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 [Repealed, 35 SR 227]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 [Repealed, 35 SR 227]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) + (Nonfacility 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) + (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 Nonfacility Practice Expense (PE) RVUs, 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 Nonfacility PE RVU is as shown in column G;

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

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

(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 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;

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(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;

(2) for dates of service from October 1, 2011, to September 30, 2012, the conversion factors are:

(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: $68.84;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: $40.55;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: $53.61; and

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $54.76;

(3) for dates of service from October 1, 2012, to September 30, 2013, the conversion factors are:

(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: $69.87;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: $41.16;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: $54.41; and

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $55.58;

(4) for dates of service from October 1, 2013, to September 30, 2014, the conversion factors are:

(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: $64.69;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: $55.68;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: $48.88;

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(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $48.83;

(5) for dates of service from October 1, 2014, to September 30, 2015, the conversion factors are:

(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: $64.73;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: $55.75;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: $48.89; and

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $48.80;

(6) for dates of service from October 1, 2015, to September 30, 2016, the conversion factors are:

(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: $65.12;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: $56.08;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: $49.18; and

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $49.09;

(7) for dates of service from October 1, 2016, to September 30, 2017, the conversion factors are:

(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: $69.48;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: $56.70;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: $55.57; and

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $49.34;

(8) for dates of service from October 1, 2017, to September 30, 2018, the conversion factors are:

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(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: $69.62;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: $56.81;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: $55.68; and

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $49.44;

(9) for dates of service from October 1, 2018, to September 30, 2019, the conversion factors are:

(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: $69.93;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: $57.07;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: $55.93; and

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $49.66; and

(10) for dates of service from October 1, 2019, to September 30, 2020, the conversion factors are:

(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: $70.24;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: $59.57;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: $58.16; and

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $50.25.

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 based on the 2019 National Physician Fee Schedule Relative Value July (RVU19C) Release:

.48 [Work RVU (.48) * Work Geographic PCI (1)]

\+ .76836 [Nonfacility PE RVU (.76) * PE GPCI (1.011)]

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+	.0181 [MP RVU (.05) * MP GPCI (.362)]
=	1.26646 [Total RVU]
*	$60.00 [Conversion factor for example only]
=	$75.9876 [Maximum fee]
=	$75.99 [Maximum fee, rounded]

Subp. 2. [Repealed, 35 SR 227]

Subp. 2a. **Key to abbreviations and terms and payment instructions.** Columns A to AE 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. 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 N 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.

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(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" status indicates an invalid CPT or HCPCS code and "H" status indicates an invalid modifier code. Another code must be used to describe these services. No payment is allowed for codes with a "G" or "H" status even if positive RVUs are listed. "I" 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 formulas in subpart 1b.

(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.

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(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) "Q" and "R" status indicate 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.

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

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

I. Column I is the "Facility Practice Expense RVU." This column lists the RVU for the 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.

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

K. Column K 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.

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

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

N. Column N 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.

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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.

O. Column O is the "Global Days indicator." 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.

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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.

P. Column P 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.

Q. Column Q 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.

R. Column R 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.

S. Column S governs payment for Multiple Procedures. The numerical indicators in column S 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 imaging procedures apply as provided in parts 5221.4035, subpart 5, item F; and 5221.4061, subpart 3.

Indicator "5" indicates special rules for multiple therapy services apply as provided in parts 5221.4035, subpart 5, item G; 5221.4051; and 5221.4061.

Indicator "6" indicates special rules for multiple diagnostic cardiovascular services apply as provided in part 5221.4035, subpart 5, item H.

Indicator "7" indicates special rules for multiple diagnostic ophthalmology services apply as provided in part 5221.4035, subpart 5, item I.

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Indicator "9" indicates that the concept of multiple procedures does not apply, except as otherwise provided in parts 5221.4051, subpart 2; and 5221.4061, subpart 1a.

T. Column T governs payment for Bilateral Procedures. Symbols in column T 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.

U. Column U governs payment for assistant-at-surgery. Symbols in column U 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 made 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.

V. Column V governs payment for Cosurgeons. Indicators in column V 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 made 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.

W. Column W governs payment for Team Surgery. Indicators in this column 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.

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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.

X. Column X 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 S.

Y. Column Y is the Medicare 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.

Z. Column Z relates to Physician Supervision of Diagnostic Procedures. This column is not used in Minnesota workers' compensation.

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

AB. Column AB is the "Diagnostic Imaging Family Indicator." Indicator "88" in this field identifies the applicable diagnostic service family for the HCPCS codes with a multiple procedure indicator of "4" in column S.

Indicator "99" indicates the concept does not apply.

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

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

AE. Column AE 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;

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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.

Subp. 4. **Codes 99455 and 99456.** The CPT manual describes two codes for "Work Related or Medical Disability Evaluation Services" (codes 99455 and 99456). These codes are used to report evaluations performed to establish baseline information prior to life or disability insurance certificates being issued. They are not to be used for reporting services for treatment or evaluation of a compensable work injury under parts 5221.0410 and 5221.0420 or Minnesota Statutes, chapter 176.

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: *18 SR 1472; 21 SR 420; 22 SR 500; 23 SR 595; 24 SR 302; 25 SR 730; 25 SR 1142; 26 SR 490; 27 SR 378; 28 SR 315; 29 SR 358; 30 SR 291; 31 SR 324; 32 SR 570; 33 SR 549; 34 SR 353; 35 SR 227; 35 SR 461; 36 SR 314; 37 SR 373; 38 SR 306; 39 SR 287; 40 SR 332; 41 SR 385; 42 SR 361; 43 SR 384; 44 SR 413*

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