5221.0700 PROVIDER RESPONSIBILITIES.

Subpart 1. **Usual charges.** No provider shall submit a charge for a service which exceeds the amount which the provider charges for the same type of service in cases unrelated to workers' compensation injuries.

Subp. 1a. **Conflicts of interest.** All health care providers subject to this chapter are bound by the federal Medicare antikickback statute in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and regulations adopted under it, pursuant to Minnesota Statutes, section 62J.23. Any medical services or supplies provided in violation of these provisions are not compensable under Minnesota Statutes, chapter 176.

Subp. 2. **Submission of information.** Providers except for hospitals must supply with the bill a copy of an appropriate record that adequately documents the service and substantiates the nature and necessity of the service or charge. Hospitals must submit an appropriate record upon request by the payer. All charges billed after January 1, 1994, for workers' compensation health care services, articles, and supplies, except for United States government facilities rendering health care services for veterans must be submitted to the payer on the forms prescribed in subparts 2a, 2b, and 2c, and in accordance with items A to C.

A. Charges for services, articles, and supplies must be submitted to the payer directly by the health care provider actually furnishing the service, article, or supply. This includes but is not limited to the following:

(1) diagnostic imaging, laboratory, or pathology testing not actually performed by the health care provider, or employee of the health care provider, who ordered the test;

(2) equipment, supplies, and medication not ordinarily kept in stock by the hospital or other health care provider facility, purchased from a supplier for a specific employee;

(3) services performed by a health care provider at a small or large hospital, as defined in part 5221.0500, subpart 2, items C and D, if the provider has an independent practice, except that a hospital may charge for services furnished by a provider who receives at least a base payment from the hospital, which is paid regardless of the number of patients seen; and

(4) outpatient medications dispensed by a licensed pharmacy pursuant to an order written by a health care provider, as described in this subpart, including both prescription and nonprescription medications.

B. Charges must be submitted to the payer in the manner required by subparts 2a, 2b, and 2c within 60 days from the date the health care provider knew the condition

being treated was claimed by the employee as compensable under workers' compensation. Failure to submit charges within the 60 days is not a basis to deny payment, but is a basis for disciplinary action against the provider under Minnesota Statutes, section 176.103. Failure to submit claims within the time frames specified in Minnesota Statutes, section 62Q.75, subdivision 3, may result in denial of payment.

C. This part does not limit the collection of other information the provider may be required to report under any other state or federal jurisdiction.

Subp. 2a. **Centers for Medicare and Medicaid Services CMS 1500 form.** Except as provided in subparts 2b and 2c, charges for all services, articles, and supplies that are provided for a claimed workers' compensation injury must be submitted to the payer on the CMS 1500 form. Charges for dental services may be submitted on the dental claim form required by Minnesota Statutes, section 62J.52, subdivision 3. The CMS 1500 form must be filled out in accordance with Minnesota Statutes, section 62J.52, and directions set forth in the "Minnesota Standards for the Use of the CMS 1500 Claim Form" manual adopted by the Department of Health under Minnesota Statutes, section 62J.61.

Subp. 2b. **Uniform billing claim form UB-92 (CMS 1450).** Hospitals licensed under Minnesota Statutes, section 144.50, must submit itemized charges on the uniform billing claim form, UB-92, (CMS 1450). The UB-92 form must be filled out according to Minnesota Statutes, section 62J.52, and the "Minnesota UB-92 manual" published by the Minnesota Hospital Association.

When the UB-92 form provides only summary information, an itemized listing of all services and supplies provided during the inpatient hospitalization must be attached to the UB-92 form. The itemized list must include:

A. where a code is assigned to a service, the approved procedure codes and modifiers appropriate for the service, in accordance with subpart 3. Charges for supplies need not be coded, but a description and charge for specific articles and supplies must be itemized;

B. the charge for each service;

C. the number of units of each service provided; and

D. the date each service was provided.

Subp. 2c. **Submission of drug charges.**

A. Itemized charges for drugs dispensed for a claimed workers' compensation injury by a licensed community/retail pharmacy must be submitted to the payer on a pharmacy billing form that includes the data elements required by Minnesota Statutes, section 62J.52, subdivision 4, or according to the electronic transaction standards that

apply to retail pharmacies specified in Code of Federal Regulations, title 45, part 162, as amended.

B. Charges for drugs dispensed by a practitioner as defined in Minnesota Statutes, section 151.01, subdivision 23, who is permitted to dispense drugs under Minnesota Statutes, chapter 151, may be submitted to the payer according to the applicable requirements of any of the following: subpart 2a; Minnesota Statutes, section 62J.535; or one of the billing methods described in item A.

C. Charges for drugs dispensed by a hospital may be submitted according to the applicable requirements of any of the following: subpart 2b; Minnesota Statutes, section 62J.535; or one of the billing methods described in item A.

D. In addition to the requirements of subpart 3 and part 5221.4070, all bills or claims for reimbursement of drug charges under this part must include the following information:

(1) the workers' compensation file number (the employee's social security number), if provided by the employee;

(2) the employee's name and address;

(3) the insurer's name and address;

(4) the date of the injury;

(5) the name of the health care provider who ordered the drug;

(6) the name and quantity of each drug provided;

(7) the prescription number for the drug;

(8) the date the drug was provided;

(9) the total charge for each drug provided;

(10) the name, address, and telephone number of the pharmacy or practitioner that provided the drug; and

(11) the pharmacy's or practitioner's usual and customary charge for the drug at the time it is dispensed.

E. The terms "community/retail pharmacy," "dispense," "drug," "practitioner," and "usual and customary charge" in this subpart have the meanings given to them in part 5221.4070, subpart 1a.

Subp. 3. **Billing code.**

A. The provider shall undertake professional judgment to assign the correct approved billing code, and any applicable modifiers, in the CPT, HCPCS, NDC, or UB-92 manual in effect on the date the service, article, or supply was rendered, using the

appropriate provider group designation, and according to the instructions and guidelines in this chapter. No provider may use a billing code which is assigned a "D," "F," "G," or "H" status as described in part 5221.4020, subpart 2a, item D. Where several component services which have different CPT codes may be described in one more comprehensive CPT code, only the single CPT code most accurately describing the procedure performed or service rendered may be reported.

Dental procedures not included in CPT or HCPCS shall be coded using any standard dental coding system.

B. The codes for services in parts 5221.4030 to 5221.4070 may be submitted with two-digit or two-letter suffixes called "modifiers" as defined in part 5221.0100, subpart 10a. Except as otherwise specifically provided in parts 5221.4000 to 5221.4070, the use of a modifier does not change the maximum fee to be calculated according to part 5221.4020.

C. Provider group designation.

(1) General. The provision of services by all health care providers is limited and governed by each provider's scope of practice as stated in the applicable statute. A provider shall not perform a service which is outside that provider's scope of practice, nor shall a provider use a procedure code for a service which is outside that provider's scope of practice. Services delivered at the direction and under the supervision of a licensed health care provider listed in this item are considered incident to the services of the licensed provider and are coded as though provided directly by the licensed provider. Services delivered by support staff such as aides, assistants, or other unlicensed providers are incident to the services of a licensed provider only if the licensed provider directly responsible for the unlicensed provider is on the premises at the time the service is rendered. Hospital charges are governed by part 5221.0500, subpart 2, items C and D. Outpatient charges by hospitals with more than 100 licensed beds are subject to the maximum fees in parts 5221.4000 to 5221.4070.

(2) Medical and surgical services. Procedure codes for medical and surgical services and supplies are listed in part 5221.4030. These include services delivered by the following types of providers or services provided incident to the services of the following types of providers: medical physicians, surgeons, osteopathic physicians, podiatrists, dentists, oral and maxillofacial surgeons, optometrists, opticians, speech pathologists, licensed psychologists, social workers, nurse practitioners, clinical nurse specialists, and physician assistants.

(3) Pathology and laboratory services. Procedure codes for services and supplies provided by a pathologist or by a technician under the supervision of a physician are listed in part 5221.4040.

(4) Physical medicine and rehabilitation services. Procedure codes for services and supplies provided by a physician, an osteopathic physician, a physical therapist, an occupational therapist, a physical therapist assistant under the direction and supervision of a physical therapist, or a certified occupational therapy assistant under the direction and supervision of an occupational therapist, or provided incident to the services of a physician, an osteopathic physician, a physical therapist, or an occupational therapist are listed in part 5221.4050.

(5) Chiropractic services. Procedure codes for services and supplies provided by a chiropractor or provided incident to a chiropractor's services are listed in part 5221.4060.

(6) Pharmacy services. Procedure codes for drugs dispensed pursuant to the order of a health care provider, are described in part 5221.4070.

Subp. 4. **Cooperation with payer.** Pursuant to Minnesota Statutes, section 176.138, providers shall comply within seven working days with payers' proper written requests for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of compensability or excessiveness.

Subp. 5. [Repealed, 18 SR 1472]

Statutory Authority: *MS s 14.38; 14.386; 14.388; 175.171; 176.101; 176.135; 176.1351; 176.136; 176.231; 176.83*

History: *9 SR 601; 13 SR 2609; 18 SR 1472; 25 SR 1142; 30 SR 1053; 38 SR 306; L 2014 c 291 art 4 s 58*

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