

CHAPTER 5221
DEPARTMENT OF LABOR AND INDUSTRY
FEES FOR MEDICAL SERVICES

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5221.0100 DEFINITIONS.

Subpart 1. **Scope.** The following terms have the meanings given in this chapter unless the context clearly indicates a different meaning.

Subp. 1a. **Ambulatory surgical center.** "Ambulatory surgical center" means a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and is accredited by Medicare or is an outpatient surgical center as defined in part 4675.0100, subpart 8, and licensed by the Minnesota Department of Health.

Subp. 1b. **Appropriate record.** "Appropriate record" is a legible medical record or report that substantiates the nature and necessity of a service being billed and its relationship to the work injury.

Subp. 2. **Bill or billing.** "Bill" or "billing" means a provider's statement of charges and services rendered for treatment of a work related injury.

Subp. 3. **Charge.** "Charge" means the payment requested by a provider on a bill for a particular service. This chapter does not prohibit a provider from billing usual and customary charges that are in excess of the amount listed in the fee schedule.

Subp. 4. **Code.** "Code" means the alphabetic, numeric, or alphanumeric symbol used to identify a specific health care service, place of service, or diagnosis as described in items A to G.

A. "Billing code" means a procedure code as defined in item F plus any applicable modifiers as defined in subpart 10a. A billing code is used to identify a specific health care service, article, or supply for billing purposes.

B. "CPT code" means a numeric code included in the Current Procedural Terminology Coding System manual, incorporated by reference in part 5221.0405, item B. A CPT code is used to identify a specific medical service, article, or supply.

C. "HCPCS code" means a numeric or alphanumeric code included in the Centers for Medicare and Medicaid Services' Common Procedure Coding System. An HCPCS code is used to identify a specific medical service, article, or supply. HCPCS level I codes are the numeric CPT codes listed in the CPT manual, incorporated by reference in part 5221.0405, item B. HCPCS level II codes are alphanumeric codes created for national use. HCPCS level II codes are listed in the HCPCS manual, incorporated by reference in part 5221.0405, item C.

D. "ICD-9-CM code" or an "ICD-10-CM code" means an alphanumeric code included in the International Classification of Diseases, Clinical Modification manual, incorporated by reference in part 5221.0405, item A. An ICD-9-CM code or ICD-10-CM code is used to identify a particular medical or chiropractic diagnosis.

E. "Place of service code" means the code used to identify the type of facility and classification of service as inpatient or outpatient service on the uniform billing claim formats required by Minnesota Statutes, sections 62J.50 to 62J.61, and the corresponding uniform companion guides adopted by the Minnesota Department of Health under Minnesota Statutes, section 62J.61.

F. "Procedure code" means a numeric or alphanumeric code used to identify a particular health care service. Procedure codes used in this chapter include CPT codes, HCPCS codes, revenue codes, Codes on Dental Procedures and Nomenclature (CDT codes), and codes in the National Drug Code Directory (NDC).

G. "Revenue code" means a numeric or alphanumeric code included in the UB-04 Data Specifications manual, incorporated by reference in part 5221.0405, item E. Revenue codes are used in institutional settings such as hospitals to identify an individual or group of medical services, articles, or supplies.

Subp. 5. **Commissioner.** "Commissioner" means the commissioner of the Department of Labor and Industry.

Subp. 6. **Compensable injury.** "Compensable injury" means an injury or condition for which a payer is liable under Minnesota Statutes, chapter 176.

Subp. 6a. **Conversion factor.** "Conversion factor" means the dollar value of the maximum fee payable for one relative value unit of a compensable health care service delivered under Minnesota Statutes, chapter 176, as specified in part 5221.4020, subpart 1b.

Subp. 6b. **Division.** "Division" means the Workers' Compensation Division of the Department of Labor and Industry.

Subp. 6c. **Emergency care.** "Emergency care" means those medical services that are required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency, but is necessary to determine whether an emergency exists.

Subp. 7. [Repealed, 18 SR 1472]

Subp. 8. [Repealed, 18 SR 1472]

Subp. 9. **Injury.** "Injury" is as defined in Minnesota Statutes, section 176.011, subdivision 16 as a "personal injury."

Subp. 10. **Medical fee schedule.** "Medical fee schedule" means the list of codes, service descriptions, and corresponding dollar amounts allowed under parts 5221.4005 to 5221.4070 and Minnesota Statutes, section 176.136.

Subp. 10a. **Modifier.** "Modifier" means a two-digit number or two-letter symbol that is added to a procedure code to indicate that the service rendered differs in some material respect from the service as described in this chapter or in the CPT or HCPCS manual in effect on the date the service was rendered. Only those modifiers listed and described in the CPT or HCPCS manual in effect on the date the service was rendered may be used. Applicable modifiers must be used with a procedure code, even if the modifier has no effect on the payment level.

Subp. 11. **Payer.** "Payer" refers to any entity responsible for payment and administration of workers' compensation claims under Minnesota Statutes, chapter 176.

Subp. 11a. **Physician.** "Physician" means a person who is authorized by law to practice the medical profession within the United States, is in good standing in the profession, and includes only those persons holding the degree D.O. (Doctor of Osteopathic Medicine) or M.D. (Doctor of Medicine), as defined in Minnesota Statutes, sections 176.011, subdivision 17, and 176.135, subdivision 2a.

Subp. 12. **Provider.** "Provider" means a health care provider as defined in Minnesota Statutes, section 176.011, subdivision 12a.

Subp. 13. [Repealed, 18 SR 1472]

Subp. 14. [Repealed, 18 SR 1472]

Subp. 14a. **Relative value unit or RVU.** "Relative value unit" or "RVU" means the numeric value assigned to a health care service or procedure to represent or quantify its worth, as compared to a standard service. Relative value units are in the tables described in part 5221.4005.

Subp. 15. **Service or treatment.** "Service" or "treatment" means any procedure, operation, consultation, supply, product, or other thing performed or provided for the purpose of curing or relieving an injured worker from the effects of a compensable injury under Minnesota Statutes, section 176.135, subdivision 1.

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; 15 SR 124; 18 SR 1472; 25 SR 1142; L 2002 c 277 s 32; 30 SR 1053; 38 SR 306; 40 SR 328; L 2016 c 119 s 7; 41 SR 1127*

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5221.0200 AUTHORITY.

This chapter is adopted under the authority of Minnesota Statutes, sections 175.171; 176.135, subdivisions 2 and 7; 176.136; 176.231; and 176.83.

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

History: 9 SR 601; 13 SR 2609; 18 SR 1472; 41 SR 1127
Published Electronically: March 24, 2017

5221.0300 PURPOSE.

This chapter is intended to prohibit health care providers treating employees with compensable injuries from receiving excessive reimbursement for their services. This chapter defines the payer's maximum liability for medical services, articles, and supplies. This chapter also governs health care provider communication with parties; required reporting of medical, disability, and billing information under Minnesota Statutes, chapter 176; change of health care provider; and criteria for determining, serving, and filing maximum medical improvement.

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

History: 9 SR 601; 13 SR 2609; 18 SR 1472

Published Electronically: June 11, 2008

5221.0400 SCOPE.

The following are subject to this chapter: all entities responsible for payment and administration of medical claims compensable under Minnesota Statutes, chapter 176; providers of medical services or supplies for compensable injuries under Minnesota Statutes, section 176.135, subdivision 1; and employees as defined in Minnesota Statutes, section 176.011, subdivision 9. This chapter shall be applied in all relevant determinations made by compensation judges at the department and the Office of Administrative Hearings, and by the commissioner.

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

History: 9 SR 601; 13 SR 2609; 18 SR 2545

Published Electronically: June 11, 2008

5221.0405 INCORPORATIONS BY REFERENCE.

The following documents are incorporated by reference to the extent cited in this chapter. Many of these documents may be accessed through the Internet by contacting the organization listed.

A. The following documents are related to the International Classification of Diseases diagnostic codes.

(1) The International Classification of Diseases, Clinical Modification, 9th revision (ICD-9-CM), and updates through 2014. It is no longer updated because it has been replaced by ICD-10-CM. It is published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), and may be accessed on the CMS website. It is available through the Minitex interlibrary loan system.

(2) The International Classification of Diseases, Clinical Modification, 10th revision (ICD-10-CM), and annual updates. It is subject to frequent change. It is published by the World Health Organization (WHO), and may be accessed on the WHO website. It is also available through the Minitex interlibrary loan system.

(3) The General Equivalence Mappings (GEMs) and annual updates, which is a tool for the conversion of codes between ICD-9-CM and ICD-10-CM. It is subject to frequent change. GEMs was jointly developed by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention agencies. GEMs may be accessed on the CMS website. It is also available through the Minitex interlibrary loan system.

B. The Physician's Current Procedural Terminology (CPT manual), 2016 Professional Edition, and any subsequent revisions. CPT codes are subject to frequent change. The manual is published by and may be purchased from the American Medical Association, Order Department: P.O. Box 930876, Atlanta, GA, 31193-0876, or from the American Medical Association website at <https://commerce.ama-assn.org/store/>. It is available through the Minitex interlibrary loan system.

C. The alphanumeric Healthcare Common Procedure Coding System (HCPCS manual), 2016 edition and any subsequent revisions. It is subject to frequent change. It is published by the Practice Management Information Corporation (PMIC) under the authority of the Centers for Medicare and Medicaid Services and may be purchased from medical bookstores, or through PMIC, 200 West 22nd Street, #253, Lombard, IL 60148, (800) 633-7467, or www.pmiconline.com. It is available through the Minitex interlibrary loan system and on the Centers for Medicare and Medicaid **S e r v i c e s w e b s i t e a t** <http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html>.

D. The Codes on Dental Procedures and Nomenclature (CDT code), 2016, and any subsequent revisions. The CDT code is published by the American Dental Association and may be purchased from its website at <http://www.ada.org/en/store>. It is available through the Minitex interlibrary loan system.

E. The UB-04 Data Specifications Manual (UB-04 Manual), 2016, and any subsequent revisions adopted by the National Uniform Billing Committee (NUBC). It is subject to frequent change. It is published by and may be purchased from the American Hospital Association. It is available through the Minitex interlibrary loan system and on the American Hospital Association's website at <http://www.ahaonlinestore.com>.

F. The National Drug Code Directory, published, maintained, and distributed by the federal Department of Health and Human Services, U.S. Food and Drug Administration. The directory is available for viewing or printing free of charge on the Internet at the U.S. Food and Drug Administration's website at <http://www.fda.gov/cder/ndc/>. The directory is subject to frequent change and amendments to the directory are also incorporated by reference into this chapter.

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; 20 SR 530; 25 SR 1142; L 2002 c 277 s 32; 30 SR 1053; 40 SR 328; 41 SR 1127*

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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: *MSs 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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5221.0420 HEALTH CARE PROVIDER PARTICIPATION WITH RETURN TO WORK PLANNING.

Subpart 1. Cooperation with return to work planning. In addition to completing the required report of work ability under part 5221.0410, subpart 6, a health care provider must participate cooperatively in the planning of an injured employee's return to work by communicating with the employee, employer, insurer, rehabilitation providers, and the commissioner in accordance with this part. A health care provider must release the employee to return to work, with restrictions if necessary, at the earliest appropriate time.

If no qualified rehabilitation consultant has requested an opinion under subpart 2, item B, subitem (1), the health care provider must respond within ten calendar days of receipt of a request by the employee, employer, or insurer regarding whether the physical requirements of a proposed job are within the employee's medical restrictions or whether the health care provider requires further information. The health care provider may respond in writing, in person, or by telephone. The health care provider may require that the proposed job be described in writing. The provider may also agree to review a videotape of the job.

Subp. 2. Communication with assigned qualified rehabilitation consultant. When an employee is receiving vocational rehabilitation services under Minnesota Statutes, section 176.102, the health care provider must communicate with the assigned qualified rehabilitation consultant as follows:

A. A valid patient authorization is required for communication with the assigned qualified rehabilitation consultant. Under part 5220.1802, it is the assigned qualified rehabilitation consultant's responsibility to obtain the patient authorization and send it to the health care provider. Within ten calendar days of receipt of a request for information, the health care provider must respond to the assigned qualified rehabilitation consultant in person, by telephone, or in writing when any of the circumstances specified in item B occur. When an opinion about a proposed job is requested, the health care provider may require that the proposed job be described in writing. The provider may also agree to review a videotape of the job.

B. The health care provider must respond to a request for communication from the assigned qualified rehabilitation consultant upon initial assignment of a qualified rehabilitation consultant. Thereafter, the health care provider must respond to a request no more than once in any 30-calendar day period, except that the provider must also respond to a request when any of the following occur:

- (1) when an opinion is requested regarding whether the physical requirements of a proposed job are within the employee's restrictions;
- (2) when there has been an unanticipated or substantial change in the employee's condition;
- (3) when a job search is initiated; or
- (4) when there has been a change in the employee's work status.

Subp. 3. **Reimbursement for services.** A health care provider may not require prepayment for communication required by this part. The provider must bill the employer and insurer for the services rendered. Return to work services for communication directly with the employee alone must be included in the appropriate level of evaluation and management service. For a return to work service provided to anyone other than the employee, a provider may charge a reasonable amount under this part using code 99199 (unlisted special service or report). Payment for return to work services coded as 99199 under this subpart is not subject to the 85 percent payment limit as specified in part 5221.0500, subpart 2, item F.

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

History: *18 SR 1472; 25 SR 1142*

Published Electronically: *June 11, 2008*

5221.0430 CHANGE OF HEALTH CARE PROVIDER.

Subpart 1. **Primary health care provider.** The individual health care provider directing and coordinating medical care to the employee following the injury is the primary health care provider. If the employee receives medical care after the injury from a provider on two occasions, the provider is considered the primary health care provider if that individual directs and coordinates the course of medical care provided to the employee. The employee may have only one primary health care provider at a time. The selection of a provider by an employee covered by a certified managed care plan is governed by chapter 5218.

Subp. 2. **Change of health care provider.** Following selection of a primary provider, the employee may change primary providers once within the first 60 days after initiation of medical treatment for the injury without the need for approval from the insurer, the department, or a workers' compensation judge. After the first 60 days following initiation of medical treatment for the injury, any further changes of primary provider must be approved by the insurer, the department, or a workers' compensation judge. However, at any time throughout the claim, transfer of medical care coordination due to conditions beyond the employee's control, such as retirement, death, cessation from practice of the primary provider, or a referral from the primary provider to another provider, does not require prior approval. If the employee is covered by a certified managed care plan, a change of providers is governed by chapter 5218, Minnesota Statutes, section 176.1351, subdivision 2, clause (11), and procedures under the plan.

Subp. 3. **Unauthorized change; prohibited payments.** If the employee or health care provider fails to obtain approval of a change of provider before commencing treatment where required by

this part, the insurer is not liable for the treatment rendered prior to approval unless the insurer has agreed to pay for the treatment. Treatment rendered before a change of provider is approved under this subpart is not inappropriate if the treatment was provided in an emergency situation and prior approval could not reasonably have been obtained.

Subp. 4. **Change of primary provider not approved.** After the first 60 days following initiation of medical treatment for the injury, or after the employee has exercised the employee's right to change doctors once, the department, a certified managed care organization, or a compensation judge shall not approve a party's request to change primary providers, where:

- A. a significant reason underlying the request is an attempt to block reasonable treatment or to avoid acting on the provider's opinion concerning the employee's ability to return to work;
- B. the change is to develop litigation strategy rather than to pursue appropriate diagnosis and treatment;
- C. the provider lacks the expertise to treat the employee for the injury;
- D. the travel distance to obtain treatment is an unnecessary expense and the same care is available at a more reasonable location;
- E. at the time of the employee's request, no further treatment is needed; or
- F. for another reason, the request is not in the best interest of the employee and the employer.

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

History: *18 SR 1472; 25 SR 1142*

Published Electronically: *June 11, 2008*

5221.0500 EXCESSIVE CHARGES; LIMITATION OF PAYER LIABILITY.

Subpart 1. **Excessive health care provider charges.** A billing charge for services, articles, or supplies provided to an employee with a compensable injury is excessive if any of the conditions in items A to I apply to the charge. A payer is not liable for a charge which meets any of these conditions:

- A. the charge wholly or partially duplicates another charge for the same service, article, or supply, such that the charge has been paid or will be paid in response to another billing;
- B. the charge exceeds the provider's current usual and customary charge, as specified in subpart 2, item B, for the same or similar service, article, or supply in cases unrelated to workers' compensation injuries;
- C. the charge is described by a billing code that does not accurately reflect the actual service provided;
- D. the service does not comply with the treatment standards and requirements adopted under Minnesota Statutes, section 176.83, subdivision 5, concerning the reasonableness and necessity, quality, coordination, level, duration, frequency, and cost of services;

E. the service was performed by a provider prohibited from receiving reimbursement under Minnesota Statutes, chapter 176, pursuant to Minnesota Statutes, sections 176.83, 176.103, 176.1351, and 256B.0644;

F. the service, article, or supply is not usual, customary, and reasonably required for the cure or relief of the effects of a compensable injury or is provided at a level, duration, or frequency that is excessive, based on accepted medical standards for quality health care and accepted rehabilitation standards under Minnesota Statutes, section 176.136, subdivision 2, clause (2);

G. the service, article, or supply was delivered in violation of the federal Medicare anti-kickback statutes and regulations as specified in part 5221.0700, subpart 1a;

H. where approval for a change of doctor is required by part 5221.0430 for the provider submitting the charge, and approval has not been obtained from the payer, commissioner, or compensation judge; or

I. the service is outside the scope of practice of the particular provider or is not generally recognized within the particular profession of the provider as of therapeutic value for the specific injury or condition, under Minnesota Statutes, section 176.136, subdivision 2, clause (3).

Subp. 2. Limitation of payer liability. A payer is not liable for health care charges which are excessive under subpart 1. If the charges are not excessive under subpart 1, a payer's liability for payment of charges is limited as provided in items A to F.

A. If the medical fee schedule applies to the service according to part 5221.4005, subpart 3, the payer's liability shall be limited to the maximum amount allowed for any service, article, or supply in the medical fee schedule in effect on the date of the service, or the provider's usual and customary fee, whichever is lower.

B. Except as provided in items C to F, if the maximum fee for service, article, or supply is not limited by parts 5221.4005 to 5221.4070, the payer's liability for payment shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charge for similar treatment, articles, or supplies furnished to an injured person when paid for by the injured person, whichever is lower.

(1) A usual and customary charge under Minnesota Statutes, section 176.136, subdivision 1b, paragraphs (a) and (b), means the amount actually billed by the health care provider to all payers for the same service, whether under workers' compensation or not, and regardless of the amount actually reimbursed under a contract or government payment system.

(2) A prevailing charge under Minnesota Statutes, section 176.136, subdivision 1b, paragraph (b), is the 75th percentile of the usual and customary charges as defined in subitem (1), based on no more than two years of billing data immediately preceding the date of service, for each service, article, or supply if the database for the service meets all of the following criteria:

(a) the database includes only Minnesota providers, with at least three different, identifiable providers of the same provider type, distinguished by whether the service is an inpatient

hospital service, or an outpatient physician, pathology, laboratory, chiropractic, physical therapy or occupational therapy service, or provider of other similar service, article, or supply;

(b) there are at least 20 billings for the service, article, or supply; and

(c) the standard deviation is less than or equal to 50 percent of the mean of the billings for each service in the data base or the value of the 75th percentile is not greater than or equal to three times the value of the 25th percentile of the billings.

C. Payment for services, articles, and supplies provided to an employee while an outpatient at a hospital shall be as provided in parts 5221.4005 to 5221.4070, except as provided in Minnesota Statutes, section 176.136, subdivision 1b. The payer's liability for services provided by a nursing home that participates in the medical assistance program shall be the rate established by the commissioner of human services.

D. Payment for services, articles, and supplies provided to an employee who is an inpatient at a hospital shall be as provided in Minnesota Statutes, sections 176.136, subdivision 1b, and 176.1362.

E. Charges for cost of copies of medical records and postage are governed by parts 5219.0100 to 5219.0300 and are not subject to the 85 percent reimbursement limit specified in item B. Travel expenses incurred by an employee for compensable medical services shall be paid at the rate equal to the rate paid by the employer for ordinary business travel expenses, or the rate paid by the state of Minnesota under the commissioner's plan for employment-related travel, whichever is lower. Reimbursement for employee travel expenses is not subject to the 85 percent reimbursement limit specified in item B.

F. Charges for supplementary reports that are not required reports under part 5221.0410, subpart 7, and charges for return to work services under part 5221.0420, subpart 3, are not subject to the 85 percent reimbursement limit specified in item B.

Subp. 3. Collection of excessive charges. A provider may not collect or attempt to collect payment from an injured employee, or any other source, charges for a compensable injury which the payer has determined are excessive under subpart 1 or which exceed the maximum amount payable specified in subpart 2, unless payment is ordered by the commissioner, compensation judge, or Workers' Compensation Court of Appeals. Unless the provider or the employee has filed a claim for a determination of the amount payable with the commissioner, the health care provider must remove the charges from the billing statement. If a dispute exists as to whether an employee's injury is compensable under Minnesota Statutes, chapter 176, and the employee has general health insurance, payment of medical bills is governed by Minnesota Statutes, section 176.191, subdivision 3.

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; 38 SR 306; 41 SR 1127*

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5221.0600 PAYER RESPONSIBILITIES.

Subpart 1. **Compensability.** This chapter does not require a payer to pay a charge for a service that is not for the treatment of a compensable injury or a charge that is the primary obligation of another payer.

Subp. 2. **Determination of excessiveness.** Subject to a determination of the commissioner or compensation judge, the payer shall determine whether a charge or service is compensable by evaluating the charge and service according to the conditions of excessiveness and payer liability specified in part 5221.0500, subparts 1 and 2, and Minnesota Statutes, section 176.136, subdivision 2. If the payer determines that the provider has assigned an incorrect code for a service, the payer may determine the correct code for the service and evaluate liability for payment on the basis of the correct code.

Subp. 3. **Determination of charges.** As soon as reasonably possible, and no later than 30 calendar days after receiving the bill, the payer shall:

- A. pay the charge or any portion of the charge that is not denied;
- B. deny all or a portion of a charge on the basis that the injury is noncompensable; the charge is excessive or noncompensable under Minnesota Statutes, section 176.136, subdivision 2; or part 5221.0500, subparts 1 and 2; or the charges are not submitted on the appropriate billing form prescribed in part 5221.0700; or
- C. request specific additional information to determine whether the charge or the condition is compensable. The payer shall make a determination as set forth in items A and B no later than 30 calendar days following receipt of the provider's response to the initial request for specific additional information.

Subp. 4. **Notification.** Within 30 calendar days of receipt of the bill, the payer shall provide written notification to the employee and provider of denial of part or all of a charge, or of any request for additional information, except that the employer or insurer is not required to notify the employee of payment of charges that have been reduced according to Minnesota Statutes, section 176.136, subdivision 1, 1a, or 1b. Written notification shall include:

- A. the basis for denial of all or part of a charge that the payer has determined is not for a compensable injury under part 5221.0100, subpart 6;
- B. the basis for denial or reduction of each charge and the specific amounts being denied or reduced for each charge meeting the conditions of an excessive or noncompensable charge under part 5221.0500, subparts 1 and 2, or Minnesota Statutes, section 176.136, subdivision 2;
- C. denial of a charge for failure to submit it on the billing form prescribed in part 5221.0700, subpart 2; and

D. a request for an appropriate record or the specific information requested to allow for proper determination of the bill under this part.

The payer shall specify the applicable rule, part, and subpart in this chapter supporting its denial or reduction of a charge. A general statement that a service or charge "exceeds the fee schedule or treatment parameters" is not adequate notification.

If payment is denied under item B, C, or D, the payer shall reconsider the charges in accordance with this rule as soon as reasonably possible, and no later than 30 calendar days after receipt of additional relevant information or documents. Notice of denial of part or all of a charge shall be given by the payer consistent with the guidelines in this subpart.

Subp. 5. **Penalties.** Failure to comply with the requirements of this part may subject the payer to the penalties provided in Minnesota Statutes, sections 176.221, 176.225, and 176.194.

Subp. 6. **Collection of excessive payment.** Any payment made to a provider which is determined to be wholly or partially excessive, according to the conditions prevailing at the time of payment, may be collected from the provider by the payer in the amount that the reimbursement was excessive. The payer must demand reimbursement of the excessive payment from the provider within one year of the payment.

Statutory Authority: *MS s 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; 35 SR 2015*

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5221.0650 DATA COLLECTION, RETENTION, AND REPORTING REQUIREMENTS.

Subpart 1. **Scope.** This part applies to workers' compensation insurers, self-insurers, group self-insurers, adjusters, and third-party administrators who act on behalf of an insurer, self-insurer, the assigned risk plan, and the Minnesota Insurance Guaranty Association.

Subp. 2. **Purpose.** The purpose of this part is to establish procedures and requirements for reporting medical and related data regarding treatment of work-related injuries. The data shall be provided in order for the department to monitor and evaluate medical services and supplies under Minnesota Statutes, chapter 176.

Subp. 3. **Retention period.** Data described in subpart 4 shall be collected and stored by the parties listed in subpart 1, beginning July 1, 1994, for all medical services and supplies provided to an employee under Minnesota Statutes, chapter 176, for ten years from the date of injury, or four years from the date the claim is closed, whichever is later.

Subp. 4. **Required data.** The data in items A and B shall be collected and stored by the parties listed in subpart 1.

A. Required data for professional services and supplies includes all elements required on the uniform billing form under part 5221.0700, subpart 2a, and:

- (1) an indication of open or closed claim status;
- (2) an indication of whether the employee was incapacitated from performing labor or service for more than three calendar days under Minnesota Statutes, section 176.231, subdivision 1;
- (3) the amount of payments made for individual medical services, articles, and supplies; and
- (4) the name of the managed care plan if services were provided under contract with or referral by a certified workers' compensation managed care plan.

B. Required data for inpatient and outpatient hospital services and supplies includes all elements required on the uniform billing form under part 5221.0700, subpart 2b, and:

- (1) an indication of open or closed claim status;
- (2) an indication of whether the employee was incapacitated from performing labor or service for more than three calendar days under Minnesota Statutes, section 176.231, subdivision 1; and
- (3) the name of the managed care plan if services were provided under a contract with or referral by a certified managed care plan for workers' compensation.

Subp. 5. **Reporting requirements.** The data in subpart 4 shall be periodically sampled according to the sampling specifications prescribed by the research design for a study initiated by the commissioner under Minnesota Statutes, sections 175.17, 175.171, 176.103, and 176.1351. The samples shall be reported within 90 days of the request of the commissioner. The requested data shall be provided without charge to the department by a mutually agreeable standard of information exchange such as hard copy, computerized form, or electronic data interchange.

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

History: *18 SR 1472*

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5221.0700 PROVIDER RESPONSIBILITIES.

Subpart 1. **Usual charges.** No provider shall submit a charge for a service that exceeds the amount that 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 in the formats prescribed in subparts 2a, 2b, 2c, and 2d, 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 hospital, 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, 2c, and 2d, 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. **ASC X12 Health Care Claim: Professional (837) format.** Except as provided in subparts 2b, 2c, and 2d, charges for all services, articles, and supplies that are provided for a claimed workers' compensation injury must be submitted to the payer electronically in the ASC X12 Health Care Claim: Professional (837) format required by Minnesota Statutes, sections 62J.50 to 62J.61, and the corresponding uniform companion guide adopted by the Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61.

Subp. 2b. **ASC X12 Health Care Claim: Institutional (837) format.**

A. Hospitals licensed under Minnesota Statutes, section 144.50, must submit charges electronically in the ASC X12 Health Care Claim: Institutional (837) format required by Minnesota Statutes, sections 62J.50 to 62J.61, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61.

B. When the billing format in item A provides only summary information, an itemized listing of all services and supplies provided during the inpatient hospitalization must be attached, except as otherwise provided in Minnesota Statutes, section 176.1362. The itemized list must include:

(1) 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;

(2) the charge for each service;

(3) the number of units of each service provided; and

(4) 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/outpatient pharmacy must be submitted to the payer electronically in the National Council for Prescription Drug Programs (NCPDP) Version D, Release 0 format required by Minnesota Statutes, sections 62J.50 to 62J.61, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61.

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 this subpart or subpart 2a.

C. Charges for drugs dispensed by a hospital may be submitted according to the applicable requirements of this subpart or subpart 2b.

D. The terms "community/outpatient 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. 2d. ASC X12 Health Care Claim: Dental (837) format. Charges for dental services must be submitted to the payer electronically in the ASC X12 Health Care Claim: Dental (837) format required by Minnesota Statutes, sections 62J.50 to 62J.61, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61.

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-04 Data Specifications 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 that 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 the Code on Dental Procedures and Nomenclature (CDT code) as published by the American Dental Association.

Inpatient services shall be coded using the same codes, formats, and details that are required for billing for hospital inpatient services by the Medicare program as required by Minnesota Statutes, section 176.1362, subdivision 1, paragraph (c).

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 5221.4005 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 that is outside the provider's scope of practice, nor shall a provider use a procedure code for a service that is outside the 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.

(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*

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Subp. 2. [Repealed, 18 SR 1472]

Subp. 3. [Repealed, 18 SR 1472]

Subp. 4. [Repealed, 18 SR 1472]

Subp. 5. [Repealed, 18 SR 1472]

Subp. 6. [Repealed, 18 SR 1472]

Subp. 7. [Renumbered 5221.0700, subpart 3, item C, subitems (1) to (20)]

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Subp. 3. [Repealed, 10 SR 765]

Subp. 4. [Repealed, 10 SR 765]

Subp. 5. [Repealed, 10 SR 765]

Subp. 6. [Repealed, 10 SR 765]

Subp. 7. [Repealed, 10 SR 765]

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Subp. 2. [Repealed, 18 SR 1472]

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Subp. 3. [Repealed, 10 SR 765]

Subp. 3. [Repealed, 18 SR 1472]

Subp. 4. [Repealed, 10 SR 765]

Subp. 5. [Repealed, 10 SR 765]

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5221.3310 [Repealed, 14 SR 722]

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5221.3400 [Repealed, 13 SR 2609]

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5221.3500 [Repealed, 18 SR 1472]

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5221.4000 [Repealed, 35 SR 227]

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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; 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, 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; 41 SR 1127*

Published Electronically: *March 24, 2017*

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; 175.171; 176.101; 176.135; 176.1351; 176.136; 176.231; 176.83*

History: *18 SR 1472; 25 SR 1142; 35 SR 227*

Published Electronically: *September 30, 2010*

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 = $[(\text{Work RVU} * \text{Work GPCI}) + (\text{Nonfacility PE RVU} * \text{PE GPCI}) + (\text{MP RVU} * \text{MP GPCI})] * \text{Conversion Factor (CF)}$.

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

(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;

(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;

(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:

(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:

$$\begin{aligned}
 & .48 \text{ [Work RVU (.48) * Work Geographic PCI (1)]} \\
 + & .76836 \text{ [Nonfacility PE RVU (.76) * PE GPCI (1.011)]} \\
 + & .0181 \text{ [MP RVU (.05) * MP GPCI (.362)]} \\
 = & 1.26646 \text{ [Total RVU]} \\
 * & \$60.00 \text{ [Conversion factor for example only]} \\
 = & \$75.9876 \text{ [Maximum fee]} \\
 = & \$75.99 \text{ [Maximum fee, rounded]}
 \end{aligned}$$

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.

(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.

(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.

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.

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.

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.

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.

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;
- 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 412*

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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; 175.171; 176.101; 176.135; 176.1351; 176.136; 176.231; 176.83*

History: *18 SR 1472; 20 SR 530; 25 SR 1142; 28 SR 1209; 35 SR 227*

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5221.4032 [Repealed, 35 SR 227]

Published Electronically: *September 30, 2010*

5221.4033 OUTPATIENT LIMITATION FOR MEDICAL/SURGICAL FACILITY FEE.

Subpart 1. **No facility fee.** Procedures whose codes are listed in subpart 2b are predominantly performed in office settings and, therefore, no additional facility fees are payable when the procedure is performed by the employee's treating health care provider, unless it is an emergency or medically necessary to perform the procedure in a nonoffice setting or after normal office hours. This part does not preclude payment of a facility fee where the employee is treated by emergency room or urgent care staff.

Subp. 1a. **Payment of facility fee.** Except where the facility fee is precluded from payment in subpart 1, fees for ambulatory surgical center and hospital outpatient surgical center are paid in accordance with part 5221.0500, subpart 2.

A. Services and supplies included in facility fee. The services in subitems (1) to (8) are included in the facility fee. There may be no separate payment for these services and supplies:

- (1) nursing, technician, and related services;
- (2) use of the facilities where the surgical procedures are performed;
- (3) drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment directly related to the provision of surgical procedures;
- (4) diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
- (5) administrative, record keeping, and housekeeping items and services;
- (6) materials for anesthesia;
- (7) intraocular lenses (IOLs); and
- (8) supervision of the services of an anesthetist by the operating surgeon.

B. Services and supplies in subitems (1) to (7) are paid separately from the facility fee:

- (1) physician services;

(2) laboratory, X-ray, or diagnostic procedures, other than those directly related to performance of the surgical procedure;

(3) prosthetic devices, except IOLs;

(4) ambulance services;

(5) leg, arm, back, and neck braces and artificial limbs;

(6) durable medical equipment for use in the patient's home or take-home supplies; and

(7) anesthetist services.

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

Subp. 2b. **Procedure codes subject to limitation.**

CPT/HCPCS

Procedure Code	CPT/HCPCS Description
10040	Acne surgery
10060	Drainage of skin abscess
10061	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10081	Drainage of pilonidal cyst
10120	Remove foreign body
10121	Remove foreign body
10140	Drainage of hematoma/fluid
10160	Puncture drainage of lesion
11000	Surgical cleansing of skin
11001	Additional cleansing of skin
11100	Biopsy of skin lesion
11101	Biopsy, each added lesion
11200	Removal of skin tags
11201	Removal of added skin tags
11300	Shave skin lesion
11301	Shave skin lesion

11302	Shave skin lesion
11303	Shave skin lesion
11305	Shave skin lesion
11306	Shave skin lesion
11307	Shave skin lesion
11308	Shave skin lesion
11310	Shave skin lesion
11311	Shave skin lesion
11312	Shave skin lesion
11313	Shave skin lesion
11400	Removal of skin lesion
11401	Removal of skin lesion
11402	Removal of skin lesion
11403	Removal of skin lesion
11420	Removal of skin lesion
11421	Removal of skin lesion
11422	Removal of skin lesion
11423	Removal of skin lesion
11440	Removal of skin lesion
11441	Removal of skin lesion
11442	Removal of skin lesion
11443	Removal of skin lesion
11600	Removal of skin lesion
11601	Removal of skin lesion
11602	Removal of skin lesion
11603	Removal of skin lesion
11620	Removal of skin lesion
11621	Removal of skin lesion

11622	Removal of skin lesion
11623	Removal of skin lesion
11640	Removal of skin lesion
11641	Removal of skin lesion
11642	Removal of skin lesion
11643	Removal of skin lesion
11730	Removal of nail plate
11732	Remove additional nail plate
11740	Drain blood from under nail
11750	Removal of nail bed
11752	Remove nail bed/finger tip
11760	Reconstruction of nail bed
11762	Reconstruction of nail bed
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Added skin lesion injections
12031	Layer closure of wound(s)
12032	Layer closure of wound(s)
12041	Layer closure of wound(s)
12042	Layer closure of wound(s)
12051	Layer closure of wound(s)
12052	Layer closure of wound(s)
15780	Abrasion treatment of skin
15781	Abrasion treatment of skin
15782	Abrasion treatment of skin
15783	Abrasion treatment of skin
15786	Abrasion treatment of lesion
15787	Abrasion, added skin lesions

15851	Removal of sutures
15852	Dressing change, not for burn
16000	Initial treatment of burn(s)
16020	Treatment of burn(s)
16025	Treatment of burn(s)
17000	Destroy benign/premal lesion
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17110	Destruction of skin lesions
17250	Chemical cautery, tissue
17260	Destruction of skin lesions
17261	Destruction of skin lesions
17262	Destruction of skin lesions
17263	Destruction of skin lesions
17264	Destruction of skin lesions
17266	Destruction of skin lesions
17270	Destruction of skin lesions
17271	Destruction of skin lesions
17272	Destruction of skin lesions
17273	Destruction of skin lesions
17274	Destruction of skin lesions
17276	Destruction of skin lesions
17280	Destruction of skin lesions
17281	Destruction of skin lesions
17282	Destruction of skin lesions
17283	Destruction of skin lesions
17284	Destruction of skin lesions
17286	Destruction of skin lesions

17340	Cryotherapy of skin
17360	Skin peel therapy
19000	Drainage of breast lesion
19001	Drain added breast lesion
20500	Injection of sinus tract
20520	Removal of foreign body
20550	Inject tendon/ligament/cyst
20600	Drain/inject joint/bursa
20605	Drain/inject joint/bursa
20610	Drain/inject joint/bursa
20615	Treatment of bone cyst
20974	Electrical bone stimulation
21029	Contour of face bone lesion
21030	Removal of face bone lesion
21031	Remove exostosis, mandible
21032	Remove exostosis, maxilla
21079	Prepare face/oral prosthesis
21080	Prepare face/oral prosthesis
21081	Prepare face/oral prosthesis
21082	Prepare face/oral prosthesis
21083	Prepare face/oral prosthesis
21084	Prepare face/oral prosthesis
21085	Prepare face/oral prosthesis
21086	Prepare face/oral prosthesis
21087	Prepare face/oral prosthesis
21088	Prepare face/oral prosthesis
21089	Prepare face/oral prosthesis
21110	Interdental fixation

23031	Drain shoulder bursa
24200	Removal of arm foreign body
24650	Treat radius fracture
25500	Treat fracture of radius
25530	Treat fracture of ulna
25600	Treat fracture radius/ulna
25622	Treat wrist bone fracture
25630	Treat wrist bone fracture
25650	Repair wrist bone fracture
26010	Drainage of finger abscess
26600	Treat metacarpal fracture
26720	Treat finger fracture, each
26725	Treat finger fracture, each
26740	Treat finger fracture, each
28001	Drainage of bursa of foot
28010	Incision of toe tendon
28011	Incision of toe tendons
28022	Exploration of a foot joint
28024	Exploration of a toe joint
28052	Biopsy of foot joint lining
28108	Removal of toe lesions
28124	Partial removal of toe
28126	Partial removal of toe
28153	Partial removal of toe
28160	Partial removal of toe
28190	Removal of foot foreign body
28220	Release of foot tendon
28230	Incision of foot tendon(s)

28232	Incision of toe tendon
28234	Incision of foot tendon
28270	Release of foot contracture
28272	Release of toe joint, each
28430	Treatment of ankle fracture
28450	Treat midfoot fracture, each
28455	Treat midfoot fracture, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28495	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
28530	Treat sesamoid bone fracture
28540	Treat foot dislocation
28570	Treat foot dislocation
28600	Treat foot dislocation
28630	Treat toe dislocation
29015	Application of body cast
29020	Application of body cast
29025	Application of body cast
29035	Application of body cast
29049	Application of shoulder cast
29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29105	Apply long arm splint
29125	Apply forearm splint

29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29345	Application of long leg cast
29355	Application of long leg cast
29358	Apply long leg cast brace
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29435	Apply short leg cast
29440	Addition of walker to cast
29450	Application of leg cast
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle
29550	Strapping of toes
29580	Application of paste boot
29700	Removal/revision of cast
29705	Removal/revision of cast
29710	Removal/revision of cast
29715	Removal/revision of cast
29720	Repair of body cast
29730	Windowing of cast
29740	Wedging of cast

29750	Wedging of clubfoot cast
29850	Knee arthroscopy/surgery
30000	Drainage of nose lesion
30020	Drainage of nose lesion
30100	Intranasal biopsy
30110	Removal of nose polyp(s)
30200	Injection treatment of nose
30210	Nasal sinus therapy
30220	Insert nasal septal button
30300	Remove nasal foreign body
30901	Control of nosebleed
31000	Irrigation maxillary sinus
31002	Irrigation sphenoid sinus
31505	Diagnostic laryngoscopy
31575	Diagnostic laryngoscopy
31579	Diagnostic laryngoscopy
36000	Place needle in vein
36400	Drawing blood
36405	Drawing blood
36406	Drawing blood
36410	Drawing blood
36430	Blood transfusion service
36450	Exchange transfusion service
36470	Injection therapy of vein
36471	Injection therapy of veins
36510	Insertion of catheter, vein
40490	Biopsy of lip
40800	Drainage of mouth lesion

40804	Removal foreign body, mouth
40808	Biopsy of mouth lesion
40810	Excision of mouth lesion
40812	Excise/repair mouth lesion
41100	Biopsy of tongue
41108	Biopsy of floor of mouth
41825	Excision of gum lesion
41826	Excision of gum lesion
42100	Biopsy roof of mouth
42330	Removal of salivary stone
42400	Biopsy of salivary gland
42650	Dilation of salivary duct
42660	Dilation of salivary duct
42800	Biopsy of throat
45300	Proctosigmoidoscopy
45303	Proctosigmoidoscopy
45330	Sigmoidoscopy, diagnostic
45520	Treatment of rectal prolapse
46083	Incise external hemorrhoid
46221	Ligation of hemorrhoid(s)
46230	Removal of anal tabs
46320	Removal of hemorrhoid clot
46500	Injection into hemorrhoids
46600	Diagnostic anoscopy
46604	Anoscopy and dilation
46606	Anoscopy and biopsy
46614	Anoscopy, control bleeding
46615	Anoscopy

46900	Destruction, anal lesion(s)
46910	Destruction, anal lesion(s)
46916	Cryosurgery, anal lesion(s)
46917	Laser surgery, anal lesion(s)
46940	Treatment of anal fissure
46942	Treatment of anal fissure
46945	Ligation of hemorrhoids
46946	Ligation of hemorrhoids
51700	Irrigation of bladder
51705	Change of bladder tube
51720	Treatment of bladder lesion
52265	Cystoscopy and treatment
53270	Removal of urethra gland
53600	Dilate urethra stricture
53601	Dilate urethra stricture
53620	Dilate urethra stricture
53621	Dilate urethra stricture
53660	Dilation of urethra
53661	Dilation of urethra
54050	Destruction, penis lesion(s)
54055	Destruction, penis lesion(s)
54056	Cryosurgery, penis lesion(s)
54200	Treatment of penis lesion
54230	Prepare penis study
54235	Penile injection
55000	Drainage of hydrocele
55250	Removal of sperm duct(s)
56420	Drainage of gland abscess

56501	Destruction, vulva lesion(s)
56606	Biopsy of vulva/perineum
57061	Destruction, vagina lesion(s)
57100	Biopsy of vagina
57150	Treat vagina infection
57160	Insertion of pessary
57170	Fitting of diaphragm/cap
57452	Examination of vagina
57454	Vagina examination and biopsy
57460	LEEP procedure
57500	Biopsy of cervix
57505	Endocervical curettage
57510	Cauterization of cervix
57511	Cryocautery of cervix
58100	Biopsy of uterus lining
58301	Remove intrauterine device
59200	Insert cervical dilator
59300	Episiotomy or vaginal repair
59425	Antepartum care only
59426	Antepartum care only
59430	Care after delivery
60100	Biopsy of thyroid
61001	Remove cranial cavity fluid
64400	Injection for nerve block
64405	Injection for nerve block
64408	Injection for nerve block
64412	Injection for nerve block
64413	Injection for nerve block

64418	Injection for nerve block
64435	Injection for nerve block
64445	Injection for nerve block
64450	Injection for nerve block
64505	Injection for nerve block
64508	Injection for nerve block
64550	Apply neurostimulator
64553	Implant neuroelectrodes
64555	Implant neuroelectrodes
64565	Implant neuroelectrodes
64612	Destroy nerve, face muscle
64613	Destroy nerve, spine muscle
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65286	Repair of eye wound
65430	Corneal smear
65435	Curette/treat cornea
65436	Curette/treat cornea
65600	Revision of cornea
65772	Correction of astigmatism
65855	Laser surgery of eye
65860	Incise inner eye adhesions
66761	Revision of iris
66770	Removal of inner eye lesion
67145	Treatment of retina
67210	Treatment of retinal lesion

67228	Treatment of retinal lesion
67345	Destroy nerve of eye muscle
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67710	Incision of eyelid
67800	Remove eyelid lesion
67801	Remove eyelid lesions
67805	Remove eyelid lesions
67810	Biopsy of eyelid
67820	Revise eyelashes
67825	Revise eyelashes
67840	Remove eyelid lesion
67850	Treat eyelid lesion
67915	Repair eyelid defect
67922	Repair eyelid defect
67930	Repair eyelid wound
67938	Remove eyelid foreign body
68020	Incise/drain eyelid lining
68040	Treatment of eyelid lesions
68100	Biopsy of eyelid lining
68110	Remove eyelid lining lesion
68135	Remove eyelid lining lesion
68200	Treat eyelid by injection
68400	Incise/drain tear gland
68420	Incise/drain tear sac
68440	Incise tear duct opening
68530	Clearance of tear duct

68705	Revise tear duct opening
68760	Close tear duct opening
68761	Close tear duct opening
68770	Close tear system fistula
68840	Explore/irrigate tear ducts
69000	Drain external ear lesion
69005	Drain external ear lesion
69020	Drain outer ear canal lesion
69100	Biopsy of external ear
69105	Biopsy of external ear canal
69200	Clear outer ear canal
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
69222	Clean out mastoid cavity
69400	Inflate middle ear canal
69401	Inflate middle ear canal
69405	Catheterize middle ear canal
69420	Incision of eardrum
69433	Create eardrum opening
69540	Remove ear lesion
69610	Repair of eardrum
92002	Eye exam, new patient
92004	Eye exam, new patient
92012	Eye exam, established patient
92014	Eye exam and treatment
92019	Eye exam and treatment
92020	Special eye evaluation
92100	Serial tonometry exam(s)

92140	Glaucoma provocative tests
92225	Special eye exam, initial
92226	Special eye exam, subsequent
92230	Eye exam with photos
92260	Ophthalmoscopy/dynamometry
92287	Internal eye photography
92311	Contact lens fitting
92312	Contact lens fitting
92313	Contact lens fitting
92315	Prescription of contact lens
92316	Prescription of contact lens
92317	Prescription of contact lens
92352	Special spectacles fitting
92353	Special spectacles fitting
92354	Special spectacles fitting
92371	Repair and adjust spectacles
92504	Ear microscopy examination
92506	Speech and hearing evaluation
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92511	Nasopharyngoscopy
92512	Nasal function studies
92516	Facial nerve function test
92520	Laryngeal function studies
92565	Stenger test, pure tone
92571	Filtered speech hearing test
92575	Sensorineural acuity test
92576	Synthetic sentence test

92577	Stenger test, speech
92582	Conditioning play audiometry
93797	Cardiac rehab
93798	Cardiac rehab/monitor
95056	Photosensitivity tests
95065	Nose allergy test
95144	Antigen therapy services
95145	Antigen therapy services
95146	Antigen therapy services
95147	Antigen therapy services
95148	Antigen therapy services
95149	Antigen therapy services
95165	Antigen therapy services
95170	Antigen therapy services
95180	Rapid desensitization
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
95857	Tensilon test
96405	Intralesional chemotherapy administration
96406	Intralesional chemotherapy administration
96450	Chemotherapy, into central nervous system
96542	Chemotherapy injection
98940	Chiropractor manip of spine
98941	Chiropractor manip of spine

98942	Chiropractor manip of spine
98943	Chiropractor manip extra spinal
99201	Office/outpatient visit, new
99202	Office/outpatient visit, new
99203	Office/outpatient visit, new
99204	Office/outpatient visit, new
99205	Office/outpatient visit, new
99211	Office/outpatient visit, established
99212	Office/outpatient visit, established
99213	Office/outpatient visit, established
99214	Office/outpatient visit, established
99215	Office/outpatient visit, established
99241	Office consultation
99242	Office consultation
99243	Office consultation
99244	Office consultation
99245	Office consultation
99354	Prolonged service, office
99355	Prolonged service, office

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; 20 SR 530; 25 SR 1142; 38 SR 306*

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5221.4034 [Repealed, 25 SR 1142]

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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 O, P, Q, and R. 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 O, 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 O, 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 P, Q, and R 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 P, Q, and R) 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.

Subp. 2. Components of a global surgical package. The global surgical package includes coding and payment instructions for the following services related to the surgery when furnished by the physician who performs the surgery. The services included in the global surgical package may be furnished in any setting, for example, in hospitals, ambulatory surgical centers, outpatient hospital surgical centers, and physicians' offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, certain critical care services identified by CPT codes 99291 and 99292 are payable separately as specified in subpart 3, item L. Included in the global surgical package are:

A. preoperative visits as follows:

(1) preoperative visits beginning with the day before the day of surgery for procedures with a global period of 090 days except that the evaluation and management service to determine the need for surgery is separately coded and paid in accordance with subpart 3, item A, subitem (1), even if the evaluation and management service is the day before or the day of surgery; and

(2) preoperative visits the day of surgery for procedures with a global period of 000 or 010 days unless a significant separately identifiable evaluation and management service is performed as described in subpart 3, item A, subitem (2);

B. intraoperative services which include services that are normally a usual and necessary part of a surgical procedure;

C. all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room. Subpart 3, item G, governs services for postoperative complications which require a return trip to the operating room;

D. postoperative visits which include follow-up visits during the global period of the surgery that are related to recovery from the surgery;

E. postsurgical pain management by the surgeon;

F. supplies, except for those noted in subpart 3, item I; and

G. miscellaneous services such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes.

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.

A. The initial consultation or evaluation of the problem by the surgeon to determine the need for a surgical procedure is coded and paid as specified in subitems (1) and (2):

(1) for services with a global period of 090 days, a separate payment is allowed for the appropriate level of evaluation and management service. This circumstance must be coded by adding CPT modifier 57 to the appropriate level of evaluation and management service; or

(2) for services with a global period of 000 or 010, and endoscopies, the initial consultation or evaluation services by the same physician on the same day as the procedure, are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, an evaluation and management service on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Payment for an evaluation and management service is not appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status. The physician must document in the medical record that the patient's condition required a significant,

separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance must be coded by adding CPT modifier 25 to the appropriate level of evaluation and management service.

B. Services of other physicians are not included in the global surgical package and are separately coded and paid as follows:

(1) preoperative physical examination and postdischarge services of a physician other than the surgeon are coded by the appropriate evaluation and management code and are paid separately. No modifiers are necessary;

(2) physicians who provide follow-up services for procedures with a global period of 000 or 010 that were initially performed in emergency departments may charge the appropriate level of office visit code and are paid separately. The physician who performs the emergency room service codes for the surgical procedure without a modifier;

(3) if the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician codes the appropriate evaluation and management service and is paid separately. No modifiers are necessary. An example is a cardiologist who manages underlying cardiovascular conditions of a patient; and

(4) where the surgeon and another physician or physicians agree to transfer care otherwise included in the global period, coding and payment are governed by subpart 4.

C. Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery, are not included in the global surgical package and are separately payable. Physicians must use the following modifiers if appropriate:

(1) CPT modifier 79 identifies an unrelated procedure by the same physician during a postoperative period. The physician must document that the performance of a procedure during a postoperative period was unrelated to the original procedure; and

(2) CPT modifier 24 identifies an unrelated evaluation and management service by the same physician during a postoperative period. This circumstance must be coded by adding CPT modifier 24 to the appropriate level of evaluation and management service. The physician must document that an evaluation and management service was performed during the postoperative period of an unrelated procedure. An ICD-9-CM code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation. For treatment on or after October 1, 2015, an ICD-10-CM code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

D. Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery is not included in the global surgical package and is separately payable. Complications from the surgical procedure are governed by item G and subpart 2, item C.

E. Diagnostic tests and procedures, including diagnostic radiological procedures and diagnostic biopsies, are not included in the global surgical package and are separately coded and payable. If a diagnostic biopsy with a ten-day global period precedes a major surgery on the same day or in the ten-day period, the major surgery is payable separately.

F. Clearly distinct surgical procedures during the postoperative period which are not reoperations for complications (reoperations for complications are governed by item G) are not included in the global surgical package and are separately payable. This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy, codes 61533, 61534-61536, 61539, 61541, and 61543, which may be performed in succession within 90 days of each other.

CPT modifier 58 must be used to code for staged or related surgical procedures done during the global period of the first procedure. The global period for the staged or subsequent procedures is separate from the global period for the preceding procedure.

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 Q.

(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 Q.

(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 T, 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.

J. Splints, casting, and take-home supplies are coded and paid separately.

K. Immunosuppressive therapy for organ transplants is coded and paid separately.

L. Critical care services (CPT codes 99291 and 99292) unrelated to the surgery, where a seriously injured or burned patient is critically ill and requires constant attendance of the physician, provided during a global surgical period, are coded and paid separately.

M. Except as provided in part 5221.0410, subpart 7, item A, the physician may separately bill a reasonable amount for supplementary reports and services directly related to the employee's ability to return to work, fitness for job offers, and opinions as to whether or not the condition was related to a work-related injury. Coding and payment for these services is governed by parts 5221.0410, subpart 7; 5221.0420, subpart 3; and 5221.0500, subpart 2.

N. The global surgical package does not apply, and separate coding and payment is allowed, for an initial service that meets both of the conditions in subitems (1) and (2):

(1) the service is for initial care only to afford comfort to a patient or to stabilize or protect a fracture, dislocation, or other injury; and

(2) subsequent restorative treatment, such as surgical repair or reduction of a fracture or joint dislocation, is expected to be performed by a physician other than the physician rendering the initial care only.

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 in subitems (1) to (5).

(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.

(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 P, Q, and R 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 percentage in column P plus the
the formula in part 5221.4020, subpart 1b percentage in column R)

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 percentage in column P plus the
the formula in part 5221.4020, subpart 1b percentage in column Q)

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 percentage in column R)
the formula in part 5221.4020, subpart 1b

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 S, and column S 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 S 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 S, 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 S, the multiple endoscopy payment rules apply if the procedure is billed with another endoscopy with the same base code. Column X 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 X. 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 S has an indicator of 3 for multiple endoscopic procedures, and column X 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 X. 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 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 diagnostic imaging procedures with an indicator of 4 in column S, special rules for the technical component (TC) and professional component (PC) of diagnostic imaging procedures

apply if the procedure is billed with another diagnostic imaging procedure with indicator 88 in column AB. If the procedure is furnished by the same provider, or different providers in the same group practice, to the same patient in the same session on the same day as another procedure with indicator 88, the procedures must be ranked according to the maximum fee for the technical component and professional component, 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 50 percent. The professional component with the highest maximum fee is paid at 100 percent, and the professional component of each subsequent procedure is paid at 95 percent. For example (for illustrative purposes):

	Unadjusted Maximum Fee, Procedure 1	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
PC	\$100	\$80	\$160	\$176 ($\$100 + (.95 \times \$80)$)
TC	\$500	\$400	\$700	\$700 ($\$500 + (.50 \times \$400)$)
Global	\$600	\$480	\$860 ($\$600 + (.75 \times \$80) + (.50 \times \$400)$)	\$876 ($\$600 + (.95 \times \$80) + (.50 \times \$400)$)

G. For procedures with an indicator of 5 in column S that are not also listed in part 5221.4050, subpart 2d, or 5221.4060, subpart 2d, the rules in subitems (1) to (4) apply to establish the maximum fee according to the formula in part 5221.4020, subpart 1b.

(1) When more than one unit or procedure with an indicator of 5 is provided to the same patient on the same day, full payment is made for the unit or procedure with the highest practice expense (PE) RVU.

(2) For subsequent units and procedures furnished to the same patient on the same day, full payment is made for the work and malpractice expense RVUs and 50 percent payment is made for the practice expense RVU.

(3) For therapy services furnished by a provider, a group practice, or incident to a provider's service, the reduction described under this subitem applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, such as physical therapy, occupational therapy, or speech-language pathology, and regardless of the type of provider or supplier.

(4) For example:

	Unadjusted Maximum Fee, Procedure 1 Unit 1	Unadjusted Maximum Fee, Procedure 1 Unit 2	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
Work	\$7	\$7	\$11	\$25	No reduction
PE	\$10	\$10	\$8	\$19	$\$10 + (.50 \times \$10) + (.50 \times \$8)$
Mal- practice	\$1	\$1	\$1	\$3	No reduction
Total	\$18	\$18	\$20	\$47	$\$18 + (\$7 + \$1) + (.50 \times \$10) + (\$11 + \$1) + (.50 \times \$8)$

H. For diagnostic cardiovascular services with an indicator of 6 in column S, 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. Full payment is made for the TC service with the highest payment. Payment is made at 75 percent for subsequent TC services furnished by the same provider, or by multiple providers in the same group practice, to the same patient on the same day. There is no reduction for the professional component (26). For example:

	Unadjusted Maximum Fee, Code 78452	Unadjusted Maximum Fee, Code 93306	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
26	\$77	\$65	\$142	No reduction
TC	\$427	\$148	\$538	$\$427 + (.75 \times \$148)$
Global	\$504	\$213	\$680	$\$142 + \$427 + (.75 \times \$148)$

I. For diagnostic ophthalmology services with an indicator of 7 in column S, 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. Full payment is made for the TC service with the highest payment. Payment is made at 80 percent for subsequent TC services furnished by the same provider, or by multiple providers in the same group practice, to the same patient on the same day. There is no reduction for the professional component (26). For example:

	Code 92235	Code 92250	Total Payment	Payment Calculation
26	\$46	\$23	\$69	No reduction

TC	\$92	\$53	\$134.40	$\$92 + (.80 \times \$53)$
Global	\$138	\$76	\$203.40	$\$69 + \$92 + (.80 \times \$53)$

J. 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 T, and column T 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 T, 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 T, 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 U, and column U 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 U 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 V, and column V 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 V, 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 V, 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 W, and column W 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 W, 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 W, either team surgery is not allowed or the concept of team surgery does not apply.

Subp. 10. **Unbundling surgical services.** 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 and comprehensively describing the procedure performed or service rendered may be reported. Intraoperative services, incidental surgeries, or components of more major surgeries are not separately billable or payable.

For example, an anterior arthrodesis of the lumbar spine using the anterior interbody technique may be performed by two surgeons. One of the surgeons may perform opening or the approach for the anterior arthrodesis while a different surgeon performs the arthrodesis. In this instance, the surgeons are acting as cosurgeons performing different components of a major surgery. The opening or approach is not a separately billable or payable procedure. Both surgeons must code this service using the anterior arthrodesis code and are paid for the procedure as cosurgeons as specified in subpart 8.

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

History: *25 SR 1142; 35 SR 227; 38 SR 306; 40 SR 328; 41 SR 385; 41 SR 1127; 44 SR 412*

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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; 175.171; 176.101; 176.135; 176.1351; 176.136; 176.231; 176.83*

History: *18 SR 1472; 20 SR 530; 20 SR 1163; 25 SR 1142; 30 SR 291; 35 SR 227*

Published Electronically: *September 30, 2010*

5221.4041 [Repealed, 35 SR 227]

Published Electronically: *September 30, 2010*

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 97010 through 97799, 97810 through 97814, and V5336 to V5364 in the Medicare Physician Fee Schedule tables described in part 5221.4005.

Subp. 3. **Additional payment instructions.** The instructions and examples in items A to D are in addition to CPT code descriptions found in the CPT manual. Additional instructions include both general instructions for a group of codes as well as specific instructions for an individual specific code.

A. Supervised modalities.

(1) Additional general instructions for supervised modality codes 97010 to 97028, and G0283. All supervised modalities refer to one or more areas. For example, if diathermy is applied to the cervical and low back on the same day, the charge would be one unit. If the diathermy and electrical stimulation are applied to the low back, the charge would be one unit of diathermy and one unit of electrical stimulation.

(2) Additional specific instructions for supervised modalities.

CPT

Code	CPT Description	Specific Instructions and Examples
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97014	Electrical stimulation	Unattended electrical stimulation includes muscle stimulation, low volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic, and unattended clinical application of TENS. RVU includes the use of disposable or reusable electrodes.
G0283	Electrical stimulation	Unattended electrical stimulation, to one or more areas for indications other than wound care, as part of a therapy plan of care.

B. Constant attendance modalities.

(1) Additional general instructions for constant attendance modality codes 97032 to 97039. The application of a constant attendance modality is to one or more areas. Where the CPT manual specifies a specific time frame, count only the actual treatment time, and do not count setup, preparation of the area, cleanup, or documentation time. For example, with ultrasound treatment for two areas, the shoulder and elbow, if total treatment time for both areas is less than 15 minutes, one unit of ultrasound is appropriate. All units billed require supporting documentation.

(2) Additional specific instructions for constant attendance modalities.

CPT Code	CPT Description	Specific Instructions and Examples
97032	Electrical stimulation	Electrical stimulation (manual) includes attended clinical application of TENS. RVU includes the use of disposable or reusable electrodes.
97033	Electric current	RVU includes the use of disposable or reusable electrodes.

C. Additional specific instructions for therapeutic procedure codes 97110 to 97546.

CPT Code	CPT Description	Specific Instructions and Examples
97110	Therapeutic exercises	Examples include, but are not limited to, any type of range of motion, stretching, or strengthening exercises; e.g., stabilization and closed kinetic chain exercises, passive range of motion, active and assistive range of motion, progressive resistive exercises, prolonged stretch, isokinetic, isotonic, or isometric strengthening exercises.
97112	Neuromuscular reeducation	Examples include, but are not limited to, facilitation techniques, NDT, Rood, Brunnstrom, PNF, and Feldenkrais.
97113	Aquatic therapy	This code applies to any water-based exercise program such as Hubbard Tank or pools.

- 97140 Manual therapy In addition to the services included in the CPT manual incorporated by reference in part 5221.0405, item B, this code also includes, but is not limited to: myofascial release, joint mobilization and manipulation, manual lymphatic drainage, manual traction, soft tissue mobilization and manipulation, trigger point therapy, acupressure, muscle stimulation - manual (nonelectrical), and transverse friction massage. This code is not paid when reported with any of the osteopathic manipulative treatment (OMT) (98925-98929) or chiropractic manipulative treatment (CMT) (98940- 98943) codes on the same regions(s)/body part on the same day. This code may be paid when reported with CMT or OMT codes only if used on a different region(s)/body part on the same day and must be accompanied by CPT modifier 59 which identifies a distinct procedural service.
- 97150 Group therapeutic Therapeutic procedure(s) for a group is used when two or more patients are present for the same type of service such as instruction in body mechanics training, or group exercises when participants are doing same type exercises, etc. There is no time definition for this code. Providers may charge only one unit, regardless of size of group, number of areas treated, or length of time involved.
- 97760 Orthotic training This code applies to fabrication, instruction in use, fitting, and care and precautions of the orthotic.
- 97530 Therapeutic activities This code is used for treatment promoting functional use of a muscle, muscle group, or body part. This code is not to be used for PROM, active assistive ROM, manual stretch, or manual therapy. Examples for use of code: A patient has had rotator cuff repair. When treatment incorporates functional motion of reaching to increase range of motion and strength, 97530 should be used. A patient has a herniated disc. When treatment incorporates instruction in body mechanics and positioning and simulated activities to improve functional performance, 97530 should be used.
- 97537 Community/ work Community/work reintegration training includes jobsite analysis.
- 97545 Work hardening/ conditioning Work hardening/conditioning units are for the initial two hours each visit. Codes 97545 and 97546 refer to services provided within a work hardening or work conditioning program described in part 5221.6600, subpart 2, item D.

97546 Work hardening/ conditioning Work hardening/conditioning additional units are for each additional hour each visit. Refers to time beyond initial two hours of work conditioning or work hardening.

D. Additional specific instructions and examples for other physical medicine activities.

CPT

CPT Code	CPT Description	Specific Instructions and Examples
97750	Physical performance	Physical performance test or measurement includes isokinetic strength testing, comprehensive muscle strength or joint range of motion testing, or functional capacity evaluations.

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; 20 SR 530; 20 SR 858; 25 SR 1142; 30 SR 291; 35 SR 227; 38 SR 306; 41 SR 385; 41 SR 1127; 44 SR 412*

Published Electronically: *December 17, 2019*

5221.4051 FEE ADJUSTMENTS FOR PHYSICAL MEDICINE AND REHABILITATION SERVICES.

Subpart 1. **Multiple procedure payment reduction.** For procedures identified in part 5221.4050, subpart 2d, with indicator 5 in column S, the rules in items A to D apply to establish the maximum fee according to the formula in part 5221.4020, subpart 1b.

A. When more than one unit or procedure with an indicator of 5 is provided to the same patient on the same day, full payment is made for the unit or procedure with the highest practice expense (PE) relative value unit (RVU).

B. For subsequent units and procedures furnished to the same patient on the same day, full payment is made for the work and malpractice expense RVUs and 50 percent payment is made for the PE RVU.

C. For therapy services furnished by a provider, a group practice, or incident to a provider's service, the reduction described in this part applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, such as physical therapy, occupational therapy, or speech-language pathology, and regardless of the type of provider or supplier.

D. For example, for illustrative purposes only; example does not reflect actual maximum fee:

	Unadjusted Maximum Fee, Procedure 1 Unit 1	Unadjusted Maximum Fee, Procedure 1 Unit 2	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
Work	\$7	\$7	\$11	\$25	No reduction
PE	\$10	\$10	\$8	\$19	$\$10 + (.50 \times \$10) + (.50 \times \$8)$
Mal- practice	\$1	\$1	\$1	\$3	No reduction
Total	\$18	\$18	\$20	\$47	$\$18 + (\$7 + \$1) + (.50 \times \$10) + (\$11 + \$1) + (.50 \times \$8)$

Subp. 2. **Electrical stimulation.** For purposes of the workers' compensation fee schedule, CPT code 97014, electrical stimulation therapy, is subject to the multiple procedure payment reduction provided in subpart 1. Indicator 9 in column S of the RVU table does not apply to CPT code 97014.

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; 20 SR 530; 25 SR 1142; 35 SR 227; 38 SR 306; 41 SR 385*

Published Electronically: *October 12, 2016*

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 72020 to 73660;

B. pathology and laboratory procedure codes 81000 and 81002;

C. physical medicine and rehabilitation procedure codes from 97010 to 97150 and 97530 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;

F. procedure code 99199 (special service); and

G. acupuncture codes 97810 to 97814.

Subp. 3. **Select chiropractic procedure code descriptions, instructions, and examples.** The following instructions and examples are in addition to CPT code descriptions found in the CPT manual. Additional instructions include both general instructions for a group of codes as well as specific instructions for an individual specific code.

A. Supervised modalities.

(1) Additional general instructions for supervised modality codes 97010 to 97028, and G0283. All supervised modalities refer to one or more areas. For example, if diathermy is applied to the cervical and low back on the same day, the charge would be one unit. If the diathermy and electrical stimulation are applied to the low back, the charge would be one unit of diathermy and one unit of electrical stimulation.

(2) Additional specific instructions for supervised modalities.

CPT

CPT Code	CPT Description	Specific Instructions and Examples
97014	Electrical stimulation	Unattended electrical stimulation includes muscle stimulation, low volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic, and unattended clinical application of TENS. RVU includes the use of disposable or reusable electrodes.
G0283	Electrical stimulation	Unattended electrical stimulation, to one or more areas for indications other than wound care, as part of a therapy plan of care.

B. Constant attendance modalities.

(1) Additional general instructions for constant attendance modality codes 97032 to 97039. The application of a constant attendance modality is to one or more areas. Where the CPT manual specifies a time frame, count only the actual treatment time, and do not count setup, preparation of the area, cleanup, or documentation time. For example, with ultrasound treatment for two areas, the shoulder and elbow, if total treatment time for both areas is less than 15 minutes, one unit of ultrasound is appropriate. All units billed require supporting documentation.

(2) Additional specific instructions for constant attendance modalities.

CPT

CPT Code	CPT Description	Specific Instructions and Examples
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97032	Electrical stimulation	Electrical stimulation (manual) includes attended clinical application of TENS. RVU includes the use of disposable or reusable electrodes.
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97033	Electric current	RVU includes the use of disposable or reusable electrodes.
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C. Additional specific instructions for therapeutic procedure codes 97110 to 97546.

CPT

CPT Code	CPT Description	Specific Instructions and Examples
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97110	Therapeutic exercises	Examples include, but are not limited to, any type of range of motion, stretching, or strengthening exercises; e.g., stabilization and closed kinetic chain exercises, passive range of motion, active and assistive range of motion, progressive resistive exercises, prolonged stretch, isokinetic, isotonic, or isometric strengthening exercises.
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97112	Neuromuscular reeducation	Examples include, but are not limited to, facilitation techniques, NDT, Rood, Brunnstrom, PNF, and Feldenkrais.
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97113	Aquatic therapy	This code applies to any water-based exercise program such as Hubbard Tank or pools.
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97140	Manual therapy	In addition to the services included in the CPT manual incorporated by reference in part 5221.0405, item B, this code also includes, but is not limited to: myofascial release, joint mobilization and manipulation, manual lymphatic drainage, manual traction, soft tissue mobilization and manipulation, trigger point therapy, acupressure, muscle stimulation - manual (nonelectrical), and transverse friction massage. This
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code is not paid when reported with any of the osteopathic manipulative treatment (OMT) (98925-98929) or chiropractic manipulative treatment (CMT) (98940-98943) codes on the same region(s)/body part on the same day. This code may be paid when reported with CMT or OMT codes only if used on a different region(s)/body part on the same day and must be accompanied by CPT modifier 59 which identifies a distinct procedural service.

97150	Group therapeutic	Therapeutic procedure(s) for a group is used when two or more patients are present for the same type of service such as instruction in body
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		mechanics training, or group exercises when participants are doing same type exercises, etc. There is no time definition for this code. Providers may charge only one unit, regardless of size of group, number of areas treated, or length of time involved.
97760	Orthotic training	This code applies to fabrication, instruction in use, fitting, and care and precautions of the orthotic.
97530	Therapeutic activities	This code is used for treatment promoting functional use of a muscle, muscle group, or body part. This code is not to be used for PROM, active assistive ROM, manual stretch, or manual therapy. Examples for use of code: A patient has had rotator cuff repair. When treatment incorporates functional motion of reaching to increase range of motion and strength, 97530 should be used. A patient has a herniated disc. When treatment incorporates instruction in body mechanics and positioning and simulated activities to improve functional performance, 97530 should be used.
97537	Community/ work	Community/work reintegration training includes jobsite analysis.
97545	Work hardening/ conditioning	Work hardening/conditioning units are for the initial two hours each visit. Codes 97545 and 97546 refer to services provided within a work hardening or work conditioning program described in part 5221.6600, subpart 2, item D.
97546	Work hardening/ conditioning	Work hardening/conditioning additional units are for each additional hour each visit. Refers to time beyond initial two hours of work conditioning or work hardening.

D. Additional specific instructions and examples for other physical medicine activities.

CPT

Code	CPT Description	Specific Instructions and Examples
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97750	Physical performance	Physical performance test or measurement includes isokinetic strength testing, comprehensive muscle strength or joint range of motion testing, or functional capacity evaluations.
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Subp. 4. Evaluation and management services coding and reporting.

A. Evaluation and management services may be coded and paid separately from the chiropractic manipulative therapy services described by CPT codes 98940 to 98943 only if the condition requires a significant, separately identifiable evaluation and management service above and beyond the usual preservice, intraservice, and postservice work associated with the manipulative

procedure, as described in subitems (1) to (3). When performing the evaluation and management service on the same day as a spinal or extraspinal manipulation, the evaluation and management code must be coded using the CPT modifier 25.

(1) Preservice work for CPT codes 98940 to 98943 includes the following:

- (a) documentation and chart review;
- (b) imaging review;
- (c) test interpretation and care planning; and

(d) premanipulation procedures which include a brief evaluation of the current problem, including components of a review of symptoms, and a focused exam of the current problem and related areas.

(2) Intraservice work for CPT codes 98940 to 98943 includes the following:

- (a) manipulation; and
- (b) postmanipulation assessment and procedures.

(3) Postservice work for CPT codes 98940 to 98943 includes the following:

(a) chart documentation, including documentation of appropriate subjective and objective assessments as well as the procedural components of patient visit; and

(b) if necessary, arrange for further services and coordination of patient care. This may include telephone or written communications with other health care providers, family members, employers, medical case manager for a managed care organization certified under Minnesota Statutes, section 176.1351, or insurers regarding the coordination of patient care or consultation services.

B. Circumstances in which a separate evaluation and management service is appropriate under item A include the following:

- (1) if there is a new injury;
- (2) if there is an exacerbation of a previous injury; or
- (3) if there is an unanticipated change in condition.

C. A reexamination in the following circumstances may be coded and paid as a separate evaluation and management service if the reexamination is above and beyond the usual preservice, intraservice, and postservice work associated with the manipulative procedure as described in item A, subitems (1) to (3):

- (1) in preparation for a requested report other than a report of work ability;
- (2) if requested to render an opinion about a job offer;
- (3) when a job search is initiated;

(4) to review the patient's condition after a period of treatment by another health care provider; or

(5) to evaluate the patient's condition in anticipation of a change in the treatment plan.

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; 20 SR 530; 22 SR 500; 25 SR 1142; 30 SR 291; 35 SR 227; 38 SR 306; 41 SR 385; 41 SR 1127; 44 SR 412*

Published Electronically: *December 17, 2019*

5221.4061 FEE ADJUSTMENTS FOR CHIROPRACTIC SERVICES.

Subpart 1. **Multiple procedure payment reduction.** For procedures identified in part 5221.4060, subpart 2d, with indicator 5 in column S, the rules in items A to D apply to establish the maximum fee according to the formula in part 5221.4020, subpart 1b.

A. When more than one unit or procedure with an indicator of 5 is provided to the same patient on the same day, full payment is made for the unit or procedure with the highest practice expense (PE) relative value unit (RVU).

B. For subsequent units and procedures furnished to the same patient on the same day, full payment is made for the work and malpractice expense RVUs and 50 percent payment is made for the PE RVU.

C. For therapy services furnished by a provider, a group practice, or incident to a provider's service, the reduction described in this part applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, such as physical therapy, occupational therapy, or speech-language pathology, and regardless of the type of provider or supplier.

D. For example, for illustrative purposes only; example does not reflect actual maximum fee:

	Unadjusted Maximum Fee, Procedure 1 Unit 1	Unadjusted Maximum Fee, Procedure 1 Unit 2	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
Work	\$7	\$7	\$11	\$25	No reduction
PE	\$10	\$10	\$8	\$19	\$10 + (.50 x \$10) + (.50 x \$8)

Mal-practice	\$1	\$1	\$1	\$3	No reduction
Total	\$18	\$18	\$20	\$47	$\$18 + (\$7 + \$1) + (.50 \times \$10) + (\$11 + \$1) + (.50 \times \$8)$

Subp. 1a. **Electrical stimulation.** For purposes of the workers' compensation fee schedule, CPT code 97014, electrical stimulation therapy, is subject to the multiple procedure payment reduction provided in subpart 1. Indicator 9 in column S of the RVU table does not apply to CPT code 97014.

Subp. 2. **Extraspinal code.** If the extraspinal code (98943) is used in conjunction with any of the spinal chiropractic manipulative treatment (CMT) codes (98940 to 98942) on the same day, the extraspinal code must be coded with CPT modifier 51. The CPT modifier 51 reduces the RVU of 98943 when used in conjunction with any of the CMT codes (98940 to 98942) on the same day by 50 percent.

Subp. 3. **Diagnostic imaging procedures.** For diagnostic imaging procedures with an indicator of 4 in column S, special rules for the technical component and professional component (PC) apply if the procedure is billed with another diagnostic imaging procedure with indicator 88 in column AB. If the procedure is furnished by the same provider, or different providers in the same group practice, to the same patient in the same session on the same day as another procedure with indicator 88, the procedures must be ranked according to the maximum fee for the technical component and professional component, 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 50 percent. The professional component with the highest maximum fee is paid at 100 percent, and the professional component of each subsequent procedure is paid at 95 percent. For example (for illustrative purposes):

	Unadjusted Maximum Fee, Procedure 1	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
PC	\$100	\$80	\$160	$\$176 (\$100 + (.95 \times \$80))$
TC	\$500	\$400	\$700	$\$700 (\$500 + (.50 \times \$400))$
Global	\$600	\$480	$\$860 (\$600 + (.75 \times \$80) + (.50 \times \$400))$	$\$876 (\$600 + (.95 \times \$80) + (.50 \times \$400))$

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; 25 SR 1142; 35 SR 227; 38 SR 306; 41 SR 385; 44 SR 412

Published Electronically: December 17, 2019

5221.4062 [Repealed, 35 SR 227]

Published Electronically: September 30, 2010

5221.4070 PHARMACY.

Subpart 1. **Substitution of generically equivalent drugs.** A generically equivalent drug must be dispensed according to Minnesota Statutes, section 151.21.

Subp. 1a. **Definitions.** The terms in this part have the following meanings.

2. A. "Community/outpatient pharmacy" has the meaning given in part 6800.0100, subpart 2.
- B. "Dispense" has the meaning given in Minnesota Statutes, section 151.01.
- C. "Drug" has the meaning given in Minnesota Statutes, section 151.01.
- D. "Hospital pharmacy" has the meaning given in Minnesota Rules, part 6800.0100, subpart 3.
- E. "Pharmacy" has the meaning given in Minnesota Statutes, section 151.01, and includes:
 - (1) community/outpatient pharmacies;
 - (2) hospital pharmacies; and
 - (3) persons or entities that the pharmacy has designated by contract or other means to act on its behalf to submit its charges to the workers' compensation payer.
- F. "Practitioner" has the meaning given in Minnesota Statutes, section 151.01, and includes persons or entities that the practitioner has designated by contract or other means to act on its behalf to submit its charges to the workers' compensation payer.
- G. "Usual and customary charge" has the meaning given in part 5221.0500, subparts 1, item B, and 2, item B, subitem (1).
- H. "Workers' compensation payer" or "payer" means any of the following entities:
 - (1) the workers' compensation insurer or self-insured employer liable for a claim under Minnesota Statutes, chapter 176;
 - (2) the special compensation fund liable for a claim under Minnesota Statutes, section 176.183, where the employer was uninsured at the time of the injury; or
 - (3) any other person or entity that the workers' compensation payer has designated by contract or other means to act on its behalf in paying drug charges, or determining the compensability or reasonableness and necessity of drug charges under Minnesota Statutes, chapter 176.

Subp. 2. Procedure code; usual and customary charge.

A. Providers must use the procedure codes in the National Drug Code Directory maintained and published by the federal Department of Health and Human Services, United States Food and Drug Administration. Procedure codes are not required for over-the-counter drugs.

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

Subp. 3. Maximum fee.

A. Except as provided in subparts 4 and 5 and Minnesota Statutes, section 176.136, subdivision 1b, the workers' compensation payer's liability for compensable prescription drugs dispensed for outpatient use by a hospital pharmacy, practitioner, or community/outpatient pharmacy shall be limited to the lower of:

(1) the sum of the average wholesale price (AWP) of the drug on the date the drug was dispensed, and a professional dispensing fee of \$5.14 per prescription filled; or

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

B. Except as provided in subparts 4 and 5 and Minnesota Statutes, section 176.136, subdivision 1b, the workers' compensation payer's liability for compensable over-the-counter drugs dispensed for outpatient use by a hospital pharmacy, practitioner, or community/outpatient pharmacy shall be, on the date the drug was dispensed, the lower of:

(1) the actual retail price of the drug; or

(2) the sum of the average wholesale price (AWP) of the drug and a professional dispensing fee of \$5.14 per prescription filled.

C. Except as provided in subpart 5, the workers' compensation payer's liability for compensable prescription drugs provided to an inpatient by a hospital is governed by Minnesota Statutes, sections 176.136, subdivision 1b, and 176.1362. The maximum fee for drugs dispensed for use at home, to an inpatient being discharged, is governed by item A or B, or subpart 4, as applicable.

Subp. 4. Maximum fee for electronic transactions.

A. The maximum fee specified in this item applies only if the requirements of item B or D are met. Except as provided in subpart 5, the workers' compensation payer's liability under items B and D for compensable drugs dispensed for outpatient use by a large hospital pharmacy, a practitioner, or a community/outpatient pharmacy shall be, on the date the drug was dispensed, the lower of:

(1) the average wholesale price (AWP) of the drug minus 12 percent, and a professional dispensing fee of \$3.65 per prescription filled;

(2) the maximum allowable cost of the drug according to Minnesota Statutes, section 256B.0625, subdivision 13e, as published by the commissioner of human services in the State Register, and a professional dispensing fee of \$3.65 per prescription filled; or

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

B. The maximum fee specified in item A applies if:

(1) the pharmacy or practitioner electronically requests authorization for payment of the drug from the workers' compensation payer, according to the referral certification and authorization standards that apply to outpatient pharmacies in the NCPDP Version D, Release 0 format, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61; and

(2) the workers' compensation payer, electronically and in real time, authorizes payment for the drug according to the referral certification and authorization standards in the NCPDP Version D, Release 0 format, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61.

C. If the workers' compensation payer authorizes payment of a drug claim under item B, subitem (2), the payer may not later deny or adjust payment of the claim that was specified in the transaction. If the payer does not authorize payment under item B, subitem (2), but later pays for the drug, the maximum fee specified in subpart 3 applies.

D. If the requirements in item B have not been met, the maximum fee specified in item A also applies if all of the following requirements are met:

(1) the pharmacy or practitioner requests electronic authorization according to the referral certification and authorization standards in the NCPDP Version D, Release 0 format, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61;

(2) a workers' compensation payer has given the pharmacy or practitioner 30 calendar days' notice that the payer is able to authorize payment for drugs according to the referral certification and authorization standards in subitem (1) and either of the following has occurred:

(a) the employee notified the pharmacy or practitioner at the time the drug was dispensed that the charges should be submitted to that workers' compensation payer; or

(b) the workers' compensation payer notified the pharmacy before the drug was dispensed that it had accepted liability for the employee's claim;

(3) the pharmacy or practitioner does not electronically request authorization for payment of the drug from the workers' compensation payer according to the referral certification and authorization standards in subitem (1); and

(4) the workers' compensation payer pays for the drug within 30 days after the pharmacy or practitioner submits charges to the payer according to the applicable requirements of part 5221.0700, subpart 2c.

E. The pharmacy or practitioner must transmit reversal transactions electronically for all drugs originally billed electronically to the payer that are not picked up for the employee. Upon receipt of a reversal transaction for a previously approved billing, the payer must be able to cancel the billing if it has not yet been paid or deduct the value of the reversed billing from the next payment to the pharmacy or practitioner if the claim has already been paid. The payer may only deduct the amount of the original payment for the drug. If there is no future payment anticipated, the pharmacy or practitioner must refund the amount to the payer.

Subp. 5. **Other contracts.** Subparts 3 and 4 do not apply where a contract between a pharmacy, practitioner, or network of pharmacies or practitioners, and a workers' compensation payer provides for a different reimbursement amount.

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

History: *18 SR 1472; 25 SR 1142; 30 SR 1053; 41 SR 1127*

Published Electronically: *March 24, 2017*

5221.6010 AUTHORITY.

Parts 5221.6010 to 5221.8900 are adopted under the authority of Minnesota Statutes, sections 176.83, subdivisions 1, 3, 4, and 5, and 176.103, subdivision 2.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

Published Electronically: *June 11, 2008*

5221.6020 PURPOSE AND APPLICATION.

Subpart 1. **Purpose.** Parts 5221.6010 to 5221.6600 establish parameters for reasonably required treatment of employees with compensable workers' compensation injuries to prevent excessive services under Minnesota Statutes, sections 176.135 and 176.136, subdivision 2. Parts 5221.6010 to 5221.6600 do not affect any determination of liability for an injury under Minnesota Statutes, chapter 176, and are not intended to expand or restrict a health care provider's scope of practice under any other statute.

Subp. 2. **Application.** All treatment must be medically necessary as defined in part 5221.6040, subpart 10. In the absence of a specific parameter, any applicable general parameters govern. A departure from a parameter that limits the duration or type of treatment may be appropriate in any one of the circumstances specified in part 5221.6050, subpart 8. Parts 5221.6010 to 5221.6600 apply to all treatment provided after January 4, 1995, regardless of the date of injury. All limitations on the duration of a specific treatment modality or type of modality begin with the first time the modality is initiated after January 4, 1995. However, consideration may be given to treatment

initiated under the emergency rules (parts 5221.6050 to 5221.6500 [Emergency]). Parts 5221.6010 to 5221.6600 do not apply to treatment of an injury after an insurer has denied liability for the injury. However, in such cases the rules do apply to treatment initiated after liability has been established. References to days and weeks in parts 5221.6050 to 5221.6600 mean calendar days and weeks unless specified otherwise.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

Published Electronically: *June 11, 2008*

5221.6030 INCORPORATION BY REFERENCE.

See part 5221.0405 for incorporation by reference of documents related to the International Classification of Diseases (ICD-9-CM and ICD-10-CM) diagnostic codes.

Statutory Authority: *MS s 14.386; 176.103; 176.135; 176.83*

History: *19 SR 1412; L 2002 c 277 s 32; 40 SR 328*

Published Electronically: *September 17, 2015*

5221.6040 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 5221.6010 to 5221.6600 have the meanings given them in this part.

Subp. 2. **Active treatment.** "Active treatment" means treatment specified in parts 5221.6200, subpart 4; 5221.6205, subpart 4; 5221.6210, subpart 4; 5221.6300, subpart 4; and 5221.6305, subpart 2, item C, which requires active patient participation in a therapeutic program to increase flexibility, strength, endurance, or awareness of proper body mechanics.

Subp. 3. **Chronic pain syndrome.** "Chronic pain syndrome" means any set of verbal or nonverbal behaviors that:

- A. involve the complaint of enduring pain;
- B. differ significantly from the patient's preinjury behavior;
- C. have not responded to previous appropriate treatment;
- D. are not consistent with a known organic syndrome which has remained untreated; and
- E. interfere with physical, psychological, social, or vocational functioning.

Subp. 4. **Condition.** A patient's "condition" means the symptoms, physical signs, clinical findings, and functional status that characterize the complaint, illness, or injury related to a current claim for compensation.

Subp. 5. **Emergency treatment.** "Emergency treatment" means treatment that is:

A. required for the immediate diagnosis and treatment of a medical condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death; or

B. immediately necessary to alleviate severe pain.

Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency but that is necessary to determine whether an emergency exists.

Subp. 6. **Etiology.** "Etiology" means the anatomic alteration, physiologic dysfunction, or other biological or psychological abnormality which is considered a cause of the patient's condition.

Subp. 7. **Functional status.** "Functional status" means the ability of an individual to engage in activities of daily living and other social, recreational, and vocational activities.

Subp. 7a. **Illegal substance.** "Illegal substance" means a drug or other substance that is illegal under state or federal controlled substances law, but does not include a patient's use of medical cannabis permitted under Minnesota Statutes, sections 152.22 to 152.37.

Subp. 8. **Initial nonsurgical management or treatment.** "Initial nonsurgical management or treatment" is initial treatment provided after an injury that includes passive treatment, active treatment, injections, and durable medical equipment under parts 5221.6200, subparts 3, 4, 5, and 8; 5221.6205, subparts 3, 4, 5, and 8; 5221.6210, subparts 3, 4, 5, and 8; 5221.6300, subparts 3, 4, 5, and 8; and 5221.6305, subpart 2. Scheduled and nonscheduled medication may be a part of initial nonsurgical treatment. Initial nonsurgical management does not include surgery or chronic management modalities under part 5221.6600.

Subp. 8a. **Intractable pain.** "Intractable pain" is as defined in Minnesota Statutes, section 152.125.

Subp. 8b. **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.

Subp. 9. **Medical imaging procedures.** A "medical imaging procedure" is a technique, process, or technology used to create a visual image of the body or its function. Medical imaging includes, but is not limited to: X-rays, tomography, angiography, venography, myelography, computed tomography (CT) scanning, magnetic resonance imaging (MRI) scanning, ultrasound imaging, nuclear isotope imaging, PET scanning, and thermography.

Subp. 10. **Medically necessary treatment.** "Medically necessary treatment" means those health services for a compensable injury that are reasonable and necessary for the diagnosis and cure or significant relief of a condition consistent with any applicable treatment parameter in parts 5221.6050 to 5221.6600. Where parts 5221.6050 to 5221.6600 do not govern, the treatment must be reasonable and necessary for the diagnosis or cure and significant relief of a condition consistent with the current accepted standards of practice within the scope of the provider's license or certification.

Subp. 10a. **Modality.** A "modality" is the application or use of a therapeutic agent or regimen. Examples include the active treatment modalities described in subpart 2, the passive treatment modalities described in subpart 12, and the injection modalities described in subpart 13.

Subp. 10b. **Morphine-equivalent milligrams.** For purposes of part 5221.6110, subpart 8, morphine-equivalent milligrams shall be determined using the following conversions. Morphine 30 milligrams orally is equivalent to:

- A. codeine 200 milligrams oral;
- B. fentanyl transdermal 12.5 mcg/hr;
- C. hydrocodone 30 milligrams oral;
- D. hydromorphone 7.5 milligrams oral;
- E. levorphanol 4 milligrams oral;
- F. oxycodone 20 milligrams oral; and
- G. oxymorphone 10 milligrams oral.

Subp. 11. **Neurologic deficit.** "Neurologic deficit" means a loss of function secondary to involvement of the central or peripheral nervous system. This may include, but is not limited to, motor loss; spasticity; loss of reflex; radicular or anatomic sensory loss; loss of bowel, bladder, or erectile function; impairment of special senses, including vision, hearing, taste, or smell; or deficits in cognitive or memory function.

A. "Static neurologic deficit" means any neurologic deficit that has remained the same by history or noted by repeated examination since onset.

B. "Progressive neurologic deficit" means any neurologic deficit that has become worse by history or noted by repeated examination since onset.

Subp. 11a. **Pain medicine specialist.** A "pain medicine specialist" is a health care provider with at least five years of experience in the assessment and treatment of chronic complex pain problems for more than one patient; or who has completed fellowship training in pain management.

Subp. 12. **Passive treatment.** "Passive treatment" is any treatment modality specified in parts 5221.6200, subpart 3; 5221.6205, subpart 3; 5221.6210, subpart 3; 5221.6300, subpart 3; and 5221.6305, subpart 2, item B. Passive treatment modalities include bedrest; thermal treatment; traction; acupuncture; electrical muscle stimulation; braces; manual and mechanical therapy; massage; and adjustments.

Subp. 13. **Therapeutic injection.** "Therapeutic injection" is any injection modality specified in parts 5221.6200, subpart 5; 5221.6205, subpart 5; 5221.6210, subpart 5; 5221.6300, subpart 5; and 5221.6305, subpart 2, item A. Therapeutic injections include trigger point injections, sacroiliac injections, facet joint injections, facet nerve blocks, nerve root blocks, epidural injections, soft tissue injections, peripheral nerve blocks, injections for peripheral nerve entrapment, and sympathetic blocks.

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**5221.6050 GENERAL TREATMENT PARAMETERS; EXCESSIVE TREATMENT;
PRIOR NOTIFICATION.**

Subpart 1. **General.**

A. All treatment must be medically necessary treatment, as defined in part 5221.6040, subpart 10. The health care provider must evaluate the medical necessity of all treatment under item B on an ongoing basis.

Parts 5221.6050 to 5221.6600 do not require or permit any more frequent examinations than would normally be required for the condition being treated, but do require ongoing evaluation of the patient that is medically necessary, consistent with accepted medical practice.

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):

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

(2) the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

(3) the employee's functional status, especially vocational activities, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

Except as otherwise provided under parts 5221.6200, subpart 3, item B; 5221.6205, subpart 3, item B; 5221.6210, subpart 3, item B; and 5221.6300, subpart 3, item B, if there is not progressive improvement in at least two of subitems (1) to (3), the modality must be discontinued or significantly modified, or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional directly providing the treatment, but remains the ultimate responsibility of the treating health care provider who ordered the treatment.

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

Subp. 2. **Documentation.** A health care provider must maintain an appropriate record, as defined in part 5221.0100, subpart 1a, of any treatment provided to a patient.

Subp. 3. **Nonoperative treatment.** Health care providers shall provide a trial of nonoperative treatment before offering or performing surgical treatment unless the treatment for the condition requires immediate surgery, unless an emergency situation exists, or unless the accepted standard of initial treatment for the condition is surgery.

Subp. 4. **Chemical dependency.** The health care provider shall maintain diligence to detect incipient or actual chemical dependency to any medication prescribed for treatment of the employee's condition. In cases of incipient or actual dependency, the health care provider shall refer the employee for appropriate evaluation and treatment of the dependency.

Subp. 5. **Referrals between health care providers.** The primary health care provider directing the course of treatment shall make timely and appropriate referrals for consultation for opinion or for the transfer of care if the primary health care provider does not have any reasonable alternative treatment to offer and there is a reasonable likelihood that the consultant may offer or recommend a reasonable alternative treatment plan. This subpart does not prohibit a referral for consultation in other circumstances based on accepted medical practice and the patient's condition.

A. Referrals from consulting health care provider. If the consultant has reasonable belief that another consultation is appropriate, that consultant must coordinate further referral with the original treating health care provider unless the consultant has been approved as the employee's treating health care provider. The consultant is under no obligation to provide or recommend treatment or further referral, if in the consultant's opinion, all reasonable and necessary treatment has been rendered. The consultant shall in this situation refer the employee back to the original treating health care provider for further follow-up.

B. Information sent to consultant. When a referring health care provider arranges for consultation or transfer of care, except in cases of emergency, the referring health care provider shall, with patient authorization, summarize for the consultant orally or in writing the conditions of injury, the working diagnosis, the treatment to date, the patient's response to treatment, all relevant laboratory and medical imaging studies, return to work considerations, and any other information relevant to the consultation. In addition, the referring health care provider shall make available to the consultant, with patient authorization, a copy of all medical records relevant to the employee's injury.

Subp. 6. **Communication between health care providers and consideration of prior care.**

A. Information requested by new health care provider. Upon accepting for treatment a patient with a workers' compensation injury, the health care provider shall ask the patient if treatment has been previously given for the injury by another health care provider. If the patient reports that treatment has been previously given for the injury by another health care provider and if the medical records for the injury have not been transferred, the new health care provider shall request authorization from the employee for relevant medical records. Upon receipt of the employee authorization, the new health care provider shall request relevant medical records from the previous

health care providers. Upon receipt of the request for medical records and employee authorization, the previous health care providers shall provide the records within seven working days.

B. Treatment by prior health care provider. If the employee has reported that care for an injury has been previously given:

(1) Where a previous health care provider has performed diagnostic imaging, a health care provider may not repeat the imaging or perform alternate diagnostic imaging for the same condition except as permitted in part 5221.6100.

(2) When a therapeutic modality employed by a health care provider was no longer improving the employee's condition under subpart 1, item B, or has been used for the maximum duration allowed under parts 5221.6050 to 5221.6600, another health care provider may not employ the same modality at any time thereafter to treat the same injury except if one of the departures applies under subpart 8, after surgery, or for treatment of reflex sympathetic dystrophy under part 5221.6305.

(3) It is also inappropriate for two health care providers to use the same treatment modality concurrently.

C. Employee refusal. An employee's refusal to provide authorization for release of medical records does not justify repeat treatment or diagnostic testing. An insurer is not liable for repeat diagnostic testing or other duplicative treatment prohibited by this subpart.

Subp. 7. Determinations of excessive treatment; notice of denial to health care providers and employee; expedited processing of medical requests.

A. In addition to services deemed excessive under part 5221.0500 and Minnesota Statutes, section 176.136, subdivision 2, treatment is excessive if:

(1) the treatment is inconsistent with an applicable parameter or other rule in parts 5221.6050 to 5221.6600; or

(2) the treatment is consistent with the parameters in parts 5221.6050 to 5221.6600, but is not medically necessary treatment.

B. If the insurer denies payment for treatment that departs from a parameter under parts 5221.6050 to 5221.6600, the insurer must provide the employee and health care provider with written notice of the reason for the denial and that the treatment rules permit departure from the parameters in specified circumstances. If the insurer denies authorization for proposed treatment after prior notification has been given under subpart 9, the insurer must provide the employee and health care provider in writing with notice of the reason why the information given by the health care provider does not support the proposed treatment and notice of the right to review of the denial under subpart 9, item C. The insurer may not deny payment for a program of chronic management that the insurer has previously authorized for an employee, either in writing or by routine payment for services, without providing the employee and the employee's health care provider with at least 30 days' notice of intent to apply any of the chronic management parameters in part 5221.6600 to

future treatment. The notice must include the specific parameters that will be applied in future determinations of compensability by the insurer.

C. If the insurer denies authorization or payment for treatment governed by parts 5221.6050 to 5221.6600, the health care provider or the employee may request a determination from the commissioner or compensation judge by filing a medical request or petition under chapter 5220 and Minnesota Statutes, sections 176.106 and 176.305. The medical request may not be filed before completion of the managed care plan's dispute resolution process, if applicable. If the health care provider has notified the insurer of proposed treatment requiring prior notification under subpart 9, the health care provider or employee must describe or attach a copy of the notification, and any response from the insurer, to the medical request filed with the department. The insurer may, but is not required to, file a medical response where the insurer's response to prior notification under subpart 9 has been attached to the medical request. If the insurer elects to file a medical response in such cases, it must be received within ten working days of the date the medical request was filed with the department. The commissioner or compensation judge may issue a decision based on written submissions no earlier than ten working days after receipt of the medical request, unless a medical response has been filed sooner.

D. A determination of the compensability of medical treatment under Minnesota Statutes, chapter 176, must include consideration of the following factors:

(1) whether a treatment parameter or other rule in parts 5221.6050 to 5221.6600 applies to the etiology or diagnosis for the condition;

(2) if a specific or general parameter applies, whether the treatment is consistent with the treatment parameter and whether the treatment was medically necessary as defined in part 5221.6040, subpart 10; and

(3) whether a departure from the applicable parameter is or was necessary because of any of the factors in subpart 8.

Subp. 8. **Departures from parameters.** A departure from a parameter that limits the duration or type of treatment in parts 5221.6050 to 5221.6600 may be appropriate in any one of the circumstances specified in items A to E. The health care provider must provide prior notification of the departure as required by subpart 9.

A. Where there is a documented medical complication.

B. Where previous treatment did not meet the accepted standard of practice and the requirements of parts 5221.6050 to 5221.6600 for the health care provider who ordered the treatment.

C. Where the treatment is necessary to assist the employee in the initial return to work where the employee's work activities place stress on the part of the body affected by the work injury. The health care provider must document in the medical record the specific work activities that place stress on the affected body part, the details of the treatment plan and treatment delivered on each visit, the employee's response to the treatment, and efforts to promote employee independence in the employee's own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

D. Where the treatment continues to meet two of the following three criteria, as documented in the medical record:

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

(2) the employee's objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

(3) the employee's functional status, especially vocational activity, is objectively improving as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

E. Where there is an incapacitating exacerbation of the employee's condition. However, additional treatment for the incapacitating exacerbation may not exceed, and must comply with, the parameters in parts 5221.6050 to 5221.6600.

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.

A. The health care provider must notify the insurer of proposed treatment in subitems (1) to (4) at least seven working days before the treatment is initiated, except as otherwise provided in subitem (4):

(1) for chronic management modalities where prior notification is required under part 5221.6600;

(2) for durable medical equipment requiring prior notification in parts 5221.6200, subpart 8; 5221.6205, subpart 8; 5221.6210, subpart 8; and 5221.6300, subpart 8;

(3) for any nonemergency inpatient hospitalization or nonemergency inpatient surgery. A surgery or hospitalization is considered inpatient if the patient spends at least one night in the facility; and

(4) for treatment that departs from a parameter limiting the duration or type of treatment in parts 5221.6050 to 5221.6600. The health care provider must notify the insurer within two business days after initiation of treatment if the departure from a parameter is for an incapacitating exacerbation or an emergency.

B. The health care provider's prior notification required by item A may be made orally, or in writing, and shall provide the following information, when relevant:

(1) the diagnosis;

(2) when giving prior notification for chronic management modalities, durable medical equipment, or inpatient hospitalization or surgery required by item A, subitems (1) to (3), whether the proposed treatment is consistent with the applicable treatment parameter; and

(3) when giving prior notification for treatment that departs from a treatment parameter, or notification of treatment for an incapacitating exacerbation or emergency, the basis for departure from any applicable treatment parameter specified in subpart 8; the treatment plan, including the nature and anticipated length of the proposed treatment; and the anticipated effect of treatment on the employee's condition.

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).

(1) If the health care provider does not receive a response from the insurer within the seven working days, authorization is deemed to have been given.

(2) If the insurer authorizes the treatment, the insurer may not later deny payment for the treatment authorized.

(3) If the insurer denies authorization, the health care provider or employee may orally or in writing request that the insurer review its denial of authorization.

The insurer's review of its denial must be made by a currently licensed registered nurse, medical doctor, doctor of osteopathic medicine, doctor of chiropractic, or a person credentialed by a program approved by the commissioner of Labor and Industry. The insurer may also delegate the review to a certified managed care plan under subpart 10. In lieu of or in addition to the insurer's review under this subitem, the insurer may request an examination of the employee under subitem (4), (5), or (6) and the requirements of those subitems apply to the proposed treatment. Unless an examination of the employee is requested under subitem (4), (5), or (6), the insurer's determination following review must be communicated orally or in writing to the requester within seven working days of receipt of the request for review.

Instead of requesting a review, or if the insurer maintains its denial after the review, the health care provider or the employee may file with the commissioner a medical request or a petition for authorization of the treatment under subpart 7, item C, or except as specified in subitem (4), (5), or (6), may proceed with the proposed treatment subject to a later determination of compensability by the commissioner or compensation judge.

(4) If the insurer requests an examination of the employee by the employer's physician, the health care provider may elect to provide the treatment subject to a determination of

compensability by the commissioner or compensation judge under subpart 7, item B. However, the health care provider may not provide nonemergency surgery where the insurer has requested an examination for surgery except as provided in subitems (5) and (6), and may not provide continued passive care modalities where prior approval by the insurer, commissioner, or compensation judge is required under parts 5221.6200, subpart 3, item B, subitem (2); 5221.6205, subpart 3, item B, subitem (2); 5221.6210, subpart 3, item B, subitem (2); and 5221.6300, subpart 3, item B, subitem (2).

(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.

(6) In any case where prior notification of proposed surgery is required, the insurer may elect to obtain an examination of the employee by the employer's physician under Minnesota Statutes, section 176.155, sometimes referred to as an "independent medical examination." If the insurer notifies the employee and health care provider of the examination within seven working days of the provider's notification, the proposed nonemergency surgery may not be provided pending the examination. However, after 45 days following the insurer's request for an examination, the health care provider may elect to proceed with the surgery, subject to a determination of compensability by the commissioner or compensation judge under subpart 7.

(7) The insurer's request for additional information must be directed to the requesting health care provider and must specify the additional information required that is necessary to respond to the health care provider's notification of proposed treatment. The proposed treatment may not be given until the provider provides reasonable additional information. Once the additional information has been received, the insurer must respond within seven working days according to subitems (1) to (6).

Subp. 10. Certified managed care plans. The insurer may delegate responsibility for the notices required in subpart 7, item B, and the response to prior notification under subpart 9, to the certified managed care plan with which the insurer has contracted to manage the employee's medical treatment under Minnesota Statutes, section 176.135, subdivision 1f. Alternatively, the managed care plan may act as an intermediary between the treating health care provider and the insurer. In either case, the notices and time periods in subparts 7, 8, and 9 also apply to the managed care plan. Where the insurer has delegated responsibility to the managed care plan, the insurer may not later deny treatment authorized by the plan.

Subp. 11. **Outcome studies.** The commissioner shall perform outcome studies on the treatment modalities in parts 5221.6200 to 5221.6600. The modalities to be studied shall be selected in consultation with the Workers' Compensation Medical Services Review Board. The commissioner may require health care providers who use these modalities to prospectively gather and report outcome information on patients treated, with necessary consent of the employee. The health care providers shall report the outcome information on the modalities in parts 5221.6200 to 5221.6600 on a form prescribed by the commissioner, which may include:

- A. the name of the health care provider;
- B. the name of the patient, date of injury, date of birth, gender, and, with patient permission, level of education and social security number;
- C. the name of the workers' compensation insurer and managed care plan, if any;
- D. the pretreatment and posttreatment employment status;
- E. the nature of treatment given before and after the treatment being studied for the same condition;
- F. the diagnosis, symptoms, physical findings, and functional status before and after the treatment being studied for the same condition; and
- G. the presence or absence of preexisting or concurrent conditions.

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5221.6100 PARAMETERS FOR MEDICAL IMAGING.

Subpart 1. **General principles.** All medical imaging must comply with items A to E. Except for emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition, before ordering any imaging study.

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

B. **Appropriate imaging.** Imaging solely to rule out a diagnosis not seriously being considered as the etiology of the patient's condition is not indicated.

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

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

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

E. Alternative imaging.

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

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

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

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.

A. Computed tomography (CT) 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; or
- (3) when bony lesion is suspected on the basis of other tests or imaging procedures.

Except as specified in subitems (1) to (3), CT scanning is not indicated in the first eight weeks after an injury.

Computed tomography 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.

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:

(1) all of the following are present:

(a) back pain is the predominant complaint;

(b) the patient has failed to improve with initial nonsurgical management;

(c) other imaging has not established a diagnosis; and

(d) lumbar fusion surgery is being considered as a therapy; or

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

H. Computed tomography discography is indicated when:

(1) sciatica is the predominant complaint and lateral disc herniation is suspected; or

(2) if appropriately performed discography is equivocal or paradoxical, with a normal X-ray pattern but a positive pain response, and an annular tear or intra-annular injection is suspected.

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

J. Thermography is not indicated for the diagnosis of any of the clinical categories of low back conditions in part 5221.6200, subpart 1, item A.

K. Anterior-posterior (AP) and lateral X-rays of the lumbosacral spine are limited by subitems (1) and (2).

(1) They are indicated in the following circumstances:

(a) when there is a history of significant acute trauma as the precipitating event of the patient's condition, and fracture, dislocation, or fracture dislocation is suspected;

(b) when the history, signs, symptoms, or laboratory studies indicate possible tumor, infection, or inflammatory lesion;

(c) for postoperative follow-up of lumbar fusion surgery;

(d) when the patient is more than 50 years of age;

(e) before beginning a course of treatment with spinal adjustment or manipulation;

or

(f) eight weeks after an injury 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.

(2) They are not indicated in the following circumstances:

(a) to verify progress during initial nonsurgical treatment; or

(b) to evaluate a successful initial nonsurgical treatment program.

L. Oblique X-rays of the lumbosacral spine are limited by subitems (1) and (2).

(1) They are indicated in the following circumstances:

(a) to follow up abnormalities detected on anterior-posterior or lateral X-ray;

(b) for postoperative follow-up of lumbar fusion surgery; or

(c) to follow up spondylolysis or spondylolisthesis not adequately diagnosed by other indicated imaging procedures.

(2) They are not indicated as part of a package of X-rays including anterior-posterior and lateral X-rays of the lumbosacral spine.

M. Electronic X-ray analysis of plain radiographs and diagnostic ultrasound of the lumbar spine are not indicated for diagnosis of any of the low back conditions in part 5221.6200, subpart 1, item A.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412; 35 SR 138*

Published Electronically: *August 16, 2010*

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

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

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 NSAIDs 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 NSAIDs 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. NSAIDs are indicated only for the shortest duration needed as determined by the prescribing health care provider.

(1) NSAIDs 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) NSAIDs 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) NSAIDs 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) Continued prescription of oral opioid analgesics for more than 12 weeks may be for more than one month of medication and must comply with all of the requirements of part 5221.6110.

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) Metaxalone 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; 40 SR 5*

Published Electronically: *July 16, 2015*

5221.6110 LONG-TERM TREATMENT WITH OPIOID ANALGESIC MEDICATION.

Subpart 1. **Application.** This part applies to the use of oral, oral transmucosal, buccal, and transdermal opioid analgesic medications and does not apply to the use of parenteral or intrathecal opioid analgesic medications. The choice of specific opioid analgesic medication is governed by part 5221.6105, subpart 3. For purposes of this part, "long-term treatment with opioid analgesic medication" means that:

A. a health care provider documents a plan to initiate treatment for intractable pain by prescribing opioid analgesic medication to be taken daily for at least 90 days; or

B. a health care provider continues prescribing opioid analgesic medication for a patient who has been prescribed opioid analgesic medication to be taken daily for at least 90 days.

Subp. 2. **Indications and documentation.** Long-term treatment with opioid analgesic medication is not indicated for treatment of workers' compensation injuries unless the requirements in this part are met. The prescribing health care provider must document in the medical record the patient selection criteria, the assessments performed, whether there are any potential contraindications to the long-term prescription of opioid analgesics, the elements of the treatment program, the written treatment contract, an objective assessment of the success of the treatment program, and the results of periodic monitoring and testing.

Subp. 3. **Pain and function assessment tools.** When a health care provider initiates a plan for long-term treatment with opioid analgesic medication, the provider must assess the patient's level of pain and function using the following tools:

A. a tool validated in peer-reviewed scientific literature for the assessment of pain. Examples are the Brief Pain Inventory, the Chronic Pain Grade, the Neuropathic Pain Scale, the Visual Analog Scale, the Numeric Rating Scale, or the Verbal Descriptive Scales; and

B. a tool validated in peer-reviewed scientific literature for the assessment of function. Examples are the SF-36 Health Survey, the QuickDASH Outcome Measure, the Quality of Life (QOL) Scale, the Oswestry Disability Index, the Neck Disability Index, or the Short Musculoskeletal Function Assessment.

The results of these assessments provide the baseline for determining the success of the treatment program as specified in subpart 8, item B.

Subp. 4. **Patient selection criteria.** Before initiating a plan for long-term treatment with opioid analgesic medication, the prescribing health care provider must determine that all of the following criteria are met:

A. the patient cannot maintain function at work, or in the activities of daily living, without long-term use of opioid analgesic medication;

B. the patient does not have a Somatic Symptom Disorder as defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5);

C. all other reasonable medical treatment options have been exhausted as determined by either a pain medicine specialist or a health care provider specializing in the treatment of the area, system, or organ of the body identified as the source of the pain;

D. the patient does not have a history of failing to comply with treatment or failing to take medication as prescribed;

E. the patient does not have a current Substance Use Disorder as defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5); and

F. a qualitative urine drug test confirms that the patient is not using any illegal substances.

Subp. 5. **Potential contraindications.** Items A and B apply to potential contraindications.

A. Before beginning long-term treatment with opioid analgesic medication, the prescribing health care provider must assess whether any of the following circumstances are present and, if present, whether they constitute contraindications to the long-term treatment with opioid analgesic medication:

(1) the patient has a history of respiratory depression, or a condition that can cause respiratory depression when taking opioid analgesic medications;

(2) the patient is pregnant or is planning to become pregnant during the period of treatment with opioid analgesic medications;

(3) the patient has a Substance Use Disorder in remission as defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5);

(4) the patient has another mental disorder referenced in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5);

(5) the patient is a suicide risk;

(6) the patient has poor impulse control; and

(7) the patient regularly engages in an activity that could be unsafe for a patient taking opioid analgesic medications.

B. The prescribing health care provider may obtain an appropriate specialty consultation to assist with the assessments in this subpart or determine if the long-term prescription of opioid analgesic medication is appropriate.

Subp. 6. Opioid risk assessment; program of treatment.

A. Long-term treatment with opioid analgesic medication must be part of an integrated program of treatment that complies with this subpart and that is documented in the medical record.

B. The health care provider must complete an opioid risk assessment using a tool validated in the peer-reviewed scientific literature. Examples of this type of assessment tool are the Opioid Risk Tool; the Diagnosis, Intractability, Risk, Efficacy Scale (DIRE); and the Screener and Opioid Assessment for Patients with Pain - Revised (SOAPP-R). The provider must disclose the results of the assessment to the patient.

(1) If the assessment shows the patient to be at high risk of dependence or abuse, the provider must refer the patient to a pain medicine specialist or addiction medicine specialist for a second opinion before initiating long-term treatment with opioid analgesic medication.

(2) Following the second opinion, if long-term treatment with opioid analgesic medication is initiated in a patient at high risk, the prescribing provider must:

(a) perform urine drug testing at least twice a year;

(b) review the patient's prescription history in the Minnesota prescription monitoring program at each visit; and

(c) see the patient in clinic for follow-up every month for the first six months of treatment and every three months thereafter.

C. The patient and the prescribing health care provider must sign a formal written treatment contract that meets the requirements of subpart 7.

D. All opioid analgesic medications must be used in fixed schedules of dosing and prescribed in an amount sufficient to preclude exhaustion of a prescription on a weekend, holiday, or vacation day when the prescribing health care provider is not available.

E. Other treatment modalities are permitted in conjunction with long-term treatment with opioid analgesic medication, to the extent indicated by parts 5221.6010 to 5221.6600.

F. The prescribing health care provider must have a written plan for treatment of episodic pain due to the injury being treated, specifying the modality or medication to be used, the frequency and scheduling of the modality or dosing of medication, the duration of use, the circumstances for contacting the prescribing health care provider, and treatment of possible side effects of the medications.

G. All prescriptions for long-term treatment with opioid analgesic medication must be written only by the prescribing health care provider or the designated proxy. The patient must agree to inform the prescribing health care provider if short-term treatment with opioid analgesic

medications or other controlled drugs is prescribed by other health care providers in the treatment of acute injuries or conditions so that overall care can be properly coordinated. Examples of acute medical problems are dental procedures, acute trauma, surgery, or emergency medical treatment. The patient must also agree to inform the prescribing health care provider of any use of medical cannabis permitted under Minnesota Statutes, sections 152.22 to 152.37.

H. The prescribing health care provider must discuss with the patient the risks associated with the long-term treatment with opioid analgesic medication, the specific medications to be used, and possible side effects.

I. All medications and other treatment modalities for the work-related injury must be prescribed or provided on referral by the single health care provider party to the written treatment contract or by a proxy designated in the medical record by the health care provider party to the written treatment contract.

J. The prescribing health care provider must document in the medical record the name of the drug prescribed, the dose, the dosing schedule, the amount to be dispensed, and the number of refills allowed, if any, for each opioid analgesic prescribed.

K. The prescribing health care provider must establish a schedule of follow-up visits for monitoring the treatment.

L. The prescribing health care provider must provide written reports of work ability or restrictions as required by part 5221.0410, subpart 6.

M. If long-term treatment with opioid analgesic medication is discontinued, the prescribing health care provider must prescribe a schedule of tapering dosages and ancillary medications as needed to minimize symptoms of withdrawal, taking into account the type, dose, and duration of the opioid medication being discontinued. The health care provider must offer alternative pain management treatment or referral to another provider.

Subp. 7. **Written treatment contract.** A patient receiving long-term treatment with opioid analgesic medication must enter into a written treatment contract with the prescribing health care provider as part of the integrated program of treatment. The written contract must be made part of the patient's medical record. A copy of the contract must be provided to the patient. Except when discontinuance is required by subpart 8, items E and F, the prescribing health care provider has discretion to discontinue treatment with opioid analgesic medication if the provider believes that the patient has not complied with the terms of the contract. Discontinuance must be according to a tapering schedule as described in subpart 6, item M. The contract must include the following:

A. the goals of long-term treatment with opioid analgesic medication; the program of treatment identified in subpart 6, items D, G, H, I, K, L, and M; and the monitoring described in subpart 8, items E, F, and G;

B. an agreement by the patient to comply with treatment prescribed in addition to the opioid analgesic medication;

C. an agreement by the patient that only one replacement refill or prescription is permitted in the event of lost or stolen medication or prescription, but only the first time the patient alleges that the prescription or medication was lost or stolen and only at the discretion of the prescribing health care provider;

D. an agreement by the patient that prescriptions or medications will not be renewed earlier than scheduled;

E. an agreement by the patient to notify all other health care providers of the treatment contract and its stipulations before receiving any prescription medications and to notify the prescribing health care provider party to the contract of medications received from other health care providers;

F. an agreement by the prescribing health care provider that arrangements must be made ahead of time to renew prescriptions when the prescribing health care provider is on vacation or otherwise unavailable;

G. an agreement by the prescribing health care provider to be available or provide coverage for episodic pain not responsive to planned interventions;

H. a statement that, except for the required discontinuance provided in subpart 8, items E and F, the prescribing health care provider has discretion to discontinue treatment with opioid analgesics using a schedule of tapering dosages if the patient does not comply with any of the agreements set out in the written treatment contract; and that if opioid analgesics are discontinued the provider must offer alternative pain management treatment or referral to another provider;

I. an agreement by the patient to:

(1) follow a schedule of regular visits recommended by the prescribing health care provider and take the opioid medication exactly as prescribed;

(2) abstain from all illegal substances;

(3) cooperate with the assessments and urine drug testing requested by the prescribing health care provider;

(4) allow the prescribing health care provider to access the prescription monitoring program and contact any other health care provider who treats or has treated the patient to discuss the patient's use of opioid medication; and

(5) cooperate with referrals to other providers, as requested by the prescribing health care provider; and

J. the dated signatures of the patient and prescribing health care provider.

The commissioner shall develop a form for a model written contract addressing items A to J. If a prescribing health care provider uses the commissioner's form, then the contract shall be deemed to meet the requirements of this subpart once completed and made part of the patient's medical

record. The patient and prescribing health care provider must enter into a new written contract whenever it is deemed necessary by the prescribing health care provider.

Subp. 8. **Monitoring long-term treatment with opioid analgesic medications.** The prescribing health care provider who is party to the treatment contract must monitor treatment that includes long-term prescription of opioid analgesic medications. The prescribing health care provider must document the monitoring in the medical record. Monitoring must include everything in items A to G.

A. The prescribing health care provider must schedule regular follow-up visits with the patient. Visits must be at least quarterly in the first year of treatment and no less than annually thereafter, except for patients taking more than 120 morphine-equivalent milligrams per day who must be seen at least every three months, and except for patients at high risk of dependency or abuse under subpart 6, item B, who must be seen every month for the first six months and every three months thereafter.

B. At each follow-up visit, the prescribing health care provider must assess the success of the program treatment in meeting its goals. The prescribing health care provider must assess pain and function at each follow-up visit, using the same tools chosen for the initial assessment in subpart 3. The program is considered successful if there is improvement in both pain and function within six months after long-term treatment with opioid analgesic medication is initiated, and this improvement is at least maintained at subsequent follow-up assessments.

C. At each follow-up visit, the prescribing health care provider must assess the possible side effects of treatment, misuse of medications, aberrant behaviors indicative of addiction, or contraindications to continuing treatment.

D. At each follow-up visit, the prescribing health care provider must assess the patient's adherence to the entire program of treatment.

E. At least semiannually, the prescribing health care provider must review the patient's prescription history in the Minnesota prescription monitoring program to validate correct medication usage, except that the prescription history must be reviewed at every follow-up visit for each patient who is taking more than 120 morphine-equivalent milligrams per day or is at high risk for dependence or abuse under subpart 6, item B. If there is more than one instance of unreported opiate prescriptions from other providers, the health care provider must discontinue opioid medications using a schedule of tapering dosages as described in subpart 6, item M.

F. The prescribing health care provider has discretion to order urine drug testing as part of a patient's monitoring, except that monitoring must include urine drug testing at least twice per year for each patient who is taking more than 120 morphine-equivalent milligrams per day or is at high risk for dependence or abuse under subpart 6, item B.

(1) Urine drug testing protocol is within the discretion of the prescribing provider. After all tests requested by the prescribing provider are completed, urine drug testing is failed if it shows the presence of an illegal substance or if the results are inconsistent with the opiate and dosage

prescribed. If the urine drug testing is failed, opioid medications must be discontinued using a schedule of tapering dosages as described in subpart 6, item M.

(2) If a urine sample is sent to a laboratory for testing, the employer or insurer may designate the laboratory so long as it is accredited by the College of American Pathologists under the Forensic Urine Drug Testing Program.

G. The prescribing health care provider must provide a referral to a pain medicine specialist for consultation under any of the following circumstances:

- (1) there is a sudden or progressive increase in the dosage of opioid analgesic required;
- (2) the goals of the treatment program are not met; or
- (3) the patient requires more than 120 morphine-equivalent milligrams per day to meet or maintain the program's treatment goals.

Subp. 9. **Notice and plan for compliance.** A prescribing provider's failure to comply with any requirement of this part is not a basis to deny payment for treatment with opioid analgesics unless the insurer has previously sent the provider and the patient a copy of this part and has given the provider at least 30 days to initiate a plan to come into compliance. The insurer is required to send the provider and patient the notice and provide 30 days to initiate a plan for compliance only once.

Subp. 10. **Patients currently receiving treatment.** For a patient who is receiving long-term treatment with opioid analgesic medication on the effective date of this part, the prescribing health care provider must, within three months of receipt of written notice of this part from the insurer to the provider and patient:

- A. assess the patient's current level of pain and function using tools validated in peer-reviewed scientific literature as required in subpart 3;
- B. meet all of the requirements of subpart 6, items C to M;
- C. complete a written contract with the patient that complies with the requirements of subpart 7; and
- D. establish monitoring of the treatment that complies with the requirements of subpart 8.

Subp. 11. **Incorporation by reference.** The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), copyrighted by the American Psychiatric Association, is incorporated by reference. It is not subject to frequent change, although the American Psychiatric Association publishes DSM-5 errata and coding updates. DSM-5 is published by American Psychiatric Publishing, Inc. (APPI), and may be purchased from them by calling 800-368-5777 or by ordering online at the APPI website. It is also available from other bookstores and online retailers. It is available through the Minitex interlibrary loan system.

Statutory Authority: *MS s 176.83*

History: 40 SR 5

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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. For treatment on or after October 1, 2015, an ICD-10-CM code that is equivalent to an applicable ICD-9-CM code listed in this item must be used instead of the ICD-9-CM code. The General Equivalence Mappings tool established by the Centers for Medicare and Medicaid Services must be used to determine the equivalent ICD-10-CM code or codes.

(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.

B. Laboratory tests are not indicated in the evaluation of a patient with regional low back pain, radicular pain, or cauda equina syndrome, except in any of the following circumstances:

(1) when a patient's history, age, or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis;

(2) to evaluate potential adverse side effects of medications; or

(3) as part of a preoperative evaluation.

Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

C. Medical imaging evaluation of the lumbosacral spine must be based on the findings of the history and physical examination and cannot be ordered before the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with all of the standards in part 5221.6100, subparts 1 and 2. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are always inappropriate for regional low back pain as defined in item A, subitem (1). EMG and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and cauda equina syndrome as defined in item A, subitems (2) to (4), after the first three weeks of radicular symptoms. Repeat EMG and nerve conduction studies for radicular pain and cauda equina syndrome are not indicated unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

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

(1) surface electromyography or surface paraspinal electromyography;

(2) thermography;

(3) plethysmography;

(4) electronic X-ray analysis of plain radiographs;

(5) diagnostic ultrasound of the lumbar spine; or

(6) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing may be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit with a physician, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

G. Personality or psychosocial evaluations may be indicated for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

- (1) Is symptom magnification occurring?
- (2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?
- (3) Are there other personality factors or disorders which are interfering with recovery?
- (4) Is the patient chemically dependent?
- (5) Are there any interpersonal conflicts interfering with recovery?
- (6) Does the patient have a chronic pain syndrome or psychogenic pain?
- (7) In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

H. Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve injection, epidural differential spinal block, nerve block, and nerve root block.

- (1) These procedures are used to localize the source of pain before surgery and to diagnose conditions which fail to respond to initial nonsurgical management.
- (2) These injections are invasive and when done as diagnostic procedures only, are not indicated unless noninvasive procedures have failed to establish the diagnosis.
- (3) Selection of patients, choice of procedure, and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.
- (4) These blocks and injections can also be used as therapeutic modalities and as such are subject to the parameters of subpart 5.

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.

J. Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with accepted medical practice.

Subp. 2. General treatment parameters for low back pain.

A. All medical care for low back pain, appropriately assigned to a clinical category in subpart 1, item A, is determined by the clinical category to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 13, as follows:

- (1) subpart 11 governs regional low back pain;
- (2) subpart 12 governs radicular pain with no or static neurologic deficits; and
- (3) subpart 13 governs cauda equina syndrome and radicular pain with progressive neurologic deficits.

The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed, the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subparts 3 to 10, or to repeat a therapy or treatment previously provided for the same injury.

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

(1) First, all patients with low back problems, except patients with progressive neurologic deficit or cauda equina syndrome under subpart 1, item A, subitems (3) and (4), must be given initial nonsurgical management which may include active treatment modalities, passive treatment modalities, injections, durable medical equipment, and medications. These modalities and parameters are described in subparts 3, 4, 5, 8, and 10. The period of initial nonsurgical treatment begins with the first active, passive, medication, durable medical equipment, or injection modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subparts 6 and 11 to 13, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Patients with radicular pain with progressive neurological deficit, or cauda equina syndrome may require immediate surgical therapy.

(b) Any patient who has had surgery may require postoperative therapy in a clinical setting with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical care.

(c) Surgery must follow the parameters in subparts 6 and 11 to 13, and part 5221.6500.

(d) A decision against surgery at this time does not preclude a decision for surgery made at a later date.

(3) Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may include durable medical equipment as described in subpart 8.

C. A treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

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

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to I is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to I are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining employability; if the employee is permanently totally disabled, or if upon retirement the employee is eligible for ongoing medical benefits for the work injury, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

D. Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

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

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

(a) time for patient education and training, one to three sessions; and

(b) patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

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.

(1) Treatment given in a clinical setting:

(a) time for treatment response, three treatments;

(b) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks in a clinical setting but only if used in conjunction with other therapies.

(2) Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education:

(a) time for patient education and training, one session; and

(b) patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

G. Acupuncture treatments:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

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:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

I. Phoresis includes iontophoresis and phonophoresis:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment is nine sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

J. Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

K. Spinal braces and other movement-restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability:

(1) time for treatment response, three days;

(2) treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and

(3) maximum continuous duration, three weeks unless patient is status postfusion.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities can extend past the 12-week limitation on passive treatment modalities so long as the maximum duration for the active modality is not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow-up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the lumbosacral spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment, this shall not be the primary focus of the exercise program.

Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation and monthly thereafter.

Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, three times per week for three weeks, and should decrease in frequency thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program, and may supplement or follow the period of supervised exercise:

(a) maximum treatment frequency, up to three visits for instruction and monitoring;
and

(b) there is no limit on the duration or frequency of exercise at home.

Subp. 5. **Therapeutic injections.** Injection modalities are indicated as set forth in items A to C. Use of injections can extend past the 12-week limit on passive treatment modalities so long as the maximum treatment for injections is not exceeded.

A. Therapeutic injections, including injections of trigger points, facet joints, facet nerves, sacroiliac joints, sympathetic nerves, epidurals, nerve roots, and peripheral nerves. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

(1) Trigger point injections:

(a) time for treatment response, within 30 minutes;

(b) maximum treatment frequency, once per week to any one site if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. No more than three injections to different sites are reimbursable per patient visit; and

(c) maximum treatment, four injections to any one site.

(2) Sacroiliac joint injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first injection. Only two injections are reimbursable per patient visit; and

(c) maximum treatment, two injections to any one site.

(3) Facet joint or nerve injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks to any one site if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. No more than three injections to different sites are reimbursable per patient visit; and

(c) maximum treatment, three injections to any one site.

(4) Nerve root blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first injection. Only three injections to different sites are reimbursable per patient visit; and

(c) maximum treatment, two injections to any one site.

(5) Epidural injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection is reimbursable per patient visit; and

(c) maximum treatment, three injections.

B. Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site:

(1) time for treatment response, within one week;

(2) maximum treatment frequency, may repeat once for any site; and

(3) maximum duration, two injections to any one site.

C. Prolotherapy and botulinum toxin injections are not indicated in the treatment of low back problems and are not reimbursable.

Subp. 6. **Surgery, including decompression procedures and arthrodesis.** Surgery may only be performed if it also meets the specific parameters specified in subparts 11 to 13 and part 5221.6500. The health care provider must provide prior notification of nonemergency inpatient surgery according to part 5221.6050, subpart 9.

A. In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) eight weeks following lumbar decompression or implantation of a spinal cord stimulator or intrathecal drug delivery system; or

(2) 12 weeks following arthrodesis.

B. Repeat surgery must also meet the parameters of subparts 11 to 13 and part 5221.6500, and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if a second opinion is requested by the insurer.

C. Spinal cord stimulators have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of a spinal cord stimulator is indicated because the patient:

(a) has intractable pain;

(b) is not a candidate for another surgical therapy; and

(c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefiting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment with a spinal cord stimulator is indicated if the psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to a spinal cord stimulator.

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

D. Intrathecal drug delivery systems have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of intrathecal drug delivery systems is indicated because the patient:

(a) has intractable pain;

(b) is not a candidate for another surgical therapy; and

(c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefiting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment with an intrathecal drug delivery system is indicated if the psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to an intrathecal drug delivery system.

(3) Long-term use of an intrathecal drug delivery system is indicated if the treating health care provider documents that there has been at least a 50 percent improvement in pain during

a trial screening period of at least 24 hours, compared to the patient's pain level immediately preceding the trial screening period.

Subp. 7. **Chronic management.** Chronic management of low back pain must be provided according to the parameters of part 5221.6600.

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.

A. Lumbar braces, corsets, or supports are indicated as specified in subpart 3, item K.

B. For patients using electrical stimulation or mechanical traction devices at home, the device and any required supplies are indicated within the parameters of subpart 3, items E and F. Prior notification must be provided to the insurer for purchase of the device or for use longer than one month. The insurer may provide equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonsurgical care or during reevaluation and surgical therapy. Prior notification must be provided to the insurer for the purchase of home exercise equipment. The insurer may decide which brand of a prescribed type of exercise equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate use of that facility instead of authorizing purchase of the equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

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:

(1) whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, and loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial nonsurgical treatment is effective according to items A to C. No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in items A to C:

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

B. the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of the injury; and

C. the employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive imitations on activity.

If there is not progressive improvement in at least two items of items A to C, the modality must be discontinued or significantly modified, or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional directly providing the treatment, but remains the ultimate responsibility of the treating health care provider.

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.

Subp. 11. **Specific treatment parameters for regional low back pain.**

A. Initial nonsurgical treatment must be the first phase of treatment for all patients with regional low back pain under subpart 1, item A, subitem (1).

(1) The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

(2) The only therapeutic injections indicated for patients with regional back pain are trigger point injections, facet joint injections, facet nerve injections, sacroiliac joint injections, and epidural blocks, and their use must meet the parameters of subpart 5.

(3) After the first week of treatment, initial nonsurgical treatment must at all times contain active treatment modalities according to the parameters of subpart 4.

(4) Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

(5) Except as otherwise specified in subpart 3, passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

B. Surgical evaluation or chronic management is indicated 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. The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

(1) Surgical evaluation, if indicated, may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

(2) Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the parameters of part 5221.6100. Medical imaging studies which do not meet these parameters are not indicated.

(3) Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the parameters of subpart 1, item H.

(4) Surgical evaluation may also include personality or psychosocial evaluation, consistent with the parameters of subpart 1, item G.

(5) Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

(6) The only surgical procedures indicated for patients with regional low back pain only are decompression of a lumbar nerve root or lumbar arthrodesis, with or without instrumentation, which must meet the parameters of subpart 6 and part 5221.6500, subpart 2, items A and C. For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated; their use must meet the parameters of subpart 6, item C.

(a) If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it should be performed as expeditiously as possible consistent with sound medical practice, and consistent with any requirements of part 5221.6050, subpart 9, for prior notification of the insurer or second opinions.

(b) If surgery is not indicated, or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management according to the parameters of part 5221.6600.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management which must be provided according to the parameters of part 5221.6600.

Subp. 12. Specific treatment parameters for radicular pain, with or without regional low back pain, with no or static neurologic deficits.

A. Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional low back pain, with no or static neurologic deficits under subpart 1, item A, subitem (2), and must be the first phase of treatment. It must be provided within the parameters of subpart 11, item A, with the following modifications: epidural blocks, and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional low back pain, therapeutic facet joint injections, facet nerve injections, trigger point injections, and sacroiliac injections may also be indicated.

B. Surgical evaluation or chronic management is indicated 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. It must be provided within the parameters of subpart 11, item B.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered, the patient refused surgical therapy, or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional back pain, with static neurologic deficits must meet all of the parameters of part 5221.6600.

Subp. 13. Specific treatment parameters for cauda equina syndrome and for radicular pain, with or without regional low back pain, with progressive neurologic deficits.

A. Patients with cauda equina syndrome or with radicular pain, with or without regional low back pain, with progressive neurologic deficits may require immediate or emergency surgical evaluation at any time during the course of the overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any initial nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, except that surgical evaluation and surgical therapy may begin at any time.

B. If the health care provider decides to proceed with a course of initial nonsurgical care for a patient with radicular pain with progressive neurologic changes, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional back pain, with foot drop or progressive neurologic changes at first presentation must meet the parameters of part 5221.6600.

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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. For treatment on or after October 1, 2015, an ICD-10-CM code that is equivalent to an applicable ICD-9-CM code listed in this item must be used instead of the ICD-9-CM code. The General Equivalence Mappings tool established by the Centers for Medicare and Medicaid Services must be used to determine the equivalent ICD-10-CM code or codes.

(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.

B. Laboratory tests are not indicated in the evaluation of a patient with regional neck pain, or radicular pain, except:

(1) when a patient's history, age, or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis;

(2) to evaluate potential adverse side effects of medications; or

(3) as part of a preoperative evaluation.

Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

C. Medical imaging evaluation of the cervical spine must be based on the findings of the history and physical examination and cannot be ordered prior to the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with the standards in part 5221.6100, subpart 1. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are always inappropriate for the regional neck pain diagnoses in item A, subitem (1). EMG and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and myelopathy diagnoses in item A, subitems (2) to (4), after the first three weeks of radicular or myelopathy symptoms. Repeat EMG and nerve conduction studies for radicular pain and myelopathy are not indicated unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

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

(1) surface electromyography or surface paraspinal electromyography;

(2) thermography;

(3) plethysmography;

(4) electronic X-ray analysis of plain radiographs;

(5) diagnostic ultrasound of the spine; or

(6) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening

program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing can be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

G. Personality or psychological evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

- (1) Is symptom magnification occurring?
- (2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?
- (3) Are there other personality factors or disorders which are interfering with recovery?
- (4) Is the patient chemically dependent?
- (5) Are there any interpersonal conflicts interfering with recovery?
- (6) Does the patient have a chronic pain syndrome or psychogenic pain?
- (7) In cases in which surgery is a possible treatment, are psychological factors, such as those in subitems (1) to (6), likely to interfere with the potential benefit of the surgery?

H. Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve block, epidural differential spinal block, nerve block, and nerve root block.

- (1) These procedures are used to localize the source of pain prior to surgery and to diagnose conditions which fail to respond to initial nonsurgical management.
- (2) These blocks and injections are invasive and when done as diagnostic procedures only, are not indicated unless noninvasive procedures have failed to establish the diagnosis.
- (3) Selection of patients, choice of procedure, and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.
- (4) These blocks and injections can also be used as therapeutic modalities and as such are subject to the parameters of subpart 5.

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.

J. Consultations with other health care providers may be initiated at any time by the treating health care provider, consistent with accepted medical practice.

Subp. 2. **General treatment parameters for neck pain.**

A. All medical care for neck pain appropriately assigned to a clinical category in subpart 1, item A, is determined by the diagnosis and clinical category in subpart 1, item A, to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 14, as follows:

- (1) subpart 11 governs regional neck pain;
- (2) subpart 12 governs radicular pain with static neurologic deficits;
- (3) subpart 13 governs radicular pain with progressive neurologic deficits; and
- (4) subpart 14 governs myelopathy.

The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subparts 3 to 10, or to repeat a therapy or treatment previously provided for the same injury.

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

(1) First, all patients with neck problems, except patients with radicular pain with progressive neurological deficit, or myelopathy under subpart 1, item A, subitems (3) and (4), must be given initial nonsurgical care which may include both active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and parameters are described in subparts 3, 4, 5, 8, and 10. The period of initial nonsurgical management begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonoperative care is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice, and subparts 6 and 11 to 14, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Patients with radicular pain with progressive neurological deficit, or myelopathy may require immediate surgical therapy.

(b) Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical management.

(c) Surgery must follow the parameters in subparts 6 and 11 to 14, and part 5221.6500.

(d) A decision against surgery at this time does not preclude a decision for surgery made at a later date.

(3) Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may include durable medical equipment as described in subpart 8.

C. A treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

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

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to I is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to I are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining employability; if the employee is permanently totally disabled, or if upon retirement the employee is eligible for ongoing medical benefits for the work injury, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

D. Thermal treatment includes all superficial and deep heating modalities and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

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

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

(b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

(a) time for patient education and training, one to three sessions; and

(b) patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

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.

(1) Treatment given in a clinical setting:

(a) time for treatment response, three treatments;

(b) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks in a clinical setting, but only if used in conjunction with other therapies.

(2) Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education:

(a) time for patient education and training, one session; and

(b) a patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

G. Acupuncture treatments:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

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:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

I. Phoresis includes iontophoresis and phonophoresis:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

J. Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

K. Cervical collars, spinal braces, and other movement-restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability:

(1) time for treatment response, three days;

(2) treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and

(3) maximum continuous duration, up to three weeks unless patient is status postfusion.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities may extend past the 12-week limitation on

passive treatment modalities, so long as the maximum duration for the active modality is not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow-up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the cervical spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment, it must not be the primary focus of the exercise program.

Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation and monthly thereafter. Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, three times per week for three weeks, decreasing in frequency thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program, and may supplement or follow the period of supervised exercise:

(a) maximum treatment frequency, up to three visits for instruction and monitoring; and

- (b) there is no limit on the duration or frequency of exercise at home.

Subp. 5. **Therapeutic injections.** Injection modalities are indicated as set forth in items A to C. Use of injections may extend past the 12-week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

A. Therapeutic injections include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

- (1) Trigger point injections:
 - (a) time for treatment response, within 30 minutes;
 - (b) maximum treatment frequency, once per week if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. Only three injections are reimbursable per patient visit; and
 - (c) maximum treatment, four injections to any one site.
- (2) Facet joint injections or facet nerve blocks:
 - (a) time for treatment response, within one week;
 - (b) maximum treatment frequency, once every two weeks if a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections or blocks should be discontinued. Only three injections or blocks are reimbursable per patient visit; and
 - (c) maximum treatment, three injections or blocks to any one site.
- (3) Nerve root blocks:
 - (a) time for treatment response, within one week;
 - (b) maximum treatment frequency, can repeat injection no sooner than two weeks after the previous injection if a positive response to the first injection. No more than three blocks are reimbursable per patient visit; and
 - (c) maximum treatment, two blocks to any one site.
- (4) Epidural injections:
 - (a) time for treatment response, within one week;
 - (b) maximum treatment frequency, once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection is reimbursable per patient visit; and

(c) maximum treatment, three injections.

B. Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site:

- (1) time for treatment response, within one week;
- (2) maximum treatment frequency, may repeat once for any site; and
- (3) maximum duration, two injections to any one site.

C. Prolotherapy and botulinum toxin injections are not indicated in the treatment of neck problems and are not reimbursable.

Subp. 6. **Surgery, including decompression procedures and arthrodesis.** Surgery may only be performed if it meets the specific parameters of subparts 11 to 14 and part 5221.6500. The health care provider must provide prior notification for nonemergency inpatient surgery according to part 5221.6050, subpart 9.

A. In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

- (1) eight weeks following decompression or implantation of a spinal cord stimulator or intrathecal drug delivery system; or
- (2) 12 weeks following arthrodesis.

B. Repeat surgery must also meet the parameters of subparts 11 to 14 and part 5221.6500 and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if requested by the insurer.

C. Spinal cord stimulators have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of a spinal cord stimulator is indicated because the patient:

- (a) has intractable pain;
- (b) is not a candidate for another surgical therapy; and
- (c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefiting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment

with a spinal cord stimulator is indicated if the psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to a spinal cord stimulator.

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

D. Intrathecal drug delivery systems have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of an intrathecal drug delivery system is indicated because the patient:

- (a) has intractable pain;
- (b) is not a candidate for another surgical therapy; and

(c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefitting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment with an intrathecal drug delivery system is indicated if the psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to an intrathecal drug delivery system.

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

Subp. 7. **Chronic management.** Chronic management of neck disorders must be provided according to the parameters of part 5221.6600.

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.

A. Cervical collars, braces, or supports and home cervical traction devices may be indicated within the parameters of subpart 3, items F and K.

B. For patients using electrical stimulation at home, the device and any required supplies are indicated within the parameters of subpart 3, item E. Prior notification must be given for purchase of the device or for use longer than one month. The insurer may provide equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonoperative care or during reevaluation and surgical therapy. Prior notification must be given to the insurer before purchase of the home exercise equipment. The insurer may decide which brand of a prescribed type of exercise equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate the use of that facility instead of authorizing purchase of equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

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:

(1) whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, and loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary, and shall evaluate whether initial nonsurgical management is effective according to items A to C.

No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality has resulted in progressive improvement as specified in items A to C:

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

B. the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

C. the employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

If there is not progressive improvement in at least two items of items A to C, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional working under the direction of the treating health care provider but remains the ultimate responsibility of the treating health care provider.

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.

Subp. 11. **Specific treatment parameters for regional neck pain.**

A. Initial nonsurgical treatment must be the first phase of treatment for all patients with regional neck pain under subpart 1, item A, subitem (1).

(1) The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition.

(2) The only therapeutic injections indicated for patients with regional neck pain are trigger point injections, facet joint injections, facet nerve blocks, and epidural blocks, and their use must meet the parameters of subpart 5.

(3) After the first week of treatment, initial nonsurgical treatment must at all times contain active treatment modalities according to the parameters of subpart 4.

(4) Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

(5) Except as otherwise provided in subpart 3, passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

B. Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

(1) Surgical evaluation if indicated may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

(2) Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the parameters of part 5221.6100, subpart 1.

(3) Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the parameters of subpart 1, item H.

(4) Surgical evaluation may also include personality or psychosocial evaluation, consistent with the parameters of subpart 1, item G.

(5) Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

(6) The only surgical procedure indicated for patients with regional neck pain only is cervical arthrodesis, with or without instrumentation, which must meet the parameters of subpart 6. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

(a) If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it should be performed as expeditiously as possible consistent with sound medical practice, and consistent with any requirements of part 5221.6050, subpart 9, for prior notification of the insurer or second opinions.

(b) If surgery is not indicated or if the patient does not wish to proceed with surgical therapy, then the patient is a candidate for chronic management.

C. If the patient continues with symptoms and objective physical findings after surgery has been rendered or the patient refuses surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management according to part 5221.6600.

Subp. 12. Specific treatment parameters for radicular pain, with or without regional neck pain, with no or static neurologic deficits.

A. Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional neck pain, with no or static neurologic deficits under subpart 1, item A, subitem (2), and must be the first phase of treatment. It must be provided within the parameters of subpart 11, item A, with the following modifications: epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional neck pain, therapeutic facet joint injections, facet nerve blocks, and trigger point injections may also be indicated.

B. Surgical evaluation or chronic management is indicated 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. It must be provided within the parameters of subpart 11, item B, with the following modifications: the only surgical procedures indicated for patients with radicular pain are decompression of a cervical nerve root which must meet the parameters of subpart 6 and part 5221.6500, subpart 2, item B, and cervical arthrodesis, with or without instrumentation. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered, the patient refused surgical therapy, or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional neck pain, with static neurologic changes must meet all of the parameters of part 5221.6600.

Subp. 13. Specific treatment parameters for radicular pain, with or without regional neck pain, with progressive neurologic changes.

A. Patients with radicular pain, with or without regional neck pain, with progressive neurologic deficits may require immediate or emergency evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, with the following modifications:

- (1) surgical evaluation and surgical therapy may begin at any time; and
- (2) the only surgical procedures indicated for patients with radicular pain are decompression of a cervical nerve root which must meet the parameters of subpart 6 and part 5221.6500, subpart 2, item B, or cervical arthrodesis, with or without instrumentation. For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

B. If the health care provider decides to proceed with a course of nonsurgical care for a patient with radicular pain with progressive neurologic changes, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with

or without regional neck pain, with progressive neurologic changes at first presentation must meet all of the parameters of part 5221.6600.

Subp. 14. Specific treatment parameters for myelopathy.

A. Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, with the following modifications:

(1) surgical evaluation and surgical therapy may begin at any time; and

(2) the only surgical procedures indicated for patients with myelopathy are anterior or posterior decompression of the spinal cord, or cervical arthrodesis with or without instrumentation. For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

B. If the health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with myelopathy must meet all of the parameters of part 5221.6600.

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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. For treatment on or after October 1, 2015, an ICD-10-CM code that is equivalent to an applicable ICD-9-CM

code listed in this item must be used instead of the ICD-9-CM code. The General Equivalence Mappings tool established by the Centers for Medicare and Medicaid Services must be used to determine the equivalent ICD-10-CM code or codes.

(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.

B. Laboratory tests are not indicated in the evaluation of a patient with regional thoracic back pain, or radicular pain, except when a patient's history, age, or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis, or side effects of medications. Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications. Laboratory tests may also be ordered as part of a preoperative evaluation.

C. Medical imaging evaluation of the thoracic spine must be based on the findings of the history and physical examination and cannot be ordered prior to the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with all of the standards in part 5221.6100, subpart 1. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are always inappropriate for regional thoracic back pain and radicular pain under item A, subitems (1) to (3).

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

- (1) surface electromyography or surface paraspinal EMG;
- (2) thermography;

- (3) plethysmography;
- (4) electronic X-ray analysis of plain radiographs;
- (5) diagnostic ultrasound of the spine; or
- (6) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. Computerized range of motion or strength measuring tests are not reimbursable during the period of initial nonsurgical care, but may be reimbursable during a period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonoperative care computerized range of motion or strength testing can be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

G. Personality or psychological evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

- (1) Is symptom magnification occurring?
- (2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?
- (3) Are there other personality factors or disorders which are interfering with recovery?
- (4) Is the patient chemically dependent?
- (5) Are there any interpersonal conflicts interfering with recovery?
- (6) Does the patient have a chronic pain syndrome or psychogenic pain?
- (7) In cases in which surgery is a possible treatment, are psychological factors, such as those listed in subitems (1) to (6), likely to interfere with the potential benefit of the surgery?

H. Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve block, epidural differential spinal block, nerve block, and nerve root block.

- (1) These procedures are used to localize the source of pain prior to surgery and to diagnose conditions which fail to respond to initial nonoperative care.
- (2) These blocks and injections are invasive and when done as diagnostic procedures only are not indicated unless noninvasive procedures have failed to establish the diagnosis.

(3) Selection of patients, choice of procedure, and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

(4) These blocks and injections can also be used as therapeutic modalities and as such are subject to the guidelines of subpart 5.

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.

J. Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with standard medical practice.

Subp. 2. General treatment parameters for thoracic back pain.

A. All medical care for thoracic back pain, appropriately assigned to a category of subpart 1, item A, is determined by the diagnosis and clinical category in subpart 1, item A, to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 13, as follows:

- (1) subpart 11 governs regional thoracic back pain;
- (2) subpart 12 governs radicular pain; and
- (3) subpart 13 governs myelopathy.

The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in items C to F, or to repeat a therapy or treatment previously provided for the same injury.

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

(1) First, all patients with thoracic back problems, except patients with myelopathy under subpart 1, item A, subitem (3), must be given initial nonoperative care which may include active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and parameters are described in subparts 3, 4, 5, 8, and 10. The period of initial nonsurgical treatment begins with the first clinical passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subparts 6 and 11 to 13, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Patients with myelopathy may require immediate surgical therapy.

(b) Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical care.

(c) Surgery must follow the parameters in subparts 6 and 11 to 13, and part 5221.6500.

(d) A decision against surgery at this time does not preclude a decision for surgery made at a later date in light of new clinical information.

(3) Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may also include durable medical equipment as described in subpart 8.

C. A treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

Subp. 3. Passive treatment modalities.

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to I is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to I are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining employability; if the employee is permanently totally disabled, or if upon retirement the employee is eligible for ongoing medical benefits for the work injury, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

D. Thermal treatment includes all superficial and deep heating modalities and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

- (a) time for treatment response, two to four treatments;
- (b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and
- (c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

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

(1) Treatment given in a clinical setting:

- (a) time for treatment response, two to four treatments;
- (b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and
- (c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

- (a) maximum time for patient education and training, up to three sessions; and
- (b) patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

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.

(1) Treatment given in a clinical setting:

- (a) time for treatment response, three treatments;

(b) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks in a clinical setting but only if used in conjunction with other therapies.

(2) Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education:

(a) maximum time for patient education and training, one session; and

(b) a patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

G. Acupuncture treatments:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

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:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

I. Phoresis includes iontophoresis and phonophoresis:

(1) time for treatment response, three to five sessions;

(2) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

J. Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

K. Spinal braces and other movement-restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability:

- (1) time for treatment response, three days;
- (2) maximum treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and
- (3) maximum continuous duration, three weeks unless patient is status postfusion.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities may extend past the 12-week limit on passive treatment modalities, so long as the maximum durations for the active treatment modalities are not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow-up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, back, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the thoracic spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment this shall not be the primary focus of the exercise program.

Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance shall be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation and monthly thereafter. Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, three times per week for three weeks and should decrease with time thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program and may supplement or follow the period of supervised exercise:

(a) maximum treatment frequency, one to three visits for instruction and monitoring; and

(b) there is no limit on the duration and frequency of exercise at home.

Subp. 5. **Therapeutic injections.** Injection modalities are indicated as set forth in items A to C. Use of injections may extend past the 12-week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

A. Therapeutic injections include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

(1) Trigger point injections:

(a) time for treatment response, within 30 minutes;

(b) maximum treatment frequency, once per week if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. No more than three injections are reimbursable per patient visit; and

(c) maximum treatment, four injections to any one site.

(2) Facet joint injections or facet nerve blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections or blocks should be discontinued. Only three injections or blocks are reimbursable per patient visit; and

(c) maximum treatment, three injections or blocks to any one site.

(3) Nerve root blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first block. Only three injections are reimbursable per patient visit; and

(c) maximum treatment, two blocks to any one site.

(4) Epidural injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection is reimbursable per patient visit; and

(c) maximum treatment, three injections.

B. Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site:

(1) time for treatment response, within one week;

(2) optimum treatment frequency, may repeat once for any site; and

(3) maximum duration, two injections to any one site.

C. Prolotherapy and botulinum toxin injections are not indicated in the treatment of thoracic back problems and are not reimbursable.

Subp. 6. **Surgery, including decompression procedures.** Surgery may only be performed if it meets the specific parameters of subparts 11 to 13 and part 5221.6500. The health care provider must provide prior notification of nonemergency inpatient surgery according to part 5221.6050, subpart 9.

A. In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) eight weeks following decompression or implantation of a spinal cord stimulator or intrathecal drug delivery system; or

(2) 12 weeks following arthrodesis.

B. Repeat surgery must also meet the parameters of subparts 11 to 13 and part 5221.6500 and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if a second opinion is requested by the insurer.

C. Spinal cord stimulators have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of a spinal cord stimulator is indicated because the patient:

(a) has intractable pain;

(b) is not a candidate for another surgical therapy; and

(c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefiting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment with a spinal cord stimulator is indicated if the psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to a spinal cord stimulator.

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

D. Intrathecal drug delivery systems have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of an intrathecal drug delivery system is indicated because the patient:

(a) has intractable pain;

(b) is not a candidate for another surgical therapy; and

(c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefiting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment with an intrathecal drug delivery system is indicated if the psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to an intrathecal drug delivery system.

(3) Long-term use of an intrathecal drug delivery system is indicated if the treating health care provider documents that there has been at least a 50 percent improvement in pain during

a trial screening period of at least 24 hours, compared to the patient's pain level immediately preceding the trial screening period.

Subp. 7. **Chronic management.** Chronic management of thoracic back pain must be provided according to the parameters of part 5221.6600.

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.

A. Braces or supports may be indicated within the parameters of subpart 3, item K.

B. For patients using electrical stimulation or mechanical traction devices at home, the device and any required supplies are indicated within the parameters of subpart 3, items E and F. Prior notification of the insurer is required for purchase of the device or for use longer than one month. The insurer may provide equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonoperative care or during reevaluation and surgical therapy. Prior notification of the insurer is required for the purchase of home exercise equipment. The insurer may decide which brand of a prescribed type of exercise equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate the use of that facility instead of authorizing purchase of equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

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:

(1) whirlpools, Jacuzzis, hot tubs, special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, or loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial nonsurgical management is effective according to items A to C. No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in items A to C:

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

B. the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

C. the employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

If there is not progressive improvement in at least two items of items A to C, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional working under the direction of the treating health care provider but remains the ultimate responsibility of the treating health care provider.

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.

Subp. 11. **Specific treatment parameters for regional thoracic back pain.**

A. Initial nonsurgical treatment must be the first phase of treatment for all patients with regional thoracic back pain under subpart 1, item A, subitem (1).

(1) The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

(2) The only therapeutic injections indicated for patients with regional thoracic back pain are trigger point injections, facet joint injections, facet nerve blocks, and epidural blocks, and their use must meet the parameters of subpart 5.

(3) After the first week of treatment, initial nonsurgical management must at all times contain active treatment modalities according to the parameters of subpart 4.

(4) Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

(5) Except as provided in subpart 3, passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

B. Surgical evaluation or chronic management is indicated if the patient continues with symptoms and objective 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. The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

(1) Surgical evaluation may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgical therapy does not preclude surgery at a later date.

(2) Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the parameters of part 5221.6100. Medical imaging studies which do not meet these parameters are not indicated.

(3) Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the parameters of subpart 1, item H.

(4) Surgical evaluation may also include personality or psychosocial evaluation, consistent with the parameters of subpart 1, item G.

(5) Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and objective physical findings.

(6) The only surgical procedure indicated for patients with regional thoracic back pain only is thoracic arthrodesis with or without instrumentation, which must meet the parameters of subpart 6, and part 5221.6500, subpart 2, item C. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

(a) If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery it should be performed as expeditiously as possible consistent with sound medical practice, and consistent with any requirements of parts 5221.6010 to 5221.6500 for prior notification of the insurer or second opinions.

(b) If surgery is not indicated or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management.

C. If the patient continues with symptoms and objective physical findings after surgery has been rendered or the patient refuses surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management according to the parameters of part 5221.6600.

Subp. 12. Specific treatment parameters for radicular pain.

A. Initial nonsurgical treatment is appropriate for all patients with radicular pain under subpart 1, item A, subitem (2), and must be the first phase of treatment. It must be provided within

the parameters of subpart 11, item A, with the following modifications: epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional thoracic back pain, therapeutic facet joint injections, facet nerve blocks, and trigger point injections may also be indicated.

B. Surgical evaluation or chronic management is indicated 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. It shall be provided within the parameters of subpart 11, item B, with the following modifications: the only surgical procedures indicated for patients with radicular pain are decompression or arthrodesis. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refused surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional thoracic back pain, must meet all of the parameters of part 5221.6600.

Subp. 13. Specific treatment parameters for myelopathy.

A. Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, with the following modifications:

- (1) surgical evaluation and surgical therapy may begin at any time; and
- (2) the only surgical procedures indicated for patients with myelopathy are decompression and arthrodesis. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

B. If the health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with myelopathy must meet all of the parameters of part 5221.6600.

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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. For treatment on or after October 1, 2015, an ICD-10-CM code that is equivalent to an applicable ICD-9-CM code listed in this item must be used instead of the ICD-9-CM code. The General Equivalence Mappings tool established by the Centers for Medicare and Medicaid Services must be used to determine the equivalent ICD-10-CM code or codes.

(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.

B. Certain laboratory tests may be indicated in the evaluation of a patient with upper extremity disorder to rule out infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders such as rheumatoid arthritis, or side effects of medications. Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

C. Medical imaging evaluation of upper extremity disorders must be based on the findings of the history and physical examination and cannot be ordered before the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with the standards in part 5221.6100, subpart 1. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are only appropriate for nerve entrapment disorders and recurrent nerve entrapment after surgery.

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

- (1) surface electromyography;
- (2) thermography; or
- (3) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. The following diagnostic procedures or tests are considered adjuncts to the physical examination and are not reimbursed separately from the office visit:

- (1) vibrometry;

- (2) neurometry;
- (3) Semmes-Weinstein monofilament testing; or
- (4) algometry.

G. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing can be performed but must be done in conjunction with and are not reimbursed separately from an office visit with a physician, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

H. Personality or psychosocial evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate initial nonsurgical care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

- (1) Is symptom magnification occurring?
- (2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?
- (3) Are there other personality factors or disorders which are interfering with recovery?
- (4) Is the patient chemically dependent?
- (5) Are there any interpersonal conflicts interfering with recovery?
- (6) Does the patient have a chronic pain syndrome or psychogenic pain?
- (7) In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

I. Diagnostic analgesic blocks or injection studies.

- (1) These procedures are used to localize the source of pain and to diagnose conditions which fail to respond to appropriate initial nonsurgical management.
- (2) Selection of patients, choice of procedure, and localization of the site of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.
- (3) These blocks and injections can also be used as therapeutic modalities and as such are subject to the parameters of subpart 5.

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.

K. Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with accepted medical practice.

Subp. 2. General treatment parameters for upper extremity disorders.

A. All medical care for upper extremity disorders, appropriately assigned to a category of subpart 1, item A, is determined by the diagnosis and clinical category in subpart 1, item A, to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 16 as follows:

(1) subpart 11 governs epicondylitis;

(2) subpart 12 governs tendonitis of the forearm, wrist, and hand;

(3) subpart 13 governs upper extremity nerve entrapment syndromes;

(4) subpart 14 governs upper extremity muscle pain syndromes;

(5) subpart 15 governs shoulder impingement syndromes; and

(6) subpart 16 governs traumatic sprains and strains of the upper extremity.

The health care provider must at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category and these changes must be recorded in the medical record. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subparts 3 to 10, or to repeat a therapy or treatment previously provided for the same injury, unless the treatment or therapy is subsequently delivered to a different part of the body.

When treating more than one clinical category or body part for which the same treatment modality is appropriate, then the treatment modality should be applied simultaneously, if possible, to all indicated areas.

B. In general, a course of treatment must be divided into three phases:

(1) First, all patients with an upper extremity disorder must be given initial nonsurgical management, unless otherwise specified. Initial nonsurgical management may include any combination of the passive, active, injection, durable medical equipment, and medication treatment modalities listed in subparts 3, 4, 5, 8, and 10, appropriate to the clinical category. The period of initial nonsurgical treatment begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subparts 6 and 11 to 16, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy can be in addition to any received during the period of initial nonsurgical management.

(b) Surgery must follow the parameters in subparts 6 and 11 to 16, and part 5221.6500.

(c) A decision against surgery at this time does not preclude a decision for surgery made at a later date.

(3) Third, for those patients who are not candidates for surgery or refuse surgery, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may include durable medical equipment is described in subpart 8.

C. A treating health care provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical practice.

Subp. 3. Passive treatment modalities.

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to H is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to H are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining employability; if the employee is permanently totally disabled, or if upon retirement the employee is eligible for ongoing medical benefits for the work injury, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

D. Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

- (a) time for treatment response, two to four treatments;
- (b) maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and
- (c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

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

(1) Treatment given in a clinical setting:

- (a) time for treatment response, two to four treatments;
- (b) maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and
- (c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

- (a) time for patient education and training, one to three sessions; and
- (b) patient may use the electrical stimulation device unsupervised for one month, at which time effectiveness of the treatment must be reevaluated by the provider before continuing home use of the device.

F. Acupuncture treatments:

- (1) time for treatment response, three to five sessions;
- (2) maximum treatment frequency, up to three times per week for the first one to three weeks, decreasing in frequency thereafter; and
- (3) maximum treatment duration, 12 weeks.

G. Phoresis includes phonophoresis and iontophoresis:

- (1) time for treatment response, three to five sessions;
- (2) maximum treatment frequency, up to three times per week for the first one to three weeks, decreasing in frequency thereafter; and
- (3) maximum treatment duration is nine sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

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:

- (1) time for treatment response, three to five treatments;
- (2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and
- (3) maximum treatment duration, 12 weeks.

I. Splints, braces, and other movement-restricting appliances. Bracing required for longer than two weeks must be accompanied by active motion exercises to avoid stiffness and prolonged disability:

- (1) time for treatment response, ten days;
- (2) maximum treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and
- (3) maximum continuous duration, eight weeks. Prophylactic use is allowed indefinitely.

J. Rest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Total restriction of use of an affected body part should not be prescribed for more than two weeks, unless rigid immobilization is required. In cases of rigid immobilization, active motion exercises at adjacent joints should begin no later than two weeks after application of the immobilization.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities so long as the maximum treatment for the active treatment modality is not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to upper extremity function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which include an initial education and training session, and two follow-up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic

sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of a nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the upper extremity. While aerobic exercise may be performed as adjunctive treatment this must not be the primary focus of the exercise program.

Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the testing sooner than two weeks after the initial evaluation and monthly thereafter.

Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, up to three times per week for three weeks. Should decrease with time thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting and may supplement or follow the period of supervised exercise.

Subp. 5. **Therapeutic injections.** Therapeutic injections include injections of trigger points, sympathetic nerves, peripheral nerves, and soft tissues. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site. Use of injections may extend past the 12-week limitation on passive modalities, so long as the maximum treatment for injections in items A to C is not exceeded.

A. Trigger point injections:

(1) time for treatment response, within 30 minutes;

(2) maximum treatment frequency, once per week to any one site if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be

redirected to other areas or discontinued. No more than three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, four injections to any one site over the course of treatment.

B. Soft tissue injections include injections of a bursa, tendon, tendon sheath, ganglion, tendon insertion, ligament, or ligament insertion:

(1) time for treatment response, within one week;

(2) maximum treatment frequency, once per month to any one site if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, three injections to any one site over the course of treatment.

C. Injections for median nerve entrapment at the carpal tunnel:

(1) time for treatment response, within one week;

(2) maximum treatment frequency, can repeat injection in one month if a positive response to the first injection. Only three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, two injections to any one site over the course of treatment.

Subp. 6. **Surgery.** Surgery may only be performed if it meets applicable parameters in subparts 11 to 16 and part 5221.6500.

A. In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) for rotator cuff repair, acromioclavicular ligament repair, or any surgery for a clinical category in this part which requires joint reconstruction, 16 weeks; or

(2) for all other surgery for clinical categories in this part, eight weeks.

The health care provider must provide the insurer with prior notification of nonemergency inpatient surgery according to part 5221.6050, subpart 9.

B. Repeat surgery must also meet the parameters of subparts 11 to 16 and part 5221.6500 and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if requested by the insurer.

Subp. 7. **Chronic management.** Chronic management of upper extremity disorders must be provided according to the parameters of part 5221.6600.

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.

A. Splints, braces, straps, or supports may be indicated as specified in subpart 3, item I.

B. For patients using an electrical stimulation device at home, the device and any required supplies are indicated within the parameters of subpart 3, item E. Prior notification of the insurer is required for purchase of the device or for use longer than one month. The insurer may provide the equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonsurgical care or during reevaluation and surgical therapy. Prior notification of the insurer is required for the purchase of home exercise equipment. The insurer may decide which brand of a prescribed type of equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment the insurer may mandate use of that facility instead of authorizing purchase of the equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

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

(1) whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, and loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary and whether initial nonsurgical treatment is effective according to items A to C.

No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in items A to C:

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

B. the objective clinical findings are progressively improving as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

C. the employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

If there is not progressive improvement in at least two items in items A to C, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional directly providing the treatment, but remains the ultimate responsibility of the treating health care provider.

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.

Subp. 11. **Specific treatment parameters for epicondylitis.**

A. Initial nonsurgical management is appropriate for all patients with epicondylitis and must be the first phase of treatment.

(1) The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures specified in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition. After the first week of treatment, initial nonsurgical care must at all times include active treatment modalities according to subpart 4.

(2) Initial nonsurgical management must be provided in the least intensive setting consistent with quality health care practices.

(3) Except as provided in subpart 3, use of passive treatment modalities in a clinic setting or requiring attendance by a health care provider for a period in excess of 12 weeks is not indicated.

(4) Use of home-based treatment modalities with monitoring by the treating health care provider may continue for up to 12 months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

B. If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. The purpose and goal of surgical evaluation is to determine whether surgery is indicated for the patient who has failed to recover with appropriate nonsurgical care or chronic management.

(1) Surgical evaluation, if indicated, must begin no later than 12 months after beginning initial nonsurgical management.

(2) Surgical evaluation may include the use of appropriate laboratory and electrodiagnostic testing within the parameters of subpart 1, if not already obtained during the initial evaluation. Repeat testing is not indicated unless there has been an objective change in the patient's condition which in itself would warrant further testing. Failure to improve with therapy does not, by itself, warrant further testing.

(3) Plain films may be appropriate if there is a history of trauma, infection, or inflammatory disorder and are subject to the general parameters in part 5221.6100, subpart 1. Other medical imaging studies are not indicated.

(4) Surgical evaluation may also include personality or psychological evaluation consistent with the parameters of subpart 1, item H.

(5) Consultation with other health care providers is an important part of surgical evaluation of a patient who fails to recover with appropriate initial nonsurgical management. The need for consultation and the choice of consultant will be determined by the diagnostic findings and the patient's condition. Consultation is governed by part 5221.6050, subpart 6.

(6) If surgery is indicated, it may not be performed until 12 months after initial nonsurgical management was begun except in a patient who has had resolution of symptoms with appropriate treatment followed by a recurrence with intractable pain. In this instance, a second surgical opinion must confirm the need for surgery sooner than 12 months after initial nonsurgical management was begun.

(7) If surgery is not indicated, or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

C. If the patient continues with symptoms and objective physical findings after surgery or the patient refused surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management according to part 5221.6600.

Subp. 12. Specific treatment parameters for tendonitis of forearm, wrist, and hand.

A. Except as provided in item B, subitem (3), initial nonsurgical management is appropriate for all patients with tendonitis and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A.

B. If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

(1) For patients with a specific diagnosis of de Quervain's syndrome, surgical evaluation and surgical therapy, if indicated, may begin after only two months of initial nonsurgical management.

(2) For patients with a specific diagnosis of trigger finger or trigger thumb, surgical evaluation and potential surgical therapy may begin after only one month of initial nonsurgical management.

(3) For patients with a locked finger or thumb, surgery may be indicated immediately without any preceding nonsurgical management.

C. If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with tendonitis must meet all of the parameters of part 5221.6600.

Subp. 13. Specific treatment parameters for nerve entrapment syndromes.

A. Initial nonsurgical management is appropriate for all patients with nerve entrapment syndromes, except as specified in subitem (2), and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A, with the following modifications: nonsurgical management may be inappropriate for patients with advanced symptoms and signs of nerve compression, such as abnormal two-point discrimination, motor weakness, or muscle atrophy, or for patients with symptoms of nerve entrapment due to acute trauma. In these cases, immediate surgical evaluation may be indicated.

B. If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

(1) Surgical evaluation may begin, and surgical therapy may be provided, if indicated, after 12 weeks of initial nonsurgical management, except where immediate surgical evaluation is indicated under item A.

(2) Surgery is indicated if an EMG confirms the diagnosis, or if there has been temporary resolution of symptoms lasting at least seven days with local injection.

(3) If there is neither a confirming EMG or appropriate response to local injection, or if surgery has been previously performed at the same site, surgery is not indicated unless a second opinion confirms the need for surgery.

C. If the patient continues with symptoms and objective physical findings after all surgery, or the patient refused surgery therapy or the patient was not a candidate for surgery therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or

program of chronic management for patients with nerve entrapment syndromes must meet all of the parameters of part 5221.6600.

Subp. 14. Specific treatment parameters for muscle pain syndromes.

A. Initial nonsurgical management is appropriate for all patients with muscle pain syndromes and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A.

B. Surgery is not indicated for the treatment of muscle pain syndrome.

C. If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with muscle pain syndrome must meet all of the parameters of part 5221.6600.

Subp. 15. Specific treatment parameters for shoulder impingement syndromes.

A. Initial nonsurgical management is appropriate for all patients with shoulder impingement syndromes without clinical evidence of rotator cuff tear and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A, except as follows:

(1) continued nonsurgical management may be inappropriate, and early surgical evaluation may be indicated, for patients with:

(a) clinical findings of rotator cuff tear; or

(b) acute rupture of the proximal biceps tendon;

(2) use of home-based treatment modalities with monitoring by the health care provider may continue for up to six months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

B. If the patient continues with symptoms and objective physical findings after six months of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

(1) Surgical evaluation must begin no later than six months after beginning initial nonsurgical management.

(2) Diagnostic injection, arthrography, CT-arthrography, or MRI scanning may be indicated as part of the surgical evaluation.

(3) The only surgical procedures indicated for patients with shoulder impingement syndrome and related conditions are rotator cuff repair, acromioplasty, excision of distal clavicle,

excision of bursa, removal of adhesion, or repair of proximal biceps tendon, all of which must meet the parameters of part 5221.6500, subpart 3.

C. If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery or was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with shoulder impingement syndrome must meet the parameters of part 5221.6600.

Subp. 16. Specific treatment parameters for traumatic sprains and strains of the upper extremity.

A. Initial nonsurgical management must be the first phase of treatment for all patients with traumatic sprains and strains of the upper extremity without evidence of complete tissue disruption. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11.

B. Surgery is not indicated for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

C. If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management must meet all of the parameters of part 5221.6600.

Statutory Authority: *MS s 14.386; 176.103; 176.135; 176.83*

History: *19 SR 1412; 35 SR 138; 40 SR 328*

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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. For treatment on or after October 1, 2015, an ICD-10-CM code that is equivalent to an applicable ICD-9-CM code listed in this subitem must be used instead of the ICD-9-CM code. The General Equivalence Mappings tool established by the Centers for Medicare and Medicaid Services must be used to determine the equivalent ICD-10-CM code or codes; 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.

B. Reflex sympathetic dystrophy occurs as a complication of another preceding injury. The treatment parameters of this part refer to the treatment of the body part affected by the reflex sympathetic dystrophy. The treatment for any condition not affected by reflex sympathetic dystrophy continues to be subject to whatever treatment parameters otherwise apply. Any treatment under this part for the reflex sympathetic dystrophy may be in addition to treatment received for the original condition.

C. Thermography may be used in the diagnosis of reflex sympathetic dystrophy, but is considered an adjunct to physical examination and is not reimbursed separately from the office visit.

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.

(c) Maximum treatment duration: may be continued as long as injections control symptoms and facilitate objective functional gains, if the period of improvement is progressively longer with each injection.

(2) Epidural block may only be performed in patients who had an incomplete improvement with sympathetic block or intravenous infusion of steroids or sympatholytics.

B. Only the passive treatment modalities set forth in subitems (1) to (4) are indicated. These passive treatment modalities in a clinical setting or requiring attendance by a health care provider are not indicated beyond 12 weeks from the first modality initiated for treatment of the reflex sympathetic dystrophy.

(1) Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(a) Treatment given in a clinical setting:

- i. time for treatment response, two to four treatments;
- ii. maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and
- iii. maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies specified in this subpart.

(b) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without professional assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

(2) Desensitizing procedures, such as stroking or friction massage, stress loading, and contrast baths:

- (a) time for treatment response, three to five treatments;
- (b) maximum treatment frequency in a clinical setting, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and
- (c) maximum treatment duration in a clinical setting, 12 weeks. Home use of desensitizing procedures may be prescribed at any time during the course of treatment.

(3) Electrical stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(a) Treatment given in a clinical setting:

- i. time for treatment response, two to four treatments;
- ii. maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and

iii. maximum treatment duration, 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

(b) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

i. time for patient education and training, one to three sessions; and

ii. patient may use the electrical stimulation device unsupervised for one month, at which time effectiveness of the treatment must be reevaluated by the provider before continuing home use of the device.

(4) Acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure:

(a) time for treatment response, three to five sessions;

(b) maximum treatment frequency, up to three times per week for the first one to three weeks, decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks.

C. Active treatment includes supervised and unsupervised exercise. After the first week of treatment, initial nonsurgical management must include exercise. Exercise is essential for a return to normal activity and must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must be specifically aimed at the involved musculature. Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation, and monthly thereafter.

(1) Supervised exercise. One goal of a supervised exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, up to five times per week for three weeks. Should decrease in frequency thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting and may supplement or follow the period of supervised exercise. Maximum duration is unlimited.

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.

Subp. 3. **Surgery.**

A. Surgical sympathectomy may only be performed in patients who had a sustained but incomplete improvement with sympathetic blocks by injection.

B. Spinal cord stimulators have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of a spinal cord stimulator is indicated because the patient:

- (a) has intractable pain;
- (b) is not a candidate for another surgical therapy; and

(c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefitting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment with a spinal cord stimulator is indicated if the psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to a spinal cord stimulator.

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

C. Intrathecal drug delivery systems have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of an intrathecal drug delivery system is indicated because the patient:

- (a) has intractable pain;
- (b) is not a candidate for another surgical therapy; and

(c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefitting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment with an intrathecal drug delivery system is indicated if the psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to an intrathecal drug delivery system.

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

Subp. 4. **Chronic management.** If the patient continues with symptoms and objective physical findings after surgery, or the patient refuses surgery, or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management must satisfy all of the treatment parameters of part 5221.6600.

Statutory Authority: *MS s 14.386; 176.103; 176.135; 176.83*

History: *19 SR 1412; 35 SR 138; 39 SR 286; 40 SR 328*

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5221.6400 INPATIENT HOSPITALIZATION PARAMETERS.

Subpart 1. General principles.

A. The health care provider must provide prior notification of inpatient hospital admission for nonemergency care according to part 5221.6050, subpart 9. Hospitalization is characterized as inpatient if the patient spends at least one night in the hospital.

B. Treatment for emergency conditions, including incapacitating pain, should not be delayed to provide the insurer with prior notification. The admitting health care provider should notify the insurer within two business days following an emergency admission, or within two business days after the health care provider learns that it is a workers' compensation injury. The medical necessity for the emergency hospitalization is subject to retrospective review, based on the information available at the time of the emergency hospitalization.

C. Unless the patient's condition requires special care, only ward or semiprivate accommodations are indicated. The admitting health care provider must document the special care needs.

D. Admissions before the day of surgery are indicated only if they are medically necessary to stabilize the patient before surgery. Admission before the day of surgery to perform any or all of a preoperative work-up which could have been completed as an outpatient is not indicated.

E. Inpatient hospitalization solely for physical therapy, bedrest, or administration of injectable drugs is indicated only if the treatment is otherwise indicated and the patient's condition makes the patient unable to perform the activities of daily life and participate in the patient's own treatment and self-care.

F. Discharge from the hospital must be at the earliest possible date consistent with proper health care.

G. If transfer to a convalescent center or nursing home is indicated, prior notification is required as provided for inpatient hospitalization.

Subp. 2. Specific requirements for hospital admission of patients with low back pain. Hospitalization for low back pain is indicated in the circumstances in items A to D.

A. When the patient experiences incapacitating pain as evidenced by inability to mobilize for activities of daily living, for example unable to ambulate to the bathroom, and in addition, the intensity of service during admission meets the criteria in subitems (1) and (2).

(1) Physical therapy is necessary at least twice daily for assistance with mobility. Heat, cold, ultrasound, and massage therapy alone do not meet this criterion.

(2) Muscle relaxants or narcotic analgesics are necessary intramuscularly or intravenously for a minimum of three injections in 24 hours. Need for parenteral analgesics is determined by:

(a) an inability to take oral medications or diet (N.P.O.); or

(b) an inability to achieve relief with aggressive oral analgesics.

B. For surgery which is otherwise indicated according to part 5221.6500 and is appropriately scheduled as an inpatient procedure.

C. For evaluation and treatment of cauda equina syndrome, according to part 5221.6200, subpart 13.

D. For evaluation and treatment of foot drop or progressive neurologic deficit, according to part 5221.6200, subpart 13.

Statutory Authority: *MS s 176.103; 176.83*

History: *19 SR 1412*

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5221.6500 PARAMETERS FOR SURGICAL PROCEDURES.

Subpart 1. General.

A. The health care provider must provide prior notification according to part 5221.6050, subpart 9, before proceeding with any elective inpatient surgery.

B. Emergency surgery may proceed without prior notification. The reasonableness and necessity for the emergency surgery is subject to retrospective review based on the information available at the time of the emergency surgery.

C. For treatment on or after October 1, 2015, an ICD-10-CM code that is equivalent to an applicable ICD-9-CM code listed in this part must be used instead of the ICD-9-CM code. The

General Equivalence Mappings tool established by the Centers for Medicare and Medicaid Services must be used to determine the equivalent ICD-10-CM code or codes.

Subp. 2. **Spinal surgery.** Initial nonsurgical, surgical, and chronic management parameters are also included in parts 5221.6200, low back pain; 5221.6205, neck pain; and 5221.6210, thoracic back pain.

A. Surgical decompression of a lumbar nerve root or roots includes, but is not limited to, the following lumbar procedures: laminectomy, laminotomy, discectomy, microdiscectomy, percutaneous discectomy, or foraminotomy. When providing prior notification for decompression of multiple nerve roots, the procedure at each nerve root is subject independently to the requirements of subitems (1) to (3).

(1) Diagnoses: surgical decompression of a lumbar nerve root may be performed for the following diagnoses:

(a) intractable and incapacitating regional low back pain with positive nerve root tension signs and an imaging study showing displacement of lumbar intervertebral disc which impinges significantly on a nerve root or the thecal sac, ICD-9-CM code 722.10;

(b) sciatica, ICD-9-CM code 724.3; or

(c) lumbosacral radiculopathy or radiculitis, ICD-9-CM code 724.4.

(2) Indications: both of the following conditions in units (a) and (b) must be satisfied to indicate that the surgery is reasonably required.

(a) Response to nonsurgical care: the employee's condition includes one of the following:

i. failure to improve with a minimum of eight weeks of initial nonsurgical care;

or

ii. cauda equina syndrome, ICD-9-CM code 344.6, 344.60, or 344.61; or

iii. progressive neurological deficits.

(b) Clinical findings: the employee exhibits one of the findings of subunit i in combination with the test results of subunit ii or, in the case of diagnosis in subitem (1), unit (a), a second opinion confirms that decompression of the lumbar nerve root is the appropriate treatment for the patient's condition:

i. subjective sensory symptoms in a dermatomal distribution which may include radiating pain, burning, numbness, tingling, or paresthesia, or objective clinical findings of nerve root specific motor deficit, including, but not limited to, foot drop or quadriceps weakness, reflex changes, or positive EMG; and

ii. medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(3) Repeat surgical decompression of a lumbar nerve root is not indicated at the same nerve root unless a second opinion, if requested by the insurer, confirms that surgery is indicated.

B. Surgical decompression of a cervical nerve root. Surgical decompression of a cervical nerve root or roots includes, but is not limited to, the following cervical procedures: laminectomy, laminotomy, discectomy, foraminotomy with or without fusion. When providing prior notification for decompression of multiple nerve roots, the procedure at each nerve root is subject independently to the requirements of subitems (1) to (3).

(1) Diagnoses: surgical decompression of a cervical nerve root may be performed for the following diagnoses:

(a) displacement of cervical intervertebral disc, ICD-9-CM code 722.0, excluding fracture; or

(b) cervical radiculopathy or radiculitis, ICD-9-CM code 723.4, excluding fracture.

(2) Indications: the requirements in units (a) and (b) must be satisfied to indicate that surgery is reasonably required:

(a) response to nonsurgical care, the employee's condition includes one of the following:

i. failure to improve with a minimum of eight weeks of initial nonsurgical care;

ii. cervical compressive myelopathy; or

iii. progressive neurologic deficits;

(b) clinical findings: the employee exhibits one of the findings of subunit i, in combination with the test results of subunit ii:

i. subjective sensory symptoms in a dermatomal distribution which may include radiating pain, burning, numbness, tingling, or paresthesia, or objective clinical findings of nerve root specific motor deficit, reflex changes, or positive EMG; and

ii. medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(3) Second opinions: surgical decompression of a cervical nerve root is not indicated for the following conditions, unless a second opinion, if requested by the insurer, confirms that the surgery is indicated:

(a) repeat surgery at same level; or

(b) request for surgery at the C3-4 level.

C. Lumbar arthrodesis with or without instrumentation.

(1) Indications: one of the following conditions must be satisfied to indicate that the surgery is reasonably required:

(a) unstable lumbar vertebral fracture, ICD-9-CM codes 805.4, 805.5, 806.4, and 806.5; or

(b) for a second or third surgery only, documented reextrusion or redisplacement of lumbar intervertebral disc, ICD-9-CM code 722.10, after previous successful disc surgery at the same level and new lumbar radiculopathy with or without incapacitating back pain, ICD-9-CM code 724.4. Documentation under this item must include an MRI or CT scan or a myelogram; or

(c) traumatic spinal deformity including a history of compression (wedge) fracture or fractures, ICD-9-CM code 733.1, and demonstrated acquired kyphosis or scoliosis, ICD-9-CM codes 737.1, 737.10, 737.30, 737.41, and 737.43; or

(d) incapacitating low back pain, ICD-9-CM code 724.2, for longer than three months, and one of the following conditions involving lumbar segments L-3 and below is present:

i. for the first surgery only, degenerative disc disease, ICD-9-CM code 722.4, 722.5, 722.6, or 722.7, with postoperative documentation of instability created or found at the time of surgery, or positive discogram at one or two levels; or

ii. pseudoarthrosis, ICD-9-CM code 733.82;

iii. for the second or third surgery only, previously operated disc; or

iv. spondylolisthesis.

(2) Contraindications: lumbar arthrodesis is not indicated as the first primary surgical procedure for a new, acute lumbosacral disc herniation with unilateral radiating leg pain in a radicular pattern with or without neurological deficit.

(3) Retrospective review: when lumbar arthrodesis is performed to correct instability created during a decompression, laminectomy, or discectomy, approval for the arthrodesis will be based on a retrospective review of the operative report.

Subp. 3. **Upper extremity surgery.** Initial nonsurgical, surgical, and chronic management parameters for upper extremity disorders are found in part 5221.6300, subparts 1 to 16.

A. Rotator cuff repair:

(1) Diagnoses: rotator cuff surgery may be performed for the following diagnoses:

(a) rotator cuff syndrome of the shoulder, ICD-9-CM code 726.1, and allied disorders: unspecified disorders of shoulder bursae and tendons, ICD-9-CM code 726.10, calcifying tendinitis of shoulder, ICD-9-CM code 726.11, bicipital tenosynovitis, ICD-9-CM code 726.12, and other specified disorders, ICD-9-CM code 726.19; or

(b) tear of rotator cuff, ICD-9-CM code 727.61.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), both of the following conditions must be satisfied to indicate that surgery is reasonably required:

(a) response to nonsurgical care: the employee's condition has failed to improve with adequate initial nonsurgical treatment; and

(b) clinical findings: the employee exhibits:

- i. severe shoulder pain and inability to elevate the shoulder; or
- ii. weak or absent abduction and tenderness over rotator cuff, or pain relief obtained with an injection of anesthetic for diagnostic or therapeutic trial; and
- iii. positive findings in arthrogram, MRI, or ultrasound, or positive findings on previous arthroscopy, if performed.

B. Acromioplasty:

(1) Diagnosis: acromioplasty may be performed for acromial impingement syndrome, ICD-9-CM codes 726.0 to 726.2.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), both of the following conditions must be satisfied for acromioplasty:

(a) response to nonsurgical care: the employee's condition has failed to improve after adequate initial nonsurgical care; and

(b) clinical findings: the employee exhibits pain with active elevation from 90 to 130 degrees and pain at night, and a positive impingement test.

C. Repair of acromioclavicular or costoclavicular ligaments:

(1) Diagnosis: surgical repair of acromioclavicular or costoclavicular ligaments may be performed for acromioclavicular separation, ICD-9-CM codes 831.04 to 831.14.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), the requirements of units (a) and (b) must be satisfied for repair of acromioclavicular or costoclavicular ligaments:

(a) response to nonsurgical care: the employee's condition includes:

- i. failure to improve after at least a one-week trial period in a support brace; or
- ii. separation cannot be reduced and held in a brace; or
- iii. grade III separation has occurred; and

(b) clinical findings: the employee exhibits localized pain at the acromioclavicular joint and prominent distal clavicle and radiographic evidence of separation at the acromioclavicular joint.

D. Excision of distal clavicle:

(1) Diagnosis: excision of the distal clavicle may be performed for the following conditions:

- (a) acromioclavicular separation, ICD-9-CM codes 831.01 to 831.14;
- (b) osteoarthritis of the acromioclavicular joint, ICD-9-CM codes 715.11, 715.21, and 715.31; or
- (c) shoulder impingement syndrome.

(2) Criteria and indications: in addition to one of the diagnosis in subitem (1), the following conditions must be satisfied for excision of distal clavicle:

(a) response to nonsurgical care: the employee's condition fails to improve with adequate initial nonsurgical care; and

(b) clinical findings: the employee exhibits:

i. pain at the acromioclavicular joint, with aggravation of pain with motion of shoulder or carrying weight;

ii. confirmation that separation of AC joint is unresolved and prominent distal clavicle, or pain relief obtained with an injection of anesthetic for diagnostic/therapeutic trial; and

iii. separation at the acromioclavicular joint with weight-bearing films, or severe degenerative joint disease at the acromioclavicular joint noted on X-rays.

E. Repair of shoulder dislocation or subluxation (any procedure):

(1) Diagnosis: surgical repair of a shoulder dislocation may be performed for the following diagnoses:

(a) recurrent dislocations, ICD-9-CM code 718.31;

(b) recurrent subluxations; or

(c) persistent instability following traumatic dislocation.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following clinical findings must exist for repair of a shoulder dislocation:

(a) the employee exhibits a history of multiple dislocations or subluxations that inhibit activities of daily living; and

(b) X-ray findings are consistent with multiple dislocations or subluxations.

F. Repair of proximal biceps tendon:

(1) Diagnosis: surgical repair of a proximal biceps tendon may be performed for proximal rupture of the biceps, ICD-9-CM code 727.62 or 840.8.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), both of the following conditions must be satisfied for repair of proximal biceps tendon:

(a) the procedure may be done alone or in conjunction with another indicated repair of the rotator cuff; and

(b) clinical findings: the employee exhibits:

- i. complaint of pain that does not resolve with attempt to use arm; and
- ii. palpation of "bulge" in upper aspect of arm.

G. Epicondylitis. Specific requirements for surgery for epicondylitis are included in part 5221.6300, subpart 11.

H. Tendinitis. Specific requirements for surgery for tendinitis are included in part 5221.6300, subpart 12.

I. Nerve entrapment syndromes. Specific requirements for nerve entrapment syndromes are included in part 5221.6300, subpart 13.

J. Muscle pain syndromes. Surgery is not indicated for muscle pain syndromes.

K. Traumatic sprains and strains. Surgery is not indicated for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

Subp. 4. **Lower extremity surgery.**

A. Anterior cruciate ligament (ACL) reconstruction:

(1) Diagnoses: surgical repair of the anterior cruciate ligament, including arthroscopic repair, may be performed for the following diagnoses:

- (a) old disruption of anterior cruciate ligament, ICD-9-CM code 717.83; or
- (b) sprain of cruciate ligament of knee, ICD-9-CM code 844.2.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1) the conditions in units (a) to (c) must be satisfied for anterior cruciate ligament reconstruction. Pain alone is not an indication:

(a) the employee gives a history of instability of the knee described as "buckling or giving way" with significant effusion at time of injury, or description of injury indicates a rotary twisting or hyperextension occurred;

(b) there are objective clinical findings of positive Lachman's sign, positive pivot shift, and/or positive anterior drawer; and

(c) there are positive diagnostic findings with arthrogram, MRI, or arthroscopy and there is no evidence of severe compartmental arthritis.

B. Patella tendon realignment or Maquet procedure:

(1) Diagnosis: patella tendon realignment may be performed for dislocation of patella, open, ICD-9-CM code 836.3, or closed, ICD-9-CM code 836.4, or chronic residuals of dislocation.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), all of the following conditions must be satisfied for a patella tendon realignment:

(a) the employee gives a history of rest pain as well as pain with patellofemoral movement, and recurrent effusion, or recurrent dislocation; and

(b) there are objective clinical findings of patellar apprehension, synovitis, lateral tracking, or Q angle greater than 15 degrees.

C. Knee joint replacement:

(1) Diagnoses: knee joint replacement may be performed for degeneration of articular cartilage or meniscus of knee, ICD-9-CM codes 717.1 to 717.4.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), the following conditions must be satisfied for a knee joint replacement:

(a) clinical findings: the employee exhibits limited range of motion, night pain in the joint or pain with weight-bearing, and no significant relief of pain with an adequate course of initial nonsurgical care; and

(b) diagnostic findings: there is significant loss or erosion of cartilage to the bone, and positive findings of advanced arthritis and joint destruction with standing films, MRI, or arthroscopy.

D. Fusion; ankle, tarsal, metatarsal:

(1) Diagnoses: fusion may be performed for the following conditions:

(a) malunion or nonunion of fracture of ankle, tarsal, or metatarsal, ICD-9-CM code 733.81 or 733.82; or

(b) traumatic arthritis (arthropathy), ICD-9-CM code 716.17.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following conditions must be satisfied for an ankle, tarsal, or metatarsal fusion:

(a) initial nonsurgical care: the employee must have failed to improve with an adequate course of initial nonsurgical care which included:

i. immobilization which may include casting, bracing, shoe modification, or other orthotics; and

ii. anti-inflammatory medications;

(b) clinical findings:

i. the employee gives a history of pain which is aggravated by activity and weight-bearing, and relieved by xylocaine injection; and

ii. there are objective findings on physical examination of malalignment or specific joint line tenderness, and decreased range of motion; and

(c) diagnostic findings: there are medical imaging studies confirming the presence of:

i. loss of articular cartilage and joint space narrowing;

ii. bone deformity with hypertrophic spurring and sclerosis; or

iii. nonunion or malunion of a fracture.

E. Lateral ligament ankle reconstruction:

(1) Diagnoses: ankle reconstruction surgery involving the lateral ligaments may be performed for the following conditions:

(a) chronic ankle instability, ICD-9-CM code 718.87; or

(b) grade III sprain, ICD-9-CM codes 845.0 to 845.09.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following conditions must be satisfied for a lateral ligament ankle reconstruction:

(a) initial nonsurgical care: the employee must have received an adequate course of initial nonsurgical care including, at least:

i. immobilization with support, cast, or ankle brace, followed by

ii. a physical rehabilitation program; and

(b) clinical findings:

i. the employee gives a history of ankle instability and swelling; and

ii. there is a positive anterior drawer sign on examination; or

iii. there are positive stress X-rays identifying motion at ankle or subtalar joint with at least a 15 degree lateral opening at the ankle joint, or demonstrable subtalar movement, and negative to minimal arthritic joint changes on X-ray, or ligamentous injury is shown on MRI scan.

(3) Prosthetic ligaments: prosthetic ligaments are not indicated.

(4) Implants: requests for any plastic implant must be confirmed by a second opinion.

(5) Calcaneus osteotomy: requests for calcaneus osteotomies must be confirmed by a second opinion.

Statutory Authority: *MS s 14.386; 176.103; 176.135; 176.83*

History: 19 SR 1412; 40 SR 328

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5221.6600 CHRONIC MANAGEMENT.

Subpart 1. **Scope.** This part applies to chronic management of all types of physical injuries, even if the injury is not specifically governed by parts 5221.6200 to 5221.6500. If a patient continues with symptoms and physical findings after all appropriate initial nonsurgical and surgical treatment has been rendered, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. The purpose of chronic management is twofold: the patient should be made independent of health care providers in the ongoing care of a chronic condition; and the patient should be returned to the highest functional status reasonably possible.

A. Personality or psychological evaluation may be indicated for patients who are candidates for chronic management. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

- (1) Is symptom magnification occurring?
- (2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?
- (3) Are there other personality factors or disorders which are interfering with recovery?
- (4) Is the patient chemically dependent?
- (5) Are there any interpersonal conflicts interfering with recovery?
- (6) Does the patient have a chronic pain syndrome or psychogenic pain?
- (7) In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

B. Any of the chronic management modalities of subpart 2 may be used singly or in combination as part of a program of chronic management.

C. No further passive treatment modalities or therapeutic injections are indicated, except as otherwise provided in parts 5221.6200, subpart 3, item B; 5221.6205, subpart 3, item B; 5221.6210, subpart 3, item B; and 5221.6300, subpart 3, item B.

D. No further diagnostic evaluation is indicated unless there is the development of symptoms or physical findings which would in themselves warrant diagnostic evaluation.

E. A program of chronic management must include appropriate means by which use of scheduled medications can be discontinued or severely limited.

Subp. 2. **Chronic management modalities.** The health care provider must provide prior notification of the chronic management modalities in items B to F according to part 5221.6050, subpart 9. Prior notification is not required for home-based exercises in item A, unless durable medical equipment is prescribed for home use. The insurer may not deny payment for a program of chronic management that the insurer has previously authorized for an employee, either in writing or by routine payment for services, without providing the employee and the employee's health care provider with at least 30 days' notice of intent to apply any of the chronic management parameters in part 5221.6600 to future treatment. The notice must include the specific parameters that will be applied in future determinations of compensability by the insurer.

A. Home-based exercise programs consist of aerobic conditioning, stretching and flexibility exercises, and strengthening exercises done by the patient on a regular basis at home without the need for supervision or attendance by a health care provider. Maximum effectiveness may require the use of certain durable medical equipment that may be prescribed and reimbursed within any applicable treatment parameters in parts 5221.6200 to 5221.6305.

(1) Indications: exercise is necessary on a long-term basis to maintain function.

(2) Requirements: the patient should receive specific instruction and training in the exercise program. Repetitions, durations, and frequencies of exercises must be specified. Any durable medical equipment needed must be prescribed in advance and the insurer must be given prior notification of proposed purchase.

(3) Treatment period, one to three visits for instruction and monitoring.

B. Health clubs:

(1) Indications: the patient is deconditioned and requires a structured environment to perform prescribed exercises. The health care provider must document the reasons why reconditioning cannot be accomplished with a home-based program of exercise.

(2) Requirements: the program must have specific prescribed exercises stated in objective terms, for example "30 minutes riding stationary bicycle three times per week." There must be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a prescribed frequency of attendance and the patient must maintain adequate documentation of attendance. There must be a prescribed duration of attendance.

(3) Treatment period, 13 weeks. Additional periods of treatment require additional prior notification of the insurer. Additional periods of treatment at a health club are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment. If the employer has an appropriate exercise facility on its premises the insurer may mandate use of that facility instead of providing a health club membership.

C. Computerized exercise programs utilize computer controlled exercise equipment that allows for the isolation of specific muscle groups and the performance of graded exercise designed to increase strength, tone, flexibility, and range of motion. In combination with computerized range of motion or strength measuring tests, these programs allow for quantitative measurement of effort and progress.

(1) Indications: the patient is deconditioned and requires a structured environment to accomplish rehabilitation goals. The health care provider must document the reasons why reconditioning cannot be accomplished with a home-based program of exercise.

(2) Requirements: the program must have specific goals stated in objective terms, for example "improve strength of back extensors 50 percent." There must be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a prescribed frequency and duration of attendance.

(3) Treatment period, six weeks. Additional periods of treatment require additional prior notification of the insurer. Additional periods of treatment are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment.

D. Work conditioning and work hardening programs are intensive, highly structured, job oriented, individualized treatment plans based on an assessment of the patient's work setting or job demands, and designed to maximize the patient's return to work. These programs must include real or simulated work activities. Work conditioning is designed to restore an individual's neuromusculoskeletal strength, endurance, movement, flexibility, and motor control, and cardiopulmonary function. Work conditioning uses physical conditioning and functional activities related to the individual's work. Services may be provided by one discipline of health care provider. Work hardening is designed to restore an individual's physical, behavioral, and vocational functions within an interdisciplinary model. Work hardening addresses the issues of productivity, safety, physical tolerances, and work behaviors. An interdisciplinary team includes professionals qualified to evaluate and treat behavioral, vocational, physical, and functional needs of the individual.

(1) Indications: the patient is disabled from usual work and requires reconditioning for specific job tasks or activities and the reconditioning cannot be done on the job. The health care provider must document the reasons why work hardening cannot be accomplished through a structured return to work program. Work conditioning is indicated where only physical and functional needs are identified. Work hardening is indicated where, in addition to physical and functional needs, behavioral and vocational needs are also identified that are not otherwise being addressed.

(2) Requirements: the program must have specific goals stated in terms of work activities, for example "able to type for 30 minutes." There must be an individualized program of activities and the activities must be chosen to simulate required work activities or to enable the patient to participate in simulated work activities. There must be a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a set frequency and hours of attendance and the program must maintain adequate documentation of attendance. There must be a set duration of attendance. Activity restrictions must be identified at completion of the program.

(3) Treatment period, six weeks. Additional periods of treatment require prior notification of the insurer. Additional periods of treatment at a work hardening program or work conditioning program are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment or unless there has been a change in the patient's targeted return to work job which necessitates a redesign of the program.

E. Chronic pain management programs consist of multidisciplinary teams who provide coordinated, goal-oriented services to reduce pain disability, improve functional status, promote return to work, and decrease dependence on the health system of persons with chronic pain syndrome. Pain management programs must provide physical rehabilitation, education on pain, relaxation training, psychosocial counseling, medical evaluation, and, if indicated, chemical dependency evaluation. The program of treatment must be individualized and based on an organized evaluative process for screening and selecting patients. Treatment may be provided in an inpatient setting, outpatient setting, or both as appropriate.

(1) Indications: the patient is diagnosed as having a chronic pain syndrome.

(2) Requirements: an admission evaluation must be performed by a doctor, and a licensed mental health professional, each with at least two years experience in evaluation of chronic pain patients and chronic pain treatment, or one year of formal training in a pain fellowship program. The evaluation must confirm the diagnosis of chronic pain syndrome and a willingness and ability of the patient to benefit from a pain management program. There must be a specific set of prescribed activities and treatments, and a specific timetable of progression in those activities. There must be a set frequency and hours of attendance and the program must maintain adequate documentation of attendance. There must be a set duration of attendance.

(3) Treatment period: for initial treatment, a maximum of 20 eight-hour days, though fewer or shorter days can be used, and a maximum duration of four weeks no matter how many or how long the days prescribed. For aftercare, a maximum of 12 sessions is allowed. Only one completed pain management program is indicated for an injury.

F. Individual or group psychological or psychiatric counseling.

(1) Indications: a personality or psychosocial evaluation has revealed one or more of the problems listed in subpart 1, item A, which interfere with recovery from the physical injury, but the patient does not need or is not a candidate for a pain management program.

(2) Requirements: there must be a specific set of goals based on the initial personality or psychosocial evaluation and a timetable for achieving those goals within the prescribed number of treatment or therapy sessions. There must be a prescribed frequency of attendance and the treating health care provider must maintain adequate documentation of attendance. There must be a prescribed duration of treatment.

(3) Treatment period: a maximum of 12 sessions. Only one completed program of individual or group psychological or psychiatric counseling is indicated for an injury.

Statutory Authority: *MS s 176.103; 176.83*

History: 19 SR 1412

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5221.8900 DISCIPLINARY ACTION; PENALTIES.

Subpart 1. **Discipline.** A health care provider is subject to disciplinary action under Minnesota Statutes, section 176.103, for failure to comply with the requirements in parts 5221.6010 to 5221.6600 or the violation of any of the provisions of Minnesota Statutes, chapter 176, or other rules or orders issued pursuant thereto.

Subp. 2. **Complaints.** Complaints about professional behavior or services of health care providers relating to noncompliance with established workers' compensation laws, rules, or orders shall be made in writing to the commissioner. The commissioner or a designee shall assist a person in filing a complaint, if necessary. A complaint may be submitted by any person who becomes aware of a violation, including designees of the commissioner, administrative law judges, and presiding officials at judicial proceedings.

Subp. 3. **Review and investigation.** The commissioner shall investigate all complaints to determine whether there has been a violation of established workers' compensation laws, rules, or orders. The commissioner may refer a matter to another agency that has jurisdiction over the provider's license or conduct, or to an agency that has prosecuting authority in the event of suspected theft or fraud or to a peer review organization for an opinion. Absent suspected theft or fraud, providing treatment outside a parameter set forth in parts 5221.6020 to 5221.6500 shall not in itself result in a referral to a prosecuting authority.

If an investigation indicates that discipline may be warranted, the commissioner shall determine whether the violation involves inappropriate, unnecessary, or excessive treatment, or whether the violation involves other statutes or rules. The commissioner shall take appropriate action according to subpart 6, 7, or 8.

Subp. 4. **Cooperation with disciplinary proceedings.** A health care provider who is the subject of a complaint investigated by the commissioner under Minnesota Statutes, section 176.103, shall cooperate fully with the investigation. Cooperation includes, but is not limited to, responding fully and promptly to any questions raised by the commissioner relating to the subject of the investigation and providing copies of records, reports, logs, data, and cost information as requested by the commissioner to assist in the investigation. The health care provider shall not charge for services but may charge for the cost of copies of medical records, at the rate set in part 5219.0300, subpart 2, for this investigation. Cooperation includes attending, in person, a meeting scheduled by the commissioner for the purposes of subpart 5. This subpart does not limit the health care provider's right to be represented by an attorney.

Subp. 5. **In-person meeting.** When conferring with the parties to a complaint is deemed appropriate, the commissioner shall schedule a meeting for the purpose of clarification of issues, obtaining information, instructing parties to the complaint, or for the purpose of resolving disciplinary issues.

Subp. 6. **Resolution by instruction or written agreement.** The commissioner may resolve a complaint through instruction of a provider, or may enter into stipulated consent agreements regarding discipline with a provider in lieu of initiating a contested case or medical services review board proceeding.

Subp. 7. **Inappropriate, unnecessary, or excessive treatment.**

A. Except as otherwise provided in subparts 3 and 6, if the suspected violation involves a treatment standard set forth in parts 5221.6020 to 5221.6500 the commissioner must refer the health care provider to the medical services review board for review under Minnesota Statutes, section 176.103, subdivision 2, if:

(1) the situation requires medical expertise in matters beyond the department's general scope;

(2) wherever possible under Minnesota Statutes, chapter 176, a final determination has been made by a workers' compensation presiding official, or provider licensing or registration body that the medical treatment in issue was inappropriate, unnecessary, or excessive; and

(3) a pattern of consistently providing inappropriate, unnecessary, or excessive services exists for three or more employees.

B. Where the medical service review board's report to the commissioner indicates a violation of treatment standards or other inappropriate, unnecessary, or excessive treatment the commissioner shall order a sanction. Sanctions may include, but are not limited to, a warning; a fine of up to \$200 per violation; a restriction on providing treatment; requiring preauthorization by the board, the payor, or the commissioner for a plan of treatment; and suspension from receiving compensation for the provision of treatment.

C. Within 30 days of receipt of the order of sanction, the health care provider may request in writing a review by the commissioner of the sanction in accordance with the procedure set forth in Minnesota Statutes, section 176.103, subdivision 2a. Within 30 days following receipt of the compensation judge's decision reviewing the sanction, a provider may petition the Workers' Compensation Court of Appeals for review according to the procedures in Minnesota Statutes, section 176.103, subdivision 2a.

Subp. 8. **Violations of statutes and rules other than those involving inappropriate, unnecessary, or excessive treatment.** If the suspected violation warranting discipline involves a statute or rule other than treatment standards, the commissioner shall initiate a contested case hearing for disciplinary action under Minnesota Statutes, section 176.103, subdivision 3, paragraph (b), and the administrative procedure act in Minnesota Statutes, chapter 14.

A. Upon petition of the commissioner and following receipt of the recommendation of the administrative law judge, the medical services review board may issue a fine of up to \$200 for each violation, or disqualify or suspend the health care provider from receiving payment for services, according to Minnesota Statutes, section 176.103, subdivision 3, paragraph (b).

B. Within 30 days after service of the board's decision, a provider may petition the Workers' Compensation Court of Appeals for review according to Minnesota Statutes, section 176.421.

Subp. 9. **Penalties.** In addition to disciplinary action under subparts 1 to 8, the commissioner may assess a penalty under part 5220.2810 if a health care provider fails to release existing written medical data according to Minnesota Statutes, section 176.138. A penalty may also be assessed under part 5220.2830 and Minnesota Statutes, section 176.231, subdivision 10, if a health care provider fails to provide reports required by part 5221.0410.

Statutory Authority: *MS s 176.103; 176.83*

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