

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of Proposed Amendment
to the Rules Relating to Workers'
Compensation Medical Services
Parts 5221.0100 to 5221.0700

STATEMENT OF NEED
AND REASONABLENESS
(Medical Rules of Practice)

I. BACKGROUND

On October 7, 1983 the temporary rules governing reimbursement for workers' compensation medical services (4 MCAR 1.001 through 4 MCAR.1.0032) went into effect. These rules included the Medical Fee Schedule, which established maximum fees for medical services based on historic charge data. Also included were rules establishing authority, purpose, scope, definitions and guidelines for excessive services and charges, as well as payer's responsibilities, provider's responsibilities and procedures.

In October, 1984, the Department of Labor and Industry (DOLI) adopted the permanent rules. Since then there has been only one revision of the medical rules of practice, which was effective May 1, 1989. This revisions included additional definitions, clarification between excessive services and excessive charges, additions to payer's responsibilities, clarification of the provider's responsibilities, and updating of the dispute resolution process. This statement addresses changes to the medical rules of practice. A separate Statement of Need and Reasonableness addresses the adoption of the proposed Relative Value Fee Schedule, parts 5221.4000 to 5221.4070.

The statutory authority for the rules is discussed in detail in this statement under Part 5221.0200.

II. REASONS FOR REVISION AND NEW RULES

In the past several years, DOLI has received inquiries from health care providers, insurers, self-insurers, third-party payers, employers, qualified rehabilitation consultants, and even employees regarding disputed medical issues not addressed in the current rules. There have also been discussions with the Workers' Compensation Administrative Task Force and with the Workers' Compensation Advisory Council and the Medical Services Review Board (MSRB) about unresolved medical issues. The problems raised by these groups and individuals seem to focus on, but are not limited to, the following broad topics:

- Employers, insurers, and qualified rehabilitation consultants state they often do not receive adequate or timely information from health care providers that is necessary to evaluate claims, manage the medical aspects of a claim and promptly pay the bills.
- Employers and qualified rehabilitation consultants indicate that some health care providers do not adequately participate in return to work planning, causing delay in the employee's return to work.

- Employers, insurers and health care providers indicate that many disputes about compensability of services arise out of confusion over the various responsibilities of payers and providers with regard to billing and payment.
- Insurers, employers and health care providers, as well as DOLI request that the paperwork required in workers' compensation be limited, while still having available adequate, timely information on claims.
- Employers and insurers indicate that some employees engage in "doctor shopping" thus adding to medical costs and delaying return to work.

III. RULE DEVELOPMENT PROCESS

In 1990, in preparation for writing the rules, the MSRB in its advisory capacity to the Commissioner, conducted an internal survey about issues and problems that its members felt were critical to the workings of the system. The MSRB then formed subcommittees to address the following areas: access to medical data; communication between health care providers; treatment rules of practice; required forms; and cooperation with vocational rehabilitation.

The Rehabilitation Review Panel also participated in developing the rules for cooperation with vocational rehabilitation.

DOLI also contacted the American Guild of Patient Account Management (AGPAM), the Medical Account Managers Association (MAMA), the Minnesota Medical Group Management Association (MMGMA), and the Minnesota Medical Records Association (MMRA) for comments and guidance on these issues.

DOLI conducted a survey of insurers which was reported in The Medical Study Implementation Action Plan: A Report to the Legislature, published in February, 1991. This survey contained several questions about medical cost containment activities used by insurers, self-insurers and third-party administrators.

In addition, DOLI completed a survey of workers' compensation insurers, third-party administrators, and self-insured employers in Spring, 1991. The survey contained questions regarding use of the Physician's Report form by payers. A summary of the survey results was published in DOLI Compact (Nov. 1991).

Several drafts of the proposed rules were reviewed by the MSRB, outside health care providers, insurers, third-party payers, and self-insured employers. On February 26, 1992 a draft of the proposed rules was sent to approximately 25 different groups representing insurers, self-insured employers, rehabilitation providers, and professional organizations of medical doctors, chiropractors, nurses, and hospitals. The comments were incorporated in the final draft where appropriate.

IV. IMPACT ON SMALL BUSINESSES; EXPENDITURE OF PUBLIC MONIES

The rules are exempt from the requirements of Minnesota Statutes, section 14.115

because they regulate health care providers for standards and costs. The rules also affect self-insured employers and insurance companies, who are generally not small businesses. Nonetheless, the Department has considered methods for reducing the impact of the rule on small business health care providers. The MSRB, which includes small business health care providers, was consulted in development of the rules.

Part 5221.0410 requires reporting of medical information on the Health Care Provider Report form. It is not appropriate to modify these requirements for small health care providers because these rules already reduce the reporting burden from that required by the existing rules in that the rule combines two forms (Physician Report and Maximum Medical Improvement Report) into one form (Health Care Provider Report); the rule requires providers to report most information only upon request (mandatory reporting of maximum medical improvement and permanent partial disability is a requirement in the existing rules and therefore does not constitute an additional burden). The information on the form is the minimum necessary for the insurer and the Department to monitor the claim and ensure proper payment of benefits as required by Minnesota Statutes, section 176.231, subdivisions 3, 4 and 5.

The Report of Work Ability is a new form designed to provide the employer and other parties with the provider's most recent evaluation of the employee's ability to work. This information is critical to re-employing all employees, and therefore an exclusion for some providers would defeat the purpose of the requirement.

The rule incorporates flexibility into the system in that it permits providers to report the information in a narrative format instead of on the Health Care Provider Report or Report of Work Ability form if that is easier for the provider. Additionally, under the current rules, providers must already report the specific disability information that is unique to workers' compensation cases. The forms just specify information which is required.

Minnesota Rules Part 5221.0420 requires health care provider participation with return to work planning. This should not significantly impact small business health care providers either as it protects them from excessive requests for meetings from rehabilitation providers. Additionally, the provider is permitted to charge for the services provided under this section. Also, to exempt small business providers would defeat the purpose of the rule, namely, a coordinated effort focused on return to work for all injured workers.

Minnesota Rules Part 5221.0650 requires insurers, self-insurers, or third-party administrators to collect and retain data included on the required uniform billing forms and other claim data. No exception is appropriate since data collected by DOLI must be standardized to allow research into medical care and costs necessary for DOLI's monitoring function. Also, all payers must participate in order that data is representative of the workers' compensation population. Flexibility is built into the rule in that format is not mandated; the insurer may maintain paper copy, computerized records or in electronic format. The method of transfer of data will be agreed upon by the payer and DOLI. It is anticipated that many workers' compensation insurers will be moving toward more technologically advanced methods of handling data, much as health insurers have progressed already.

Minnesota Rules Part 5221.0700 requires a uniform billing form. This is required by

the 1992 Legislature, and therefore no exemption is appropriate. Minnesota Statutes, section 176.135, subdivision 7. The forms selected are the HCFA-1500 form, already in widespread use for federal programs, and the UB-92 (HCFA-1450). The UB-92 is an updated version of the UB-82 form currently in use by hospitals; and this new version will be required for federal programs in the fall 1993. It would be more burdensome to create a billing form specific to workers' compensation and require small businesses and hospitals to adapt their billing to yet another payer's requirements. The Department has consulted with health care providers, including small businesses, who have indicated it is feasible and preferable to use these forms which are already commonly used, for workers' compensation claims. Furthermore, MinnesotaCare's Health Care Commission is considering mandating the use of these standardized forms in Minnesota.

Fiscal note: It is not expected that implementation of the rules will require any local public body to spend more than \$100,000 in either of the next two years. Therefore, a fiscal note is not necessary under Minnesota Statutes, section 14.11, subdivision 1. The rules do not adversely impact agricultural land and do not have their primary effect on Spanish speaking people.

V. WITNESSES AND STAFF PRESENTERS

Appearing at the public hearing to present the proposed workers' compensation medical rules of practice may be any of the following persons from the Department of Labor and Industry: Leo Eide, Assistant Commissioner; Sandra Keogh, Medical Policy Analyst, Rehabilitation and Medical Affairs; Monica Ryan, Medical Policy Analyst, Rehabilitation and Medical Affairs; Gloria Gebhard, Acting Director, Rehabilitation and Medical Affairs; William Lohman, M.D., medical consultant for the Department of Labor and Industry; and Kathryn Berger, Attorney, Legal Services. The Commissioner the right to appear or call upon any of his designees or other staff to appear in support of the rules.

VI. OVERVIEW OF PROPOSED REVISIONS AND NEW RULES IN MEDICAL RULES OF PRACTICE

There are seven major sections to be either revised or added as new rules.

1. 5221.0410 Required Reporting and Filing of Medical Information. This section replaces the Physician Report and the Maximum Medical Improvement Report required by Minnesota Rules Part 5220.2590 with a single revised Health Care Provider Report which provides basic information about the injury as well as maximum medical improvement and permanent partial impairment. This section describes considerations in determining maximum medical improvement generally, and limits the factors that may be considered when one year has elapsed from the date of a musculoskeletal injury. A new report is required, Report of Work Ability, which describes the worker's contemporaneous ability to work.
2. 5221.0420 Health Care Provider Participation in Return to Work Planning. This is a new section that addresses the provider's obligation to cooperate in planning an injured workers' return to employment whether or not a qualified rehabilitation consultant has been assigned to the case.

3. 5221.0430 Change of Health Care Provider. This new section addresses the requirement of Minnesota Statutes, section 176.135, subdivision 2 that the Commissioner adopt rules establishing standards and criteria to be used when the employee or employer requests a change of doctor.
4. 5221.0500 Excessive Charge; Limitation of Payer Liability. This section combines and revises 5221.0500 Excessive Charges and 5221.0550 Excessive Services and includes the 1992 legislative amendments (Minnesota Statutes, section 176.136, subdivisions 1, 1a, 1b and 2) regarding limits on an employer's liability for medical fees. A payer's liability for medical costs is clarified by pulling together into one section the information regarding what constitutes an excessive charge, and the payer's maximum liability in light of several statutory provisions.
5. 5221.0600 Payer Responsibilities. This section revises and adds language to be consistent with amendments in Minnesota Statutes, section 176.135, subdivision 6 and these proposed rules, 5221.0500. The rule clarifies the payer's responsibility to promptly review and pay medical bills and notify the provider and employee of their actions.
6. 5221.0650 Data Collection, Retention, and Reporting Requirements. This new section requires insurers and self-insurers to report medical and other data necessary for DOLI to monitor and evaluate treatment of work-related injuries.
7. 5221.0700 Provider Responsibilities. New language prohibits payment for services violating Medicare's antikickback statute consistent with the MinnesotaCare legislation in 1992. New wording also standardizes the billing process by requiring uniform billing forms for health care providers as mandated by the 1992 Legislature.

Each section will be reviewed separately in this Statement of Needs and Reasonableness and will include specific information on the problems addressed and the rationale for the changes or new rule.

VII. CONTENT REVIEW OF RULES

PART 5221.0100 DEFINITIONS.

This part is amended to improve the accuracy of existing definitions and to add definitions for key terms and concepts which appear throughout the chapter.

Nature of Proposed Rule and Rationale:

Subp. 4. Code. The use of codes in the health care delivery system has increased dramatically in recent years, as a result of technological advances in the area of electronic data collection, storage and transmission. This subpart provides definitions of six different types of codes, all of which are required by various provisions in this chapter. Specifically, proposed Minnesota Rules Parts 5221.0410, 5221.0420, 5221.0500, and 5221.0700 require the health care provider to include specified codes in its billing and reporting documents; and proposed

Minnesota Rules Parts 5221.0600 and 5221.0650 require the payer to evaluate, collect and retain certain health care information, according to the specified codes. Services included in the Medicare Relative Value Fee Schedule are listed according to these specific codes. Thus, because our schedule incorporates the Medicare schedule, users must be familiar with these various types of codes and their application.

The codes required by this chapter and defined in this subpart are currently recognized and used not only by Medicare but also by health care providers and payers in most other sectors. These codes were also used in the current and past workers' compensation medical fee schedules. Thus, this rule reflects the Department's efforts to achieve the goal of uniformity in collection of health care data which is shared by both the private and public sector and which is mandated by the MinnesotaCare legislation.

Item A. Billing code. This item differentiates this term from other specific types of codes and establishes that its use is limited to billing purposes only. The billing code requirements are discussed in Part 5221.0700, subp. 3.

Item B. CPT code. This item explains the abbreviation "CPT" and clarifies that these codes are used to identify medical services, articles or supplies. This item also refers the user to Part 5221.0405, item D (proposed) which identifies the publisher of these codes and provides instructions for obtaining a manual containing the complete, current listing of codes.

Item C. HCPCS code. This item explains the abbreviation "HCPCS", describes the three different levels which comprise this coding system and clarifies that these codes are used to identify medical services, articles or supplies. It also refers the user to Part 5221.0405, items D and E (proposed), which identify the publishers of these codes and provides instructions for obtaining manuals containing complete, current listings of codes.

Item D. ICD-9-CM code. This item explains the abbreviation "ICD-9-CM" and clarifies that these codes are used to identify particular medical or chiropractic diagnoses. It also refers the user to Part 5221.0405, item A (proposed), which identifies the publisher of these codes and provides instructions for obtaining a manual containing complete, current listings of these codes.

Item E. Place of service code. This item differentiates this term from other specific types of codes and clarifies that it is used to identify the type of facility wherein the service was provided e.g., office, hospital inpatient, or outpatient, emergency room. It also refers the user to Minnesota Rules Part 5221.0405, items B and C (proposed), which references the prescribed billing claim forms on which this code is required.

Item F. Procedure code. This item differentiates this term from other specific types of codes in that it is a general term, intended to describe a health care procedure and may include several types of specific codes, as listed (e.g., CPT, HCPCS, chiropractic, prescription codes).

Subp. 6a. Conversion factor. This term is a key variable in the formula set forth in proposed Minnesota Rules Part 5221.4020, used to compute and determine maximum fees for services included in the proposed Relative Value Fee Schedule, Minnesota Rules Part 5221.4000

through Part 5221.4061. The use of the conversion factor is discussed in the statement of need for the proposed Relative Value Fee Schedule.

Subp. 6b. Division. This term is defined for ease and clarity and serves as an abbreviation for the more complete title of the relevant administrative body, the Workers' Compensation Division of the Department of Labor and Industry.

Subp. 10. Medical fee schedule. This part is amended only to reflect a change in numbering of the fee schedule portion of the rules.

Subp. 10a. Modifiers. Modifiers, like the codes defined in subpart 4, are currently recognized and used by providers and payers in all sectors. These modifiers are especially required in Minnesota Rules Parts 5221.0410, 5221.0420, 5221.0500, 5221.0600, 5221.0650 and 5221.0700 (proposed). The use of modifiers in this chapter allows more accurate description of the service actually provided. The code and modifier assist payers in determining correct maximum fees for services provided and ensures the compilation of uniform data which will ultimately provide the means for evaluating the efficacy of these rules and for studying health care delivery patterns and outcomes.

Subp. 11a. Physician. The two statutory definitions of this term are consolidated and included here to emphasize the limited application of this term and to distinguish physicians from other types of health care providers.

PART 5221.0200 AUTHORITY, and
PART 5221.0300 PURPOSE.

These sections are amended to reflect the expanded coverage of chapter 5221 and the statutory authority for rule-making is cited. The medical rules of practice previously and primarily governed payment for medical services. In response to escalating medical costs, the 1992 Legislature enacted a medical cost containment package. Changes are made to the rules in response to the legislation mandating a Relative Value Fee Schedule, a uniform billing form, limitations on payer liability, and permitting DOLI to collect medical data. Additional rules are intended to address problems identified with the workers' compensation system that interfere with the efficient delivery of quality medical care and communication between the health care provider and other parties in the system.

The statutory authority for these rules is as follows: Minnesota Statutes, section 175.171 provides the Department of Labor and Industry to adopt "reasonable and proper rules relative to the exercise of its powers and duties . . ." and "to collect, collate and publish statistical and other information relating to the work under its jurisdiction . . ."

Minnesota Statutes, section 176.101, subdivision 3e(f) authorizes the commissioner to monitor and adopt rules to assure the proper application of the provisions governing maximum medical improvement.

Minnesota Statutes, section 176.135, subdivision 2 and Minnesota Statutes, section 176.83, subdivision 8 requires the commissioner to adopt rules establishing standards and criteria

to be used when a dispute arises over selection or change of doctor.

Minnesota Statutes, section 176.135, subdivision 7 requires the commissioner to adopt a uniform billing form.

Minnesota Statutes, section 176.231, subdivisions 3, 4, 5, 6, and 7 and Minnesota Statutes, section 176.83, subdivision 15 authorizes the commissioner to develop forms and require reports from health care providers related to the nature and extent of the injury and disability.

Minnesota Statutes, section 176.83, subdivisions 1, 3, 4, 5, and 7 authorizes the commissioner to adopt rules to implement Chapter 176 and establish standards and procedures for evaluating the clinical consequences of services by health care providers and standards and procedures for determining whether charges and services are excessive and available to employees.

Minnesota Statutes, section 176.83, subdivision 5a authorizes the commissioner to adopt rules requiring insurers and others to reports medial and other data necessary to implement Chapter 176.

PART 5221.0400 SCOPE.

The scope of the rules is amended to reflect that employees have a responsibility to provide the Report of Work Ability form to the employer or insurer and qualified rehabilitation consultant under Part 5221.0410, subp. 6. Language is also added to reinforce that the provisions apply to all disputes in the workers' compensation system. This is necessary for consistency and predictability throughout the system, and is consistent with the statutory authority for the rules cited in part 5221.0200.

PART 5221.0405 INCORPORATION BY REFERENCE.

The documents identified in items A to D are incorporated by reference into chapter 5221. These are documents that are specifically referenced in the rules, and identifying information is therefore set forth as required by Minnesota Statutes, section 14.07.

PART 5221.0410 REQUIRED REPORTING AND FILING OF MEDICAL INFORMATION.

Minnesota Rules Part 5220.2590 is repealed and replaced with part 5221.0410 because the current rule no longer meets the information needs of the payer or DOLI.

Need for the Proposed Rule:

Inadequate, untimely medical information. Medical information is often needed early in the claim for an employer to determine liability for a claimed work injury; thereafter, regular communication with the health care provider facilitates medical management as well as return to work strategies. Requested information may not be received for many weeks and then may not be adequate to assist the payer in determining liability for the claimed condition, or the

compensability of the health care services billed. Furthermore, the payer needs to be informed of the worker's treatment and ability to work status so the case may be managed proactively to control medical costs and facilitate a prompt return to work.

Administrative burden. The current rule, Minnesota Rules Part 5220.2590, subp. 2 requires the health care provider to submit medical information routinely for every patient on the prescribed form to the insurer (if known) or to the division, if the insurer is not known. Workers' compensation claimants are a very small proportion of most health care providers' business and it is inefficient to require routine completion of the entire form on any patient that alleges to have a workers' compensation injury, whether or not the insurer needs the information to administer the claim. Further, payers have indicated that they prefer not to receive reports which have not been requested because of the resulting filing problems.

Many payers surveyed indicated a preference for narrative medical reports because more detailed information is included than is available from the currently prescribed forms, the Physician's Report and Report of Maximum Medical Improvement. Health care providers have complained that the forms ask questions requiring narrative responses yet provide inadequate space to reply. Further, health care providers on the MSRB indicate that the information required by the forms is generally contained in their narrative reports and it is a duplication of effort and an additional administrative cost to transfer the information from the narrative to the form. Redesigning a report form to include the information most needed by employers, insurers and DOLI, while making the form easier and faster for health care providers to complete, will facilitate rapid exchange of needed medical information. Also, by allowing a health care provider to submit a narrative report in lieu of completing a form, the information may be more complete and provided more quickly.

Charges for required medical reporting. Payers and health care providers are often confused about what reports must be completed without charge. This confusion has created ill will between providers and payers, and has added costs to the workers' compensation system by way of administrative costs and litigation costs. By clarifying in the rules what information is required to be reported by a health care provider and by prohibiting charging for this information (whether provided on a report form or in a narrative format) these disputes may be avoided.

Nature of Proposed Rules and Rationale:

Subpart 1. Scope. This subpart identifies the scope of the rule: the information the health care provider is required to submit to the employer and insurer or the Commissioner. The rule does not restrict an employer, insurer, or the Commissioner from requesting any additional information pursuant to Minnesota Statutes, section 176.231, subdivision 4.

Subp. 2. Health Care Provider Report. The Health Care Provider Report, a single form, replaces both the Physician's Report required by Minnesota Rules Part 5220.2590, subp. 2, and the Report of Maximum Medical Improvement, required by part 5220.2590, subp. 3. The name of the report was changed to Health Care Provider Report because not all treatment is directed by a medical doctor. This report is authorized by Minnesota Statutes, section 176.231, subdivisions 3, 4, 5, 6, and 7. A draft of the proposed form is attached.

This subpart identifies a time frame of 10 days within which a health care provider must respond to a request for required information. Ten days was considered a reasonable period for a health care provider to turn around a request for information and also meet a payer's need for prompt information. Further, a 10 day time limit is in accordance with penalty provisions of Minnesota Statutes, section 176.231, subdivision 10 and Part 5220.2830, subp. 1.

This subpart also attempts to reduce the paperwork burden within the system. Instead of requiring the health care provider to automatically report on every injured worker treated, the provider is only required to report when the employer, insurer or Commissioner requests information. This reduces the paperwork burden on the health care provider. It also reduces the paperwork received by the insurer and the Commissioner to that information which is necessary to properly manage and monitor claims. Use of one form reduces the administrative costs in that only one form would need to be stocked by the payers. It is also more efficient, where maximum medical improvement or permanent partial disability is determined early in the claim, to include all the information on one form.

This part allows the health care provider to respond to a request for required information on the Health Care Provider Report Form or with a narrative report which contains the same information. A health care provider is not required to provide the information in narrative form, but may do so if it meets the needs of the parties and the provider for prompt, meaningful information. This choice allows the health care providers to avoid duplicating information contained in narrative reports on a prescribed form. In some cases payers prefer narrative reports because the information is more extensive.

The Physician's Report and Maximum Medical Improvement Report forms may be used until January 1, 1994 in order to allow the payer and provider time to develop their procedures to implement the new communication requirements.

This rule specifies the prescribed form and the basic information that a health care provider is required to report upon request pursuant to Minnesota Statutes, section 176.231, subdivisions 3, 4, 5, 6, and 7. The information required by the rule is consistent with statutory requirements regarding reporting to DOLI the nature and extent of the injury and treatment to facilitate proper payment of compensation. Additionally, consideration was given to information most useful to payers. Table 1 outlines the required information on the Health Care Provider Report Form.

Table 1. Required Information on Health Care Provider Report Form

DATA ELEMENT	RATIONALE/USE
Information identifying the employee, employer, and insurer.	Information is necessary for all parties and DOLI to identify claimant.
Date of the first examination for the injury or disease by that health care provider.	Information assists in evaluating and managing the claim. Indicates whether the health care provider is a new provider to the case.
Diagnosis and ICD-9-CM Code	The medical diagnosis assists in evaluating the nature of the claim. The machine readable shorthand code for diagnosis (ICD-9-CM) can be used in data analysis and bill review. The ICD (International Classification of Diseases) coding system is widely used by providers and is accepted or required by payers of health care services.
History of the injury or disease as given by the employee.	Information is useful in determining compensability of a claim. It is used by DOLI to monitor denials of liability.
Relationship of the injury or disease to employment.	Information is necessary to evaluate compensability of the claim.
Information regarding any pre-existing or other conditions affecting the employee's disability.	Information is helpful in determining compensability of the claim and apportionment issues. DOLI monitoring unit also needs this information to evaluate whether a permanent partial disability payment is accurate.
Information about future treatment or referrals; surgery performed.	Information assists case management and also helps payers and DOLI evaluate the accuracy of the maximum medical improvement and permanent partial disability opinion rendered.
Information regarding the employee's ability to work; a copy of the most recent Report of Work Ability.	The insurer may require a copy of the most recent Report of Work Ability from a health care provider because the employee may not have submitted a Report of Work Ability for some time. This information is necessary to facilitate return to work.
Information regarding the employee's permanent partial disability rating.	Information is necessary for proper payment of benefits pursuant to Minnesota Statutes, sections 176.021, subdivision 3a, and 176.101.
Information regarding whether the employee is unable to return to former employment.	Information is necessary to determine eligibility for benefits pursuant to Minnesota Statutes, section 176.101, subdivision 3t(b).
Information regarding maximum medical improvement.	Information is required pursuant to Minnesota Statutes, section 176.101, subdivision 3e.
Signature, license or registration number and address of the health care provider.	Information identifies and authenticates the health care provider completing the report.

Subp. 3. Maximum medical improvement. Minnesota Rules Part 5220.2590, subp. 3 is repealed and replaced by this subpart. The information required by the proposed rule regarding maximum medical improvement and permanent partial disability are included in the Health Care Provider Report Form.

The maximum medical improvement section is intended to clarify for health care providers, employers and insurers what it is meant by "maximum medical improvement" as stated by the Minnesota Supreme Court. Maximum medical improvement is both a medical and legal concept. Hammer v. Mark Hager Plumbing & Heating, 435 N.W.2d 525 (Minn. 1988). The definition of "maximum medical improvement" from Minnesota Statutes, section 176.011, subdivision 25, is included on the form to assist portion in the accurate application of the law. The concept of maximum medical improvement was codified in Minnesota Statutes, section 176.101, subdivision 3e, effective for injuries on or after January 1, 1984. However, the health care provider may also be asked to report maximum medical improvement where an injury occurring before January 1, 1984 contributes to a subsequent injury. Hammer.

Although other questions of the Health Care Provider Report form need to be answered only upon request, a health care provider is required to report when an employee has reached maximum medical improvement. This requirement is the same as set forth in Minnesota Rules, Part 5220.2590 (repeal proposed). Because the date of maximum medical improvement is a controlling legal event, affecting entitlement to benefits under Minnesota Statutes, section 176.101, the health care provider must report maximum medical improvement as soon as it is determined. To require the insurer to estimate when maximum medical improvement has been reached, and to query all providers at various times, is not reasonable.

The Court referenced the factors to be considered by the health care provider in determining whether an employee has reached maximum medical improvement as set forth in the Department of Labor and Industry handbook, Health Care Provider's Guide to the Minnesota workers' compensation system. 11-12 (rev. ed. 1987) Hammer at 639. Because this handbook is out of date in other areas, due to recent legislation, and there has been much case law further refining the concept of maximum medical improvement, rules are appropriate. The rules set forth the basic principles discussed in the handbook and as applied in case law, including the history of improvement, current treatment, and proposed treatment. Although workers' compensation judges and providers will continue to make determinations on an individual basis, these rules are expected to provide general guidelines for providers to use in making determinations of maximum medical improvement.

Item A. The "employee's condition" and "functional status" are defined based on recommendations of the health care providers on the workers' compensation Medical Services Review Board and members of the Medical Committee of the International Association of Industrial Accident Boards and Commissions (IAIABC). These terms are used in the items which follow. This item defines the employee's "condition" to include signs, symptoms, findings and functional status that characterize the complaint, illness or injury. This is an appropriate definition, because all these factors constitute the nature of an injury, and may be relevant in determining whether maximum medical improvement has been reached.

Subitem 1 specifies the factors which indicate that maximum medical improvement has

been reached.

Unit (a) requires consideration of the history of treatment and proposed treatment. If neither of these indicate significant lasting improvement is likely, an employee may have reached maximum medical improvement. Because some providers expect that maximum medical improvement means full recovery, a clarification is added that maximum medical improvement may have been reached even if there is some ongoing minimal treatment for management of symptoms. See, Wittrock v. Bor Son Construction, 40 W.C.D. 395 (1987) (S. Aff'd. 11/2/87).

Unit (b) provides that maximum medical improvement may have been reached if all diagnostic evaluations and treatment options that may reasonably be expected to improve or stabilize the condition have been exhausted or declined by the employee. The concept of stabilization is one that has been reflected in several cases. See, Polski v. Consolidated Freightways, 39 W.C.D. 740 (1987); Peterson v. Mills Enterprises, 40 W.C.D. 963 (1987) (S. Aff'd. 4/87); Wilson v. Decker Lumber Co., 46 W.C.D. 319 (1991) (S. Aff'd. 3/25/92); Korthals v. McNeilus Truck Manufacturing, (WCCA 5/19/92). Additionally, if no further treatment is available, either because all options have been tried or because an employee declines further treatment, maximum medical improvement likely has been reached. An example is when an employee decides against surgery that might, if performed, further improve the employee's condition. A further evaluation that is likely to lead to treatment that will improve the employee's condition may mean the employee has not reached maximum medical improvement. Fontaine v. Johnson Bros. Corp., 45 W.C.D. 370 (S. Aff'd. 10/31/91); Decker, supra.

Units (c) and (d) reinforce that ongoing treatment does not necessarily mean the employee continues to improve. For instance, a person with a serious, permanent injury who is receiving treatment to prevent complications may have reached maximum medical improvement. Similarly, if treatment is designed to simply temporarily relieve symptoms or maintain the employee's condition without significant lasting improvement to the underlying condition, maximum medical improvement has likely been reached. Heiderscheit v. Sanborn Manufacturing, (WCCA 12/1/89).

Item 2 specifies that the converse of the factors set forth in item 1 may be an indication that maximum medical improvement has not been reached, for the reasons set forth above.

Item B. This item provides that when more than one year has elapsed since the date of a musculoskeletal injury, the relevant factors in determining maximum medical improvement (MMI) are whether a decrease is anticipated in the estimated permanent partial disability (PPD) rating or whether improvement is anticipated in the employee's work ability. This rule is necessary because, despite medical evidence that MMI is generally reached well within one year for these injuries, the workers' compensation system continues to receive disputes about MMI issues beyond this time period, resulting in unnecessary litigation and delay in benefit resolution.

The time period of one year is selected because, from a medical perspective, maximum improvement of a musculoskeletal injury is almost always reached sooner than one year. As noted above, attainment of MMI does not preclude further treatment, but rather is an indication that, even with additional treatment, "no further significant lasting improvement to a personal injury can reasonably be anticipated, based upon reasonable medical probability."

MMI is a legal, as well as medical, concept, and is significant in workers' compensation because it governs eligibility for certain benefits. Hammer, supra. Therefore, musculoskeletal injuries are not typically analyzed in the medical literature in terms of maximum medical improvement. However, medical literature does address expected treatment and disability periods for these injuries, which are indicative of whether further improvement can be anticipated based on reasonable medical probability.

The workers compensation treatment standards were adopted in May, 1993. Minnesota Rules, parts 5221.6010 to 5221.6500 [Emergency]. The treatment parameters as adopted were approved by the Minnesota Medical Association and the workers' compensation Medical Services Review Board. After extensive review and comment by medical specialists and others in the medical community familiar with workers' compensation injuries, the rules set forth parameters for appropriate treatment of the most common workers' compensation injuries, primarily low back and upper extremity disorders. Under these treatment parameters, initial non-surgical management for most upper extremity disorders and low back disorders is expected to end at 12 weeks; at that time, evaluation is made for chronic management or surgery. Chronic management and surgery are expected to be completed within 12 months under the rules. (Initial nonsurgical management for some upper extremity disorders can continue for up to 12 months, at which time surgery must be considered.)

Medical literature provides additional support for the one year time period. For instance, Presley Reed, M.D., in consultation with other medical experts, has developed guidelines for expected periods of disability for most musculoskeletal injuries.¹ He defines disability as "a state in which the individual is unable to perform his/her job at the same level and efficiency as before the illness or injury occurred."² No musculoskeletal injury is given an expected length of disability greater than 16 weeks for medium work activity. Although he does not establish expected periods of disability for heavy work activity or for severe injuries, he defines permanent disability as "a length of disability greater than 52 weeks."³ This indicates that further improvement after 52 weeks is not likely.

Also supporting that treatment is likely to be completed for musculoskeletal injuries within one year are The Minnesota Chiropractic Association Standards of Practice.⁴ These establish parameters for the treatment of many musculoskeletal injuries; none of the parameters indicate that chiropractic management beyond one year is expected for any of the

¹ The Medical Disability Advisor; Workplace Guidelines for Disability Duration. Horsham, Penn: LRP Publications, 1991.]

² Id at xxvi

³ Id. at xxvii

⁴ Minnesota Chiropractic Association; Roseville, MN: 1991.

musculoskeletal injuries cited.⁵

The adopted workers' compensation treatment parameters and the medical community support that the expected treatment and disability for most musculoskeletal injuries is significantly less than one year. Therefore, where MMI has not been reached within that time, it is appropriate to evaluate these injuries more carefully.

The rule provides that the only relevant factors in determining MMI after one year are whether there is likely to be a decrease in the estimated PPD rating, or an improvement in work ability. These are factors which are an objective measurement of "significant and lasting" improvement after all reasonable treatment to improve the condition should have been exhausted, according to established medical standards of expected treatment and disability periods. Documenting objective improvement in these areas allows for individual determinations of MMI later than one year in medically unique or complicated cases, while removing other, less quantifiable factors that are difficult to measure and that, based on reasonable medical probability, are not likely to significantly change after a year of treatment.

The rule also provides that if there is not an improvement in the estimated PPD rating or work ability within any 3 month period following the injury, MMI is presumed, unless improvement in these areas is later established. This period is reasonable to avoid further delay in determining MMI where the improvement is merely speculative. The definition of MMI provides that it is reached where no significant, lasting improvement is reasonably anticipated, based upon reasonable medical probability. Where MMI has not been reached within one year, and there has been no further change in three months, it is reasonable to presume, consistent with the prevailing medical evidence, that further significant, lasting improvement is not likely.

The rule only applies to the musculoskeletal conditions listed in the workers' compensation permanent partial disability schedule because the schedule is comprehensive for almost all musculoskeletal injuries that occur in workers' compensation. This will promote consistency in determining whether an improvement in the employee's PPD rating is likely. Not all musculoskeletal injuries can be expected to maximally improve within the one year time period. For example, where surgery is necessary, the likely recovery period will be delayed. Additionally, for critical conditions such as head injuries and spinal cord injuries, the expected period of MMI is difficult to anticipate, and may extend beyond one year. Therefore, these are exceptions to the rule.

Item C. Notice to the employee of maximum medical improvement. The insurer is required to serve notice of maximum medical improvement on an employee under Minnesota Statutes, section 176.101, subdivision 3e. This item addresses the problem of notice to the employee when a narrative report indicating that maximum medical improvement has been

⁵ Other sources supporting that treatment is likely to be completed for musculoskeletal injuries well within one year include Clinical Policies, American Academy of Orthopedic Surgeons, Park Ridge, Ill. 1991; and Richard Doyle, M.D., Healthcare Management Guidelines, Return to Work Planning, San Diego: Milliman and Robertson, 1991.

reached is served on the employee. The employee may not be aware of the significance of the maximum medical improvement report to his or her claim. The workers' compensation appellate courts have consistently held that timely, adequate notice to an employee of the significance of maximum medical improvement is crucial. Busso v. Transfleet Enterprises, 40 W.C.D. 19 (1987), Larsen v. Pace Dairy Foods, 41 W.C.D. 167 (1988). The prescribed Health Care Provider Report Form specified in subp. 1 will include instructions to the employee if maximum medical improvement is served using the form. Because a narrative report does not include information on the form, item C requires an insurer to send a cover letter notifying the employee of the significance of the narrative report of maximum medical improvement when the Health Care Provider Report form is not used, or when the Notice of Intention to Discontinue (which also provides additional information) or Petition to Discontinue is not served. The information required in the cover letter will inform the employee of the significance of the attached narrative report. By explaining the process and the significance of maximum medical improvement to the employee, prompt resolution of disputes may be facilitated. Table 2 indicates the information required in the cover letter and the rationale.

Table 2. Required Information in the Cover Letter for the Maximum Medical Improvement Narrative Report.

DATA ELEMENT	RATIONALE/USE
Information identifying the employee.	Information is necessary to identify the claimant and the workers' compensation case.
Information identifying the employer and insurer.	Information identifies the employer and the insurer who are serving the maximum medical improvement report on the employee.
The date the report was mailed to the employee.	The date is significant in that service of the report commences the 90 day time frame at the end of which temporary total disability benefits cease (Minnesota Statutes, section 176.101, subdivision 3e).
The statement that the attached report indicates that maximum medical improvement has been reached and specifies the date.	Statement informs that in the health care provider's opinion maximum medical improvement was reached as of a specific date. This information assists the employee in evaluating the appropriateness of the opinion.
The definition of maximum medical improvement.	Definition informs the employee of the statutory meaning of the term "maximum medical improvement."
Statement that there may be an impact on the employee's benefits and instructs the employee where they may have questions answered.	This informs the employee of the significance of the maximum medical improvement report in relation to temporary total benefits and informs the employee where questions may be answered. Facilitates prompt resolution of disputes.

Subp. 4. Permanent Partial Impairment. Some health care providers are reported to routinely delay rating even minimal permanent partial disability until a year or so after an injury and this delays prompt payment of appropriate benefits. This subpart requires a health care provider to render an opinion on permanent partial disability when ascertainable but no later than the date of maximum medical improvement, at which time the rating should be ascertainable, because the employee's condition is not likely to further improve. Prompt reporting is facilitated by including permanent partial disability rating information with the maximum medical improvement information on the Health Care Provider Report form; this is consistent with the existing rule and form (see Minnesota Rules Part 5221.2590, subp. 3). Permanent partial disability information may be included in a provider's narrative report, for the reasons cited earlier.

Because there are several permanent partial disability schedules in effect based on the employee's date of injury, the health care provider is instructed that the rating must be based on a correct schedule and the appropriate category must be reported. The provider must also indicate ratings of zero since this informs the payers that permanent partial disability has been evaluated. Prompt reporting of a permanent partial disability rating will assist the payer in complying with statutory requirements for payment of permanent partial disability.

This section also addresses the situation where a primary provider may not feel capable of complicated determinations of permanent partial disability. The situations cited are typically where ratings may involve separate sections of the schedule, making a rating more difficult. Where only one section of the permanent partial disability schedule is involved, the health care provider should be able to accurately rate the condition. The section allows the provider to refer the employee to another provider for the purpose of determining a complicated rating, but the primary provider must be available to consult regarding the nature of the condition and must provide records at no charge. This will ensure referrals are made only when necessary, and will minimize the costs of such a referral while facilitating accurate ratings.

Subp. 5. Required reporting to Division. DOLI considered what information is necessary to perform its benefit monitoring function as required by Minnesota Statutes, sections 176.231, subdivision 6 and 176.251. The Department requires filing of permanent partial disability information because this is needed to properly monitor the closing of claims. Maximum medical improvement reports are required to be filed with the Division in accordance with Minnesota Statutes, section 176.101, subdivision 3e(c). Also, health care provider reports may be requested by the Commissioner at additional times to monitor compliance under Minnesota Statutes, section 176.231, subdivisions 3 and 4. The ICD-9-CM diagnostic code is required for DOLI to monitor trends in workers' compensation injuries and medical care in accordance with Minnesota Statutes, section 176.103, subdivisions 1 and 2.

Subp. 6. Report of Work Ability. Minnesota Statutes, section 176.231, subdivision 5 requires the Commissioner to prescribe forms for required information. Under Minnesota Statutes, section 176.231, subdivisions 3, 4, and 6 the health care provider is required to provide information about the nature and extent of an employee's injury or disability. The Report of Work Ability is a new requirement which is intended to properly communicate to employers and insurers the information necessary to plan return to work for an injured worker. A draft of the proposed form is attached to this statement.

This subpart identifies which health care providers must complete the work status report. By limiting the requirement to those health care providers independently directing and coordinating the course of treatment confusion over possibly differing opinions of providers may be reduced. For example, if an M.D. is directing treatment but a physical therapist is treating under that physician's referral only the M.D. would complete the Report of Work Ability.

Item A. This item identifies the required frequency of completing a Report of Work Ability. Here the rule is intended to reconcile the employer and insurer's need to know the employee's work status as soon as possible to promote a prompt return to work, with the health care provider's need to keep paperwork to a minimum. Beyond payer input, the frequency of reporting was determined through discussions with medical and chiropractic providers since these two groups have different practice patterns. Where an M.D. may see a patient every two weeks or every month, a chiropractor may initially provide treatment several times a week. Reporting work status several times per week when there is little or no change may be burdensome and unnecessary. The requirement to file a Work Ability Report at the prescribed frequency may be waived when restrictions are documented as permanent. Open-ended durations of disability are not allowed because constant monitoring of an employee's status is crucial to effective case management and return to work.

Item B. To accommodate the preferences and current practices of both providers and payers the health care provider may submit the required information either in a narrative report which may include the provider's own format, or on the Report of Work Ability, the form prescribed by the Commissioner. Many providers have developed reporting formats which describe restrictions and capabilities specific to the condition(s) they commonly treat, e.g., detailed hand function or back function. Therefore, flexibility is given to accommodate other formats which may be more useful and informative.

The work ability information required to be submitted was identified through discussions with the MSRB, the Workers' Compensation Administrative Task Force, and qualified rehabilitation consultants. The information required by the Report of Work Ability is identified in Table 3.

Table 3. Required Information on the Report of Work Ability

DATA ELEMENT	RATIONALE/USE
Information identifying the employee, employer, and insurer.	Information is necessary to properly identify the claim for the parties.
Date of most recent examination.	Information identifies the examination on which the report is based.
Information regarding whether the employee is able to work and any restrictions.	Information is necessary to determine if employee is disabled or able to return to work in some capacity.
Nature of restrictions.	Information is necessary to develop a job for an injured employee that is within physical restrictions.
Date any disability or restriction of work activity is to begin and the anticipated ending date.	Information identifies expected period of disability which will assist the employer and qualified rehabilitation consultant in planning a return to work for this employee. It will also help the payer to determine any benefits that may be due the employee.
Date of next scheduled visit.	Information assists in medical and vocational planning.
Signature, license or registration number and address of health care provider.	The information identifies and authenticates the health care provider completing the report.
Notice to the employee that the report must be provided to the employer, insurer and qualified rehabilitation consul	This statement is necessary to notify the employee that he/she is required to submit this report to the employer, or insurer, and qualified rehabilitation consultant. This encourages the employee to be an active participant in the return to work effort, and places responsibility on the employee to communicate about return to work with the necessary parties.

Item C. This section specifies that the Report of Work Ability must be based on the health care provider's most recent evaluation of the employee which will include the objective and subjective information considered by the health care provider in forming an opinion. An opinion should not be based solely on what would be expected in a typical patient with this condition, or solely on a patient's subjective statements.

Item D. In an effort to actively involve the employee in the return to work process and to maintain communication between the health care provider, employee and the employer, the employee is required to submit the Report of Work Ability to the employer or the insurer, and the qualified rehabilitation consultant. This minimizes the employee's experience as a passive participant, and the sense that others are controlling the process. This also removes from the health care provider the administrative task of conveying the return to work information. By requiring that the health care provider retain a copy of the Report of Work Ability in the medical records, the information is available to any other requesting party, including the Commissioner.

Subp. 7. Charge for required reports. This subpart continues the requirement of the existing rule, part 5221.2590, subp. 4 that prohibits a health care provider from charging for completing the Health Care Provider Report or the Report of Work Ability forms, or any narrative report prepared in lieu of these forms. Both payers and providers contacted agreed that there should be no charge for submitting the required information if these submission requirements could be filled via either the form or a narrative report. Further, since the information on the form is required by the insurer to administer the claims and by the Department to monitor claims there should be no charge for this reporting. On the other hand, the provider may charge a reasonable amount for reviewing medical records and preparing a report in response to a request for additional information (i.e., supplementary reports).

Subp. 8. Proper filing of documents with the division. Employers and insurers as well as DOLI have expressed interest in reducing the paper flow in the workers' compensation system. Many insurers and employers submit information by facsimile now and the Department is actively investigating electronic transmission of data. Since the Department's business hours are 8:00 a.m. to 4:30 p.m., facsimiles received after business hours are deemed received as of the next business day. If the electronically or faxed document is of poor quality, DOLI may require the original to be filed to ensure accurate information is filed and retained.

The rule requires that any narrative report filed with the Division identify the claim and the reason the report is filed. Such identification will facilitate proper, efficient handling of the more than 30,000 medical documents received by the Department annually. For instance, the law requires maximum medical improvement reports and permanent partial disability ratings to be filed. If DOLI received a lengthy report of several pages discussing many medical issues, it may not be apparent that maximum medical improvement has been filed.

PART 5221.0420 HEALTH CARE PROVIDER PARTICIPATION WITH RETURN TO WORK PLANNING.

This rule is intended to clarify the role of the health care provider in return to work planning and to improve communication regarding return to work issues between the health care provider, the employer, the insurer, and the qualified rehabilitation consultant.

Need for the Proposed Rule:

Health care providers need to fully participate in return to work planning. Some health care providers are not fully aware of their responsibility to facilitate a return to work for injured workers. Throughout their training health care providers traditionally focus on treatment and are less aware of the return to work component of workers' compensation. Thus they may not communicate medical information to the employers and insurers who are attempting to return the employee to work as soon as possible. Timely transmission of this return to work information is important so that a job may be offered as soon as possible in accordance with Minnesota Statutes, section 176.101 and the employer and insurer's liability for unnecessary benefits may be contained.

When a job has been developed for an employee, the insurer, employer or qualified rehabilitation consultant may need an opinion regarding whether a job offered to an employee is within the employee's physical restrictions. Since under Minnesota Statutes, section 176.101, subdivision 3e, the employer and insurer have only 90 days after maximum medical improvement to make a suitable job offer, it is critical that the health care provider gives the necessary input within a reasonable period of time.

Health care providers need to provide necessary information to qualified rehabilitation consultants. Qualified rehabilitation consultants complain that some health care providers refuse to meet or talk with them about their clients. This communication is required for a successful rehabilitation plan since the qualified rehabilitation consultant coordinates return to work efforts among the employee, the health care provider and the employer and insurer. The qualified rehabilitation consultant must have prompt, accurate information regarding the employee's ability to work and any restrictions in order to facilitate the return to work. On the other hand, health care providers have indicated that they do not have time to unnecessarily communicate with qualified rehabilitation consultants, and that the information is oftentimes already in their notes which the qualified rehabilitation consultant may have access to upon request. The Training Content Advisory Committee of Rehabilitation Professionals (a rehabilitation professional group that plans qualified rehabilitation consultant training programs with the Department of Labor and Industry) felt the issue was so important, they identified communication with health care providers regarding vocational management as a primary topic of concern to be addressed in training programs.

Some health care providers require payment in advance of scheduling a meeting with a qualified rehabilitation consultant. This policy creates barriers to effective and timely communication about rehabilitation and the employee's work status. Important information may be delayed for up to several weeks resulting in a delayed return to work. Furthermore, this policy creates cash flow problems for qualified rehabilitation consultants since the required prepayment sometimes exceeds \$100. The qualified rehabilitation consultant must make the prepayment and then bill the charge back to the insurer, or, the qualified rehabilitation consultant may request an advance from the insurer. Either way, prepayment delays the meeting.

Nature of the Proposed Rules:

Subpart 1. Cooperation with vocational rehabilitation. This subpart identifies a

primary responsibility of health care providers working within the workers' compensation system to participate actively in the vocational rehabilitation process which has the goal of returning an employee to work.

Eighty-five percent of indemnity claims are managed by the employer and insurer without the assistance of a qualified rehabilitation consultant. This section requires the health care provider to respond within a 10 calendar day period to a request from an employer, insurer or employee regarding whether the physical requirements of a job offer are within the employee's medical restrictions given the importance of the provider's opinion to the return to work effort. The 10 day time frame is considered a reasonable time for a health care provider to respond to a request for input on a job offer and is consistent with other health care provider reporting obligations. Further, Minnesota Statutes, section 176.101, subdivision 3e(e) allows that an employee has 14 calendar days after receipt of a written description and offer to accept or reject a suitable job offer. The 10 day time frame will allow the employee an opportunity to discuss a job offer with a health care provider prior to making a decision about accepting or rejecting the job.

This subpart allows the provider flexibility in responding in person, in writing or by phone. A provider may wish to have a clearly documented description of a job so there is no misunderstanding of the requirements of the job being proposed. Disputes have often occurred where the job that a provider may have approved is not the job that was actually offered to an employee or actually assigned to that employee. To avoid this problem the health care provider may request a written description of the job or agree to view a videotape of the job prior to giving an opinion. The rule is flexible to allow the employer, insurer, employee and health care provider to determine the best avenue of communication.

Subp. 2. Communication with qualified rehabilitation consultant.

This subpart reconciles the need of the qualified rehabilitation consultant to meet with the health care provider to obtain information relative to vocational rehabilitation, with the health care provider's need to limit the qualified rehabilitation consultant's demand on the provider's time. The rule allows flexibility for the most appropriate communication between the provider and the qualified rehabilitation consultant. The rule specifies the times in vocational rehabilitation when the health care provider's input is critical to the success of a rehabilitation plan. These times were agreed upon by committees of the MSRB and rehabilitation professionals associated with the Rehabilitation Review Panel.

Item A: The doctor/patient relationship as well as patient right to privacy is protected by clearly requiring that the patient's authorization is necessary for a qualified rehabilitation consultant to obtain information from a health care provider. Minnesota Rules Part 5220.1802, subp. 5 prohibits a qualified rehabilitation consultant from communicating with a health care provider without written consent of the employee.

This section requires the health care provider to respond within ten calendar days of a request for communication from a qualified rehabilitation consultant when any of the circumstances listed in B occur. The ten days allows the health care provider a reasonable response time while minimizing the delay in developing a rehabilitation plan. The health care

provider is also given flexibility to choose the manner of response (meeting, phone or written). Where the issue is a job being proposed the health care provider may request documentation of the proposed job in written description or agree to view a videotape to reduce disputes.

Item B. This section identifies and limits the circumstances under which the health care provider must respond to a request for communication from the qualified rehabilitation consultant. These circumstances include:

- Upon initial assignment of a qualified rehabilitation consultant, the newly assigned qualified rehabilitation consultant may need medical information which is not in the record to develop a rehabilitation plan.
- After the initial communication the health care provider is not required to respond more often than once every 30 days. More frequent communication is unnecessary unless one of the following occur:
 - (1) When an opinion is requested regarding whether the physical requirements of a proposed job are within the employee's physical restrictions, the qualified rehabilitation consultant needs a prompt response from the health care provider to facilitate prompt return to appropriate work.
 - (2) An unanticipated or substantial change in the employee's condition will affect the rehabilitation plan and the qualified rehabilitation consultant is responsible for accommodating such changes.
 - (3) When job search is initiated, prompt information from a health care provider is necessary regarding the employee's abilities in order that appropriate jobs may be targeted.
 - (4) The provider's input is necessary when there has been a change in the employee's work status. For instance, if the restrictions need to be re-evaluated, the reasons for the change in work status or restrictions and any changes in the treatment plan should be communicated to the qualified rehabilitation consultant so that the rehabilitation plan may be modified appropriately. Further, this information is needed by the insurer so appropriate benefits may be paid.

Subp. 3. Reimbursement for services. This section addresses the problem of a few health care providers who require prepayment for conferences with the qualified rehabilitation consultant prior to scheduling the meeting. As stated earlier prepayment creates cash flow problems for the qualified rehabilitation consultant and delays necessary communication. Payers have indicated a preference for being billed directly by the health care provider for this service and the MSRB has expressed its opposition to the practice of prepayment and the resulting delay in furthering the vocational rehabilitation process. Appropriate procedure codes for this case management consulting service are identified to assist providers and payers with reimbursement.

5221.0430 CHANGE OF HEALTH CARE PROVIDER.

Minnesota Statutes, section 176.135, subdivision 2 requires rules to establish standards and criteria for determining a change of doctor. The previous Minnesota Rules Part 5220.2620, subp. 7, which broadly sets out the procedure and a "best interest of the parties" standard for change of doctor is repealed and replaced with more detailed information concerning the process to change providers and the criteria for approval in the event of a dispute. When an employee can change doctors is often the subject of litigation, and clear specific guidelines are necessary to identify for the parties when a doctor becomes a treating doctor and the circumstances under which a change is counterproductive or inappropriate.

Subp. 1. Primary health care provider. This subpart codifies current practice. In order to avoid conflicting decisions among judges and confusion among the parties, this paragraph sets out a description of the primary health care provider. For some time, workers' compensation parties have debated when a provider becomes the treating doctor, the primary health care provider. The rule indicates that when the employee returns for treatment the employee is choosing that health care provider as the primary provider. However, if the practitioner with whom the employee treats does not coordinate all of the employee's medical care for the injury, it would not be appropriate to refer to that individual as the primary health care provider. Since a duty of the primary provider is to coordinate the employee's care to avoid duplicate services and unnecessary or inappropriate services, the primary health care provider must be capable of doing so and willing to fulfill that function. Careful coordination of the employee's care promotes recovery, quality care, and cost-effective service. To avoid confusion concerning the selection of services and reimbursement of services, only one primary health care provider may be involved in a case at one time. Pursuant to Minnesota Statutes, sections 176.135, subdivision 1f and 176.1351, an employee covered by a certified managed care plan must receive care from plan providers. The employee's selection of a doctor under the managed care plan is governed by these statutes and Minnesota Rules, chapter 5218.

Subp. 2. Change of health care provider. As is the case with the employee's change of a rehabilitation provider, the employee has the option to freely change to another health care provider within the first 60 days of treatment. If the employer participates in a certified managed care health plan, that provider must be selected from participating providers in accordance with Minnesota Statutes, section 176.1351, subdivision 2 (11) and Minnesota Rules Chapter 5218. After one free choice is exercised, further changes of health care provider must be approved by either the managed care organization, the insurer, the Department or a compensation judge.

This section indicates what situations are not considered a change of provider. Consistent with the current practice, referral by the primary provider to another provider is not considered a change of provider, where the referral is the provider's decision. An example would be in a case where complications arise that the initial health care provider feels unable to treat. Likewise, the employee cannot reasonably be said to have exercised a choice for a change of doctor when other circumstances beyond the employee's control necessitate a change from one primary provider to another. As is the case with selection of a rehabilitation provider under Minnesota Statutes, section 176.102, subdivision 4, the selection of a health care provider after the first choice must be approved by the insurer or a decisionmaker in the workers'

compensation system. The rule reasonably balances the employee's right to select appropriate care personally and the employer and insurer's right to manage the workers' compensation claim.

Subp. 3. Unauthorized change; prohibited payment. This subpart sets out the sanction for failing to obtain approval for a change of doctor when required by subp. 2. In order to encourage employees and health care providers to obtain approval for the change in provider, the sanction is lack of payment to the health care provider for failing to do so. Of course, in an emergency situation such prior approval is not necessary. Many workers' compensation judges have historically approved medical treatment retroactively, even where a change of health care provider was not necessary or appropriate. To prevent such a result, the rule creates an incentive for the health care provider and the employee to seek approval of a change of primary health care provider before treatment expenses are incurred. This discourages an employee from seeking duplicative care or care similar to treatment rendered by a previous health care provider before the insurer is even aware that the employee is seeking additional treatment. While it is understandable that an employee may wish to seek treatment from another source where excellent results have not been obtained from the first provider, a change of provider is not always in the employee's best interest. Since rising medical costs are a significant portion of the workers' compensation dollar, an effort is made in these rules to contain unnecessary costs as directed by the 1992 Legislature.

Subp. 4. Change of primary provider not approved. This subpart lists the situations in which a change of primary health care provider should not be approved. A change of doctor is not in the parties' best interests where the employee is simply seeking to avoid appropriate treatment, is doing so at the request of an attorney or other professional as a litigation strategy instead of for medical reasons, or the treatment is at a great distance from the employee's residence and comparable treatment is available at a more reasonable location. Change of doctor requests are also appropriately denied where the desired provider lacks the expertise to treat the employee's injury or where the employee has been released from treatment and no further treatment is advisable. The sixth rule factor is the general test contained in existing rule that a change of doctor should not be allowed if it is not in the best interests of the parties. This list is not meant to be exhaustive. There may be other factors that are also significant; these reasons summarize the major bases upon which the decisionmaker should deny a request for a change of doctor. The basic principle is that the employee is entitled to treatment that is reasonably required for that employee's injury. This treatment may likely be obtained from a number of qualified providers. The above factors do not interfere with the employee's right to reasonably required treatment and therefore are not a basis to change doctors.

PART 5221.0500 EXCESSIVE CHARGES; LIMITATIONS OF PAYER LIABILITY.

Minnesota Rules Part 5221.0550 is repealed because the provisions on excessive services are incorporated into the amended rule on excessive charges. This single rule pulls together concepts of excessive charges from the previous provisions in part 5221.0500 and 5221.0550, as appropriate, with the excessive charge provisions in the 1992 amendments to Minnesota Statutes, section 176.136, subdivision 2, and proposed rules. Employer liability is distinguished from excessive charge rules based on amendments to Minnesota Statutes, section 176.136, subdivisions 1, 1a, 1b and 2. This part will clarify for payers and providers the liability

limitations for medical charges.

Nature of the Proposed Rule and Rationale:

Subp. 1. Excessive health care provider charges. This section identifies the conditions under which a billing charge is excessive and therefore for which a payer is not liable. An excessive charge is an inappropriate charge that the provider should not submit for payment. This is distinguished from the payers liability for the cost of treatment, which is established by Minnesota Statutes, section 176.136, and subp. 2.

Items A and B of the current rule are repealed. The provider should always submit his or her usual charge, and Minnesota Statutes, section 176.135, subdivision 3 has been replaced by Minnesota Statutes, section 176.136, subdivision 1b(b).

A. This item indicates that charges for articles and supplies, as well as services, which duplicate other billing charges are excessive. Medical articles, supplies and services should be paid for only once.

B. This item clarifies that charges exceeding the provider's usual and customary charge as defined in subpart 2, item B are excessive. This requirement is found in Minnesota Statutes, section 176.136, subdivision 1b(b).

C. This item is renumbered from the existing rule.

D. This item replaces the current item E because it reflects the intent of the treatment parameters (Minnesota Rules [Emergency] part 5221.6010 to 5221.6500), in that services, articles and supplies which are outside the parameters are excessive. pursuant to Minnesota Statutes, section 176.136, subdivision 2.

E. This item refers to Minnesota Statutes, section 176.103 under which providers may be sanctioned by prohibiting them from receiving payment for services rendered for providing inappropriate, unnecessary, or excessive treatment, or any violation under Chapter 176 or rule adopted under this chapter. Minnesota Statutes, section 256B.0644 was enacted as part of the MinnesotaCare law which provides that health care providers must participate in the Medical Assistance program in order to receive payment under the workers' compensation system.

F. This item refers to Minnesota Statutes, section 176.135 and 176.136, subdivision 2 (1992) regarding the standards for determining whether a service is excessive.

G. If the provider violates antikickback statutes a workers' compensation payer should not be liable for those services either. This refers to proposed Minnesota Rules Part 5221.0700, subp. 1a, which reflects the provision in the MinnesotaCare law which adopts the federal Medicare antikickback regulations, and applies those standards to all Minnesota providers.

H. This item refers to proposed Minnesota Rules Part 5221.0430, subp. 3 which prohibits payment for treatment provided prior to authorization for change of provider.

I. This item adds language that indicates that treatment which is outside the scope of the provider or is not recognized as therapeutically valuable treatment, is excessive. The reader is referred to Minnesota Statutes, section 176.136, subdivision 2, clause (3).

Subp. 2. Limitation of payer liability. If charges are not excessive under subp. 1 a payer's liability for payment is limited as described in Minnesota Statutes, section 176.136, subdivisions 1a, 1b and 2. These provisions are included here to simplify payment decisions for the payers, to inform the health care provider, and to coordinate the various statutes and rules into one section.

A. For those services included in the workers' compensation medical fee schedule, payment liability is limited to the maximum allowed by the medical fee schedule or the actual fee whichever is lower. This refers to Minnesota Statutes, section 176.136, subdivision 2a.

B. Where the service is not included in the fee schedule, liability is limited according to the provisions of Minnesota Statutes, section 176.136, subdivisions 1b and c. The terms "usual and customary" and "prevailing charge" are defined for the purposes of workers' compensation in accordance with Minnesota Statutes, section 176.136, subdivision 1b(b). There has been significant confusion regarding these terms and therefore clarification is needed.

"Usual and customary" is defined as the amount actually billed by the health care provider to all payers, whether under workers' compensation or not, and regardless of the amount actually reimbursed. There are a variety of payment contracts for health care providers, and determining what is the usual and customary charge based on many different contracts would be difficult. This definition reflects the concept in Minnesota Statutes, section 176.136, subdivision 1b(b), that the usual and customary charge should not be different for workers' compensation patients than for anyone else. See also, Minnesota Rule part 5221.0700, subp. 1. It is not likely that the legislature intended the 15 percent reduction of usual and customary charges to be a further reduction from the amount reimbursed under a contract with another payer.

Many payers have applied their own database in determining a prevailing charge. Sometimes the database contains nationwide data, sometimes the database includes a variety of provider types. There are many disputes regarding an appropriate basis for prevailing charge determinations. Therefore, a standard is set forth to assist payers in evaluating data and to reduce disputes. This standard is based on the criteria set forth in Minnesota Statutes, section 176.136 for the data set used by the Department of Labor and Industry to develop its charge based fee schedule from 1983 to 1991. The maximum fees in the charged-based fee schedules were set at the 75th percentile. This is determined to be a reasonable basis for the prevailing charge as well. The other requirements adopted from the previous statutory criteria are to ensure statistical validity of the data. Distinctions based on inpatient and outpatient services, and on provider type, are appropriate because the fee schedule required to be adopted under Minnesota Statutes, section 176.136, subdivision 1a makes similar distinctions.

C. & D. The provisions of Minnesota Statutes, section 176.136, subdivision 1a and 1b for hospital charges and nursing home charges are included to reflect the requirements in Minnesota Statutes, section 176.136, subdivision 1b(a) and (b).

E. This item is new and addresses the disputes that have arisen regarding an employer's liability for payment of medical services, articles and supplies being limited to 85 percent under the broad language of Minnesota Statutes, section 176.136, subdivision 1b. This item specifically addresses payment for records and employee travel expenses for medical care. Payment for medical records is governed by chapter 5218 and should not be subject to the 85 percent payment. A reduced payment for records would invalidate the existing rule and discourage providers from submitting records to a payer as they are required to do. This dispute delays transfer of necessary information from the provider to the payer and can delay the employee's return to work.

Employee travel expenses for medical services should not be subject to an 85 percent reimbursement policy because it will leave the employee to absorb the additional 15 percent of the cost of travel, and Minnesota Statutes, section 176.136, subdivision 1b(b) only refers to a reduction of health care provider charges.

F. This item specifies that charges for supplementary reports and return to work services are not subject to the 85 percent reimbursement rule either. Distinguished from required reports in part 5221.0410, supplementary reports are not required, and reducing the charge for these would discourage providers from providing these reports. Such a reduced payment would be a significant obstacle in obtaining necessary health care provider input regarding an employee's condition and work status. Communication between the health care provider and the employer and insurer is essential to management of a claim.

Subp. 3. Collection of excessive charges. This subpart consolidates existing language of Minnesota Statutes, section 176.136, subdivision 2 and rule 5221.0700, subp. 5 (repeal proposed) so all information regarding excessive charges may be easily reviewed by payers and providers. This section also directs the health care provider to remove charges which were determined excessive by the payer from the billing unless a formal request for dispute resolution has been filed. The purpose is to clearly identify the correct balance due and not carry over excessive charges to new billings, which would be confusing to employees and payers.

PART 5221.0600 PAYER RESPONSIBILITIES

Subp. 2. Determination of Excessiveness. This subpart is amended to reflect the consolidation of the excessive charge, excessive service and payer liability rules under Part 5221.0500, consistent with the statutory amendments to Minnesota Statutes, section 176.136. This subpart also allows the payer to assign a correct code to a service if the payer determines the service was incorrectly coded. This is necessary because the payer must be able to interpret and apply the provisions of the fee schedule in order to administer the claim. Notice of any reduction in payment resulting from recoding must be given to the provider and employee under subpart 4, so the provider is able to review and discuss any coding issues with the payer.

Subp. 3. Determination of Charges. Amendments to this subpart are made to reflect the consolidation of the excessive charge, service and payer liability rules into Part 5221.0500, consistent with the statutory changes to Minnesota Statutes, section 176.136. The payer's right to deny a charge that is not submitted on a uniform billing form is necessary due to the addition of this requirement in Minnesota Statutes, section 176.135, subdivision 7. Item B is deleted

because the corresponding statutory provision, Minnesota Statutes, section 176.135, subdivision 3, was repealed.

Subp. 4. Notification. Amendments are made to items B and C for the reasons set forth for amendments to subparts 2 and 3 above. Language is added to item D, consistent with the statutory amendments to Minnesota Statutes, section 176.135, subdivision 6, which require the payer to reconsider charges within 30 days after the corrected submission.

PART 5221.0650 DATA COLLECTION, RETENTION, AND REPORTING REQUIREMENTS.

This part addresses DOLI's need for medical service and cost information for the purpose of monitoring care provided to injured workers and evaluating the medical cost containment program.

Need for the Rule:

Medical data is inadequate for DOLI to perform its monitoring function. DOLI has conducted several studies in the past few years on medical issues related to workers' compensation. The acquisition of accurate and complete medical data was difficult. Currently there is not a uniform method of collecting nor reporting medical data. This makes any type of comparison or analysis of medical information nearly impossible.

There has been no standardization of data elements or format that a health care provider must submit to a payer, nor standardization of data retained by a payer. This lack of standardization prevents aggregation of data across payers and makes any research activity very difficult.

This data is not only necessary for research purposes, it is necessary to implement the monitoring requirements in Minnesota Statutes, sections 175.17, 175.171, 176.103, 176.1351, 176.136, and 176.83. Under these statutes the Commissioner is required to monitor the medical and surgical treatment provided to injured workers. The monitoring shall include determinations concerning the appropriateness of the service, whether the treatment is necessary and effective, the proper cost of services, the quality of treatment, and the right of providers to receive payment for services rendered or payment for future services rendered under this chapter.

Due to these data problems, the Department and the MSRB are unable to fill their research roles with regard to utilization review, quality assurance, and evaluating the clinical consequences of the services provided (Minnesota Statutes, sections 176.103 and 176.83, subdivision 5).

Nature of the Proposed Rule and Rationale:

Subpart 1. Scope. This section identifies which parties are responsible for data collection. The 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 Guarantee Association are required to collect data because most of the needed data is available on the billing statements sent to the payer by the provider. The payer

generally reviews the bill for accuracy of information in the bill review process, thereby increasing the likelihood of valid information being collected and tracked with an individual claim.

Subp. 2. Purpose. This subpart establishes procedures and requirements for reporting medical and related data regarding treatment of workers' compensation injuries. This data is necessary for the Department to monitor and evaluate the effectiveness of medical and surgical treatment and the services of health care providers, including those providers providing services under the new Managed Care Plans for workers' compensation (chapter 5218) and subject to the newly promulgated treatment parameters (part 5221.6010 to 5221.6500 [Emergency]).

Subpart 3. Retention period. This part requires that specified data must be collected and stored for a period of ten years from the date the service or supply was provided to the employee. A ten year period is required because of the potential for long term case study. The most costly cases in workers' compensation are generally the longer term cases. With the ten year retention span, the Department would be able to follow cases for this extended period of time. The insurers and self-insurers would not be required to maintain the data on active file, but will be allowed to store the data on computer tape or in hard copy.

Subp. 4. Required data. Table 4 lists the data which must be collected from the uniform billing forms, and the rationale. Table 5 lists the data which must be collected and stored in addition to the data required on the uniform billing forms. The rationale for collecting this additional information is included.

This subpart provides that all the data required on the uniform billing forms must also be collected and retained by payers. The rationale is that DOLI must have ongoing claim level data in order to fulfill its statutory mandate to monitor treatment provided to injured workers. The 1992 amendments require the Commissioner to develop standards for treatment; data is needed to develop standards that reflect appropriate care for injured workers as well as to update standards as medical treatment changes.

Table 4. Data to be collected from uniform billing forms. Claim level data includes:

DATA ELEMENT	RATIONALE/USE
Diagnosis	To determine the condition being treated. Necessary to identify norms of treatment specific to a condition.
Date of injury	To determine timing of treatment. Was it provided in acute stage or much later.
Type of primary health care provider	Identify practice patterns of different types of providers. Recognize different scopes of practice.
Date of treatment	Frequency and length of treatment are critical factors in surveying appropriateness of care.
Treatment provided	Nature of service identified. Necessary in developing practice patterns.
Type of provider delivering the service	Some services may be delivered by a variety of providers, including licensed or registered professionals, office staff, or unregulated independent providers. Information helps clean up the data collected on practice patterns.
Place of service	Place of service, i.e., hospital, office, emergency room, can significantly impact cost of a service. Necessary in developing treatment standards.
Charge of each service	Necessary to evaluate the performance of a medical fee schedule.

Table 5. Data to be collected and retained in addition to data required on uniform billing forms.

DATA ELEMENT	RATIONALE/USE
Open or closed claim status.	Necessary to track which services are for which date of injury. Especially important where there are multiple injuries.
Was the employee incapacitated from work for more than three days.	Indicates if indemnity benefits paid. Significant in evaluating the outcome of treatment necessary to access claims with no lost time from work since these are not reported to DOLI.
Amount of payments for individual services, articles, supplies. ⁶	Necessary to monitor trends in the charges for a service versus the amount actually paid. Allows evaluation of efforts to control cost per service.
Name of managed care plan if services were provided under such contract.	Necessary to evaluate cost of treatment through a managed care plan and compare with non-managed care plan.

⁶ Only a required data element for professional services and supplies billed on uniform billing form HCFA-1500 as described in 5221.0700, subp. 2a. Payments for individual services may differ from the actual charge since the employer may reduce an individual charge for reason of excessiveness. Hospital charges, reported on the UB-92 form in subp. 2b, may be discounted a straight percentage of compensable charges so payment of individual services is not possible.

Subp. 5. Reporting Requirements. DOLI does not need and does not have the capacity to collect all medical data on all injured employees. For this reason, we are only requesting a sampling of data depending upon the research designs and monitoring needs of the Commissioner. These needs will change from year to year and it would not be appropriate to specify and require the reporting of all the potential data. Therefore, DOLI proposes to only require a portion of the data depending on the immediate needs. DOLI and the insurer, self-insurer, or third-party administrator will mutually agree on the standard of information exchange in order to minimize any administrative or technical problems and in an attempt to provide flexibility for the business needs of these entities. This exchange standard may include hard copy, computerized format, or electronic data interchange (a technology coming into widespread use in the insurance industry).

This section also provides that the data maintained by the payers must be reported to DOLI within 90 days of a request for data. Ninety days was discussed with insurers and was considered to be a reasonable time period for the payer to provide the data in the agreed upon format without significantly interfering with the payer's other business activities involving the information system.

This section further specifies that the data will be provided without charge to DOLI. There is no statutory provision for payment for this data under Minnesota Statutes, section 176.82, subdivision 5a.

Part 5221.0700 PROVIDER RESPONSIBILITIES.

The purpose of this rule is to implement federal antikickback regulations with workers' compensation and to mandate transfer of necessary medical information from the health care provider to the payer.

Nature of Proposed Rule and Rationale:

Subp. 1a. Conflicts of interest. The 1992 Legislature enacted, as part of the MinnesotaCare law, Minnesota Statutes, section 62J.23. This statute provides that all health care providers in Minnesota are subject to the Medicare "Antikickback" regulations for any service provided in Minnesota, whether under Medicare or not. These regulations prohibit certain health care provider referral of patients for treatment to facilities in which the health care provider has a financial interest. The concern addressed by that law is that the provider's financial interest results in unnecessary treatment or diagnostic testing. This provision in the MinnesotaCare law, applies to all treatment, including workers' compensation treatment, by Minnesota health care providers. This rule prohibits payment for workers' compensation services delivered in violation of this law. A workers' compensation insurer should not be liable for treatment that is prohibited by federal and state law.

Subp. 2. Submission of Information.

Minnesota Rules Part 5221.0700, subp. 2 is repealed, it is replaced with new wording which standardizes the billing process by requiring the use of two uniform billing forms. This subpart also clarifies when the appropriate record must be submitted.

Need for Subp. 2:

Medical records substantiating the services billed are not routinely submitted to the payer. While Minnesota Statutes, section 176.135, subdivision 7 (1992) requires that a health care provider submit to the payer medical records that substantiates the nature of the charge and the relationship to the work injury, there is confusion over when such records must be submitted.

Indirect billing for services. Some providers include on their billing statements, the services and charges provided by another health care provider under referral from the treating doctor. This combined billing creates difficulties for the payer in determining the reasonable payment for that outside service. For example, charges for a lumbar brace prescribed by the treating provider and ordered from a separate business entity may be billed by the ordering facility. The billed charge may include the cost of the brace to the provider, plus a mark-up of up to 40 percent.

Delayed billing. Bills are occasionally not submitted to a payer for several months during which time significant amounts of treatment may be provided without the payer's knowledge.

Nonstandard billing procedures. Minnesota Statutes, section 176.135, subdivision 5 (1992) requires the adoption of a uniform billing form. Historically, workers' compensation health care providers have been free to submit their bills in whatever format they chose. Given that there are over 8000 medical physicians alone in the state, this means that payers are subject to non-standard billing procedures. Added to the difficulty of processing different formats, billers give information that is inconsistent, incomplete or absent altogether, and unreliable from one health care provider to another. This somewhat erratic billing pattern increases costs and delays claims processing in the workers' compensation system because payers (a) take longer to find information on forms that are markedly different from each other; (b) must follow-up and correct incomplete or inconsistent data; and (c) cannot optically scan and electronically process bills. The result has been that payers complain of their added costs, while billers complain of the long lag time between services rendered and bills paid. Thus, neither the payer nor the biller can efficiently manage the cases.

Costs and treatment data invalid. Finally, given the inconsistent charge documentation procedures, the Department is hamstrung in its efforts to reliably compare cost and treatment data across health care providers to determine necessity, reasonableness and excessiveness. Additionally, workers' compensation billing procedures are inconsistent with other major billing systems, such as Medicare, making comparability of data invalid, if not outright impossible. The Department cannot meet its mandate to review services and charges (Minnesota Statutes, sections 176.103, 176.136 and 176.83).

Nature of Proposed Rule and Rationale:

Subp. 2. Submission of Information. This new language clarifies Minnesota Statutes, section 176.135, subdivision 7 which requires that health care providers submit an appropriate medical record that substantiates the nature of the charge and its relationship to the work injury.

The rule requires that health care providers, except hospitals, submit an appropriate record with the billing statement; hospitals must submit the records upon request of the payer. Documentation to support the change is required by Minnesota Statutes, section 176.135, subdivision 7.

Hospitals are distinguished from other medical services due to the nature of the services provided. The hospital services are often more numerous and of greater variety (e.g., surgery, laboratory, radiology, medication, supplies, therapy services are frequently billed in one hospital stay) than those provided in a clinic setting. The records for these hospital services are often voluminous and would be costly to routinely send with each bill. Furthermore, payers have indicated a preference for requesting specific records from a hospital for a review; or for reviewing records on site at the hospital. Under Minnesota Statutes, section 176.135, subdivision 7 and Minnesota Rules Chapter 5219 health care providers may charge for copies of existing records or reports related to a claim under chapter 176. Payers did not want to be required to pay for copies of extensive hospital records they did not request.

Health care providers other than hospitals are required to send a copy of the appropriate record with the bill. Disputes often arise over delayed payment of a bill where the problem is lack of records to support the services. A payer may deny payment where an appropriate record is not presented. In order to comply with timely payment of bills under Minnesota Statutes, section 176.135, subdivision 6, payers have indicated a preference for receiving an appropriate medical record with the bill from a clinic or other outpatient setting. Review of these records facilitates payment for services. The records also inform the payer of the medical status of the patient.

In this subpart, the Department is also prescribing the use of two uniform billing forms for all workers' compensation cases as required by Minnesota Statutes, section 176.136, subdivision 7, with the exception of dental charges, pharmacy charges and services in a veterans hospital. Dental and pharmacy services are unique and comprise only a small portion of workers' compensation charges. The uniform billing forms adopted by the Health Care Financing Administration would not be easily used for these services. Both dental and pharmacy services have standard forms in common use; it is unnecessary to mandate a uniform form at this time. Minnesota Statutes, section 176.135, subdivision 7 specifically exempts services in the veterans hospital from the billing form requirement.

Item A requires direct billing to the payer from the health care provider actually providing the services. Billing the payer directly allows the payer to review the charge for a service or supply and assess the reasonableness of the charge or compare the charge with other similar services. The problem of mark-up for services provided by another business entity but billed by the referring provider is avoided, thus reducing costs and minimizing disputes. Prompt payment is facilitated by direct billing because the bill is not sent first to another health care provider, or the employer or employee to be forwarded to the payer. This item applies, but is not limited to, charges for services, supplies or articles that are often referred out, including: diagnostic imaging, lab and pathology testing performed by other than the ordering health care provider; equipment, supplies, and medication not ordinarily kept in stock and ordered specifically for a patient from another entity.

This item also applies to services provided in a hospital by a provider with an independent practice who is not an employee of the hospital. Professional services are generally billed by the provider, separate from the facility bill. This procedure has been generally accepted by most payers and providers and is recommended by the administrative uniformity committee to the MinnesotaCare Health Care Commission.

Finally, the proposed rule specifies that pharmacies must bill outpatient medications directly to the payer. This protects the injured worker from paying in full for a medication, either under Part 5221.4070 or Minnesota Statutes, section 176.136, subdivision 1b(b), and then requesting reimbursement from the payer. If the payer determines the pharmacy charge is excessive the worker may have difficulty getting full reimbursement.

Item B requires that charges must be submitted to the payer within 60 days from the date the health care provider knew the treatment was for a condition claimed to be work related. Prompt billing informs the payer that the employee is treating with a provider and allows the payer to manage the claim. When a payer receives bills months after the service is rendered the opportunity to manage the claim and resolve issues related to treatment is severely compromised. Also, the health care provider is informed of the payer's position on a claim (acceptance or denial) early in the course of treatment, thus limiting the provider's exposure. Sixty days was specifically chosen as the limit, based on a recommendation passed by the MSRB at its February 19, 1992 meeting. In addition, the following groups were consulted and concur that the time is sufficient for bill processing: Minnesota Chiropractic Association; Minnesota Medical Association; and Minnesota Hospital Association.

Item C indicates this that part does not limit the collection of other information which may be required under state or federal jurisdiction. The workers' compensation law is only one law that payers and providers are governed by. The rules cannot limit the application of other jurisdictions.

Subp. 2a, 2b, 2c. Prescribed uniform billing forms. According to workers' compensation statutes, the employer must pay the charge for health care services or any portion of the charge which is not denied or stipulate the basis for denial, delay, or non-compensability (Minnesota Statutes, section 176.135, subdivision 6). Payers report that bills are often delayed due to inadequacy of billing information (Medical Study Implementation Action Plan, Chapter 5, "Survey of Utilization Review Services among Minnesota Insurers", February 1991). By specifying what information must be provided in this rule and specifying the time limit within which the billing form must be submitted to the payer, the Department anticipates a faster turn-around on bill processing and a decrease in number of disputes related to adequacy of billing information and excessive data demands on the part of the insurer.

Minnesota Statutes, section 176.135, subdivision 7 requires the Commissioner to prescribe a uniform billing form for submission of charges to an insurer. The forms adopted in subparts 2a and 2b by the Department are also required by the Health Care Financing Administration for all of its Title 18 and 19 claims processing under the federal entitlement programs. The forms are incorporated by reference in part 5221.0405, items B and C, and are attached to this statement. These forms have been under national review and used throughout the country, including here in Minnesota. By adoption of HCFA-1500 and UB-92 as the

Department-designated forms, the Department is consistent with other major health care payers and with MinnesotaCare efforts and recommendations to control medical administrative costs through standardization of billing. The standard billing forms and required data elements will be required as of January 1, 1994. This timeframe allows for anticipated modifications in provider's billing systems. Also, in January of 1994, the UB-92 form will replace the older UB-82 form in federal programs.

The Department has reduced the number of data elements required for workers' compensation so as to ease the data reporting burden on health care providers and to make the forms compatible with the needs of the workers' compensation system. Further, use of these forms will minimize the cost for small businesses, because it allows them to order worker compensation forms in bulk with their order of Medicare and Medicaid forms. Importantly, as well, commonly used forms will also facilitate treatment and cost comparisons of health care across populations.

Tables 6 through 9 identify the data elements required on each of the required billing forms and the rationale for inclusion.

Table 10 identifies the required information for pharmacy services and the rationale. A form is not prescribed for pharmacy services because standard billing forms are in use for pharmacy services which are specifically designed for these services. However, by rule the Department of Labor and Industry prescribed information which must be submitted to the payer to facilitate appropriate and timely payment.

Table 6. Required Information on the Uniform Billing Form, HCFA-1500.

DATA ELEMENT	RATIONALE/USE
Payer name, address	Identifies to whom bill is being/was sent.
Workers' compensation file number	Identifies the claimant; using DOLI filing system: the employee's social security number.
Employee's name, address, phone	Identifies claimant.
Claim number of insurer	Used to reference insurer records.
Name of certified managed care plan	Used to manage claim and determine excessiveness.
Date of Injury	To help establish compensability of the service.
Diagnosis or nature of illness (using ICD-9 codes)	Machine-readable shorthand code for a service; can be used in data analysis and bill review. ICD-9 coding system is commonly used by providers and payers.
Date of service	Helps establish compensability. Matches bill to medical records to substantiate claim.
Approved procedure codes and modifier for service	Identifies the service billed using standard shorthand code. Code is used in data analysis and conducting computerized bill reviews. Allows application of fee schedule where appropriate.
Charge for service	Identifies amount being billed/charged. Necessary to determine amount of payment.
Place of service	For data analysis purposes; documents location for those services for which reimbursement amount is dependent on location.
Units of service	Indicates the number of units of each service provided on that date and is used to establish total charge for that service.
Name of facility where service rendered	Identifies provider and location of service and location of records.
Health care provider's or supplier's name, address, phone	Documents biller and where payment is to be sent; phone number in the event of questions.
License or registration number of provider	Provider identification information.
Provider name and degree	Provider identification information.

Table 7. Required Information on the Uniform Billing Form, UB-92 (HCFA 1450).

(Tables 8 and 9 indicate the additional information required specific to outpatient or inpatient services.)

DATA ELEMENT	RATIONALE/USE
Name of the hospital and address	Documents the service provider and where payment is to be sent.
Patients unique control numbers	Identifies patient account and facilitates hospital's retrieval of financial records for a particular service period.
Type of bill	First two digits identify facility as hospital, surgical center, clinic, skilled nursing, emergency room and whether patient was inpatient/outpatient. Necessary for determining compensability and proper payment as well as Department monitoring of medical care. Third digit not required.
Service period included on bill	Facilitates accounting of bills paid or pending.
Patient's name, address	Identifies claimant.
Admission date for inpatient care	Facilitates payer's accounting and medical management.
Priority of care	Identifies emergency, urgent and elective care. Necessary to determine appropriateness of service.
Identification for work-related accident and date of injury	Assists payer identifying compensable services.
Name of workers' compensation payer	Identifies to whom bill is being/was sent.
Employee's workers' compensation file number	Identifies the claimant. Using DOLI's filing system: the employee's social security number.
Name of managed care plan involved	Necessary for payer to manage claim and determine excessiveness.
Diagnosis code	Necessary to determine compensability of services.
Principal procedure performed	Identifies for payer the primary reason for hospital's services. Assists case management.
Attending health care provider	Necessary for medical management, e.g., who is directing case.
Health care provider performing principal procedure	Necessary for payer's accounting and medical management.
Authorized signature	Necessary so an accounts manager acknowledges responsibility for accuracy in billing.

Table 8. Outpatient services require the following itemization in addition to information from Table 7.

DATA ELEMENT	RATIONALE/USE
Approved procedure codes and modifiers	Identifies the service billed using standard shorthand code. Code is used in data analysis and conducting computerized bill reviews. Necessary for application of fee schedule where appropriate.
Date of each service	Helps establish compensability. Matches bill to medical records to substantiate claim. Necessary to determine applicable statute and rules.
Units of service	Indicates the number of units of each service provided on that date and is used to established total charge for that service.
Total charge for each service.	Charges cross checked for accuracy. (Charge x units = total).
Sum of all charges	Cross check totals for accuracy.

Table 9. Inpatient services require the following information in addition to information in Table 7.

DATA ELEMENT	RATIONALE/USE
Revenue code and description of revenue category	A code designating a type of service, e.g., lab, radiology, physical therapy. Code summarizes the individual services by category.
Total charge for each category of service and the sum.	Gives payer a summary of charges for each category of service and the total of all categories. Cross check for accuracy.
Where a summary is used, an itemization of services and supplies must be submitted with the summary. Itemization must include:	
Approved procedure codes and modifiers, supply codes	Identifies the service billed using standard shorthand code. Code is used in data analysis and conducting computerized bill reviews. Allows application of fee schedule where appropriate.
Date of each service	Helps establish compensability. Matches bill to medical records to substantiate claim. Necessary to determine applicable statute and rules.
Units of service	Indicates the number of units of each service provided on that date and is used to establish total charge for that service.
Charge for each service	Identifies amount being billed/charged. Necessary to determine amount of payment.

Table 10. Required information on pharmacy charges (including outpatient hospital pharmacy).

DATA ELEMENT	RATIONALE/USE
Employees workers' compensation file number	Identifies claimant; using DOLI's filing system: the employee's social security number.
Employee's name and address	Identifies claimant.
Payer's name and address	Identifies the payer responsible and to whom bill was sent.
Date of injury.	Helps establish compensability of the service.
Name of HCP who ordered the medication	Facilitates medical management of claim.
Name of certified managed care plan.	Used to manage claim and determine excessiveness
Medication provided and procedure code.	Identify service being billed; necessary to determine amount of payment under Part 5221.4070.
Date medication provided	Establishes compensability. Matches bill to medical records to substantiate claim. Necessary to determine applicable statute and rules.
Total charge for each medication.	Necessary to determine amount of payment.
Name, address and phone number of pharmacy	Identifies the provider and where to send payment.

Subp. 3. Billing code. This part establishes that the provider is responsible for determining which code correctly describes the medical service rendered. New language is added to clarify that instructions and guidelines for determining correct codes are provided in this chapter and in the CPT and HCPCS manuals, incorporated by reference in Minnesota Rules 5221.0405. Because these manuals are updated at least annually, the manual in effect on the date this service was rendered is designated as the controlling document. This documentation is intended to prevent disputes arising from conflicting information and different versions of coding manuals and to maintain consistency and uniformity with other providers and payers.

Item A. This item limits the types of procedure codes that can be used by providers and requires that appropriate modifiers be included in billing codes. These requirements are intended to bring about uniformity in billing and record keeping which, as noted above, is required by MinnesotaCare legislation and which will assist all parties in administering and adjudicating claims and which will contribute to collection of reliable, valuable health care data. Language pertaining to the existing fee schedule is deleted for services after the effective date of the proposed fee schedule.

Item B. This item defines the term “modifier” and refers the user to the CPT and HCPCS manuals, incorporated by reference in Minnesota Rules Part 5221.0405, items D and E. These manuals are designated as the definitive source for the list of modifiers available for use in workers’ compensation, in an effort to prevent disputes arising from disagreements related to the use or meaning of a particular modifier. These modifiers are in widespread use. Language pertaining primarily to the format and use of modifiers in the existing fee schedule is deleted, because it will be replaced by the proposed relative value fee schedule.

Item C. This item provides general guidelines related to provider group designations, defines and describes each provider group and directs the user to the specific rules which contain the lists of provider group services.

Subitem (1). Minnesota Statutes, section 176.136, subdivision 2, establishes that payers are not liable for excessive charges and that “a charge for a health service or medical service is excessive if it . . . (3) is for a service that is outside the scope of practice of the particular provider. . . .” The scope of practice for each type of provider is generally established by statute and is intended to ensure the delivery of appropriate health care and guard the public from harm caused by unsafe practices or unskilled providers. The reiteration of this restriction here is necessary because there is nothing in any procedure code which signifies the scope of practice limitations, since all services are coded using the HCPCS system.

The rule states that services delivered by assistants of a provider are coded as though delivered directly by the provider, reflects the fact that maximum fees for all services are calculated at the same rate, as long as a licensed provider ordered or supervised the service. This is consistent with Medicare’s payment methodology and with existing Minnesota fee schedule rules. It reflects the reality that, in practice, many services are provided by personnel working under the direction of a licensed provider. The fact that the licensed provider is ultimately responsible for these staff and liable for any damages caused by staff negligence serves to encourage prudent delegation by the licensed provider and obviates the need for oversight of such delegation by the Commissioner.

Specific reference of the application of the fee schedule to hospitals is made for clarity, as this area has been subject to litigation in the past and specific statutes and rules apply.

Subitems (2) - (6). These items identify the group of services and providers generally providing these services and directs the user to the portion of the medical fee schedule containing the list of actual services. A discussion of the four provider groups, and pharmacies, and corresponding services is found in the Statement of Need for the proposed Relative Value Fee Schedule, Parts 5221.4000 to 5221.4070.

REPEALERS

Part 5221.0100, subps. 7 and 8, the definitions of “excessive charge” and “excessive service” are repealed because they do not appear in the chapter other than in part 5221.0500.

Part 5221.0100, subps. 13 and 14 are repealed because the terms are not used in the chapter.

Parts 5221.0550 “Excessive Services, is repealed because the provisions on excessive services are incorporated into the amended part 5221.0500, governing excessive charges and services and employer liability. This is consistent with Minnesota Statutes, section 176.136, subdivision 3, which blurs the distinction between an excessive charge and an excessive service.

Part 5221.0700, subp. 5, “Collection of Excessive Charges” is repealed because it is incorporated into part 5221.0500.

Part 5221.0800, “Dispute Resolution” is repealed because Minnesota Statutes, section 176.136, subdivision 2 now permits a health care provider to file a medical request for an alleged excessive service as well as an excessive charge. This provision conflicted with the statute. Dispute resolution rules are now contained in Minnesota Rules, chapter 5220.

Part 5221.2620, subp. 7 is repealed because the broad procedures set forth a “best interest of the parties” standard which has not proved useful or effective in reducing disputes. It is replaced by proposed 5221.0430.

Parts 5221.1000 to 5221.3500 are repealed for services after the effective date of the proposed Relative Value Fee Schedule. The repealed sections are references to the existing fee schedule, which will be replaced by the Relative Value Fee Schedule.

Tables

1. Required information on Health Care Provider Report Form
2. Required information in the cover letter for the Maximum Medical Improvement Narrative Report
3. Required information on the Report of Work Ability
4. Data to be collected and retained from the Uniform Billing Forms.
5. Data to be collected and retained in addition to data required on uniform billing forms.
6. Required information on the Uniform Billing Form, HCFA-1500.
7. Required information on Uniform Billing Form, UB-92 (HCFA-1450)
8. Outpatient services require the following itemization in addition to information from Table 7
9. Inpatient services require the following information in addition to information on Table 7.
10. Required information on pharmacy charges (including outpatient hospital pharmacy).

APPENDIX

1. HCP Report
2. Report of Work Ability
3. HCFA-1500 claim form
4. UB-92 (HCFA 1450) claim form

SK/KB/ckc

Health Care Provider Report



H C O 1

EMPLOYEE	SOCIAL SECURITY NO.	DATE OF INJURY	See Instructions on Reverse Side, Type or Print (WHEN COMPLETED RETURN TO REQUESTER)	Do not use this space
	NAME			
	ADDRESS (include city, state and zip)			
EMPLOYER	NAME		INSURER	INSURER'S CLAIM NO.
	ADDRESS (include city, state and zip)			COMPANY NAME
				ADDRESS (Include City, State and Zip)

REQUESTER must specify all questions to be completed by health care provider.
 Questions: _____ PPI (#9) MMI (#10)

HEALTH CARE PROVIDER TO COMPLETE QUESTIONS REQUESTED ABOVE

- Date of first examination for this injury by this office:
- Diagnosis (include ICD 9 CM Code for all diagnoses):
- History of injury or disease given by employee:
- In your opinion (as substantiated by the history and physical examination) was the injury or disease caused, aggravated or accelerated by the employee's alleged employment activity or environment? NO YES
- Is there evidence of preexisting or other conditions that affect this disability? If yes, describe: NO YES
- Is further treatment of this injury or referral to another doctor planned? If yes, describe: NO YES
- Has surgery been performed? If yes, describe: NO YES
- What is the employee's ability to work? Attach the most recent report of work ability. Date of report (mm/dd/yy): _____

9. Has the employee sustained any permanent partial disability from this injury? To early to determine NO YES

The permanent partial disability is % of the whole body. This rating is based on Minnesota Rules part(s):

522 . . . : % .	522 . . . : % .
522 . . . : % .	522 . . . : % .

If the PPD rating is zero, is the employee unable to return to former employment for medical reasons attributable to the injury? NO YES

10. **MAXIMUM MEDICAL IMPROVEMENT** means "The date after which no further significant recovery from or significant lasting improvement to a personal injury can reasonably be anticipated, based upon reasonable medical probability. Based upon this definition: has the patient reached Maximum Medical Improvement? NO YES Date Reached _____ (If yes complete question #9)

Certified by me, a licensed/registered (give degree) _____ Health Care Provider in the State of _____

this _____ day of _____ 19____

Signature _____	Address _____
Name (Type or Print) _____	License #/Registration # _____ Phone No. _____

NOTICE TO EMPLOYEE: SERVICE OF THIS REPORT OF MAXIMUM MEDICAL IMPROVEMENT (QUESTION 10) MAY HAVE AN IMPACT ON YOUR TEMPORARY TOTAL DISABILITY WAGE LOSS BENEFITS. IF THE INSURER PROPOSES 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 OR THE WORKERS' COMPENSATION DIVISION.

INSTRUCTIONS TO THE INSURER AND HEALTH CARE PROVIDER

Within ten (10) calendar days of receipt of a request for information on the Health Care Provider Report 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 (Minn. Rules part 5221.0410, subp. 2).

A. The employer, Insurer, or Commissioner may request required medical information on the Health Care Provider Report form.

1. The requestor must complete the general information identifying the employee, employer and insurer.
2. The requestor must specify all questions to be answered by the health care provider.
3. For those injuries that are required to be reported to the Division under Minn. Stat. 176.231, subd. 1, the self-insured employer or insurer must file reports with the Division as required by Minn. Rules 5221.0410, subp 5 and subp. 8.
4. The self-insured employer or insurer must serve the report of MMI on the employee according to Minn. Stat. 176.101, subd. 3e and Minn. Rules part 5221.0410, subp. 3.

B. Instructions to the Health Care Provider for completing the Health Care Provider Report:

Answer the requested questions as follows:

1. Fill in the date the employee was first examined for this condition by a health care provider in this office.
2. Describe the claimed work-related condition(s) being treated using accepted terminology and the ICD-9-CM diagnostic code(s).
3. Describe history of the illness or disease as given by employee.
4. State whether, in your opinion, the employee's injury or disease was caused, aggravated or accelerated by the employee's employment activity or environment.
5. Indicate whether there are pre-existing or other conditions affecting this disability. Briefly describe these conditions.
6. Indicate if further treatment or referral is planned. Describe the plans (e.g. continue medication, physical therapy, refer to a specialist, plan surgery).
7. State if surgery has been performed. If yes, describe the procedure using the ICD-9-CM code, and the date performed.
8. Describe the employee's ability to work. Attach the most recent report of work ability (see Minn. Rules part 5221.0410 subp. 6).
9. The health care provider must render an opinion of permanent partial disability when ascertainable, but no later than the date of Maximum Medical Improvement (MMI). (Minn. Rules part 5221.0410, subp. 4).

Indicate if the employee sustained permanent partial disability from this injury. Check one of the three boxes (too early, yes, no). If yes, specify any applicable category of the permanent partial disability schedule in effect for the employee's date of injury. Report any zero ratings.

If the PPD rating is zero, indicate if the employee is unable to return to former employment for medical reasons attributable to the injury.

10. Indicate if the employee has reached MMI. Check either no or yes. If yes, indicate the date MMI was reached. At MMI, permanent partial disability must be reported (question 9). (Minn. Rules part 5221.0410, subp. 3)

The health care provider must certify the information submitted is accurate by signing the report and identifying his/her profession, license or registration number, address and phone number.

INSTRUCTIONS FOR COMPLETING REPORT OF WORK ABILITY

Each health care provider directing the course of treatment for an employee who alleges to have incurred an injury on the job must complete a report of work ability at the applicable interval: (Minn. Rules part 5221.0410, subp. 6):

- 1) every visit if visits are less frequent than once every two weeks;
- 2) every 2 weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; and
- 3) upon expiration of the ending or review date of the restriction specified in a previous report of work ability.

The report of work ability must either be on this prescribed form or in a report that contains the same information. The report of work ability must:

- A. Identify the employee by name, social security number and date of injury.
- B. Identify the employer at the time of the employee's claimed work injury.
- C. If known, identify the workers' compensation insurer at the time of the claimed work injury, or the workers' compensation third party administrator. Also indicate this workers' compensation payer's claim number.
- D. Indicate the date of the most recent examination by this office. The report of work ability should be completed based on this evaluation.
- E. Select the appropriate option which best describes the employee's current ability to work by checking box 1, 2 or 3.
 1. If the patient is able to work without restrictions indicate the beginning date.
 2. If the patient is able to work with restrictions indicate the date any restriction of work activity is to begin and the anticipated ending or review date.
 3. If patient is unable to work at all indicate the date the restriction of work activity is to begin and the anticipated ending or review date.
- F. If box 2 is checked, describe any restrictions in functional terms, (e.g. patient can lift up to 20 pounds 15 times per hour; should have 10 minute break every hour.)
- G. Indicate the date of the next scheduled visit or that additional visits will be scheduled as needed.
- H. Indicate the date the report is completed.
- I. Identify the health care provider completing the report by name, degree, license or registration number, address and phone number.

The health care provider must provide the Report of Work Ability to the employee and place a copy in the medical record.

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured", i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part-B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits; and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanatorium services are on file.
5. Signature of patient or his representative or certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services, will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:

If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and other information to release to Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance, disability, no fault, workers' compensation, or other insurance which is responsible to pay for the services to which this Medicare claim is made.

8. For Medicaid purposes:

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes

This is to certify that:

- (a) the information submitted as a part of this claim is true, accurate and complete, and the services shown on this form were medically indicated and necessary for the health of the patient;
- (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within the catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
- (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim, except those that are exclusively supplemental payments to CHAMPUS-determined benefits;
- (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;
- (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
- (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services For purposes of this certification, an employee of the Uniformed Services is an employee appointed in civil service (refer to 5 USC 2105), including part-time or intermittent, but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services, and not on active duty.
- (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1985, all providers participating in Medicare, must also participate in CHAMPUS to provide medical services provided pursuant to agreement to provide consulting or after January 1, 1987.
- (h) If CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claim processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form, I will accept the CHAMPUS-determined reasonable charge over if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient, or his or her parent, or guardian, amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS