**5221.0410 REQUIRED REPORTING AND FILING OF MEDICAL INFORMATION.**

Subpart 1. **Scope.** This part prescribes information the health care provider is required to submit to the employer, insurer, or commissioner. This part does not preclude any party or the commissioner from requesting supplementary reports from the health care provider under Minnesota Statutes, section 176.231, subdivision 4.

Subp. 2. **Health care provider report.** Within ten days of receipt of a request for information on the prescribed health care provider report form from an employer, insurer, or the commissioner, a health care provider must respond on the report form or in a narrative report that contains the same information requested on the form.

The health care provider's report form prescribed by the commissioner must include the information required by items A to M:

A. information identifying the employee and employer, and insurer, if known;

B. date of first examination for this injury or disease by the health care provider;

C. for reports dated before October 1, 2015, the diagnosis and appropriate ICD-9-CM diagnostic codes for the injury or disease. For reports dated on or after October 1, 2015, the diagnosis and appropriate ICD-10-CM diagnostic codes for the injury or disease must be used;

D. history of the injury or disease as given by the employee;

E. the relationship of the injury or disease to employment activities;

F. information regarding any preexisting or other conditions affecting the employee's disability;

G. information about future treatment including, but not limited to, hospital admission, surgery, or referral to another doctor;

H. information regarding any surgery that has been performed;

I. information regarding the employee's ability to work, any work restrictions, and dates of disability;

J. information regarding the employee's permanent partial disability rating, in accordance with subpart 4;

K. information regarding whether the employee is unable to return to former employment for medical reasons attributed to the injury;

L. information regarding maximum medical improvement in accordance with subpart 3; and

M. signature of health care provider, license or registration number, and identification information.

Subp. 3. **Maximum medical improvement.** For injuries occurring on or after January 1, 1984, or upon request for earlier injuries, the health care provider must report to the self-insured employer or insurer, maximum medical improvement, when ascertainable, on the health care provider report form or in a narrative report. "Maximum medical improvement" is a medical and legal concept defined by Minnesota Statutes, section 176.011, subdivision 13a.

A. For purposes of subitems (1) and (2), "the employee's condition" includes the signs, symptoms, physical and clinical findings, and functional status that characterize the complaint, illness, or injury. "Functional status" means the ability of an individual to engage in activities of daily life and vocational activities. Except as otherwise provided in item B:

(1) In determining maximum medical improvement, the following factors shall be considered by the health care provider as an indication that maximum medical improvement has been reached:

(a) there has been no significant lasting improvement in the employee's condition, and significant recovery or lasting improvement is unlikely, even if there is ongoing treatment;

(b) all diagnostic evaluations and treatment options that may reasonably be expected to improve or stabilize the employee's condition have been exhausted, or declined by the employee;

(c) any further treatment is primarily for the purpose of maintaining the employee's current condition or is considered palliative in nature; and

(d) any further treatment is primarily for the purpose of temporarily or intermittently relieving symptoms.

(2) The following factors should be considered by the health care provider as an indication that maximum medical improvement has not been reached:

(a) the employee's condition is significantly improving or likely to significantly improve, with or without additional treatment;

(b) there are diagnostic evaluations that could be performed that have a reasonable probability of changing or adding to the treatment plan leading to significant improvement; or

(c) there are treatment options that have not been applied that may reasonably be expected to significantly improve the employee's condition.

B. This item applies to musculoskeletal injuries that fall within any category under parts 5223.0070, 5223.0080, 5223.0110 to 5223.0150, and 5223.0170 for dates of injury before July 1, 1993, and that fall within any category under parts 5223.0370 to 5223.0390 and 5223.0440 to 5223.0550 for dates of injury on or after July 1, 1993. When more than one year has elapsed since the date of a musculoskeletal injury that falls within any of the above categories, the only factors in determining maximum medical improvement shall be whether a decrease is anticipated in the employee's estimated permanent partial disability rating or a significant improvement is anticipated in the employee's work ability as documented on the report of work ability described in subpart 6. If medical reports show no decrease in the employee's estimated permanent partial disability or no significant improvement in the employee's work ability in any three-month period later than one year after the injury, the employee is presumed to have reached maximum medical improvement. This presumption can only be rebutted by a showing that a decrease in the employee's permanent partial disability rating or significant improvement in the work ability has occurred or is likely to occur beyond this three-month period. The medical reports relied upon as establishing maximum medical improvement under this item must be served on the employee in accordance with item C.

This item applies only to injuries of the musculoskeletal system, except where the injury is a spinal cord injury resulting in permanent paralysis, a head injury with loss of consciousness, or where surgery has been performed within the previous six months. In these cases, the factors listed in item A shall be used to determine maximum medical improvement.

C. If the employer or insurer does not serve a notice of intention to discontinue benefits or a petition to discontinue benefits under Minnesota Statutes, section 176.238, at the same time a narrative maximum medical improvement report is served, then the report must be served with a cover letter containing the information in subitems (1) to (6). Serving the cover letter with the maximum medical improvement report does not replace the notice of intention to discontinue benefits or petition to discontinue benefits required by Minnesota Statutes, section 176.238. The cover letter must include:

(1) information identifying the employee by name, worker identification number (WID) or Social Security number, and date of injury;

(2) information identifying the employer and insurer;

(3) the date the report was mailed to the employee;

(4) a statement that the attached report indicates that in the opinion of the health care provider, the employee reached maximum medical improvement by the specified date or an explanation that the attached reports indicate the employee has reached maximum medical improvement under the circumstances specified in item B;

(5) the definition of maximum medical improvement as defined by Minnesota Statutes, section 176.011, subdivision 13a; and

(6) the statement: "There may be an impact on your temporary total disability benefits. If we propose to stop your benefits, a notice of discontinuance of benefits will be sent to you first. If you have any questions concerning your benefits or maximum medical improvement, you may call the claims person at ..... or the workers' compensation division at ..... (specify telephone numbers)."

Subp. 4. **Permanent partial disability.** The health care provider must render an opinion of permanent partial disability when ascertainable, but no later than the date of maximum medical improvement. The rating must be reported on the health care provider report form or in a narrative report. In making a rating of permanent partial disability, the health care provider must specify any applicable category of the permanent partial disability schedule in effect for the employee's date of injury. If a zero rating is appropriate, this rating must also be reported.

The health care provider may refer the employee to another health care provider for an opinion of the employee's permanent partial disability rating if the primary health care provider feels unable to make the determination in complicated cases involving impairments to more than one body part or multiple citations under the permanent partial disability schedule. In such cases, the treating provider must be available for consultation with the evaluating provider, and must make all relevant medical records available, without charge to the payer. The evaluating provider is entitled to reimbursement from the payer for a consultation as limited by the medical fee schedule.

Subp. 5. **Required reporting to division.** For those injuries that are required to be reported to the division under Minnesota Statutes, section 176.231, subdivision 1, the self-insured employer or insurer or third-party administrator shall file with the division the health care provider report form prescribed in subpart 2 or a narrative report that indicates that the employee has reached maximum medical improvement, or that indicates a preliminary or final permanent partial disability rating. The commissioner shall, by written request under Minnesota Statutes, section 176.231, subdivisions 3 and 7, require the filing of the health care provider report at additional times as necessary to monitor compliance with Minnesota Statutes, chapter 176, in accordance with Minnesota Statutes, sections 176.231, subdivision 6, and 176.251. Reports dated before October 1, 2015, filed under this subpart must include the appropriate ICD-9-CM diagnostic codes for the injury or disease. Reports dated on or after October 1, 2015, filed under this subpart must include the appropriate ICD-10-CM diagnostic codes for the injury or disease.

Subp. 6. **Report of work ability.** Each primary health care provider as defined in part 5221.0430, subpart 1, must complete and submit to the employee a report of work ability. A

health care provider providing service under the direction or prescription of another provider is not required to complete a report of work ability.

A. For all work injuries, the primary health care provider must complete a report of work ability within ten days of a request by an insurer or at the intervals stated in subitems (1) to (3), unless there are no restrictions or the restrictions are permanent and have been so indicated in a report of work ability:

(1) every visit if visits are less frequent than once every two weeks;

(2) every two weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; or

(3) upon expiration of the ending or review date of the restriction specified in a previous report of work ability. Open-ended durations of disability or restriction may not be given.

B. The report of work ability must be either on the form prescribed by the commissioner or in a report that contains the same information as the report of work ability. The report of work ability prescribed by the commissioner shall include:

(1) information identifying the employee and employer, and insurer, if known;

(2) the date of the most recent examination;

(3) information stating whether the employee is able to work without restrictions, able to work with restrictions, or unable to work;

(4) work restrictions stated in functional terms, if the employee is able to work with restrictions;

(5) the date any restriction of work activity is to begin and the anticipated ending or review date;

(6) the date of the next scheduled visit;

(7) the signature of the health care provider, license or registration number, and identification information; and

(8) a notice to the employee that a copy of the report must be promptly provided to the employer or workers' compensation insurer and assigned qualified rehabilitation consultant.

C. The report of work ability must be based on the health care provider's most recent evaluation of the employee's signs, symptoms, physical and clinical findings, and functional status.

D. The report of work ability must be provided to the employee and a copy of the report must be placed in the employee's medical record. Promptly upon receipt, the employee shall submit the report of work ability to the employer or the insurer and the assigned qualified rehabilitation consultant. The commissioner shall, by written request under Minnesota Statutes, sections 176.102, subdivision 7, and 176.231, subdivisions 3 and 7, require the filing of a report of work ability when necessary to monitor compliance with Minnesota Statutes, chapter 176, in accordance with Minnesota Statutes, sections 176.231, subdivision 6, and 176.251.

Subp. 7. **Payment and coding for required and supplementary reporting.**

A. No charge may be assessed for completion of a health care provider report or report of work ability required by subparts 2 and 6, or for a narrative or other report prepared in lieu of a health care provider report or report of work ability. If a provider itemizes this service on the billing form, the provider must use code 99080 (special reports) when reporting this service.

B. A payer or other party may request supplementary reports from the health care provider for information not required in the health care provider report or the report of work ability. A provider may charge a reasonable amount for requested supplementary reports using code 99199 (unlisted special service or report). Payment for supplementary reports is not subject to the 85 percent payment limit as specified in part 5221.0500, subpart 2, item F.

Subp. 8. **Proper filing of documents with division.** A health care provider report or narrative report required by the division under this part may be filed by facsimile or electronic transmission, if available at the division. Filing is completed at the time that the facsimile or electronic transmission is received by the commissioner. A report received after 4:30 p.m. shall be deemed received on the next open state business day. The filed facsimile or transmitted information has the same force and effect as the original. Where the quality of the document is at issue, the commissioner shall require the original document to be filed.

A narrative report filed with the division must, at the top of the first page, identify the employee by name, Social Security number, and date of injury. The name of the self-insured employer, insurer, and administrator if appropriate, must also be identified. The filer must identify the reason the report is submitted, and must highlight the corresponding pertinent sections of the report.

**Statutory Authority:** *MS s 14.386; 14.388; 175.171; 176.101; 176.135; 176.1351; 176.136; 176.231; 176.83*

**History:** *18 SR 1472; 25 SR 1142; 40 SR 328; 41 SR 1127*

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