CHAPTER 5221
DEPARTMENT OF LABOR AND INDUSTRY
FEES FOR MEDICAL SERVICES

5221.4000 [Repealed, 35 SR 227]

5221.4005 INSTRUCTIONS FOR APPLICATION OF FEE SCHEDULE.

Subpart 1. **Workers' compensation medical fee schedule; incorporation of Medicare National Physician Relative Value Files.** The workers' compensation medical fee schedule consists of items A and B:

A. the tables in the Medicare National Physician Fee Schedule Relative Value File and the Geographic Practice Cost Indices File most recently incorporated by reference by the commissioner by publishing in the State Register pursuant to Minnesota Statutes, section 176.136, subdivision 1a, paragraph (h); and

B. parts 5221.4005 to 5221.4061, which contain instructions for applying the Medicare Physician Fee Schedule tables described in item A to determine the maximum fees for treatment of injured workers under Minnesota Statutes, section 176.136.

Subp. 2. **Effective date.** The medical fee schedule applies to treatment provided on or after the effective date of:

A. the most recent fee schedule tables adopted pursuant to Minnesota Statutes, section 176.136, subdivision 1a, paragraph (h), as described in subpart 1; and

B. corresponding rules in parts 5221.4005 to 5221.4061 to implement the fee schedule tables.

Subp. 3. **Applicability.** The medical fee schedule applies to a charge for a particular health care service if:

A. the medical service is compensable under Minnesota Statutes, section 176.135;

B. the service conforms to a CPT, HCPCS, or revenue billing code in effect on the date the service was rendered; and

C. the billing code for the service is listed under the appropriate provider group designation for the health care provider that rendered the service.

Statutory Authority: *MS s 14.38; 14.386; 14.388*

History: *35 SR 227*

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

Unless the maximum fee is adjusted under part 5221.4035, 5221.4051, or 5221.4061, the employer's liability for services included in parts 5221.4030 to 5221.4061 is limited to 100 percent of the fee schedule amount calculated according to the formula in part

5221.4020 or the provider's usual and customary fee for the service, whichever is lower. The employer's liability for pharmacy services is as provided in part 5221.4070.

Statutory Authority: *MS s 14.38; 14.386; 14.388*

History: *35 SR 227*

5221.4020 DETERMINING FEE SCHEDULE PAYMENT LIMITS.

Subpart 1. [Repealed, 35 SR 227]

Subp. 1a. [Repealed, 35 SR 227]

Subp. 1b. **Conversion factors and maximum fee formulas.**

A. Except as provided in parts 5221.4035, 5221.4050, 5221.4051, 5221.4060, 5221.4061, and 5221.4070, the maximum fee in dollars for a health care service subject to the medical fee schedule is calculated according to subitems (1) to (4).

(1) The maximum fee for services, articles, and supplies that are provided in the provider's office or clinic = [(Work RVU * Work GPCI) + (Transitioned Non-facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor (CF).

(2) The maximum fee for services, articles, and supplies that are provided at a facility such as a hospital or ambulatory surgical center = [(Work RVU * Work GPCI) + (Transitioned Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor (CF).

(3) For purposes of the formulas in subitems (1) and (2):

(a) the Work GPCI, PE GPCI, and MP GPCIs are the Minnesota GPCIs specified in the Geographic Practice Cost Indices file referenced in part 5221.4005, subpart 1, item A;

(b) the Transitioned Nonfacility Practice Expense (PE) RVUs, Transitioned Facility Practice Expense (PE) RVUs, Work RVUs, and Malpractice (MP) RVUs, as further described in subpart 2a, are specified in the following columns of the Medicare National Physician Fee Schedule Relative Value File referenced in part 5221.4005, subpart 1, item A:

i. the Work RVU is as shown in column F;

ii. the Transitioned Non-facility PE RVU is as shown in column G;

iii. the Transitioned Facility PE RVU is as shown in column K; and

iv. the Malpractice RVU is as shown in column O.

(4) The maximum fees calculated according to the formulas in subitems (1) and (2) must be rounded to the nearest cent, according to standard mathematical principles.

B. The conversion factors for services, articles, and supplies included in parts 5221.4030 to 5221.4061 are as provided in Minnesota Statutes, section 176.136, subdivision 1a, as adjusted by paragraph (g) of that subdivision, as follows:

(1) for dates of service from October 1, 2010, to September 30, 2011, the conversion factors are:

(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: $67.23;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: $39.60;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: $52.35; and

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $53.48.

Subp. 1c. **Sample calculation.** The following is a sample calculation for determining the maximum fee, excluding any applicable adjustments in parts 5221.4030 to 5221.4061, for a new patient office examination (procedure code 99201) in a clinic:

	.44640 [Work RVU (.45) * Work Geographic PCI (.992)]
+	.53082 [Transitioned Nonfacility PE RVU (.54) * PE GPCI (.983)]
+	.00735 [MP RVU (.03) * MP GPCI (.245)]
=	.98457 [Total RVU]
*	$60.00 [Conversion factor for example only]
=	$59.0742 [Maximum fee]
=	$59.07 [Maximum fee, rounded]

Subp. 2. [Repealed, 35 SR 227]

Subp. 2a. **Key to abbreviations and terms and payment instructions.** Columns A to AK are found in the tables in the Medicare National Physician Fee Schedule Relative Value File most recently incorporated by reference by the commissioner by publishing in the State Register pursuant to Minnesota Statutes, section 176.136, subdivision 1a, paragraph (h). These columns list indicators necessary to determine the maximum fee for the service. Further payment adjustments may apply as specified in this subpart.

A. Column A is the "HCPCS code." This column identifies the CPT/HCPCS code. This code identifies the health care service described in column 4.

B. Column B is the "modifier." This column identifies when there is a technical/professional modifier. Column B contains a modifier if there is a technical component (TC) and a professional component (26) for the service. Column T governs the use of the modifiers. Column B also contains a modifier "53" to identify codes that have a separate RVU for a procedure that has been terminated by the physician before completion.

(1) Indicator "26" indicates professional component only codes. This indicator identifies codes that describe the physician work portion of selected services for which there is an associated code that describes the technical component of the service only.

(2) Indicator "TC" indicates technical component only codes. This indicator identifies codes that describe the technical component, such as staff and equipment costs, of selected services for which there is an associated code that describes the professional component of the service only.

(3) A blank in this field denotes the global service, which includes both the professional and the technical component of providing the service.

C. Column C is the "Description." This column is an abbreviated CPT/HCPCS narrative description of the procedure code. A detailed description of the service appears in the CPT or HCPCS manual incorporated by reference in the applicable medical fee schedule.

D. Column D is the "Status Code."

(1) "A" status indicates an active code. These services are separately paid under the medical fee schedule. The maximum fee for this service is calculated according to the formula in subpart 1b and as adjusted by other instructions in this subpart.

(2) "B" status indicates a bundled code. Payment for covered services are always bundled into payment for other services. There is no separate payment for these services even if an RVU is listed. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident. An example is a telephone call from a hospital nurse regarding care of a patient.

(3) "C" status indicates a coverage status that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the maximum fee for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b.

(4) "D" status indicates an invalid or deleted CPT or HCPCS code. Another CPT or HCPCS code must be used to describe the service. No payment is allowed for codes with a "D" status even if positive RVUs are listed.

(5) "E" status indicates a coverage status that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the maximum fee for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b, if the code has no positive RVUs. If positive RVUs are listed, the maximum fee for the service is the amount established according to the formula in subpart 1b.

(6) "F" status indicates an invalid or deleted CPT or HCPCS code. Another CPT or HCPCS code must be used to describe the service. No payment is allowed for codes with an "F" status even if positive RVUs are listed.

(7) "G," "H," and "I" status. "G" and "I" status indicate an invalid CPT or HCPCS code and "H" status indicates an invalid modifier code. Another code must be used to describe these service. No payment is allowed for codes with a "G," "H," or "I" status even if positive RVUs are listed.

(8) "J" status indicates Anesthesia Services. There are no RVU amounts for these codes. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the maximum fee for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b.

(9) "M" status indicates a coverage status that is unique to the federal Medicare fee schedule for measurement codes used for reporting purposes only. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the maximum fee for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b.

(10) "N" status indicates a code that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the liability for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b, if the code has no positive RVUs. If positive RVUs are listed, the maximum fee for the service is the amount established according to the formula in subpart 1b.

(11) "P" status indicates a bundled or excluded code.

(a) If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. An example is an elastic bandage furnished by a physician incident to physician service.

(b) If the item or service is covered as other than incident to a physician service, such as colostomy supplies, it may be paid for separately. If the item or service is not provided incident to the services of a licensed provider, the liability for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b, if the code has no positive RVUs. If positive RVUs are listed, the maximum fee for the service is the amount established according to the formula in subpart 1b.

(12) "R" status indicates a coverage status that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the maximum fee for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b, if the code

has no positive RVUs. If positive RVUs are listed, the maximum fee for the service is the amount established according to the formula in subpart 1b.

(13) "T" status indicates injections. There are RVUs listed for these services, but they are only paid if there are no other services payable under the fee schedule billed on the same date by the same provider. If any other services payable under the fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. Payment for the injected material is separate from the injection services and is governed by part 5221.0500, subpart 2, items B to F.

(14) "X" status indicates a code that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the maximum fee for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b, if the code has no positive RVUs. If positive RVUs are listed, the maximum fee for the service is the amount established according to the formula in subpart 1b.

E. Column E is "Not Used for Medicare Payment." This column is not used in Minnesota workers' compensation.

F. Column F is the "Work RVU." This column lists the RVU for the physician work component of the formulas in subpart 1b, item A.

G. Column G is the "Transitioned Nonfacility Practice Expense RVU." This column lists the RVU for the transitioned resource-based practice expense component of the formulas in subpart 1b, item A, for the nonfacility setting.

H. Column H is the "Transitioned Nonfacility NA Indicator." This column is not used in Minnesota workers' compensation.

I. Column I is the "Fully Implemented Nonfacility Practice Expense RVU." This column is not used in Minnesota workers' compensation.

J. Column J is the Fully Implemented Nonfacility NA Indicator." This column is not used in Minnesota workers' compensation.

K. Column K is the "Transitioned Facility Practice Expense RVU." This column lists the RVU for the transitioned resource-based practice expense component of the formulas in subpart 1b, item A, for services provided by a health care provider in a facility setting, such as a hospital or ambulatory surgical center.

L. Column L is the "Transitioned Facility NA Indicator." This column is not used in Minnesota workers' compensation.

M. Column M is the "Fully Implemented Facility Practice Expense RVU." This column is not used in Minnesota workers' compensation.

N. Column N is the "Fully Implemented Facility NA Indicator." This column is not used in Minnesota workers' compensation.

O. Column O is the "Malpractice RVU." This column lists the RVU for the malpractice expense component of the formulas in subpart 1b, item A, for services provided by a health care provider in both nonfacility and facility settings.

P. Column P is the "Transitioned Nonfacility Total." This column is not used in Minnesota workers' compensation.

Q Column Q is the "Total Fully Implemented Nonfacility RVU." This column is not used in Minnesota workers' compensation.

R. Column R is the "Total Transitioned Facility RVU." This column is not used in Minnesota workers' compensation.

S. Column S is the "Total Fully Implemented Facility RVU." This column is not used in Minnesota workers' compensation.

T. Column T is the "PC/TC Indicator."

Indicator "0" indicates physician service codes. This indicator identifies codes that describe physician services such as office visits, consultations, and surgical procedures. The concept of PC/TC does not apply to codes with this indicator since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The RVUs include values for physician work, practice expense, and malpractice expense. There are some codes with no work RVUs.

Indicator "1" identifies codes for diagnostic tests. Codes with this indicator have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier include values for physician work, practice expense, and malpractice expense.

Indicator "2" indicates professional component only codes. This indicator identifies stand-alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only, and another associated code that describes the global test. An example of a professional component only code is CPT code 93010, electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

Indicator "3" indicates technical component only codes. This indicator identifies stand-alone codes that describe the technical component, such as staff and equipment costs, of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic test only. An example of a technical component only code is CPT code 93005, electrocardiogram; tracing only, without interpretation and report. A "3" indicator also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVU for technical component only codes includes values for practice expense and malpractice expense only.

Indicator "4" indicates global test only codes. This indicator identifies stand-alone codes that describe selected diagnostic tests for which there are associated codes that describe (a) the professional component of the test only; and (b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVU for the professional component only and technical component only codes combined.

Indicator "5" indicates incident to codes. Indicator 5 is not used in Minnesota workers' compensation.

Indicator "6" indicates laboratory physician interpretation codes. This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Modifier TC cannot be used with these codes. The total RVU for laboratory physician interpretation codes includes values for physician work, practice expense, and malpractice expense.

Indicator "7" indicates physical therapy services, for which payment may not be made. This indicator is not used in Minnesota workers' compensation.

Indicator "8" indicates physician interpretation codes. This indicator is not used in Minnesota workers' compensation.

Indicator "9" indicates "not applicable." The concept of a professional/technical component does not apply.

U. Column U is "Global Surgery." This column indicates the application of the global surgery package. It provides time frames and other circumstances that apply to each surgical procedure. Part 5221.4035 provides additional factors affecting payment.

Indicator "000" indicates endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the RVU amount.

Indicator "010" indicates a procedure with preoperative relative values on the day of the procedure and postoperative relative values during a ten-day postoperative period included in the RVU amount.

Indicator "090" indicates major surgery with a one-day preoperative period and a 90-day postoperative period included in the RVU amount.

Indicator "MMM" indicates maternity codes. The usual global period does not apply.

Indicator "XXX" indicates the global surgery package concept does not apply to the code.

Indicator "YYY" indicates the global surgery package concept may apply. If the provider and payor cannot agree to a specified global period, the global period shall be determined by the commissioner or compensation judge. For purposes of indicator YYY, the global period shall include normal, uncomplicated follow-up care for the procedure.

Indicator "ZZZ" indicates the code is related to a primary service and has the same global period as the primary service. However, it is considered an add-on code and is paid separately.

V. Column V is the "Preoperative Percentage." This column indicates the percentage of the total maximum fee calculated under subpart 1b that applies to the preoperative portion of the global surgical package. This percentage is paid when a separate physician performs the preoperative portion of a surgical procedure.

W. Column W is the "Intraoperative Percentage." This column indicates the percentage of the total maximum fee calculated under subpart 1b that applies to the intraoperative portion of the global surgical package, including postoperative work in the hospital. This percentage is paid when a physician performs the intraoperative portion of a surgical package.

X. Column X is the "Postoperative Percentage." This column indicates the percentage of the total maximum fee calculated under subpart 1b that applies to the postoperative portion of the global surgical package that is provided in the office after discharge from the hospital. This is the percentage amount of the global surgical package that is paid when a physician performs the postoperative portion of a surgical package.

Y. Column Y governs payment for "Multiple Procedures." The numerical indicators in column Y indicate applicable payment adjustment rules for multiple procedures.

Indicator "0" indicates no payment adjustment rules for multiple procedures apply.

Indicator "2" indicates standard payment adjustment rules for multiple procedures apply as provided in part 5221.4035, subpart 5.

Indicator "3" indicates special rules for multiple endoscopic/arthroscopic procedures apply as provided in part 5221.4035, subpart 5, item E.

Indicator "4" indicates special rules for multiple diagnostic procedures apply as provided in part 5221.4035, subpart 5, item F.

Indicator "9" indicates that the concept of multiple procedure does not apply.

Z. Column Z governs payment for a bilateral procedure. Symbols in column Z indicate services subject to payment adjustment according to part 5221.4035, subpart 6.

Indicator "0" indicates that no payment adjustments apply to bilateral procedures.

Indicator "1" indicates that bilateral payment adjustments apply.

Indicator "2" indicates no further bilateral payment adjustments apply.

Indicator "3" indicates that no bilateral payment adjustments apply.

Indicator "9" indicates that the concept of bilateral procedures does not apply.

AA. Column AA governs payment for assistant-at-surgery. Symbols in column AA indicate services when an assistant-at-surgery may be paid.

Indicator "0" indicates an assistant-at-surgery may not be paid unless supporting documentation is submitted to establish medical necessity, in which case payment is according to part 5221.4035, subpart 7.

Indicator "1" indicates an assistant-at-surgery may not be paid.

Indicator "2" indicates that an assistant-at-surgery may be paid according to part 5221.4035, subpart 7.

Indicator "9" indicates that the concept of assistant-at-surgery does not apply.

AB. Column AB governs payment for cosurgeons. Indicators in column AB indicate services for which two surgeons may be paid.

Indicator "0" indicates cosurgeons are not permitted for this procedure and no payment for a cosurgeon may be made.

Indicator "1" indicates cosurgeons may be paid, with supporting documentation establishing the medical necessity of two surgeons for the procedure. Where necessity is established, payment is according to part 5221.4035, subpart 8.

Indicator "2" indicates cosurgeons are paid according to part 5221.4035, subpart 8.

Indicator "9" indicates that the concept of cosurgeons does not apply.

AC. Column AC governs payment for team surgery. Indicators in column AC indicate services for which team surgeons may be paid. Part 5221.4035, subpart 9, defines team surgery.

Indicator "0" indicates team surgeons are not permitted for this procedure and no payment may be made for team surgeons.

Indicator "1" indicates team surgeons may be paid, if supporting documentation establishes medical necessity of a team. The maximum fee for the service is limited by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b.

Indicator "2" indicates team surgeons are permitted. The maximum fee for the service is limited by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b.

Indicator "9" indicates that the concept of team surgery does not apply.

AD. Column AD is the "Endoscopic Base Code." The code in this column identifies an endoscopic base code for each code with a multiple surgery indicator of 3 in column Y.

AE. Column AE is the "Conversion Factor." The conversion factor in this column is not used in Minnesota workers' compensation. The conversion factors for Minnesota workers' compensation are specified in subpart 1b.

AF. Column AF is the "Physician Supervision of Diagnostic Procedures." This column is not used in Minnesota workers' compensation.

AG. Column AG is the "Calculation Flag." This column is not used in Minnesota workers' compensation.

AH. Column AH is the "Diagnostic Imaging Family Indicator." This field identifies the applicable diagnostic service family for the HCPCS codes with a multiple procedure indicator of "4" in column Y. The values are:

Indicator "01" indicates ultrasound (chest/abdomen/pelvis-nonobstetrical).

Indicator "02" indicates CT and CTA (chest/thorax/abdomen/pelvis).

Indicator "03" indicates CT and CTA (head/brain/orbit/maxillofacial/neck).

Indicator "04" indicates MRI and MRA (chest/abdomen/pelvis).

Indicator "05" indicates MRI and MRA (head/brain/neck).

Indicator "06" indicates MRI and MRA (spine).

Indicator "07" indicates CT (spine).

Indicator "08" indicates MRI and MRA (lower extremities).

Indicator "09" indicates CT and CTA (lower extremities).

Indicator "10" indicates MR and MRI (upper extremities and joints).

Indicator "11" indicates CT and CTA (upper extremities).

Indicator "99" indicates the concept does not apply.

AI. Column AI is the "Nonfacility Practice Expense Used for OPPS Payment Amount." This column is not used in Minnesota workers' compensation.

AJ. Column AJ is the "Facility Practice Expense Used for OPPS Payment Amount." This column is not used in Minnesota workers' compensation.

AK. Column AK is the "Malpractice Used for OPPS Payment Amount." This column is not used in Minnesota workers' compensation.

Subp. 3. **Supplies, separate billing allowed.** Except as otherwise provided in subpart 2a, charges for the following supplies provided during an evaluation and management service in the office may be billed separately and paid according to the maximum fee established by the formula in subpart 1b if positive RVUs are assigned or, if no positive RVUs are assigned, the charges are limited by part 5221.0500, subpart 2:

A. injectable drugs and antigens;

B. splints, casts, and other devices used in the treatment of fractures and dislocations;

C. all take-home supplies provided by the health care provider or hospital, regardless of type;

D. orthotic device used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Braces meet this definition. Elastic stockings and bandages applied in the office do not meet this definition; and

E. prosthetic devices which replace all or part of an internal body organ, or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. A foley catheter for a permanently incontinent patient meets this definition. A catheter used to obtain a urine specimen does not meet this definition.

[For text of subp 4, see M.R.]

Statutory Authority: *MS s 14.38; 14.386; 14.388*

History: *35 SR 227; 35 SR 461*

5221.4030 MEDICAL/SURGICAL PROCEDURE CODES.

Subpart 1. **Key to abbreviations and terms.** For descriptions of columns, abbreviations, and terms, see part 5221.4020, subpart 2a.

Subp. 2. [Repealed, 20 SR 530]

Subp. 2a. [Repealed, 25 SR 1142]

Subp. 2b. [Repealed, 35 SR 227]

Subp. 3. **List of medical/surgical procedure codes.** The medical/surgical conversion factor in part 5221.4020, subpart 1b, item B, for the applicable date of service applies to the health care providers listed in part 5221.0700, subpart 3, item C, subitem (2), when they provide services, articles, or supplies identified by a procedure code in the Medicare Physician Fee Schedule tables described in part 5221.4005, except for:

A. Procedure codes described in part 5221.4040;

B. Procedure codes described in part 5221.4050;

C. Chiropractic procedure codes 98940, 98941, 98942, and 98943 in part 5221.4060.

Statutory Authority: *MS s 14.38; 14.386; 14.388*

History: *35 SR 227*

5221.4032 [Repealed, 35 SR 227]

5221.4035 FEE ADJUSTMENTS FOR MEDICAL/SURGICAL SERVICES.

Subpart 1. **Definition of a global surgical package.** Coding and payment for all surgical procedures is based on a global surgical package as described in this part and part 5221.4020, subpart 2a, items U, V, W, and X. Physicians are not paid separately for visits or other services that are included in the global package.

A. To determine the global period for surgeries with a 090 global period in column U, include the day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.

EXAMPLE: Date of surgery, September 10; preoperative period, September 9; last day of global period, December 9.

To determine the global period for procedures with a 010 global period in column U, count the day of surgery and the appropriate number of days immediately following the date of surgery.

EXAMPLE: Date of surgery, January 5; last day of global period, January 15.

The global period for procedures with a 000 global period include only the services provided on the day of surgery.

B. Columns V, W, and X of the Medicare Relative Value tables incorporated by reference in part 5221.4005 designate the percentages of the global package assigned to preoperative services, intraoperative services, and postoperative services. These are used to determine the percent of the maximum fee, established by the formula in part 5221.4020, subpart 1b, that is paid to physicians providing one or more components of the global package.

EXAMPLE: For physicians who perform the surgery and furnish all of the usual preoperative, intraoperative, and postoperative work the maximum fee is 100 percent (the sum or the percentages in columns V, W, and X) of the maximum fee established by the formula in part 5221.4020, subpart 1b, for the appropriate CPT code and any appropriate modifiers for the surgical procedure only. Payment for physicians who furnish less than the full global package is described in subpart 4.

Other subparts may affect coding and payment for services for which a global period applies. Subpart 2 further defines services included in the global surgical package. Subpart 3 further defines services not included in the global surgical package. Subpart 4 governs coding and payment adjustment for physicians furnishing less than the full global package. Subpart 5 specifies additional coding and payment requirements for multiple surgeries. Subpart 6 specifies additional coding and payment requirements for bilateral procedures. Subpart 7 specifies additional coding and payment requirements for assistant-at-surgery. Subpart 8 specifies additional coding and payment requirements for cosurgeons. Subpart 9 specifies additional coding and payment requirements for team surgery.

[For text of subp 2, see M.R.]

Subp. 3. **Services not included in global surgical package.** The services listed in items A to O are not included in the global surgical package. These services may be coded and paid for separately. Physicians must use appropriate modifiers as set forth in this subpart.

[For text of items A to F, see M.R.]

G. Treatment for postoperative complications which requires a return trip to the operating room is not included in the global surgical package and is separately coded and paid as specified in this item. This additional procedure is referred to as a reoperation.

"Operating room," for this purpose, is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. Operating room includes a cardiac catheterization suite, laser suite, and endoscopy suite. It does not include a patient's room, minor treatment room, recovery room, or intensive care unit, unless the patient's condition was so critical there would be insufficient time for transportation to an operating room.

(1) When coding for treatment for postoperative complications for services with a global period of 090 or 010 days which requires a return trip to the operating room, as defined in this item, physicians must code the CPT code that describes the procedures performed during the return trip as follows:

(a) Some reoperations have been assigned separate, distinct reoperation CPT procedure codes and RVUs. The maximum fee for these procedures is calculated using the RVUs for the coded reoperation and the formula in part 5221.4020.

(b) Reoperations that have not been assigned separate, distinct reoperation CPT codes must be identified on the bill with the CPT procedure code that describes the procedure or treatment for the complication plus CPT modifier 78 which indicates a return to the operating room for a related procedure during the global period. The CPT procedure code may be the one used for the original procedure when the identical procedure is repeated or another CPT procedure code which describes the actual procedure or service performed.

The maximum fee for a reoperation procedure without a separate distinct reoperation CPT code is the maximum fee established by the formula in part 5221.4020, subpart 1b, multiplied by the intraoperative percentage listed in column W.

(c) When no CPT code exists to describe the treatment for complications, use an unlisted surgical procedure code plus CPT modifier 78 which indicates a return to the operating room for a related procedure during the global period. The maximum fee for the reoperation is the maximum fee for the original procedure established by the formula in part 5221.4020, subpart 1b, multiplied by 50 percent of the intraoperative percent listed in column W.

(2) When coding for treatment for postoperative complications for a procedure with a 000 global period, physicians must use CPT modifier 78 which indicates a return trip to the operating room for a related procedure during the postoperative global period. The full value for the repeat procedure is paid according to the formula in part 5221.4020.

(3) If additional procedures are performed during the same operative session as the original surgery to treat complications which occurred during the original surgery, the additional procedures are coded and paid as multiple surgeries as specified in subpart 5. Only surgeries that require a return to the operating room due to complications from the original surgery are coded and paid as specified in subitems (1) and (2).

(4) If the patient is returned to the operating room after the initial operative session and during the postoperative global surgery period of the original surgery, for one or more additional procedures as a result of complications from the original surgery, each procedure required to treat the complications from the original surgery is paid as specified in subitem (1) or (2).

The multiple surgery rules under subpart 5 do not also apply. The original operation session and the reoperation session are separate and distinct surgical sessions. The reoperation is not considered a multiple surgery, as described in subpart 5, of the original operation. If during the reoperation session multiple surgeries are performed, the additional surgeries

are not governed by the multiple surgery payment rules in subpart 5 but are governed by subitems (1) and (2).

(5) If the patient is returned to the operating room during the postoperative global surgery period of the original surgery, not on the same day of the original surgery, for bilateral procedures that are required as a result of complications from the original surgery, subitems (1) to (4) apply. The bilateral rules in subpart 6 and part 5221.4020, subpart 2a, item Z, do not apply.

H. If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is coded and paid separately.

I. Surgical trays are not paid separately. Payment for the surgical tray is included in the RVUs for the surgical procedure.

[For text of items J to N, see M.R.]

O. Surgeries for which services performed are significantly greater or more complex than usually required must be coded with CPT modifier 22 added to the CPT code for the procedure. Additional requirements for use of this modifier are as follows:

(1) This modifier may only be used where circumstances create a more complex procedure such as congenital or developmental disorders of the anatomy, multiple fractures of the same long bone, coexisting disease, when there has been previous surgery on the same body part or where there is a significant amount of scar tissue.

(2) This modifier may only be reported with procedure codes that have a global period of 000, 010, or 090 days.

(3) Physicians must provide:

(a) a concise statement about how the service is significantly more complex than usually required; and

(b) an operative report with the claim.

(4) The maximum fee for a surgical procedure that has satisfied all of the requirements for use of CPT modifier 22 is up to 125 percent of the maximum fee calculated under part 5221.4020, subpart 1b, for that CPT code listed in subpart 2b.

(5) CPT modifier 22 is not used to report additional procedures that are performed during the same operative session as the original surgery to treat complications which occurred during the original surgery. Additional procedures to treat complications which occurred during surgery are governed by subpart 5.

Subp. 4. **Physicians furnishing less than full global package.** There are occasions when more than one physician provides services included in the global surgical package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the postoperative and postdischarge care is split between two or more physicians where the physicians agree on the transfer of care. Coding and payment requirements for physicians furnishing less than the full global package are:

A. When more than one physician furnishes services that are included in the global surgical package, the maximum fee for each physician is a percentage of the total maximum fee established by the formula in part 5221.4020, subpart 1b, multiplied by the sum of the percentages in columns V, W, and X for the type of operative service provided. For example, the maximum fee for a physician who performs the preoperative and postoperative services, but not the intraoperative service, would be as follows:

The maximum fee for the CPT code established by the formula in part 5221.4020, subpart 1b	*	(the percentage in column V plus the percentage in column X

B. Where physicians agree on the transfer of care during the global period, they must add the appropriate CPT modifier to the surgical procedure code:

(1) CPT modifier 54 for surgical care only; or

(2) CPT modifier 55 for postoperative management only.

C. Physicians who share postoperative management with another physician must submit additional information showing when they assumed and relinquished responsibility for the postoperative care. If the physician who performed the surgery relinquishes care at the time of discharge, the physician need only show the date of surgery when billing with CPT modifier 54.

However, if the surgeon also cares for the patient for some period following discharge, the surgeon must show the date of surgery and the date on which postoperative care was relinquished to another physician. The physician providing the remaining postoperative care must show the date care was assumed.

D. If a surgeon performs a procedure with a global period of 010 or 090 days, and cares for the patient until time of discharge from a hospital or ambulatory surgical center, the maximum fee for this surgeon's services is:

The maximum fee for the CPT code established by the formula in part 5221.4020, subpart 1b	*	(the percentage in column V plus the percentage in column W)

Modifier 54 is used to identify these services.

E. If a health care provider who did not perform the surgery assumes surgical follow-up care of a patient after discharge from the hospital or ambulatory surgical center, then the maximum fee for this practitioner's services is:

The maximum fee for the CPT code established by the formula in part 5221.4020, subpart 1b	*	(the percentage in column X)

CPT modifier 55 is used to identify these services.

F. If several health care providers furnish postoperative care, the maximum fee for the postoperative period is divided among the practitioners based on the number of days for which each health care provider was primarily responsible for care of the patient. CPT modifier 55 (for postoperative management only) is used to identify postoperative services furnished by more than one provider.

G. If the providers have agreed to a payment distribution of the global fee that differs from the distributions set forth in items D to F, then payments will be made accordingly, if the agreed-upon distribution is documented and explained on the bill for the procedure and is not prohibited by Minnesota Statutes, section 147.091, subdivision 1, paragraph (p).

Subp. 5. **Coding and payment for multiple surgeries and procedures.** Part 5221.4020, subpart 2a, item Y, and column Y in the tables incorporated by reference in part 5221.4005, subpart 1, item A, describe codes subject to the multiple procedures payment restrictions. Multiple surgeries are separate surgeries performed by a single physician on the same patient at the same operative session or on the same day for which separate payment may be allowed.

A. The coding requirements in subitems (1) and (2) apply to multiple surgeries that have an indicator of 2 or 3 in column Y by the same physician on the same day as specified in items D and E:

(1) the surgical procedure with the highest maximum fee calculated according to part 5221.4020, subpart 1b, is reported without the multiple procedures CPT modifier 51;

(2) the additional surgical procedures performed are reported with CPT modifier 51.

B. There may be instances in which two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day, for example, in some multiple trauma cases. When this occurs, CPT modifier 51 is not used and the multiple procedure payment reductions do not apply unless one of the surgeons individually performs multiple surgeries.

C. If any of the multiple surgeries are bilateral or cosurgeries, first determine the allowed amount for the procedure as specified in subpart 6 or 8, next rank this amount with the remaining procedures, and finally, apply the appropriate multiple surgery payment reductions as specified in items D and E.

D. For procedures with an indicator of 2 in column Y, if the procedures are reported on the same day as another procedure with an indicator of 2, the maximum fee for the procedure with the highest amount calculated under part 5221.4020, subpart 1b, is paid at 100 percent of the amount calculated, and the maximum fee for each additional procedure with an indicator of 2 is paid at 50 percent of the amount calculated under part 5221.4020, subpart 1b.

E. For procedures with an indicator of 3 in column Y, the multiple endoscopy payment rules apply if the procedure is billed with another endoscopy with the same base code. Column AD lists the endoscopic base code for each code in column A with a multiple surgery indicator of 3. For purposes of this item, the term "endoscopy" also includes arthroscopy procedures. If an endoscopy procedure is performed on the same day as another endoscopy procedure within the same base code, the maximum fee for the procedure with the highest amount calculated under part 5221.4020, subpart 1b, is 100 percent of the amount calculated. The maximum fee for every other procedure with the same base code is reduced by the amount calculated under part 5221.4020, subpart 1b, for the endobase code in column AD. No separate payment is made for the endobase procedure when other endoscopy procedures with the same base code are performed on the same day.

(1) For example, if column Y has an indicator of 3 for multiple endoscopic procedures, and column AD lists the endoscopic base code as 29805, with a maximum allowable fee of $400 calculated according to the formula in part 5221.4020, subpart 1b, the maximum amount payable would be as follows:

Procedures performed (code listed in column A)	Maximum fee under formula in part 5221.4020, subpart 1b	Maximum fee under part 5221.4035, subpart 5, item E	Description
29827	$950	$950	Pay 100 percent of the maximum fee for the procedure with the highest maximum fee under formula in part 5221.4020, subpart 1b
29828	$790	$390	Reduce the maximum fee by $400 (the maximum fee for endobase code 29805) $790 - $400 = $390
29823	$540	$140	Reduce the maximum fee by $400 (the maximum fee for endobase code 29805) $540 - $400 = $140
Total allowable payment:		$1480	

(2) For two unrelated series of endoscopy procedures, the endoscopy pricing rule is applied first to all codes with the same base code in column AD. The multiple surgery pricing rule as depicted by indicator 2 is then applied as follows. The maximum fee for the codes in the series with the highest total amount calculated under this item is 100 percent of the amount calculated. The maximum fee for codes in the series with the lower total amount calculated under this item is 50 percent of the amount calculated.

(3) Endoscopy procedures billed with other surgery procedures. All procedures subject to the multiple surgery pricing rule are ranked from highest to lowest to determine which codes, or groups of codes, are allowed at 100 percent or 50 percent of

the their calculated maximum value. If two or more of the billed codes belong to the same endoscopy family, the endoscopy pricing rule is applied first, and the total value of the endoscopy series is used in the array.

F. For procedures with an indicator of 4 in column Y, special rules for the technical component (TC) of diagnostic imaging procedures apply if the procedure is billed with another diagnostic imaging procedure with the same indicator in column AH. If the procedure is reported in the same session on the same day as another procedure with the same family indicator, the procedures must be ranked according to the maximum fee for the technical component (TC), calculated according to the formula in part 5221.4020, subpart 1b. The technical component with the highest maximum fee is paid at 100 percent, and the technical component of each subsequent procedure is paid at 75 percent. The payments for subsequent procedures are based on the lower of (a) the actual charge, or (b) the maximum fee according to the formula in part 5221.4020, subpart 1b, reduced by the appropriate percentage. The professional component (PC) is paid at 100 percent for all procedures.

G. For procedures with an indicator of 0 or 9, no payment rules for multiple or endoscopy procedures apply.

Subp. 6. **Coding and payment for bilateral surgeries and procedures.** Part 5221.4020, subpart 2a, item Z, and column Z in the tables incorporated by reference in part 5221.4005, subpart 1, describe codes subject to the bilateral procedures payment restrictions. Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.

A. For procedures with an indicator of 0, 3, or 9 in column Z, no bilateral payment provisions apply.

For procedures with an indicator of 0, the 150 percent bilateral adjustment in item B is inappropriate because of physiology or anatomy or because the code description specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. If the procedure is reported with modifier 50, or with modifiers RT and LT, the maximum fee for both sides is the fee calculated according to part 5221.4020, subpart 1b, for a single code. If the provider or payer reassigns a correct code for a bilateral procedure the maximum fee is the amount calculated according to part 5221.4020, subpart 1b, for the correct code and corresponding indicator.

Services with an indicator of 3 are generally radiology procedures or other diagnostic tests that are not subject to bilateral payment adjustments. If the procedure is reported with modifier 50 or is reported for both sides on the same day by any other means, such as with RT and LT modifiers or with a 2 in the units field, the maximum fee for each side is the amount calculated according to the formula in part 5221.4020, subpart 1b, for each side. If the procedure is reported as a bilateral procedure and with other procedure codes on the same day, determine the maximum fee for the bilateral procedure before applying any multiple procedure rules as specified in subpart 5, item C.

For procedures with an indicator of 9, the concept of bilateral surgeries does not apply.

B. For procedures with an indicator of 1 in column Z, if the code is billed with modifier 50 or is reported twice on the same day by any other means, such as with RT and LT modifiers or with a 2 in the units field, the maximum fee is 150 percent of the amount calculated according to the formula in part 5221.4020, subpart 1b, for a single code. The bilateral adjustment is applied before any multiple procedure rules as specified in subpart 5, item C.

C. For procedures with an indicator of 2, no further bilateral adjustments apply because the RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier 50 or is reported twice on the same day by any other means, such as with RT and LT modifiers or with a 2 in the units field, the maximum fee for both sides is the amount calculated according to part 5221.4020, subpart 1b, for a single code.

Subp. 7. **Coding and payment for assistant-at-surgery.** Part 5221.4020, subpart 2a, item AA, and column AA in the tables incorporated by reference in part 5221.4005, subpart 1, describe codes subject to the assistant-at-surgery payment restrictions. An assistant-at-surgery must use the appropriate CPT or HCPCS modifier in accordance with their provider type. Payment for a physician assistant-at-surgery is not allowed when payment is made for cosurgeons or team surgeons for the same procedures. For procedures with an indicator of 0 (where medical necessity is established) or 2 in column AA the maximum fee for an assistant-at-surgery is as follows:

A. For a physician who is an assistant-at-surgery, 16 percent of the global surgery fee is paid. This is paid in addition to the global fee paid to the surgeon.

B. If the assistant surgery service is performed by a provider who is not a physician, but who has advanced training to act as an assistant-at-surgery consistent with their scope of practice, 13.6 percent of the global surgery fee is paid. This is paid in addition to the global fee paid to the surgeon.

Subp. 8. **Coding and payment for cosurgeons.** Part 5221.4020, subpart 2a, item AB, and column AB in the tables incorporated by reference in part 5221.4005, subpart 1, describe codes subject to the cosurgeon's payment adjustments. Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedures or the patient's condition. It is cosurgery if two surgeons, each in a different specialty, are required to perform a specific procedure, for example, heart transplant. Cosurgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, for example, bilateral knee replacement. In these cases, the additional physicians are not acting as assistants-at-surgery.

A. If cosurgeons are required to do a procedure, each surgeon codes for the procedure with CPT modifier 62 which indicate two surgeons.

B. For procedures with an indicator of 1, where necessity of cosurgeons is established, or 2 in column AB, the amount paid for the procedure is 125 percent of the global fee, divided equally between the two surgeons. If the cosurgeons have agreed to a different payment distribution, payments will be made accordingly, if the agreed-upon distribution is documented and explained on the bill for the procedure, and is not prohibited by Minnesota Statutes, section 147.091, subdivision 1, paragraph (p).

C. For procedures with an indicator of 0 or 9 in column AB, either cosurgeons are not allowed or the concept of cosurgery does not apply and cosurgery fee adjustments do not apply.

D. If surgeons of different specialties are each performing a distinctly different procedure with specific CPT codes, cosurgery fee adjustments do not apply even if the procedures are performed through the same incision. If one of the surgeons performs multiple procedures, the multiple procedure rules in subpart 5 apply to that surgeon's services.

Subp. 9. **Coding and payment for team surgery.** Part 5221.4020, subpart 2a, item AC, and column AC in the tables incorporated by reference in part 5221.4005, subpart 1, govern application of the team surgery concept.

A. If a team of surgeons, that is, more than two surgeons of different specialties, is required to perform a specific procedure, each surgeon bills for the procedure with the CPT modifier 66 which indicates a surgical team.

B. For procedures with an indicator of 1, where necessity of a team is established, or 2 in column AC, the amount paid for the procedure is limited by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b.

C. For procedures with an indicator of 0 or 9 in column AC, either team surgery is not allowed or the concept of team surgery does not apply.

[For text of subp 10, see M.R.]

Statutory Authority: *MS s 14.38; 14.386; 14.388*

History: *35 SR 227*

5221.4040 PATHOLOGY AND LABORATORY PROCEDURE CODES.

Subpart 1. **Key to abbreviations and terms.** For descriptions of columns, abbreviations, and terms, see part 5221.4020, subpart 2a.

Subp. 2a. [Repealed, 25 SR 1142]

Subp. 2b. [Repealed, 30 SR 291]

Subp. 2c. [Repealed, 35 SR 227]

Subp. 3. **List of pathology and laboratory codes.** The pathology and laboratory conversion factor in part 5221.4020, subpart 1b, item B, applies to the health care providers listed in part 5221.0700, subpart 3, item C, subitem (3), when they provide the services, articles, or supplies identified by procedure codes 80000 through 89999 in the Medicare Physician Fee Schedule tables described in part 5221.4005.

Statutory Authority: *MS s 14.38; 14.386; 14.388*

History: *35 SR 227*

5221.4041 [Repealed, 35 SR 227]

5221.4050 PHYSICAL MEDICINE AND REHABILITATION PROCEDURE CODES.

Subpart 1. **Key to abbreviations and terms.** For descriptions of columns, abbreviations, and terms, see part 5221.4020, subpart 2a.

Subp. 2a. [Repealed, 25 SR 1142]

Subp. 2b. [Repealed, 30 SR 291]

Subp. 2c. [Repealed, 35 SR 227]

Subp. 2d. **List of physical medicine and rehabilitation procedure codes.** The physical medicine and rehabilitation conversion factor in part 5221.4020, subpart 1b, item B, applies to the health care providers listed in part 5221.0700, subpart 3, item C, subitem (4), when they provide, within their scope of practice, the services, articles, or supplies identified by procedure codes 97001 through 97799 and V5336 to V5364 in the Medicare Physician Fee Schedule tables described in part 5221.4005.

[For text of subp 3, see M.R.]

Statutory Authority: *MS s 14.38; 14.386; 14.388*

History: *35 SR 227*

5221.4051 FEE ADJUSTMENTS FOR PHYSICAL MEDICINE AND REHABILITATION SERVICES.

Maximum fees for the physical medicine and rehabilitation modalities in the following list are determined according to the following payment schedule when more than one modality on the list is provided to the same patient on the same day: 100 percent of the fee calculated according to the formula in part 5221.4020 for the modality with the highest RVU and 75 percent of the fee calculated according to the formula in part 5221.4020 for each additional modality. All modalities after the first modality with the highest RVU shall be coded by adding modifier 51 to the applicable procedure code.

97012	Mechanical traction therapy
97014	Electric stimulation therapy
97016	Vasopneumatic device therapy

97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy treatment
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Unlisted therapy service

Statutory Authority: *MS s 14.38; 14.386; 14.388*

History: *35 SR 227*

5221.4060 CHIROPRACTIC PROCEDURE CODES.

Subpart 1. **Key to abbreviations and terms.** For descriptions of columns, abbreviations, and terms, see part 5221.4020, subpart 2a.

Subp. 2a. [Repealed, 25 SR 1142]

Subp. 2b. [Repealed, 30 SR 291]

Subp. 2c. [Repealed, 35 SR 227]

Subp. 2d. **List of chiropractic procedure codes.** The chiropractic conversion factor in part 5221.4020, subpart 1b, item B, applies to the health care providers listed in part 5221.0700, subpart 3, item C, subitem (5), when they provide, within their scope of practice, services, articles, or supplies identified by any of the following procedure codes in the Medicare Physician Fee Schedule tables described in part 5221.4005:

A. radiologic examination procedure codes from 72010 to 73610;

B. pathology and laboratory procedure codes 81000 and 81002;

C. physical medicine and rehabilitation procedure codes from 97010 to 97799;

D. chiropractic manipulative treatment procedure codes 98940, 98941, 98942, and 98943;

E. evaluation and management service procedure codes 99201, 99202, 99203, 99211, 99212, and 99213; and

F. procedure code 99199 (special service).

[For text of subps 3 and 4, see M.R.]

Statutory Authority: *MS s 14.38; 14.386; 14.388*

History: *35 SR 227*

5221.4061 FEE ADJUSTMENTS FOR CHIROPRACTIC SERVICES.

Subpart 1. **Multiple modalities.** Maximum fees for the chiropractic modalities in the following list are determined according to the following payment schedule when more than one modality on the list is provided to the same patient on the same day: 100 percent of the fee calculated according to the formula in part 5221.4020 for the modality with the highest relative value and 75 percent of the fee calculated according to the formula in part 5221.4020 for each additional modality. All modalities after the first modality with the

highest relative value, shall be coded by adding modifier 51 to the applicable modality code.

97012	Mechanical traction therapy
97014	Electrical stimulation therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy treatment
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Unlisted therapy service

[For text of subp 2, see M.R.]

Statutory Authority: *MS s 14.38; 14.386; 14.388*

History: *35 SR 227*

5221.4062 [Repealed, 35 SR 227]

5221.6040 DEFINITIONS.

[For text of subps 1 to 8, see M.R.]

Subp. 8a. **Medical contraindication.** "Medical contraindication" means a condition that makes the use of a particular treatment or medication inadvisable because of an increased risk of harm to the patient.

[For text of subps 9 to 13, see M.R.]

Statutory Authority: *MS s 176.103; 176.83*

History: *35 SR 138*

5221.6050 GENERAL TREATMENT PARAMETERS; EXCESSIVE TREATMENT; PRIOR NOTIFICATION.

Subpart 1. **General.**

[For text of item A, see M.R.]

B. The health care provider must evaluate at each visit whether initial nonsurgical treatment for the low back, cervical, thoracic, upper extremity, complex regional pain syndrome, reflex sympathetic dystrophy, causalgia, and cognate conditions specified in parts 5221.6200, 5221.6205, 5221.6210, 5221.6300, and 5221.6305, is effective according to subitems (1) to (3). No later than any applicable treatment response time in parts 5221.6200 to 5221.6305, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in subitems (1) to (3):

[For text of subitems (1) to (3), see M.R.]

[For text of item C, see M.R.]

[For text of subps 2 to 8, see M.R.]

Subp. 9. **Prior notification; health care provider and insurer responsibilities.** Prior notification is the responsibility of the health care provider who wants to provide the treatment in item A. Prior notification need not be given in any case where emergency treatment is required.

[For text of items A and B, see M.R.]

C. The insurer must provide a toll-free facsimile and telephone number for health care providers to provide prior notification. The insurer must respond orally or in writing to the requesting health care provider's prior notification of proposed treatment in item A within seven working days of receipt of the request. Within the seven days, the insurer must either approve the request, deny authorization, request additional information, request that the employee obtain a second opinion, or request an examination by the employer's physician. A denial must include notice to the employee and health care provider of the reason why the information given by the health care provider in item B does not support the treatment proposed, along with notice of the right to review of the denial under subitem (3).

[For text of subitems (1) to (4), see M.R.]

(5) If prior notification of surgery is required under item A, subitem (3), the insurer may require that the employee obtain a second opinion from a physician of the employee's choice under Minnesota Statutes, section 176.135, subdivision 1a. If within seven working days of the prior notification the insurer notifies the employee and health care provider that a second opinion is required, the health care provider may not perform the nonemergency surgery until the employee provides the second opinion to the insurer. Except as otherwise provided in parts 5221.6200, subpart 6, items B and C; 5221.6205, subpart 6, items B and C; 5221.6210, subpart 6, items B and C; 5221.6300, subpart 6, item B; and 5221.6305, subpart 3, item B, if the insurer denies authorization within seven working days of receiving the second opinion, the health care provider may elect to perform the surgery, subject to a determination of compensability by the commissioner or compensation judge under subpart 7.

[For text of subitems (6) and (7), see M.R.]

[For text of subps 10 and 11, see M.R.]

Statutory Authority: *MS s 176.103; 176.83*

History: *35 SR 138*

5221.6100 PARAMETERS FOR MEDICAL IMAGING.

[For text of subp 1, see M.R.]

Subp. 2. **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 patient's condition, before ordering any imaging study of the low back.

[For text of item A, see M.R.]

B. Magnetic resonance imaging (MRI) scanning is indicated any time that one of the following conditions is met:

(1) when cauda equina syndrome is suspected;

(2) for evaluation of progressive neurologic deficit;

(3) when previous surgery to the lumbar spine has been performed and there is a need to differentiate scar due to previous surgery from disc herniation, tumor, or hemorrhage; or

(4) suspected discitis.

Except as specified in subitems (1) to (4), MRI scanning is not indicated in the first eight weeks after an injury.

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

C. Myelography is indicated in the following circumstances:

(1) may be substituted for otherwise indicated CT scanning or MRI scanning in accordance with items A and B, if those imaging modalities are not locally available;

(2) in addition to CT scanning or MRI scanning, if there is progressive neurologic deficit and CT scanning or MRI scanning has been negative; or

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

D. Computed tomography myelography is indicated in the following circumstances:

(1) the patient's condition is predominantly sciatica, and there has been previous surgery to the lumbar spine, and tumor is suspected;

(2) the patient's condition is predominantly sciatica and there has been previous surgery to the lumbar spine and MRI scanning is equivocal;

(3) when spinal stenosis is suspected and the CT or MRI scanning is equivocal;

(4) in addition to CT scanning or MRI scanning, if there is progressive neurologic deficit and CT scanning or MRI scanning has been negative; or

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

E. Intravenous enhanced CT scanning is indicated only if there has been previous surgery to the lumbar spine, 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.

F. Gadolinium enhanced MRI scanning is indicated when:

(1) there has been previous surgery to the lumbar spine, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor;

(2) hemorrhage is suspected;

(3) tumor or vascular malformation is suspected;

(4) infection or inflammatory disease is suspected; or

(5) unenhanced MRI scanning was equivocal.

G. Discography is indicated when:

[For text of subitem (1), see M.R.]

(2) there has been previous surgery to the lumbar spine, and pseudoarthrosis, recurrent disc herniation, annular tear, or internal disc disruption is suspected.

[For text of items H to M, see M.R.]

Statutory Authority: *MS s 176.103; 176.83*

History: *35 SR 138*

5221.6105 MEDICATIONS.

Subpart 1. **Scope.** Subparts 2 to 4 apply to use of medication in an outpatient setting. Subparts 2 to 4 do not require a health care provider to prescribe any class of drugs in the treatment of any patient.

Subp. 2. **Nonsteroidal anti-inflammatory drugs (NSAID's).** Nonsteroidal anti-inflammatory drugs (NSAID's) are drugs with analgesic, antipyretic, and anti-inflammatory effects. The term "nonsteroidal" is used to distinguish these drugs from steroids. NSAID's act as inhibitors of the enzyme cyclooxygenase. For the purposes of this subpart, NSAID's include diflunisal but not other salicylates or acetaminophen. NSAID's can be divided into two groups, nonselective NSAID's and COX-2 inhibitors. Examples of nonselective NSAID's 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.

A. NSAID's are indicated for the symptomatic relief of acute and chronic musculoskeletal pain. NSAID's 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.

B. When treating musculoskeletal pain, a generic nonselective NSAID is indicated unless a COX-2 inhibitor is indicated as specified in item C.

(1) 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.

(2) Other generic nonselective NSAID's are not indicated unless one-week trials of each of ibuprofen and naproxen have been ineffective in reducing the patient's pain by at least 50 percent as determined by the prescribing health care provider.

(3) Nonselective NSAID's that are not available as generics are not indicated.

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

(1) patients over 60 years of age;

(2) patients with a history of gastrointestinal bleeding or peptic ulcer disease; or

(3) patients with a history of gastrointestinal side effects with nonselective NSAID use.

However, for any patient meeting any of the criteria of subitems (1) to (3) 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 in items A and B, together with gastroprotective medication.

D. NSAID's are indicated only for the shortest duration needed as determined by the prescribing health care provider.

(1) NSAID's prescribed within the first four weeks after the date of injury are limited to no more than two weeks of medication per prescription or refill.

(2) NSAID's prescribed more than four weeks after the date of injury may not be for more than one month of medication per prescription or refill.

(3) NSAID's prescribed more than 12 months after the date of injury may not be for more than three months of medication per prescription or refill.

Subp. 3. **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.

A. 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.

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

(1) 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 medications in this item, then treatment may begin with any other generic oral opioid analgesic.

(2) 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 patient's pain by at least 50 percent as determined by the prescribing health care provider.

(3) Generically available combinations of an oral opioid and a nonopioid analgesic may be prescribed instead of that opioid analgesic as otherwise allowed under subitems (1) and (2).

(4) 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.

C. A course of oral opioid analgesics or combination of an oral opioid and a nonopioid analgesic is limited as provided in subitems (1) to (3).

(1) Oral opioid analgesics prescribed within the first four weeks after the date of injury are limited to no more than two weeks of medication per prescription.

(2) Oral opioid analgesics prescribed more than four weeks after the date of injury may not be for more than one month of medication per prescription.

(3) 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.

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

E. Transcutaneous opioid analgesics are only indicated in patients with a documented disorder that prevents adequate oral dosing.

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

Subp. 4. **Muscle relaxants.** A muscle relaxant is a drug which decreases the tone of a muscle. For the purposes of this subpart, muscle relaxants include carisoprodol, chlorzoxazone, cyclobenzaprine, metaxalone, methocarbamol, orphenadrine, and tizanidine. This subpart does not limit the use of medications that may be used to treat spasticity.

A. 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.

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

(1) 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.

(2) 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 patient's pain by at least 50 percent as determined by the prescribing health care provider.

(3) Generically available combinations of a muscle relaxant and an analgesic may be prescribed instead of that muscle relaxant as otherwise allowed under subitems (1) and (2).

(4) 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.

C. A course of muscle relaxants or combination of a muscle relaxant and an analgesic is limited as provided in subitems (1) to (3).

(1) Muscle relaxants prescribed within the first four weeks after the date of injury are limited to no more than two weeks of medication per prescription or refill.

(2) Muscle relaxants prescribed more than four weeks after the date of injury are limited to no more than one month's worth of medication per prescription or refill.

(3) Treatment with muscle relaxants for more than three consecutive months is not indicated.

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

Statutory Authority: *MS s 176.103; 176.83*

History: *35 SR 138*

5221.6200 LOW BACK PAIN.

Subpart 1. **Diagnostic procedures for treatment of low back injury.** A health care provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular pain" means pain radiating distal to the knee, or pain conforming to a dermatomal distribution and accompanied by anatomically congruent motor weakness or reflex changes. This part does not apply to fractures of the lumbar spine, or back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

(1) Regional low back pain, includes referred pain to the leg above the knee unless it conforms to an L2, L3, or L4 dermatomal distribution and is accompanied by anatomically congruent motor weakness or reflex changes. Regional low back pain includes the diagnoses of lumbar, lumbosacral, or sacroiliac: strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, spondylosis, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the lumbar spine or sacroiliac joints and which effects the lumbosacral region, with or without referral to the buttocks and/or leg above the knee, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721, 721.3, 721.5 to 721.90, 722, 722.3, 722.32, 722.5, 722.51, 722.52, 722.6, 722.8, 722.80, 722.83, 722.9, 722.90, 722.93, 724.2, 724.5, 724.6, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.2 to 739.4, 756.1 to 756.19, 846.0, 847.2 to 847.9, 922.3, 922.31, 926.1, 926.11, and 926.12.

(2) Radicular pain, with or without regional low back pain, with static or no neurologic deficit. This includes the diagnoses of sciatica; lumbar or lumbosacral radiculopathy, radiculitis or neuritis; displacement or herniation of intervertebral disc with myelopathy, radiculopathy, radiculitis or neuritis; spinal stenosis with myelopathy, radiculopathy, radiculitis or neuritis; and any other diagnoses for pain in the leg below the knee believed to originate with irritation of a nerve root in the lumbar spine, including, but not limited to, the ICD-9-CM codes 721.4, 721.42, 721.91, 722.1, 722.10, 722.11, 722.2, 722.7, 722.73, 722.8, 722.80, 722.83, 724.0, 724.00, 724.02, 724.09, 724.3, 724.4, and 724.9. In these cases, neurologic findings on history and physical examination are either absent or do not show progressive deterioration.

(3) Radicular pain, with or without regional low back pain, with progressive neurologic deficit. This includes the same diagnoses as subitem (2), however, this category applies when there is a history of progressive deterioration in the neurologic symptoms and physical findings which include worsening sensory loss, increasing muscle weakness, or progressive reflex changes.

(4) Cauda equina syndrome, which is a syndrome characterized by anesthesia in the buttocks, genitalia, or thigh and accompanied by disturbed bowel and bladder function, ICD-9-CM codes 344.6, 344.60, and 344.61.

[For text of items B to H, see M.R.]

I. A comprehensive functional capacity assessment or evaluation (FCE) is an individualized examination and evaluation that objectively measures the patient's current level of function and the ability to perform functional or work-related tasks, and it predicts the potential to sustain these tasks over a defined time frame. The components of a comprehensive FCE include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance.

(1) A comprehensive FCE is not indicated during the period of initial nonsurgical management.

(2) After the period of initial nonsurgical management, a comprehensive FCE is indicated in either of the following circumstances:

(a) permanent activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to do a specific job.

(3) A comprehensive FCE is not indicated to establish baseline performance before treatment or to evaluate change in performance during a course of treatment.

(4) Only one completed comprehensive FCE is indicated per injury.

(5) Functional tests or physical performance tests done as part of a work conditioning program or work hardening program as provided in part 5221.6600, subpart 2, item D, or in conjunction with active treatment modalities as provided in subpart 4, are not a comprehensive FCE and are not limited by this item.

[For text of item J, see M.R.]

[For text of subp 2, see M.R.]

Subp. 3. **Passive treatment modalities.**

[For text of items A to D, see M.R.]

E. Electrical muscle stimulation includes muscle stimulation, low-volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic stimulation, TENS, interferential, and microcurrent techniques.

[For text of subitems (1) and (2), see M.R.]

F. Mechanical traction is the therapeutic use of mechanically induced tension created by a pulling force to produce a combination of distraction and gliding to relieve pain and increase flexibility. Mechanical traction may be continuous, static, intermittent, inversion, gravity, or positional. Examples of mechanical traction include power traction, intersegmental motorized mobilization, vertebral axial decompression, autotraction (active), and 90/90.

[For text of subitems (1) and (2), see M.R.]

G. Acupuncture treatments:

[For text of subitems (1) to (3), see M.R.]

H. Manual therapy includes manual traction, myofascial release, joint mobilization and manipulation, manual lymphatic drainage, soft-tissue mobilization and manipulation, trigger point therapy, acupressure, muscle stimulation - manual (nonelectrical), and any form of massage:

[For text of subitems (1) to (3), see M.R.]

[For text of items I to K, see M.R.]

[For text of subps 4 to 7, see M.R.]

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only in the situations specified in items A to D. The health care provider must provide prior notification as required in items B and C according to part 5221.6050, subpart 9.

[For text of items A to C, see M.R.]

D. The following durable medical equipment is not indicated for home use for any of the low back conditions described in subpart 1, item A:

[For text of subitems (1) and (2), see M.R.]

[For text of subp 9, see M.R.]

Subp. 10. **Scheduled and nonscheduled medication.** The health care provider must document the rationale for the use of any medication. Treatment with medication may be appropriate during any phase of treatment and must comply with all of the applicable parameters in part 5221.6105. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and that the most cost-effective regimen is used.

[For text of subps 11 to 13, see M.R.]

Statutory Authority: *MS s 176.103; 176.83*

History: *35 SR 138*

5221.6205 NECK PAIN.

Subpart 1. **Diagnostic procedures for treatment of neck injury.** A health care provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular pain" means pain radiating distal to the shoulder. This part does not apply to fractures of the cervical spine or cervical pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

(1) Regional neck pain includes referred pain to the shoulder and upper back. Regional neck pain includes the diagnoses of cervical strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the cervical spine and which affects the cervical region, with or without referral to the upper back or shoulder, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.0, 722.2, 722.3 to 722.30, 722.39, 722.4, 722.6, 722.8, 722.80, 722.81, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.2, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 847.9, 920, 922.3, 925, and 926.1 to 926.11.

(2) Radicular pain, with or without regional neck pain, with no or static neurologic deficit. This includes the diagnoses of brachialgia; cervical radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and other diagnoses for pain in the arm distal to the shoulder believed to originate with irritation of a nerve root in the cervical spine, including, but not limited to, the ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 722.8, 722.80, 722.81, 723.4, 724, and 724.9. In these

cases neurologic findings on history and examination are either absent or do not show progressive deterioration.

(3) Radicular pain, with or without regional neck pain, with progressive neurologic deficit, which includes the same diagnoses as subitem (2); however, in these cases there is a history of progressive deterioration in the neurologic symptoms and physical findings, including worsening sensory loss, increasing muscle weakness, and progressive reflex changes.

(4) Cervical compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes. Cervical compressive myelopathy includes the ICD-9-CM code 336.9.

[For text of items B to H, see M.R.]

I. A comprehensive functional capacity assessment or evaluation (FCE) is an individualized examination and evaluation that objectively measures the patient's current level of function and the ability to perform functional or work-related tasks, and it predicts the potential to sustain these tasks over a defined time frame. The components of a comprehensive FCE include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance.

(1) A comprehensive FCE is not indicated during the period of initial nonsurgical management.

(2) After the period of initial nonsurgical management, a comprehensive FCE is indicated in either of the following circumstances:

(a) permanent activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to do a specific job.

(3) A comprehensive FCE is not indicated to establish baseline performance before treatment or to evaluate change in performance during a course of treatment.

(4) Only one completed comprehensive FCE is indicated per injury.

(5) Functional tests or physical performance tests done as part of a work conditioning program or work hardening program as provided in part 5221.6600, subpart 2, item D, or in conjunction with active treatment modalities as provided in subpart 4, are not a comprehensive FCE and are not limited by this item.

[For text of item J, see M.R.]

[For text of subp 2, see M.R.]

Subp. 3. **Passive treatment modalities.**

[For text of items A and D, see M.R.]

E. Electrical muscle stimulation includes muscle stimulation, low-volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic stimulation, TENS, interferential, and microcurrent techniques.

[For text of subitems (1) and (2), see M.R.]

F. Mechanical traction is the therapeutic use of mechanically induced tension created by a pulling force to produce a combination of distraction and gliding to relieve pain and increase flexibility. Mechanical traction may be continuous, static, intermittent, inversion, gravity, or positional. Examples of mechanical traction include power traction, intersegmental motorized mobilization, vertebral axial decompression, autotraction (active), and 90/90.

[For text of subitems (1) and (2), see M.R.]

G. Acupuncture treatments:

[For text of subitems (1) to (3), see M.R.]

H. Manual therapy includes manual traction, myofascial release, joint mobilization and manipulation, manual lymphatic drainage, soft-tissue mobilization and manipulation, trigger point therapy, acupressure, muscle stimulation - manual (nonelectrical), and any form of massage:

[For text of subitems (1) to (3), see M.R.]

[For text of items I to K, see M.R.]

[For text of subps 4 to 7, see M.R.]

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only as specified in items A to D. The health care provider must provide prior notification as required in items B and C according to part 5221.6050, subpart 9.

[For text of items A to C, see M.R.]

D. The following durable medical equipment is not indicated for home use for any of the neck pain conditions described in subpart 1, item A:

[For text of subitems (1) and (2), see M.R.]

[For text of subp 9, see M.R.]

Subp. 10. **Scheduled and nonscheduled medication.** The health care provider must document the rationale for the use of any medication. Treatment with medication may be appropriate during any phase of treatment and must comply with all of the applicable parameters in part 5221.6105. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and the most cost-effective regimen is used.

[For text of subps 11 to 14, see M.R.]

Statutory Authority: *MS s 176.103; 176.83*

History: *35 SR 138*

5221.6210 THORACIC BACK PAIN.

Subpart 1. **Diagnostic procedures for treatment of thoracic back injury.** A health care provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the consistency appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular pain" means pain radiating in a dermatomal distribution around the chest or abdomen. This part does not apply to fractures of the thoracic spine or thoracic back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

(1) Regional thoracic back pain includes the diagnoses of thoracic strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and any other diagnosis for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the thoracic spine and which effects the thoracic region, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12.

(2) Radicular pain, with or without regional thoracic back pain, includes the diagnoses of thoracic radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and any other diagnoses for pain believed to originate with

irritation of a nerve root in the thoracic spine, including, but not limited to, the ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00.

(3) Thoracic compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes. Thoracic compressive myelopathy includes the ICD-9-CM code 336.9.

[For text of items B to H, see M.R.]

I. A comprehensive functional capacity assessment or evaluation (FCE) is an individualized examination and evaluation that objectively measures the patient's current level of function and the ability to perform functional or work-related tasks, and it predicts the potential to sustain these tasks over a defined time frame. The components of a comprehensive FCE include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance.

(1) A comprehensive FCE is not indicated during the period of initial nonsurgical management.

(2) After the period of initial nonsurgical management, a comprehensive FCE is indicated in either of the following circumstances:

(a) permanent activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to do a specific job.

(3) A comprehensive FCE is not indicated to establish baseline performance before treatment or to evaluate change in performance during a course of treatment.

(4) Only one completed comprehensive FCE is indicated per injury.

(5) Functional tests or physical performance tests done as part of a work conditioning program or work hardening program as provided in part 5221.6600, subpart 2, item D, or in conjunction with active treatment modalities as provided in subpart 4, are not a comprehensive FCE and are not limited by this item.

[For text of item J, see M.R.]

[For text of subp 2, see M.R.]

Subp. 3. **Passive treatment modalities.**

[For text of items A to D, see M.R.]

E. Electrical muscle stimulation includes muscle stimulation, low-volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic stimulation, TENS, interferential, and microcurrent techniques.

[For text of subitems (1) and (2), see M.R.]

F. Mechanical traction is the therapeutic use of mechanically induced tension created by a pulling force to produce a combination of distraction and gliding to relieve pain and increase flexibility. Mechanical traction may be continuous, static, intermittent, inversion, gravity, or positional. Examples of mechanical traction include power traction, intersegmental motorized mobilization, vertebral axial decompression, autotraction (active), and 90/90.

[For text of subitems (1) and (2), see M.R.]

G. Acupuncture treatments:

[For text of subitems (1) to (3), see M.R.]

H. Manual therapy includes manual traction, myofascial release, joint mobilization and manipulation, manual lymphatic drainage, soft-tissue mobilization and manipulation, trigger point therapy, acupressure, muscle stimulation - manual (nonelectrical), and any form of massage:

[For text of subitems (1) to (3), see M.R.]

[For text of items I to K, see M.R.]

[For text of subps 4 to 7, see M.R.]

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only in certain specific situations, as specified in items A to D. The health care provider must provide the insurer with prior notification as required by items B and C, according to part 5221.6050, subpart 9.

[For text of items A to C, see M.R.]

D. The following durable medical equipment is not indicated for home use for any of the thoracic back pain conditions described in subpart 1, item A:

[For text of subitems (1) and (2), see M.R.]

[For text of subp 9, see M.R.]

Subp. 10. **Scheduled and nonscheduled medication.** The health care provider must document the rationale for the use of any medication. Treatment with medication may be appropriate during any phase of treatment and must comply with all of the applicable parameters in part 5221.6105. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and the most cost-effective regimen is used.

[For text of subps 11 to 13, see M.R.]

Statutory Authority: *MS s 176.103; 176.83*

History: *35 SR 138*

5221.6300 UPPER EXTREMITY DISORDERS.

Subpart 1. **Diagnostic procedures for treatment of upper extremity disorders (UED).** A health care provider shall determine the nature of an upper extremity disorder before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must at each visit assign the patient to the appropriate clinical category according to subitems (1) to (6). The diagnosis must be documented in the medical record. Patients may have multiple disorders requiring assignment to more than one clinical category. This part does not apply to upper extremity conditions due to a visceral, vascular, infectious, immunological, metabolic, endocrine, systemic neurologic, or neoplastic disease process, fractures, lacerations, amputations, or sprains or strains with complete tissue disruption.

(1) Epicondylitis. This clinical category includes medial epicondylitis and lateral epicondylitis, ICD-9-CM codes 726.31 and 726.32.

(2) Tendonitis of the forearm, wrist, and hand. This clinical category encompasses any inflammation, pain, tenderness, or dysfunction or irritation of a tendon, tendon sheath, tendon insertion, or musculotendinous junction in the upper extremity at or distal to the elbow due to mechanical injury or irritation, including, but not limited to, the diagnoses of tendonitis, tenosynovitis, tendovaginitis, peritendinitis, extensor tendinitis, de Quervain's syndrome, intersection syndrome, flexor tendinitis, and trigger digit, including, but not limited to, ICD-9-CM codes 726.4, 726.8, 726.9, 726.90, 727, 727.0, 727.00, 727.03, 727.04, 727.05, 727.09, 727.2, 727.3, 727.4 to 727.49, 727.8 to 727.82, 727.89, and 727.9.

(3) Nerve entrapment syndromes. This clinical category encompasses any compression or entrapment of the radial, ulnar, or median nerves, or any of their branches, including, but not limited to, carpal tunnel syndrome, pronator syndrome, anterior interosseous syndrome, cubital tunnel syndrome, Guyon's canal syndrome, radial tunnel syndrome, posterior interosseous syndrome, and Wartenburg's syndrome, including, but not limited to, ICD-9-CM codes 354, 354.0, 354.1, 354.2, 354.3, 354.8, and 354.9.

(4) Muscle pain syndromes. This clinical category encompasses any painful condition of any of the muscles of the upper extremity, including the muscles responsible for movement of the shoulder and scapula, characterized by pain and stiffness, including, but not limited to, the diagnoses of chronic nontraumatic muscle strain, repetitive strain injury, cervicobrachial syndrome, tension neck syndrome, overuse syndrome, myofascial pain syndrome, myofasciitis, nonspecific myalgia, fibrositis, fibromyalgia, and fibromyositis, including, but not limited to, ICD-9-CM codes 723.3, 729.0, 729.1, 729.5, 840, 840.3, 840.5, 840.6, 840.8, 840.9, 841, 841.8, 841.9, and 842.

(5) Shoulder impingement syndromes, including tendonitis, bursitis, and related conditions. This clinical category encompasses any inflammation, pain, tenderness, dysfunction, or irritation of a tendon, tendon insertion, tendon sheath, musculotendinous junction, or bursa in the shoulder due to mechanical injury or irritation, including, but not limited to, the diagnoses of impingement syndrome, supraspinatus tendonitis, infraspinatus tendonitis, calcific tendonitis, bicipital tendonitis, subacromial bursitis, subcoracoid bursitis, subdeltoid bursitis, and rotator cuff tendinitis, including, but not limited to, ICD-9-CM codes 726.1 to 726.2, 726.9, 726.90, 727 to 727.01, 727.2, 727.3, 840, 840.4, and 840.6 to 840.9.

(6) Traumatic sprains or strains of the upper extremity. This clinical category encompasses an instantaneous or acute injury, as a result of a single precipitating event to the ligaments or the muscles of the upper extremity including, without limitation, ICD-9-CM codes 840 to 842.19. Injuries to muscles as a result of repetitive use, or occurring gradually over time without a single precipitating trauma, are considered muscle pain syndromes under subitem (4). Injuries with complete tissue disruption are not subject to this parameter.

[For text of items B to D, see M.R.]

E. The following diagnostic procedures or tests are not indicated for the diagnosis of any of the clinical categories in item A:

[For text of subitems (1) to (3), see M.R.]

[For text of items F to I, see M.R.]

J. A comprehensive functional capacity assessment or evaluation (FCE) is an individualized examination and evaluation that objectively measures the patient's current level of function and the ability to perform functional or work-related tasks, and it predicts the potential to sustain these tasks over a defined time frame. The components of a comprehensive FCE include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance.

(1) A comprehensive FCE is not indicated during the period of initial nonsurgical management.

(2) After the period of initial nonsurgical management, comprehensive FCE is indicated in either of the following circumstances:

(a) permanent activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to do a specific job.

(3) A comprehensive FCE is not indicated to establish baseline performance before treatment or to evaluate change in performance during a course of treatment.

(4) Only one completed comprehensive FCE is indicated per injury.

(5) Functional tests or physical performance tests done as part of a work conditioning program or work hardening program as provided in part 5221.6600, subpart 2, item D, or in conjunction with active treatment modalities as provided in subpart 4, are not a comprehensive FCE and are not limited by this item.

[For text of item K, see M.R.]

[For text of subp 2, see M.R.]

Subp. 3. **Passive treatment modalities.**

[For text of items A to D, see M.R.]

E. Electrical muscle stimulation includes muscle stimulation, low-volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic stimulation, TENS, interferential, and microcurrent techniques.

[For text of subitems (1) and (2), see M.R.]

F. Acupuncture treatments:

[For text of subitems (1) to (3), see M.R.]

[For text of item G, see M.R.]

H. Manual therapy includes manual traction, myofascial release, joint mobilization and manipulation, manual lymphatic drainage, soft-tissue mobilization and manipulation, trigger point therapy, acupressure, muscle stimulation - manual (nonelectrical), and any form of massage:

[For text of subitems (1) to (3), see M.R.]

[For text of items I and J, see M.R.]

[For text of subps 4 to 7, see M.R.]

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only in the situations specified in items A to D. The health care provider must provide the insurer with prior notification as required in items B and C and part 5221.6050, subpart 9.

[For text of items A to C, see M.R.]

D. The following durable medical equipment is not indicated for home use for the upper extremity disorders described in subpart 1, item A:

[For text of subitems (1) and (2), see M.R.]

[For text of subp 9, see M.R.]

Subp. 10. **Scheduled and nonscheduled medication.** The health care provider must document the rationale for the use of any medication. Treatment with medication may be appropriate during any phase of treatment and must comply with all of the applicable parameters in part 5221.6105. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and the most cost-effective regimen is used.

[For text of subps 11 to 16, see M.R.]

Statutory Authority: *MS s 176.103; 176.83*

History: *35 SR 138*

5221.6305 COMPLEX REGIONAL PAIN SYNDROME (CRPS); REFLEX SYMPATHETIC DYSTROPHY; AND CAUSALGIA OF THE UPPER AND LOWER EXTREMITIES.

Subpart 1. **Scope.**

A. This clinical category encompasses:

(1) any condition diagnosed as complex regional pain syndrome, reflex sympathetic dystrophy, or causalgia, or any other condition included in ICD-9-CM codes 337.20, 337.21, 337.22, 337.29, 337.9, 354.4, 355.71, 355.9, or 733.7; or

(2) any condition of the upper or lower extremity characterized by concurrent presence in the involved extremity of five of the following conditions: edema; local skin color change of red or purple; osteoporosis in underlying bony structures demonstrated by radiograph; local dyshidrosis; local abnormality of skin temperature regulation; reduced passive range of motion in contiguous joints; local alteration of skin texture of smooth or shiny; or typical findings of reflex sympathetic dystrophy on bone scan; or

(3) any condition of the upper or lower extremity that develops after trauma or nerve injury and is characterized by continuing pain, allodynia, or hyperalgesia that is nonanatomic in distribution and disproportionate to the original injury and to stimulation, and the patient has or has had edema, vasomotor abnormality, or sudomotor abnormality on examination, and there is no other explanation for the degree of pain and dysfunction.

[For text of items B and C, see M.R.]

Subp. 2. **Initial nonsurgical management.** Initial nonsurgical management is appropriate for all patients with reflex sympathetic dystrophy and must be the first phase of treatment. Any course or program of initial nonsurgical management is limited to the modalities specified in items A to D.

A. Therapeutic injection modalities. The only injections allowed for reflex sympathetic dystrophy are sympathetic block, intravenous infusion of steroids or sympatholytics, or epidural block.

(1) Unless medically contraindicated, sympathetic blocks or the intravenous infusion of steroids or sympatholytics must be used if reflex sympathetic dystrophy has continued for four weeks and the employee remains disabled as a result of the reflex sympathetic dystrophy.

(a) Time for treatment response: within 30 minutes.

(b) Maximum treatment frequency: can repeat an injection to a limb if there was a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections must be discontinued. No more than three injections to different limbs are reimbursable per patient visit.

[For text of unit (c), see M.R.]

[For text of subitem (2), see M.R.]

[For text of items B and C, see M.R.]

D. The health care provider must document the rationale for the use of any medication. Treatment with medication may be appropriate during any phase of treatment and must comply with all of the applicable parameters in part 5221.6105. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and that the most cost-effective regimen is used.

[For text of subps 3 and 4, see M.R.]

Statutory Authority: *MS s 176.103; 176.83*

History: *35 SR 138*