical Fee Schedule Rules to complete this exercise.

For all the following examples, assume primary liability has been accepted and all treatments rendered are reasonable and necessary.

1. The bill for Richard Cunningham's claim is for a chiropractic appointment following a back injury.
 - a) Determine the amount to be paid.

- b) What modifier should be used on CPT code 97012?
2. The bill for Warren Weber's claim is for emergency room treatment following a forearm laceration.
- a) Is the hospital required to send a copy of the medical records with this bill?
 - b) What do you need to know in order to pay a hospital bill correctly?
 - c) Assume it is a large hospital of 100 beds or more. Determine the amount to be paid.
 - d) What if the hospital had 78 licensed beds?
3. The bill for Ralph Malph's claim is for treatment following a hand injury.
- a) Why might you want the medical record?
 - b) What would you do if the medical record was not included with the bill?
 - c) How long does the provider have to supply the medical record if it was not included with the bill?
 - d) What is the maximum amount the provider can be reimbursed for copying and sending the medical record if it is two pages?
 - e) Determine the amount to be paid.