176.136 MEDICAL FEE REVIEW.

Subdivision 1. **Schedule.** (a) The commissioner shall by rule establish procedures for determining whether or not the charge for a health service is excessive. In order to accomplish this purpose, the commissioner shall consult with insurers, associations and organizations representing the medical and other providers of treatment services and other appropriate groups.

(b) The procedures established by the commissioner must limit, in accordance with subdivisions 1a, 1b, and 1c, the charges allowable for medical, chiropractic, podiatric, surgical, hospital and other health care provider treatment or services, as defined and compensable under section 176.135. The procedures established by the commissioner for determining whether or not the charge for a health service is excessive must be structured to encourage providers to develop and deliver services for rehabilitation of injured workers. The procedures must incorporate the provisions of sections 144.701, 144.702, and 144.703 to the extent that the commissioner finds that these provisions effectively accomplish the intent of this section or are otherwise necessary to ensure that quality hospital care is available to injured employees.

Subd. 1a. **Relative value fee schedule.** (a) The liability of an employer for services included in the medical fee schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee, whichever is lower. The commissioner shall adopt permanent rules regulating fees allowable for medical, chiropractic, podiatric, surgical, and other health care provider treatment or service, including those provided to hospital outpatients, by implementing a relative value fee schedule. The commissioner may adopt by reference, according to the procedures in paragraph (h), clause (2), the relative value fee schedule tables adopted for the federal Medicare program. The relative value fee schedule must contain reasonable classifications including, but not limited to, classifications that differentiate among health care provider disciplines. The conversion factors for the original relative value fee schedule must reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in effect. The reduction need not be applied equally to all treatment or services, but must represent a gross 15 percent reduction.

(b) Effective October 1, 2005, the commissioner shall remove all scaling factors from the relative value units and establish four separate conversion factors according to paragraphs (c) and (d) for each of the following parts of Minnesota Rules:

(1) medical/surgical services in Minnesota Rules, part 5221.4030, as defined in part 5221.0700, subpart 3, item C, subitem (2);

(2) pathology and laboratory services in Minnesota Rules, part 5221.4040, as defined in part 5221.0700, subpart 3, item C, subitem (3);

(3) physical medicine and rehabilitation services in Minnesota Rules, part 5221.4050, as defined in part 5221.0700, subpart 3, item C, subitem (4); and

(4) chiropractic services in Minnesota Rules, part 5221.4060, as defined in part 5221.0700, subpart 3, item C, subitem (5).

(c) The four conversion factors established under paragraph (b) shall be calculated so that there is no change in each maximum fee for each service under the current fee schedule, except as provided in paragraphs (d) and (e).

(d) By October 1, 2006, the conversion factor for chiropractic services described in paragraph (b), clause (4), shall be increased to equal 72 percent of the conversion factor for

medical/surgical services described in paragraph (b), clause (1). Beginning October 1, 2005, the increase in chiropractic conversion factor shall be phased in over two years by approximately equal percentage point increases.

(e) When adjusting the conversion factors in accordance with paragraph (g) on October 1, 2005, and October 1, 2006, the commissioner may adjust by no less than zero, all of the conversion factors as necessary to offset any overall increase in payments under the fee schedule resulting from the increase in the chiropractic conversion factor.

(f) The commissioner shall give notice of the relative value units and conversion factors established under paragraphs (b), (c), and (d) according to the procedures in section 14.386, paragraph (a). The relative value units and conversion factors established under paragraphs (b), (c), and (d) are not subject to expiration under section 14.386, paragraph (b).

(g) The conversion factors shall be adjusted as follows:

(1) After permanent rules have been adopted to implement this section, the conversion factors must be adjusted annually on October 1 by no more than the percentage change computed under section 176.645, but without the annual cap provided by that section.

(2) Each time the workers' compensation relative value fee schedule tables are updated under paragraph (h), the commissioner shall adjust the conversion factors so that, for services in both fee schedules, there is no difference between the overall payment in each category of service listed in paragraph (b) under the new schedule and the overall payment for that category under the workers' compensation fee schedule most recently in effect. This adjustment must be made before making any additional adjustment under clause (1).

(h) The commissioner shall give notice of the adjusted conversion factors and updates to the relative value fee schedule as follows:

(1) The commissioner shall annually give notice in the State Register of the adjusted conversion factors and any amendments to rules to implement Medicare relative value tables incorporated by reference under this subdivision. The notices of the adjusted conversion factors and amended rules to implement the relative value tables are subject to the requirements of section 14.386, paragraph (a). The annual adjustments to the conversion factors and the medical fee schedules adopted under this section, including all previous fee schedules, are not subject to expiration under section 14.386, paragraph (b).

(2) The commissioner shall periodically, but at least once every three years, update the workers' compensation relative value tables by incorporating by reference the relative value tables in the national physician fee schedule relative value file established by the Centers for Medicare and Medicaid Services. The commissioner shall publish the notices of the incorporation by reference in the State Register at least 60 days before the tables are to become effective for purposes of payment under this section. Each notice of incorporation must state the date the incorporated tables will become effective and must include information on how the Medicare relative value tables may be obtained. The published notices of incorporation by reference and the incorporated tables are not rules subject to section 14.386 or other provisions of chapter 14, but have the force and effect of law as of the date specified in the notices.

Subd. 1b. **Limitation of liability.** (a) The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a small hospital shall be the hospital's usual and customary charge, unless the charge is determined by the commissioner

or a compensation judge to be unreasonably excessive. A "small hospital," for purposes of this paragraph, is a hospital which has 100 or fewer licensed beds.

(b) The liability of the employer for the treatment, articles, and supplies that are not limited by subdivision 1a or 1c or paragraph (a) shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower. On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph. A prevailing charge established under Minnesota Rules, part 5221.0500, subpart 2, must be based on no more than two years of billing data immediately preceding the date of the service.

(c) The limitation of liability for charges provided by paragraph (b) does not apply to a nursing home that participates in the medical assistance program and whose rates are established by the commissioner of human services.

(d) An employer's liability for treatment, articles, and supplies provided under this chapter by a health care provider located outside of Minnesota is limited to the payment that the health care provider would receive if the treatment, article, or supply were paid under the workers' compensation law of the jurisdiction in which the treatment was provided.

Subd. 1c. **Charges for independent medical examinations.** The commissioner shall adopt rules that reasonably limit amounts which may be charged for, or in connection with, independent or adverse medical examinations requested by any party, including the amount that may be charged for depositions, witness fees, or other expenses. No party may pay fees above the amount in the schedule.

Subd. 2. **Excessive fees.** If the employer or insurer determines that the charge for a health service or medical service is excessive, no payment in excess of the reasonable charge for that service shall be made under this chapter nor may the provider collect or attempt to collect from the injured employee or any other insurer or government amounts in excess of the amount payable under this chapter unless the commissioner, compensation judge, or court of appeals determines otherwise. In such a case, the health care provider may initiate an action under this chapter for recovery of the amounts deemed excessive by the employer or insurer. A charge for a health service or medical service is excessive if it:

(1) exceeds the maximum permissible charge pursuant to subdivision 1, 1a, 1b, or 1c;

(2) is for a service provided at a level, duration, or frequency that is excessive, based upon accepted medical standards for quality health care and accepted rehabilitation standards;

(3) is for a service that 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 treated; or

(4) is otherwise deemed excessive or inappropriate pursuant to rules adopted pursuant to this chapter.

Subd. 3. **Report.** The commissioner shall contract with a review organization as defined in section 145.61 for the purposes listed in section 145.61, subdivision 5, and report to the legislature

on January 15 of every odd-numbered year, regarding the delivery of medical and health care services, including rehabilitation services, under the workers' compensation laws of this state.

The commissioner shall also conduct a study of the qualifications and background of rehabilitation consultants and vendors providing services under section 176.102 for the purpose of determining whether there are adequate professional standards provided, including safeguards to protect against conflicts of interest.

Subd. 4. [Repealed, 1987 c 332 s 117]

Subd. 5. [Repealed, 1992 c 510 art 4 s 26]

History: *Ex1979 c 3 s 45; 1981 c 346 s 87; 1982 c 424 s 130; 1983 c 289 s 114 subd 1; 1983 c 290 s 108; 1984 c 432 art 2 s 25; 1984 c 640 s 32; 1984 c 655 art 1 s 92; 1985 c 234 s 11; 1987 c 332 s 39; 1989 c 282 art 2 s 51,52; 1992 c 510 art 4 s 14-18; 1993 c 194 s 6; 1995 c 231 art 2 s 64-66; 1996 c 374 s 4; 1997 c 187 art 5 s 26; 1Sp2005 c 1 art 4 s 40; 2008 c 250 s 7,8; 2013 c 70 art 2 s 9*