

**STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY**

In the Matter of the Proposed Adoption
of Rules of the Minnesota Department of
Labor and Industry, Workers' Compensation
Division, Governing Workers' Compensation
Treatment Parameters

STATEMENT OF NEED
AND REASONABLENESS

I. BACKGROUND/HISTORY

In 1990 the Department of Labor and Industry released a report on medical costs in the Minnesota workers' compensation system. Minnesota Costs in Workers' Compensation: Interstate Comparisons, Minnesota and Other Selected States, a report to the Minnesota Legislature, Minnesota Department of Labor and Industry, (March, 1990). Research indicated that Minnesota workers' compensation medical costs between 1985 and 1990 grew even more rapidly than the 10% annual inflation for general medical costs. Although Minnesota's workers' compensation medical costs were similar to other states, the average cost of a workers' compensation injury was, on average, twice as high as a similar injury outside of workers' compensation.

A systemic approach to controlling the growth of workers' compensation medical expenditures is necessary. In order to effectively contain medical costs it is essential to control the utilization of services as well as the price per service. If either element is left unattended, medical costs rise. As a result of this study, the commissioner proposed four recommendations for controlling medical expenditures:

- Adopt a uniform billing form for all health care providers
- Establish a health care provider enrollment program
- Replace the current fee schedule with a relative value fee schedule
- Examine guidelines for utilization review by insurers and employers

In 1991 the Department of Labor and Industry published an action plan for implementing these four recommendations for controlling medical costs. Medical Study Implementation Action Plan, a report of the Minnesota Legislature, Minnesota Department of Labor and Industry (February, 1991). A guiding principle for this program was the Department's commitment to ensure that injured workers receive the most effective health care possible.

Accordingly, as part of a comprehensive package to contain the rapidly rising workers' compensation medical costs, the 1992 Minnesota Legislature passed a workers' compensation reform package. This reform package included:

- Adopting of a uniform billing form for health care providers
- Replacing the medical fee schedule with a relative value based schedule
- Mandating a 15% reduction in reimbursement for services not included in the fee schedule (small hospitals excluded)
- Developing a managed care plan option for employers
- Mandating standards for health care provider treatment

The Legislature recognized that an integrated approach to cost containment was necessary, which included controlling utilization of services as well as the fees for each service. Utilization is addressed through the managed care plan and the treatment standard elements of this program.

The Legislature granted the Commissioner of Labor and Industry authority to promulgate emergency and permanent rules establishing standards and procedures for treatment. The treatment standards rules are intended to be used to determine whether a provider of health care services . . . “is performing procedures or providing services at a level or with a frequency that is excessive, unnecessary, or inappropriate based upon accepted medical standards for quality health care . . .” (Minnesota Statutes § 176.83, subd. 5). The statute requires that the rules shall include criteria for:

- low back injuries and upper extremity repetitive trauma injuries
- surgical procedures
- medical imaging
- use of appliances, adaptive equipment, use of health clubs and exercise facilities
- inpatient hospitalization
- treatment of chronic pain

The Legislature acknowledged that quality must be monitored and enforced. Minnesota Statutes § 176.103, subd. 2 was amended to require insurers “to assist the commissioner in this monitoring by reporting to the commissioner cases of suspected excessive, inappropriate, or unnecessary treatment.” The Medical Services Review Board is charged with a judicial function in reviewing “specific cases referred by the commissioner to determine whether there is inappropriate, unnecessary, or excessive treatment based on rules . . .”

II. RULE DEVELOPMENT PROCESS

The Department of Labor and Industry initiated the emergency rulemaking procedures by publishing a Notice of Solicitation of Outside Information of Opinions in the *State Register* on June 29, 1992.

The Medical Services Review Board (hereinafter MSRB), an advisory group of health care providers and others to the commissioner, worked on developing treatment parameters over the summer of 1992. (See Appendix 1 for a list of MSRB members.) The goal was to define treatment that was outside of generally accepted norms of practice rather than to specify how care should be provided. The MSRB recognized that the rules must apply to health care providers with differing scopes of practice as well as differing techniques (e.g., physicians, physician-specialists, chiropractors, therapists). Primary consideration was given to effectiveness of treatment and cost containment.

The MSRB divided into committees, working on low back care, upper extremity care, and chronic pain management. These committees each included representatives of physicians, surgeons, and chiropractors. In addition, a physical therapist participated in the low back committee. Health care providers, including physicians in the chronic pain management arena, participated in the chronic pain management meetings. Drafts of proposed rule were distributed to members of the Minnesota Medical Association, Minnesota Chiropractic Association, Minnesota Physical Therapy Association, Minnesota Occupational Therapy Association, Minnesota Orthopaedic Society, radiologists, surgeons, chiropractors and other individuals, who responded with comments.

The rule draft from the MSRB and the comments from expert health care providers were reviewed by the Department's medical consultant, William Lohman, M.D., a Board certified specialist in both internal medicine and occupational medicine. Many of the comments were incorporated into a subsequent draft.

The proposed rules were published February 1, 1993 under the emergency rulemaking authority in Minnesota Statutes §§ 14.29 and 14.36 . Comments were received through February 26, 1993. Based on additional comments the rules were further modified. The rules were approved by the Attorney general and became effective on May 18, 1993. The emergency rules were extended for an additional 180 days pursuant to Minnesota Statutes § 14.35, and expired on May 13, 1994.

Since the emergency rules were promulgated, the Department has been monitoring the application and effect of the rules and gathering further comments. On July 19, 1993 a Notice of Solicitation of outside opinion was published in the *State Register* for the permanent rules. In September of 1993 a draft of the Proposed Permanent Rule was developed by Department staff and sent to the Medical Services Review Board for comment. The Medical Services Review Board impanelled a subcommittee to review the rules in depth and take comments from members of the health care community. At the same time the Department sent notice of the proposed final rulemaking and an initial draft of the proposed permanent rules to individual health care providers and organizations that had commented on the Emergency Rules either during their development or since their promulgation. In addition, the notice along with a copy of the proposed rules were sent to health care provider associations, including the Minnesota Medical Association, Minnesota Chiropractic Association, Minnesota Orthopaedic Association, and Minnesota Physician Therapy Association, whose members might be affected by the proposed rules. All of the resulting comments were collated and considered by the Department staff and medical consultant and interim drafts of the permanent rules were presented to the Medical Services Review Board for consideration as they became available. They were also

made available to other constituents.

The treatment parameters are intended be used as strategies for managing patient care in workers' compensation. They are to reflect not only general strategies applicable to all patients but also specific strategies for patients with certain diagnoses. These strategies are meant to assist the health care provider in decision making and improve the quality of care while at the same time making it more effective and cost-efficient. The parameters are meant to optimize outcomes for injured workers while reasonably containing costs for employers and insurers.

As noted above, the parameters were developed with extensive input from health care providers and the Medical Services Review Board as well as from information gathered in the medical and workers' compensation literature. The standards are meant to mandate some minimum levels of care as well as maximum levels of treatment. They represent reasonable and necessary care for the referenced conditions or situations.

Several types of parameters were reviewed during the initial design of the rules. As discussed under Part 5221.6050, Minnesota Statutes § 176.83, subd. 5 specifies that the parameters be promulgated as formal rules. Employers, insurers and workers' compensation judges would have a great deal of difficulty applying parameters which were discretionary in nature. Parameters as rules meant that definite time frames and indications had to be set for the various treatments and procedures considered in the rules. The statutory rule requirements are discussed more fully under Part 5221.6010 of this Statement.

Having chosen the type of parameter, consideration was given to the target of the parameters. Parameters could be written for the practices of certain provider groups, or directed at certain specialists within provider groups, or they could be written for patients. It was decided to orient the parameters to the patients since the injured worker is the focus of workers' compensation and since Minnesota Statutes § 176.83, subd. 5 requires the parameters to be applied to all health care providers. This also allows the rules to efficiently address situations that are common to all disciplines and specialties with one single parameter, tailoring the rules to specific treatment modalities based on the type of condition.

Having chosen to target the patients as the subject of the treatment parameters it was necessary to determine what would be the fundamental unit of a patient-based parameter. Patient-based parameters could be written in terms of specific procedures and modalities without regard to the integration of those procedures or modalities into an overall treatment plan, or parameters could be written for an overall treatment plan.

A review of Minnesota Statutes § 176.83, subd. 5 indicates the Legislature intended the rules to address the entire episode of care for patients with specific diagnoses. The statute requires the parameters to address diagnostic, conservative (nonsurgical) care, surgery, hospitalization, medical equipment and chronic pain for the most common work related injuries, including back and upper extremity injuries. This language requires the parameters to govern the course of treatment from diagnosis to chronic pain for work injuries.

Accordingly, separate treatment parameters were then developed for the entire episode of care for each of the targeted diagnoses. The episode of care is defined as those services received by

a patient during a period of relatively continuous contact with one or more health care providers in relationship to a particular medical problem. This most accurately reflects the workers' compensation process where an injured worker is entitled to medical services rendered from the date of injury throughout the course of treatment for the particular condition related to a personal injury at work.

Consideration was also given to the application of the parameters. The parameters could simply proscribe unwanted behavior. This is often characterized as the "few bad apples" approach. Parameters would then have identified patterns of treatment which were felt to be inappropriate. These patterns of treatment would be "banned." No comments would have been made on other patterns of treatment which would be considered acceptable by default. This is not a workable approach. First of all, there are very few treatments or treatment patterns which are absolutely incorrect for all patients with a given diagnosis. Very few controls would have been placed on medical care. Secondly, the appropriateness of care is best judged in relationship to the specific facts of a case and the kind of treatment that has already been given and the kind of alternate treatment that is available. These kinds of complicated fact situations require a more complicated approach to the development of treatment parameters. Finally, simply proscribing certain activities does not do anything to improve the quality of care and direct providers to the most cost-efficient alternatives.

Another possibility is to rigidly prescribe care. This is often characterized as the "cook book" approach to parameters. This was also rejected as the sole intent of these rules. There is no consensus as to what is the exactly appropriate course of treatment for all patients with a specified condition. The medical literature usually supports a variety of options. Individuals do vary in their needs and in their responses to treatments.

Therefore, it was decided to combine both proscription and prescription while trying to preserve realistic but limited choice for the physician to tailor individualized treatment plans within a larger framework of rules. This resulted in the framework set forth, for example, in part 5221.6200, subpart 2, items A and B: The health care provider must assign a clinical category to each patient and then must proceed through the three states of care: initial nonsurgical, surgical evaluation, and chronic management. For each of these stages the parameters include a wide variety of treatment modalities from which the health care provider may select the appropriate treatment.

Having decided the structure of the parameters, consideration was given to the basis upon which parameters would be developed. Available options were the opinions (written and verbal) of medical societies and medical institutions; the scientific medical literature; the efforts of other administrative agencies (state and federal); and the advice of experts and consultants. The Department has solicited and received information and recommendations from all of these sources. A list of sources referenced in this Statement of Need and Reasonableness is attached as Appendix 2.

Finally, consideration was given to the means for evaluating the information and recommendations received. It was obvious almost immediately that unanimity within the health care provider community was not available or possible on many of the issues. Likewise, statistical analyses such as meta-analysis was not necessarily definitive given the nature of the

scientific literature. There are very few peer-reviewed double-blinded prospective studies of either treatment plans or treatment modalities in the scientific literature for these conditions.^{1,2,3,4} The Department therefore judged comments and recommendations on the proposals on the basis of the breadth and depth of agreement in the medical community and scientific literature, the recognized expertise of the commentators, and as required by Minnesota Statutes § 176.83, subd. 5, the opinion of the Medical Services Review Board.

III. IMPACT ON SMALL BUSINESSES; EXPENDITURE OF PUBLIC MONIES; EFFECT ON SPANISH SPEAKING PEOPLE AND AGRICULTURAL LAND

The proposed treatment parameters regulate health care providers for standards and costs. Therefore, the requirements of Minnesota Statutes § 14.115 do not apply, pursuant to subd. 7(3) of that law. However, careful consideration has been given to imposing only these requirements on health care providers that are deemed essential for quality, cost-effective care.

The proposed rules do not require the expenditure of public monies by local public bodies, pursuant to Minnesota Statutes § 14.11.

The rules do not affect Spanish speaking people under Minnesota Statutes § 3.9223, subd. 4 or agricultural land under Minnesota Statutes § 13.11, subd. 2.

IV. WITNESSES AND STAFF PRESENTERS

In addition to Special Assistant Attorney General Gilbert S. Buffington and Department of Labor and Industry staff attorney, Kathryn Berger, appearing at the public hearing to present any portion of the proposed rules may be any of the following persons from the Department of Labor and Industry: Leo Eide, Assistant Commissioner for Workers' Compensation; Deborah Cordes, Director, Special Compensation Fund; Kate Kimpan, Acting Director, Research and Education; William Lohman, M.D., Medical Consultant for the Department of Labor and Industry and Board certified in internal medicine and occupational medicine. The Commissioner reserves the right to appear or call upon any of his designees or other staff to appear in support of the rules. Members of the Medical Services Review Board appearing in support of the rules are Dr. Joseph Wegner, M.D., chair of the MSRB, and Board certified in occupational medicine; Dr. Jeff Bonsell, D.C., chiropractor; Dr. James House, M.D., orthopedic surgeon; Dr. Lawrence Schut, M.D., neurologist and specialist in pain management; and James Hoyme, physical therapist. These health care providers can be expected to address the rule development process and those rules relative to their area of expertise.

V. OVERVIEW OF RULES

It is helpful to give a board overview of the rules before discussing each provision individually.

General Treatment Parameters, Part 5221.6050. This section identifies standards that apply to treatment of any work-related condition. Treatment must be adequately documented, evaluated for effectiveness and medical necessity, provided in the least intensive setting with a goal of self-management of the condition.

The rules require communication between primary providers and referrals or consultants, and require that a new provider consider prior care in determining an appropriate treatment plan. Tests and procedures may not be repeated or duplicated except as permitted by rule.

Excessive treatment is defined in relation to the treatment standards. In cases where the health care provider believes treatment is warranted that departs from the parameters the rules set forth the proper procedure to follow. This section sets forth factors which must be considered by the workers' compensation insurer, commissioner or a compensation judge in determining whether treatment is excessive. The rules specify that the health care provider must notify the insurer before providing certain services, e.g., non-emergency inpatient hospitalization, surgery, medical equipment, or for a departure from the parameter.

Parameters for Medical Imaging, Part 5221.6100. This section identifies general principles that must be adhered to when ordering medical imaging studies. These principles include:

- a history, physical and review of records must be documented before ordering an imaging study
- ordering more than the single most effective imaging study for the condition is not indicated
- imaging solely to "rule out" a diagnosis is not indicated
- routine imaging is not indicated
- repeat or alternative imaging is not indicated except in specified circumstances

Specific imaging procedures and their indications for low back pain are delineated.

Low Back Pain, Part 5221.6200, Neck Pain, Part 5221.6205, Thoracic Back Pain, Part 5221.6210. These sections address the statutory requirement that these rules include criteria for diagnosis and treatment of back injuries.

Generally accepted diagnostic procedures for back pain are identified. A health care provider must perform an appropriate history and physical and assign the employee to a diagnostic category before ordering further diagnostic tests or initiating treatment. For each of the diagnostic categories there are parameters for appropriate diagnostic and treatment procedures.

Treatment of back pain is divided into three phases:

1. Initial non-surgical care may include any combination of passive, active, and injection and medication treatment modalities. Emphasis is on early active treatment directed toward return to work, possibly in a modified job.
2. Re-evaluation of diagnosis, and surgery, if indicated. Diagnosis and treatment options including surgery must be re-evaluated where the employee's symptoms persist.
3. Chronic management is appropriate for employees who are not candidates for, or refuse surgery, or who do not have complete resolution of symptoms with surgery.

Upper Extremity Disorders, Part 5221.6300. This section addresses the statutory requirement

that these rules include criteria for diagnosis and treatment of upper extremity repetitive trauma injuries.

Generally accepted diagnostic procedures for upper extremity disorders are stated. A health care provider must perform an appropriate history and physical before ordering further diagnostic tests or initiating treatment. For each of the diagnostic categories there are specific parameters for appropriate diagnostic and treatment procedures in addition to the general treatment parameters that apply to all upper extremity disorders.

The three phases of treatment for upper extremity repetitive trauma injuries are the same as for back injuries. Treatment modalities are identified and parameters for their use provided. Modalities include passive and active treatment, injections, medication, as well as surgery and chronic management modalities.

Reflex Sympathetic Dystrophy, Part 5221.6305. This section describes parameters for this condition, which is a complication of injuries to upper and lower extremities. The rules define the condition, and set forth parameters for initial nonsurgical, surgical and chronic management modalities unique to this diagnosis.

Inpatient Hospitalization Parameters, Part 5221.6400. This section addresses the statutory requirement that the rules include criteria for inpatient hospitalization.

Criteria include:

- Except in emergency situations, prior notification must be given for inpatient hospitalization.
- Only ward or semiprivate accommodations are indicated unless special needs are documented.
- Admissions prior to the day of surgery are rarely indicated.
- Hospitalization for low back pain is indicated only in specified circumstances.

Parameters for Surgical Procedures, Part 5221.6500. This section addresses the statutory requirement that the rules include criteria for surgical procedures, including, but not limited to, diagnosis, prior initial nonsurgical treatment, and supporting diagnostic imaging and testing.

The health care provider must provide prior notification for elective in-patient surgery.

Parameters for various common surgical procedures for the spine, upper extremity, and lower extremity are described.

- Diagnoses for which the surgery may be indicated are identified.
- Indications for the surgery include documentation of response to non-surgical care and clinical findings.

Parameters for Chronic Management, Part 5221.6600. This section is also required by Minnesota Statutes § 176.83, subd. 5. It sets forth the principle of chronic management: to be made independent of health care providers in the ongoing care of a chronic pain condition; and the patient must be returned to the highest functional status reasonably possible. The rules include diagnostic criteria for a chronic pain condition and indications and parameters for chronic management modalities such as exercise, health clubs; computerized exercise programs; work conditioning programs; chronic pain management programs and psychological counseling. These modalities may be used singly or in combination.

Disciplinary Action; Penalties Part 5221.8900. This section requires the health care provider to cooperate with an investigation and clarifies the Department's administrative process in investigating complaints about health care providers, consistent with the requirements of Minnesota Statutes § 176.103.

The rules allow the commissioner to resolve a complaint through instruction or written agreement in appropriate cases, in lieu of initiating a contested case or Medical Services Review Board proceeding.

In 1992 Minnesota Statutes § 176.103 was amended to provide for two tracks for resolving health care conduct issues:

1. For cases of suspected excessive, inappropriate, or unnecessary treatment, the commissioner may refer specific cases to the MSRB to review whether the treatment was excessive, inappropriate or unnecessary. The commissioner shall determine the sanction.
2. For violations of statutes or rules other than those involving inappropriate, unnecessary, or excessive treatment a contested case hearing may be initiated under Chapter 14. The MSRB may determine the sanction, as appropriate.

VI. CONTENT REVIEW OF THE RULES

Part 5221.6010. AUTHORITY

There are a number of statutory provisions which provide the authority for the rules. The primary provision is found in Minnesota Statutes § 176.83, subd. 5, which requires the Commissioner to adopt rules "establishing standards and procedures for health care provider treatment." This section also requires the rules to be used to determine whether . . . "a provider of medical, chiropractic, podiatric, surgical, hospital or other services, is performing procedures or providing services at a level or with a frequency that is excessive, unnecessary, or inappropriate based upon accepted medical standards for quality health care . . ." That statute further specifies that the rules must include criteria in the following areas:

1. Diagnosis and treatment of the most common work-related injuries including, but not limited to, low back injuries and upper extremity repetitive trauma injuries; (Parts 5221.6100; 5221.6200; 5221.6205; 5221.6210; 5221.6300 and 5221.6305).
2. Surgical procedures, including diagnosis, prior conservative treatment, diagnostic

imaging and testing and anticipated outcome criteria; (Parts 5221.6100 and 5221.6500 and the above sections).

3. Appliances and adaptive equipment (subpart 8 of Parts 5221.6205, 5221.6210; 5221.6300, and 5221.6305); health clubs and exercise facilities (Part 5221.6600).
4. Diagnostic imaging (Part 5221.6100).
5. Inpatient hospitalization (Part 5221.6400).
6. Chronic pain (Part 5221.6600).

As noted above, Minnesota Statutes § 176.83, subd. 5 requires the rules to include standards and “procedures.” Part 5221.6050 includes general parameters for treatment of all injuries, and in addition includes procedures, such as prior notification and required communication between health care providers, designed to facilitate communication about a workers’ compensation claim thereby reducing unnecessary treatment and litigation.

There are other relevant statutory provisions as well. Minnesota Statutes § 176.103, subd. 2 requires the Commissioner to monitor treatment provided to an employee, including the appropriateness of the services; whether the treatment is necessary and effective; the proper cost; the quality of treatment; and the right of providers to receive payment for future services. That section further provides that the Commissioner in consultation with the Medical Services Review Board, “shall adopt rules defining standards of treatment, including inappropriate, unnecessary or excessive treatment and the sanctions to be imposed for inappropriate, unnecessary or excessive treatment.” These are the same rules referenced in Minnesota Statutes § 176.83, subd. 5. This statute also requires the MSRB to consider (1) the effectiveness of treatment (2) the clinical cost of the treatment and (3) the length of time of the treatment. The proposed rules governing the sanctioning process for health care providers who deliver excessive treatment are in Part 5221.8900.

Another relevant statute is Minnesota Statutes § 176.136, subd. 2 which references the rules that define excessive treatment. That provision states in part:

“A charge for a health service or medical service is excessive if it: (1) exceeds the maximum permissible charge pursuant to subdivision 1, 1a, 1b, or 1c; (2) is for a service provided at a level, duration, or frequency that is excessive, based upon accepted medical standards for quality health care and accepted rehabilitation standards; (3) is for a service that is outside the scope of practice of the particular provider or is not generally recognized within the particular profession of the provider as of therapeutic value for the specific injury or condition treated; or (4) is otherwise deemed excessive or inappropriate pursuant to rules adopted pursuant to this chapter.”

Finally, other subdivisions in Minnesota Statutes § 176.83 provide authority. Subdivision 4 of that section authorizes the commissioner to adopt “rules establishing standards and procedures for determining whether or not charges for health services and rehabilitation services

rendered under this chapter are excessive.”

Minnesota Statutes § 176.83, subd. 3 authorizes “rules establishing standards for reviewing and evaluating the clinical consequences of services provided . . . to an employee by health care providers . . .”

Despite the above statutory authority, a number of legal challenges to the emergency rules were raised, and are pending at the Workers’ Compensation Court of Appeals (WCCA) and the Minnesota Supreme Court. Four basic challenges are as follows:

■ It has been argued that under Minnesota Statutes § 176.135, the treatment parameter rules may not impose different requirements than workers’ compensation caselaw over the years. For example, if the WCCA ordered ongoing chiropractic treatment for many years in a particular case then the treatment rules may not restrict chiropractic treatment less than that.

The treatment parameter rules were not intended to codify the numerous individual cases on compensability of medical treatment, but are consistent with the underlying principles set forth in the cases.

The key requirements of Minnesota Statutes § 176.135, subd. 1 and 176.83, subd. 5 are that treatment must be reasonable as defined by accepted medical standards. The definition of “reasonable” is subject to interpretation.

In this regard, the legislative intent contained in the plain language of Minnesota Statutes § 176.83, subd. 5 on the subject of determining reasonableness is clear and unambiguous. This statute requires the commissioner to define what is “reasonable” treatment by rules that must include “standards, procedures, and criteria” for determining whether conservative, surgical or chronic treatment of injuries is at a “level or frequency” that is excessive, based on “accepted medical standards” as recommended by the Medical Services Review Board.

The legislature could not reasonably have intended the Commissioner to adopt rules first by emergency, and now permanent, rulemaking merely to preserve the status quo by an implicit codification of case law. On the contrary, the legislature had a grave concern about the extent of litigation over medical treatment and the cost of that treatment. The 1992 legislature and the governor responded to the workers’ compensation crisis by adopting a medical cost containment package and requiring a reduction of workers’ compensation premiums by 16 percent. 1992 Laws of Minnesota, Chapter 510, Article 4, Section 35. The Commissioner of Labor and Industry was required not only to adopt by emergency rule these parameters for the treatment of common work injuries, but also to put in place a managed care system and a new relative value medical fee schedule. Minnesota Statutes § 176.83, subd. 5; 176.1351, subd. 6 and 176.136, subd. 1a. This does not demonstrate an intent to maintain the status quo.

Statements made during the legislative hearings on the 1992 workers’ compensation medical cost containment bill, also reflect the 1992 legislature’s concern about escalating workers’ compensation medical costs. Senator Chmielewski, author of the legislation, noted during the

Senate Employment Committee hearing on March 24, 1992 on Senate File 1877 that “there is little provider agreement under the standard course of treatment” and “a great deal of litigation occurs over the reasonableness of treatment, and the use of expensive new technologies for diagnostic purposes.” A summary of the history of the 1992 legislation is attached as appendix 3. He further cited the 1990 study by the Department of Labor and Industry that showed that the cost of treating a workers’ compensation injury was more than twice as high as the cost of treating a back injury outside of the workers’ compensation system.

The statute requires the rules to be based on current medical standards, now, not current at the time of earlier court decisions. For example, chymopapain injections and stomach stapling were treatment for back injuries offered by health care providers in the 1980’s, as reflected in cases before this court. (See for example. Adkins v. University Health Care Center, 39 W.C.D 898, 405 N.W.2d 213 (1987)) However, these are no longer deemed effective treatment, as demonstrated by the Medical Services Review Board’s exclusion of them from the rules. Simply because payment for treatment was awarded in the past does not mandate inclusion of such treatment in the treatment parameter rules when it is known now to be ineffective. Medical science is continuously advancing. The legislature required the Commissioner to adopt standards to be used by providers, payers and judges which reflect the most current medical knowledge for treatment of workers’ compensation injuries.

Before the emergency treatment parameters were adopted, compensation judges evaluated the reasonableness of treatment based on often conflicting doctor reports. This is precisely what the legislature intended the commissioner, in consultation with the Medical Services Review Board, to address by developing standardized treatment parameters which health care providers, insurers, and judges can use to determine whether treatment is excessive. It would simply be impossible to incorporate every decision from the Workers’ Compensation Court of Appeals (hereinafter WCCA) on the reasonableness of treatment because they are so fact specific. In cases on appeal, the Workers’ Compensation Court of Appeals is typically evaluating whether substantial evidence supports the compensation judge’s decision as required by the Minnesota Supreme Court in Hengemuhle v. Long Prairie Jaycees, 358 N.W.2d 54; 37 W.C.D 235 (Minn. 1984). The Workers’ Compensation Court of Appeals has stated that:

“It is not the role of this Court to make its own evaluation of credibility or probative value of conflicting testimony or to chose different inference than those drawn by the compensation judge The point is not whether this court might have viewed the evidence differently, but whether the findings of the compensation judge are supported by evidence that a reasonable mind might accept as adequate.”

Lyseng v. Armour Foods, Inc., (WCCA, August 26, 1991); citing Redgate v. Sroga’s Standard Service, 421 N.W.2d 729, 40 W.C.D. 948 (Minn. 1988).

Because the Court primarily evaluates whether there is substantial evidence to support the compensation judge’s decision, the cases on the reasonableness of treatment are often factually inconsistent. For example, in Friedland v. Star Iron Works, (WCCA, August 31, 1992) the court affirmed the compensation judge’s determination that chiropractic treatment providing ten days to two weeks of relief 12 years after the injury was compensable. However, the court stated that it affirmed the judge based on the substantial evidence standard, even though it

expressed concern about the reasonableness of the treatment.

In another case, the court affirmed the judge's award of chiropractic treatment two or three times per month, two years after the injury, noting that the employee's ability to continue working at his full job "is perhaps a credit to his therapy." Burns v. Firestone Tire and Rubber Co., (WCCA, June 29, 1993).

Yet in another case, the court affirmed the denial of treatment providing one to two weeks of relief five years after the injury. The denial was in part based on the employee's ability to continue working (contrary to Burns) and due to concern that the treatment promoted dependency, pain behaviors and delayed recovery. McAlonie v. Conagra/Home Brands, (WCCA, May 13, 1994).

Although in each of these cases the court also addressed other factors in support of the judge's decision, they provide evidence that it would be impossible to incorporate into the rules all of the cases on the reasonableness of treatment.

However, that is not to say that the rules and caselaw are fundamentally inconsistent. To the contrary, there are several cases repeatedly cited by the WCCA that fully support the principles expressed in the parameters.

In Wright v. Kimro, 34 W.C.D 702 (1982) the court noted that the burden is on the employee to establish the need for and reasonableness of all medical treatment; the fact that treatment has been rendered does not make the expense reasonable and necessary. Consistent with this case, the rules require the health care provider to evaluate the effectiveness and medical necessity of treatment on an ongoing basis under part 5221.6050, subpart 1. The court has also repeatedly noted that testimony of relief is only one factor in determining the necessity of treatment. "It is not the only factor." Horst v. Perkins Restaurant, 45 W.C.D. 9 (1991). The court has set forth a variety of other factors in determining whether medical treatment is reasonable and necessary.

The cases reflecting these factors to be considered in determining whether treatment is reasonable are Field-Seifert v. Goodhue County, (WCCA, March 1, 1990); Horst v. Perkins Restaurant; 45 W.C.D 9 (1991); Fuller v. Naegle/Shivers Trading Slip op (WCCA April 14, 1993). In these cases, the WCCA set forth principles that are also reflected in the rules.

In Field-Seifert v. Goodhue Co; Slip. op (WCCA, March 5, 1990). The WCCA specified 8 factors to be considered in determining whether treatment was excessive:

- 1&2. There must be evidence of a reasonable treatment plan and documentation of details of the treatment. The rules require the health care provider to document the details of the treatment plan in several places: parts 5221.6050, subs. 2, 8 C, 8 D and 9 B. This is also reflected subpart 2 A of parts 5221.6200, 5221.6205, 5221.6210 and 5221.6300.
3. The degree and duration of the relief resulting from the treatment, reflected in parts 5221.6050, subp. 1 A and 1 B, and subp. 9 of 5221.6200; 5221.6205; 5221.6210 and 5221.6300 and other areas throughout the rules.

4. Whether the frequency of treatment was warranted. The rules include parameters for treatment frequency throughout in subparts 3-5 in parts 5221.6050 to 5221.6305.
5. The relationship of the treatment to the goal of returning the employee to suitable employment. The rules include repeated references to the employee's functional level and return to work: Parts 5221.6040, subp. 7; 5221.6050, subp. 1 B(3); 5221.6050, subp. 8 C and 8 D; and 5221.6200 to 5221.6300, subp. 3 B.
6. The potential aggravation of underlying conditions by additional chiropractic treatment: Parts 5221.6200 to 5221.6205, subpart 2 (requiring reassessment at each visit of the appropriateness of the diagnostic clinical category and consultations with other providers). Referrals for consideration of alternative treatment is required by part 5221.6050, subp. 5. The three stages of treatment, which is the basic structure of the rules, reflected in parts 5221.6200 to 5221.6300, subps. 2 A and 2 B also require consideration of alternative treatment.
7. Duration of treatment. The rules specify the appropriate duration of treatment in subparts 3-5 in parts 5221.6050 to 5221.6305.
8. The cost of treatment in light of relief obtained. The definition of medically necessary specifically reflects the concept that relief must be significant Part 5221.6040, subp. 10. The parameters throughout reflect consideration of this factor.

In Horst v. Perkins Restaurant, 45 W.C.D 9 (WCCA 1991) the court identified the following additional factors:

1. The employee's testimony about relief, reflected in part 5221.6040, subp. 3, 4 and 5; and part 5221.6050, subp. 1 B (1); and 5221.6200-6305, subps. 2 A and 2 B.
2. The possibility that other conditions not discovered by the chiropractor may be causing the problem, (similar to factor #6 in Field-Seifert).
3. Whether scheduling is on a regular basis as opposed to an as-needed basis, reflected in part 5221.6200-5221.6300, subp. 3B.
4. The period of relief from pain. (Similar to factor #2 in Field-Seifert).
5. The use of alternative medical providers in the event of continuing pain (similar to factor 6 in Field-Seifert). The rules require surgical evaluation in Part 5221.6200 to 5221.6300, subpart 6 chronic pain treatment in part 5221.6600 where there is continuing pain after initial nonsurgical treatment and surgical evaluation.
6. The employees overall activities and the extent of the employee's ability to continue work. (Similar to Field-Seifert factor #5).
7. A recommendation of long-term chiropractic care into the future, which suggests a maintenance program rather than treatment of the injury. The rules require strict

documentation of the need for ongoing chiropractic care after the initial 12 weeks. See subparts 3, B in Parts 5221.6200 to 5221.6300.

8. Psychological dependency of the employee as chiropractic care. The rules require health care providers to promote employee independence from health care providers in a clinical setting in Part 5221.6050, subp. 1, item C; 5221.6050, subp. 4; 5221.6050, subp. 8, item C; and subpart 3 item B (1)(c) of parts 5221.6200 to 5221.6300.

Accordingly, the proposed treatment rules are consistent with general principles expressed by the Workers' Compensation Court of Appeals.

- A second challenge raised is that the rules should not apply to workers' compensation judges under Minnesota Statutes § 176.411 and Minnesota Statutes § 176.83, subd. 5. Minnesota Statutes § 176.411 provides that in workers' compensation judges are not bound by "common law or statutory rules of evidence nor by technical or formal rules of pleading or procedures."

The treatment parameter rules are not rules of evidence or procedure within the meaning of Minnesota Statutes § 176.411.

The applicable law is, instead, (1) Minnesota Statutes § 176.371, which specifies that the compensation judge is indeed bound by all workers' compensation rules, and (2) Minnesota Statutes § 176.83, subd. 5, which specifically requires promulgation of the medical parameter rules, as follows:

"In consultation with the medical services review board or the rehabilitation review panel, the commissioner shall adopt emergency and permanent rules establishing standards and procedures for health care provider treatment." (Emphasis added.)

The treatment rules, including the general parameters and bases for departure in part 5221.6050, are not rules of evidence, but rather simply establish the standards, procedures, and criteria explicitly required by the legislature to define when treatment is excessive under the workers' compensation law.

The legislature did not intend through Minnesota Statutes § 176.411 to permit a compensation judge to ignore properly promulgated workers' compensation rules and instead apply some other standard of reasonableness. This would make adoption of workers' compensation rules an exercise in futility and is contrary to Minnesota Statutes § 176.371, inasmuch as no incentive would exist for employees, employers, insurers and health care providers to comply with a rule that administrative law judges were free to ignore.

Minnesota Statutes § 176.83, subd. 5 is also cited as authority for allowing judges to ignore the rules. That law states in part as follows:

"The rules shall be used to determine whether a provider of health services ... is performing services at a level or with a frequency that is excessive, unnecessary or inappropriate based upon accepted medical standards for quality health care ... If it is determined by the payer that the level, frequency or cost of a procedure of service

of a provider is excessive, unnecessary or inappropriate according to the standards established by the rules, the provider shall not be paid for the procedure, service or cost ... unless the commissioner or compensation judge determines at a hearing or administrative conference that the level, frequency or cost was not excessive, in which case the insurer ... shall make the payment deemed reasonable.”

Again, the legislature could not have intended an unreasonable result. Providers, insurers, and employees would have no incentive to apply the rules if they could be ignored in litigation by workers' compensation judges. This would have the effect of actually encouraging litigation. Rather, a reasonable interpretation of the above language is that judges must apply the rules, just as they apply the medical fee schedule under Minnesota Statutes § 176.135, subd. 1a and the permanent partial disability schedule adopted pursuant to Minnesota Statutes § 176.105. There will likely be disputes about application and interpretation of the rules, specifically including whether one of the stated bases for departure from a parameter applies under part 5221.6050, subp. 8. In these cases the compensation judge may decide that the treatment in issue is not excessive under the rules.

This is consistent with Minnesota Statutes §176.136, subd. 2, which defines an excessive charge as one which: exceeds the medical fee limits; is for a service that is at an excessive level, duration or frequency based on accepted medical standards; is for a service that is outside the scope of practice or not generally recognized as therapeutic value; “or is otherwise deemed excessive or inappropriate pursuant to rules adopted pursuant to Chapter 176.”

Similar language about the compensation judge's role is also found in the Minnesota Statutes § 176.136, subd. 2: The provider may not be reimbursed from anyone if the insurer finds any of the above conditions of excessiveness exist, “unless the commissioner or compensation judge or court of appeals determines otherwise.” This can hardly mean that all the medical rules, such as the medical fee schedule and the treatment rules, may be ignored by any compensation judge who disagrees with the rule. Rather, the law simply requires the compensation judge to determine whether in denying payment the insurer properly applied and interpreted the rules, which have the force and effect of law once properly promulgated.

■ A third challenge is that the rules do not promote “quick and efficient” delivery of medical benefits as required by Minnesota Statutes § 176.001, which also requires treatment to be “at a reasonable cost.”

The treatment parameter rules promote “quick and efficient” delivery of medical benefits at a reasonable cost as required by Minnesota Statutes § 176.011 by establishing a three-part framework for the entire course of treatment that reflects current accepted medical practice.

The treatment parameters are intended to promote quick and efficient delivery of reasonable medical treatment but also consistent with the legislature's requirement that the Commissioner, in consultation with the MSRB, define by rule what “reasonable” treatment is. Minnesota Statutes § 176.83, subd. 5 requires the treatment parameter rules to contain “criteria” for diagnosis and treatment of low back and upper extremity repetitive trauma injuries, surgical procedures, medical equipment, inpatient hospitalization, and chronic pain. Therefore, the legislature expected the rules to address the entire course of treatment for common work

injuries. Complying with these requirements, the rules have established a substantive and procedural framework for review of the entire course of treatment, from diagnosis through three stages of treatment.

For example, the framework for review of a course of treatment involving the low back under the treatment parameter rules can be summarized as follows: Parameters for appropriate diagnostic procedures of back pain are set forth in parts 5221.6100, and 5221.6200, subps. 1 and 2. After a diagnosis is made, the first stage of treatment is typically initial nonsurgical care, including passive treatment, active treatment, injections, medical equipment, and medication. See Minn. Rules, part 5221.6200, subps. 3, 4, 5 and 10.

If the employee doesn't recover from the injury condition with such initial nonsurgical treatment within time frames specified for the diagnosis under part 5221.6200, subps. 11 to 13, prompt surgical evaluation may then be appropriate. The requirements for surgical evaluation and surgery are found in part 5221.6200, subps. 6, 11 to 13, and in part 5221.6500.

Finally, if the employee has not recovered with initial nonsurgical care and is not a candidate for surgery, chronic management could be appropriate. Chronic management may include a variety of programs, including exercise, work conditioning or work hardening, and psychological or chronic pain treatment. Parameters for chronic management programs are set forth in part 5221.6600.

Minnesota Statutes § 176.83, subd. 5 provides that the rules must include "standards and procedures" for health care provider treatment. Accordingly, the parameters within this framework establish rebuttable presumptions that treatment that departs from the above parameters is excessive. If treatment departs from a parameter or is invasive or expensive, the rules specify a methodology for review of the treatment, including prior notification of the insurer, and rigorous documentation and justification. These are procedural requirements designed to ensure that treatment is not only quick and efficient, but also "at a reasonable cost to the employer." Because not every employee responds to treatment in the typical manner, the rules allow for departure from these presumptive limitations in those circumstances specified in part 5221.6050, subp. 8.

There are time limitations in all the above stages of treatment, consistent with the requirement of Minnesota Statutes § 176.83, subd. 5 that the rules be used to determine whether the treatment is performed at an unreasonable "level or frequency." (Emphasis added.) For example, the MSRB recommended that a CT scan is not ordinarily indicated before eight weeks after an injury, except in certain specified circumstances. Part 5221.6100, subp. 2, item A. The MSRB also recommended time frames for the appropriate use of injections and scheduled medication, part 5221.6200, subp. 5 and 10; specific surgical procedures, part 5221.6500, subp. 2 (C)(1)(d); and chronic management modalities such as health clubs, work hardening programs, and pain clinics, part 5221.6600.

The parameters limiting the duration of passive care are an integral part of the comprehensive framework for the entire course of treatment of an injury. Consistent with the previously mentioned caselaw, the purpose of the limitations are to require prompt evaluation for alternative types of modalities or surgical or chronic pain treatment if an employee has not

recovered from a back or upper extremity injury in the specified period. The Medical Services Review Board recommended early intervention with other types of treatment, including the chronic management modalities, to promote patient independence and provide an effective and efficient alternative to potentially indefinite passive care in a clinical setting.

This time limitation approach, as reflected in Minn. Rules, part 5221.6030, subp. 1 and part 5221.6200, subp. 2 (B), tracks the dominant practice, as recommended by the Medical Services Review Board, in medical care delivery in settings other than workers' compensation, thereby complying with the legislative instruction that the rules reflect "accepted medical standards for quality health care," in general. Minnesota workers' compensation law does not call for a standard of care for occupationally-incurred injuries different from that for injuries that occur in other settings. The previously noted disparity in the cost of treatment within and without the workers compensation system is a particular concern in addressing the escalating costs of workers' compensation medical treatments.

While individual opinions on applicable standards of care may differ, the law requires the Medical Services Review Board, rather than the workers' compensation trial bench, to assist in the development of the rules. In performing this duty, the MSRB reasonably recognized that nothing is gained by delaying surgery or chronic pain management; on the contrary, such delays tend to permit long-term dependency on health care providers in a clinical setting. Early intervention for chronic pain to avoid dependency on passive care and the use of alternative types of treatment is consistent with this court's analysis in Horst v. Perkins Restaurant, 45 W.C.D 9 (WCCA 1991).

Accordingly, the rules do result in "quick, efficient and cost-effective" medical care consistent with Minnesota Statutes § 176.011.

Nonetheless, it has been suggested that the rules prescribe a rigid "formula" which ignores the facts and medical condition in individual cases. This issue has been one of the greatest challenges in developing the rules: to develop parameters reflective of the community standards that are flexible enough to permit practitioners to use independent judgement in individual cases, yet specific enough to minimize excessive treatment.

The symptomatology of each injured worker is fundamental in applying the parameters: Each employee must first be assigned to a diagnostic group based on symptoms and findings (e.g. 3221.6200, subp. 1, 11, 12, and 13). There is no established formula for treatment; rather each provider is able to select from any of the modalities in subparts 3 to 10, for treatment of a back injury, again based on the symptoms and the response to treatment. Chronic management in part 5221.6600 offers a variety of treatment modalities that can be utilized based on the provider's preferences and the individual employee's specific condition. Evaluation of effective treatment in part 5221.6050, subp. 1 is also dependent on the employee's individual symptoms and functional ability.

Injured workers lose no reasonable care. The rules simply provide a more rigorous and reliable system for ensuring and documenting that the treatment be reasonable.

■ Finally, a fourth challenge is that the rules should not apply to all treatment after the

effective date of the rules, but only to dates of injury after the effective date. The issue is whether there has been a change in the law such that the rules cannot be applied to all dates of injury.

Legislative intent and whether the law enlarges or restricts an employee's right to receive or an employer's obligation to pay compensation are factors to be considered in determining whether the law applies to all dates of injury. Sherman v. Whirlpool Corporation, 386 N.W.2d 221 (Minn. 1986); Leahy v. St. Mary's Hospital, 339 N.W.2d 267 (Minn. 1983); Nelson v. Mid-Minnesota Women's Center, 40 W.C.D. 580 (WCCA 1988); Tri-State Insurance Company of Minnesota v. Bouma, 306 N.W.2d 564, 33 W.C.D. 659, 661 (Minn. 1983).

The legislature intended that the rules be applied to all treatment for all treatment for all dates of injury, including dates of injury before the effective date of the treatment parameter rules, as demonstrated by testimony at hearings about rising medical costs and by a mandated roll-back in workers' compensation premium rates.

This legislative intent is supported by legislative testimony on the medical cost containment package in Senate File 1877. (A summary of legislative history is attached as Appendix 3.) Senator Chmielewski, author of the legislation, in his opening statement at the Senate Employment Committee hearing on February 24, 1992, said:

“... what happened in the last decade to health care costs in workers' compensation increased fifty percent faster than all other forms of health care, the 1990 Labor and Industry study on health care noted that back disorders cost twice as much under the workers' compensation system compared to Blue Cross. And the disparities in the charges occur because there is little provider agreement under the standard ... course of treatment. A great deal of litigation occurs over the reasonableness of treatment, and the use of expensive new technologies for diagnostic purposes ...”

This issue was also addressed by Senator Kroening, Senator Chmielewski and Senate Counsel John Fuller during the Senate Employment Committee hearing on Senate File 1877 on March 9, 1992, as follows:

Senator Kroening: “What is the cut in workers' benefits under 1877? I know the cost is 5.7, is that transferrable to workers' benefits?”

John Fuller: “That's a difficult question to answer but I don't think there are any real cuts - only to the extent that a provider is being reimbursed for unnecessary or excessive treatment - treatment that doesn't comply with standards are the ... cuts from this bill were intended to reduce the medical costs under the workers' compensation system, while maintaining the requirement to provide treatment.”

Senator Kroening: "I think I understand that, but you can't tell me that you're going to regulate medical benefits, and workers aren't going to get any benefit cuts."

John Fuller: "That is a complex question... If someone is receiving inappropriate treatment and doesn't go back to work, in that instance I'm not sure the employee is benefitting"

Senator Chmielewski: "If this bill is passed, it will save businesses 180 million bucks."

In addition to legislative testimony, the legislature's clear intent to apply the rules to all dates of injury is also demonstrated by the mandated 16 percent roll back in premiums to employers, effective October 1, 1992.

1992 Laws of Minnesota, Chapter 510, Article 4, Section 35 says:

"As a result of the workers' compensation law changes in this act and the resulting savings to the costs of Minnesota's workers' compensation system, an insurer's approved schedule of workers' compensation rates in effect on October 1, 1992, must be reduced by 16 percent and applied by the insurer to all policies with an effective date between October 1, 1992 and March 31, 1993." (Emphasis added).

The 1992 workers' compensation legislation included significant medical cost containment provisions, including the mandate in Minnesota Statutes § 176.83, subd. 5 that the commissioner must adopt by emergency rule treatment parameters. Clearly, all cost savings measures, including the treatment parameter rules, were to govern treatment for all dates of injury, because the premium roll back was effective October 1, 1992.

Perhaps most significant, however, is that the treatment parameter rules do not modify the employee's underlying right to reasonable medical care. but merely define what treatment is reasonable.

Even if the legislature had not evidenced the intent discussed above, the treatment parameter rules apply to all dates of injury because there has been no change in an employee's entitlement to medical benefits under Minnesota Statutes § 176.135. The medical benefit to which the employee is entitled remains as stated in Minnesota Statutes § 176.135, subd. 1, which was not amended: The employee is entitled to all treatment "as may reasonably be required at the time of the injury and any time thereafter to cure and relieve from the effects of the injury." (Emphasis added.)

The key issue is what is "reasonably required" under this statute and who is ultimately authorized to define the term. The commissioner, in consultation with the MSRB, is required by the legislature to establish by emergency rule what "reasonable" treatment is. Treatment found reasonable and ordered by the compensation courts in the past is not precedent as reasonable in every future case, if the efficacy of the treatment is no longer demonstrated.

Medical knowledge and opinions change over time and it is not logical or required that yesterday's medical knowledge be applied to a previous date of injury. The reasonableness of treatment is an evaluation to be done utilizing current knowledge.

It is furthermore incorrect to say the treatment rules are retroactive; since they apply only to future treatment. This is similar to the Medical Fee Schedule, which establishes maximum fees for future treatment, regardless of the date of injury. The authority for the treatment rules existed in Minnesota Statutes § 176.83, subd. 5 before the 1992 legislation. The 1992 amendments simply made the rules mandatory and more specifically set out their required contents.

The treatment parameter rules will continue to be modified pursuant to results of the outcome studies now mandated by part 5218.6050, subp. 11, as well as evidence of other medical advances. Future changes in the rules will not be limited to future dates of injury, but rather to future treatment. The "controlling event" in this context legitimately is the treatment that is reasonable at the time it is rendered, not what treatment was reasonable on the date of injury. See, Yaeger v. Delano Granite Works, 84 N.W.d 363, 20 W.C.D. 27, 250 Minn. 303 (Minn. 1957).

In a case involving retroactive application of the rehabilitation law, Minnesota Statutes § 176.102, the Minnesota Supreme Court identified as a relevant factor that the application of the statute to earlier dates of injury did not necessarily cost the employer and insurer more money, to the extent the employee was rehabilitated sooner. Sherman v. Whirlpool Corporation, 386 N.W.d 221 (Minn. 1986). Similarly, all employees will benefit from application of the most recent standards of treatment.

Support for application to all dates of injury is also found in the case of Martin v. U. S. Steel Corporation (37 W.C.D 45)(1984). In that case the WCCA determined that where statutory procedure for determining a permanent partial disability rating has changed, the new procedure applied regardless of the date of injury. Similarly, the legislature has not changed the standard of reasonable treatment, but only the mechanism by which such treatment can be measured. No longer must medically untrained workers' compensation judges make the determination based on "dueling doctor reports." The legislature mandated the adoption of standardized rules, developed with the assistance of the medical community, that are the measure against which treatment is measured. All treatment must be measured against these standards; the doctors in the community who assisted in the development of the rules certainly do not apply different standards of treatment based on the date of injury.

Part 5221.6020. PURPOSE AND APPLICATION

Subpart 1. Purpose. This section identifies the primary focus of the rules as set forth in Minnesota Statutes § 176.83, subd. 5: They establish parameters ("criteria") for appropriate treatment of the specified conditions. Treatment outside of these parameters is excessive and therefore not compensable under Minnesota Statutes § § 176.135 and 176.136, subd. 2.

However, the rules do not address liability for a workers' compensation injury. For example, simply because there is a section on reflex sympathetic dystrophy, which may be a

complication of an upper extremity injury also included in the rules, does not necessarily prove that the upper extremity condition caused the reflex sympathetic dystrophy. This must be proved by medical evidence as any other issue involving liability.

Nor do the rules expand a provider's scope of practice. For example, medical doctors, chiropractors, osteopaths, podiatrists, physical therapists and occupational therapists may utilize any of the passive therapy modalities, but only as permitted by their scope of practice. If podiatrists are not permitted by their scope of practice to perform adjustments to the low back these rules do not expand that scope of practice governed elsewhere in Minnesota statutes.

Subpart 2. Application. This subpart describes how the rules are to be applied. The requirement that all treatment must be medically necessary as defined in part 5221.6040, subp. 10 reflects the intent of the rules that each service must be medically necessary, even if the treatment is on the surface consistent with a parameter. For example, even if 12 weeks of passive care is permitted for a back condition, it is not necessary after 10 weeks if the employee has recovered by then.

Subpart 2 references the general parameters applicable to all injuries, and specific parameters for specific injuries. If a specific parameter does not apply, a general one may. For example, part 5221.6050, subparts 1 to 6 (except for subpart 1B) apply to treatment of all injuries, even in the absence of a specified condition.

Subpart 2 also specifies that the rules apply to future treatment for all dates of injury. Legislative history indicates that the rules were intended to apply to future treatment for all dates of injury. Also, there has been no change in an employee's statutory right to all "reasonable" medical care under Minnesota Statutes § 176.135, subd. 1. The legislature authorized the Commissioner of Labor and Industry, in consultation with the Medical Services Review Board, to establish what the current standard of reasonable treatment is. Medical knowledge changes over time; an employee injured in 1950 who still requires treatment is not given treatment based on the 1950 standard of care, but rather on the most current standard of care. This issue is more fully discussed under part 5221.6010, with other legal issues.

Subpart 2 further clarifies how the time limits are to be applied by stating that they begin with the first time the modality is initiated after the effective date of the rules, although consideration may be given to treatment given under the emergency rules. For example, if passive care is initiated for an injury in July, 1994, the 12 week parameter in part 5221.6200, subpart 3 does not begin to run until the first passive modality given after the effective date of the rules. However, the rules are not intended to allow added treatment where the treatment was governed by the emergency rules, even though there has been a lapse between expiration of the emergency rules and adoption of the permanent rules. Under these circumstances, the health care provider, insurer, and compensation judge may consider treatment given under the emergency rules in determining whether it is excessive.

This subpart also states that the rules do not apply to treatment of an injury after an insurer has denied liability, but do apply to treatment given after liability has been established. Minnesota Statutes § 176.83, subd. 5, the authority for the rules, govern only treatment of workers' compensation injuries. If liability for a workers' compensation injury has not been

accepted or established the rules do not apply.

Finally, subpart 2 states that the time references are to calendar days and weeks. This is consistent with Minnesota Rules, Part 5220.2520, subp. 3.

Part 5221.6030. INCORPORATION BY REFERENCE

The ICD-9-CM diagnostic codes are developed by the World Health Organization to assist in the international standardization of diagnosis. These codes are utilized by health care providers in Minnesota and are therefore referred to in the rules. These codes are also required in part 5221.0700 for the uniform billing forms and part 5221.0410 for the Workers' Compensation Health Care Provider Report form. Incorporation by reference is specifically governed by Minnesota Statutes § 14.07.

Part 5221.6040. DEFINITIONS

All the definitions are based upon current medical usage. In some cases, definitions are created for administrative convenience; this occurs when terms of medical art are gathered together into a group and those groups are labelled so that all of the items of the group can be referred to in the rules by a single term.

Subpart 2. Active Treatment. This is a term created for the convenience of users of the rules and refers to the treatment modalities listed in the definition.

Subpart 3. Chronic Pain Syndrome. This is the definition provided by the Chronic Pain Society of the Twin Cities and accepted by the Medical Services Review Board. It incorporates the experience and expertise of those practitioners actively involved in treating chronic pain.

Subpart 4. Condition. This represents common medical usage, and reflects that injury or illnesses include objective, subjective and functional manifestations.

Subpart 5. Emergency Treatment. This definition is derived from Minnesota Statutes § 256B.0625, subd. 4. The definition reflects that emergency care should be treatment which is immediately necessary for a condition that, if not immediately treated, could lead to serious physical or mental disability or death. Emergency care is also appropriate if immediately necessary to alleviate severe pain. This will permit employees and managed care plans to more accurately determine when emergency care is appropriate.

The second part of the definition is intended to acknowledge that health care providers make good faith decisions based on symptoms presented at the time of the emergency treatment. This is based on comment received that a retrospective review might well determine that an emergency did not actually exist. However, the information may not have been available to the physician who made the original decision on emergency treatment and who was motivated by welfare of the patient. For instance, for a patient presenting with chest pain, treatment might be required to determine if an acute heart attack is occurring. At the time of the admission the tests immediately available may not be able to clearly distinguish whether or not the patient is actually having a heart attack. At the conclusion of the admission to the hospital, further

extensive and time consuming testing may have determined that in fact the patient was not having a heart attack. From this point of view admission to the hospital for treatment of a heart attack was not necessary because the patient did not have a heart attack. However, this information was not available to the admitting physician and prudent medical care requires that in cases of possible heart attack the patient should be in the controlled environment of a hospital for further evaluation and proper treatment based upon that evaluation. Therefore, the rule provides that the evaluation of emergency treatment must be based on the symptoms at the time that the emergency treatment is given.

Subpart 6. Etiology. This represents common medical usage and is congruent with Stedman's Medical Dictionary, 25th Edition.

Subpart 7. Functional Status. This represents common medical usage. The vocational element is included because the focus of the rules in treatment of workers' compensation injuries, which necessarily includes vocational function.

Subpart 8. Initial Non-surgical Management. This is a term created for ease in using the rules, rather than restating the sections of the rules that comprise initial nonsurgical management.

Subpart 9. Medical Imaging Procedures. This is another term of convenience for users of the rule which references a number of imaging techniques listed in the definition.

Subpart 10. Medically Necessary Treatment. This subpart defines medically necessary treatment depending on whether there is an applicable treatment parameter. If a parameter applies, it will define the limits of reasonable and necessary treatment, but does not necessarily mean that all the treatment within the parameter is necessary. For example, even though the parameters allow health club membership as a form of chronic management of a back injury, that membership must be established as necessary for each individual employee; it is not to be presumed that every employee with a back injury is entitled to a health club membership. The rule also requires that treatment given for relief must significantly relieve the condition. Insignificant relief is not reasonable. This is consistent with past caselaw which requires that the degree and duration of relief is a factor in determining compensability of treatment. Field - Seifert v. Goodhue Co., (WCCA March 1, 1990); Jaime v. Archdiocese of St. Paul and Minneapolis, (WCCA December 20, 1993).

This subpart states that medically necessary treatment where there is no specific applicable parameter for the condition must be reasonable and necessary for the diagnosis or cure and significant relief of a condition, consistent with the current accepted standards of practice for the health care provider, and within the scope of practice. Since the specific parameters are intended to reflect current reasonable standards of practice, so must treatment that is not governed by a parameter. This is also reflected in Minnesota Statutes § 176.136, subd. 2, which identifies the provider's scope of practice and accepted standard of care as relevant in determining whether treatment is excessive.

Subpart 11. Neurologic Deficit. This represents common medical usage and the consensus opinion of the Medical Services Review Board.

Subpart 12. Passive Treatment. This is another term of convenience for users of the rule, and refers to the treatment modalities listed in the definition.

Subpart 13. Therapeutic Injections. This is another term of convenience for users of the rules, and refers to a number of treatment modalities listed in the definition.

Part 5521.6050. GENERAL TREATMENT PARAMETERS.

A number of parameters in this section and others address treatment situations which are relatively common to all workers' compensation injuries, not just for the specific back and upper extremity conditions governed by parts 5221.6200 to 6500.

Subpart 1. General. Item A. This item, consistent with good medical practice generally, requires that all medical treatment must be medically necessary, and requires the provider to evaluate the medical necessity and effectiveness of the treatment on an ongoing basis. An issue was raised under the emergency rules whether this subpart requires or allows the provider to charge separately for additional examinations. This clarifies that the rule is simply intended to reflect accepted medical practice, which requires continuous evaluation of the necessity and effectiveness of treatment. No more or fewer examinations are required for treatment than if the employee sustained an injury off the job.

Item B. This test of effectiveness is used to determine whether treatment is providing relief of the patient's condition. Absent objectively demonstrable anatomic damage, the physical examination findings and functional limitations seen in patients with back and upper extremity disorders are the result of the ongoing pain. Loss of range of motion, weakness, abnormal gait and other physical manifestations are the result of pain limiting the use of the back or upper extremity. Likewise, inability to work is the result of pain interfering with performance of typical activities of daily life. Therefore if a treatment does relieve pain, this relief should be manifested in the improvement of those findings on the physical examination, or those limitations in daily activity, which were the result of the pain. This is why at least two of the three criteria must be met.

The health care provider is required to evaluate the employee's progress continuously, consistent with standard medical practice and within the specific response times for the initial non-surgical treatment modalities. These are derived from recommendations in the medical literature⁵ as modified by the Medical Services Review Board based on comments received from experts in the medical community. If there is not progressive improvement in two of the three criteria specified, modification of the treatment plan is appropriate. Progressive improvement is required of initial non-surgical treatment because, as described more fully later, most patients recover with initial non-surgical treatment. It is during this period that cure is still anticipated. If the employee does not recover with initial non-surgical treatment, then the employee must be evaluated for surgery, or the focus of treatment becomes rehabilitation which is aimed at improving deconditioning, stiffness, weakness, incoordination and anxiety that result from pain and prolonged inactivity due to pain. Adaptation, not cure, becomes the goal.

So long as an employee is still expected to recover, the health care provider must monitor the treatment, and, if the patient fails to improve, reconsider the diagnosis and/or modify the

treatment plan. If the employee is no longer expected to recover with non-surgical management, then surgery must be considered or the treatment goal changed from anticipated cure to rehabilitation with chronic management modalities. The need to consider alternate treatment or modify the treatment plan if there is not improvement with non-surgical care is supported by the cases of Sternquist v. Rem-Ramsey & Metro Services, (WCCA October 26, 1993); Lyseng v. Armour Foods, Inc., (WCCA August 26, 1991); and Wells v. Kenyon Sunset Homes, (WCCA July 16, 1992).

Evaluation of the effectiveness of a modality can be delegated to another health care provider actually performing the treatment, such as a physical therapist, but the treating health care provider remains responsible for monitoring the progress, because that person prescribed the treatment and directs the care plan.

Item C. This item requires the provider to promote employee independence in health care. It is not cost effective or appropriate for employees to become dependent upon treatment in a clinical setting. Horst v. Perkins Restaurant, 45 W.C.D. 9 (WCCA 1991); McAlonie v. Conagra/Home Brands, 47 W.C.D. 43 (1992).

It is empowering and cost effective to facilitate employee independence in his or her own care to the extent possible. This is particularly true with respect to relief of chronic pain with exercise and fitness programs. Chronic pain programs are designed to educate employees in managing their own pain through the use of home pain relief modalities and other measures intended to minimize focusing on the pain. Studies have shown that long term professional intervention in a clinical setting do not result in reported relief of pain to a significant degree.^{1,6} Home treatment is also more effective because the employee can use the measures whenever the need arises, rather than waiting for a scheduled appointment.

Another example is exercise programs, which are uniquely dependent on the employee's motivation; again continuous professional intervention to ensure compliance is not appropriate.

The rule also promotes the use of same day surgical centers rather than inpatient hospitalization, when safe and appropriate for the type of surgery being performed. This is another example of cost savings that can be realized by the rule requiring treatment in the least intensive setting appropriate for the condition.

Subpart 2. Documentation. This rule incorporates by reference the requirements of Minnesota Statutes § 176.135, subs. 6 and 7 and part 5221.0100, subp. 1a. These require a provider to document the nature and necessity of treatment for which the provider is requesting payment under workers' compensation.

Subpart 3. Non-operative treatment. This represents a consensus of the Medical Services Review Board that non-operative treatment should be considered first unless there is an emergency or life threatening situation or the medical literature supports immediate surgery as the best and most cost efficient method for the treatment of the condition. Surgery is an invasive procedure with a number of risks that are unnecessary when non-surgical treatment can be more effective.

Subpart 4. Chemical dependency. This represents the consensus opinion of the Medical Services Review Board and the majority opinion of the health care community. Health care providers need to be aware of the development of chemical dependency to any medication and, when such dependency is discovered, the health care provider must refer the employee elsewhere or treat it appropriately.

Subpart 5. Referrals between health care providers. This represents the majority opinion of the health care community and the consensus of the Medical Services Review Board. It outlines the procedures for consultations between health care providers. This is necessary to provide the best quality of care where a consultant has alternative treatment to offer. A clarification is added that this is not the only circumstance in which a consultation may be obtained, for instance where a provider would like a confirming opinion in a complicated case.

Item A. The limitations on consultation are necessary to preserve the treating health care provider as an overall case manager who collects and integrates all of the relevant information regarding the patient's condition. As the person cognizant of all of the facts of the case, the treating health care provider is in the best position to determine whether another consultation is going to be useful in developing a treatment plan for the patient. This provision is also important to reflect that an employee should have only one treating doctor, who is responsible for making disability and maximum medical improvement determinations.

Item B. This lists the minimum information required by a consultant from the referring health care provider in order to provide a well-founded opinion without unnecessary duplication of diagnostic testing or treatment. This reflects standard medical practice.

Subpart 6. Communication between health care providers and consideration of prior care. Again, this represents the consensus of the Medical Services Review Board and the majority opinion of the health care community. It is intended to prevent the costly duplication of diagnostic service and treatments and to provide the best quality of care. It sets out the expectations for transfer of information between health care providers when the patient has made a change of health care providers and a new provider is to assume responsibility for the patient's care. The importance of reviewing and considering past medical care is supported by Torgerson v. ELO Engineering, (WCCA, March 16, 1994).

Item A. This makes the new health care provider responsible along with the patient for the required transfer of necessary information and obligates the previous health care provider to release the information. It is accepted medical practice to obtain information about the history of treatment. Because patients often have difficulty remembering details of past treatment, it is reasonable to require the new provider to review the previous records. This item is limited to circumstances where the employee has reported previous care (in response to the required inquiry under item A.) The health care provider cannot be required to obtain records if the employee does not, for example, remember the treatment. Seven working days for the previous provider to release the medical records pertaining to prior treatment for the injury is the time frame required by Minnesota Statutes § 176.138 for the release of medical information in other circumstances so it is reasonable by analogy here as well.

Item B. This item prohibits a provider from repeating previously ineffective treatment or

treatment that is no longer appropriate under a specific parameter. For example, if a CT scan is negative, it is not necessary for another provider to repeat the scan the following week. Rather, the cost effective approach is to get a copy of the previous scan. As another example, if therapeutic injections given under part 5221.6200, subp. 5 have been given for the maximum number of times, it would defeat the nature of the parameter to allow another provider to begin the injections again.

Item C. This provides the new health care provider with notice that failing to obtain permission from the employee for the transfer of records is no excuse for duplicating treatment provided by the previous health care provider. The new health care provider should not be complicit by providing unnecessary, duplicative or inappropriate treatment to an employee who reports previous treatment but refuses to disclose previous medical records. It has been alleged that a health care provider is legally or ethically unable to refuse treatment to any patient. However, these obligations apply only in an emergency. For example, the Federal Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 13955dd, requires hospitals to screen anyone seeking medical care and, if an emergency exists, stabilize the condition before transferring the patient to another facility. Nor may a provider abandon a patient in need of treatment without providing an alternative. Minnesota Statutes § 147.091 identifies as grounds for discipline a physician's willful or careless disregard for the health, welfare or safety of a patient. These restrictions do not require a provider to accept a new ongoing patient for non-emergency treatment where the patient refuses to disclose relevant medical history. Although the insurer is not liable for repeat testing or treatment, the rule leaves open an opportunity for the provider to collect from the employee where relevant information has been withheld.

Subpart 7. Determinations of Excessive Treatment; Notice of Denial to Health Care Providers and Employee; Expedited Processing of Medical Requests.

Item A. This item identifies services which are excessive. For completeness, there is a referral to other rules and statutes which also define excessive treatment. This item identifies treatment which is excessive under the parameters. Specifically, if the treatment is inconsistent with a parameter it is excessive. An example would be a CT scan given sooner than 8 weeks after an injury under part 5221.6100, subp. 2, item A, unless one of the specified conditions is present. The second element is where treatment is consistent with a parameter, but is not medically necessary. This may occur with any of the modalities in subparts 3 to 10. For example, therapeutic injections are allowed for treatment of low back pain under part 5221.6200, subp. 5. Even though the rules allow up to 4 trigger point injections to any one site, given once per week, only one injection may be indicated if the employee did not have a positive response, or if the employee has recovered before all 4 injections are given.

Item B. This item specifies notice requirements when an insurer denies payment for treatment that departs from a parameter. The rule requires that the insurer give written notice of the reason to the employee and health care provider. The rule also requires the insurer to notify the parties that the treatment rules permit departure in some circumstances. This rule is reasonable because some health care providers stated under the emergency rules that they received incomplete or erroneous interpretations of the treatment rules when treatment was denied. This rule does not require the insurer to suggest all possible ways in which the provider can challenge the denial, but merely requires the insurer to acknowledge that there may be

additional information or other circumstances under which the treatment may be permitted under either part 5221.6050, subp. 8 or a specific parameter. This additional information facilitates the understanding of the parameters and allows the health care provider or employee to inquire further.

This item also requires the insurer to provide the reason for denial of a service for which prior notification has been given under part 5221.6050, subp. 9. Since subpart 9, item B requires the health care provider to include specific information justifying the treatment with the notification, this rule requires the insurer to respond directly to the information given, rather than with a non-specific denial.

The intent of this item is to encourage communication between the parties about the medical treatment, thus discouraging unnecessary delays in treatment due to misunderstandings or litigation.

Item C. This item addresses the dispute resolution process when there has been a denial of treatment. The employee or health care provider may proceed under any of the referred statutory procedures, by filing a medical request, claim petition or petition under the workers' compensation small claims court. Consistent with Minnesota Statutes § 176.1351, subd. 3, the health care provider and employee must complete the dispute resolution process of the managed care plan, if applicable, before filing with the agency.

In circumstances requiring prior notification of treatment under subp. 9, the rules allow for expedited processing of a medical request. This is because if the insurer denies authorization for surgery, chronic management, durable medical equipment or a departure from a parameter, the employee and health care provider may wish to obtain a determination prior to proceeding with treatment. Therefore, the procedure in the rule allows the health care provider or employee to attach the provider's notification and the insurer's denial, which under item B must be specific, to the medical request. This information allows the commissioner or compensation judge to issue a decision based on these written submission within 10 working days (generally 2 weeks), or even sooner if the insurer elects to file a medical response. This encourages the provider and the insurer to be thoughtful and specific in their communication with each other and not assume that they will more carefully consider the information if litigation occurs.

Item D. This item specifies the factors to be considered by the insurer, commissioner, or compensation judge in determining whether treatment is compensable. Subitem 2 is similar to the factors of excessiveness in subpart 7. Subitem 3 requires that consideration must be given to the basis for departure from a parameter in subpart 8. Subitem 1 requires consideration of whether a parameter even applies. For example, there is a parameter for knee surgery, but no parameter for initial non-surgical care of a knee injury. Therefore, applying the low back passive treatment parameters to a knee injury is not appropriate.

Subpart 8. Departure from Parameters. As noted earlier, the rules are designed to be flexible to allow for application depending on the unique condition of each employee. Not every employee responds in the same way to treatment, although the parameters in parts 5221.6200 to 5221.6600 are flexible enough that they are expected to reflect the entire course of treatment needed for the majority of employees with these conditions.

Accordingly, this subpart specifies factors that may be the basis for allowing treatment that departs from a given parameter.

Item A. This item allows a departure where there has been a medical complication. The term "medical complication" is not defined because it would be impossible to do so and not leave something out. An example of a complication would be another medical condition that delays recovery from the work injury.

Item B. This item allows a departure where previous treatment did not meet the accepted standard of practice (or where applicable the treatment parameters) for the health care provider who delivered the treatment. For example, an employee with a simple low back strain should not be denied further passive care if a previous health care provider prescribed 12 weeks of bed rest, (since that is not the standard of care for any provider). On the other hand, simply because there are different approaches to treatment by different types of health care professionals does not permit a new course of treatment by another professional, since statistics indicate that all types of health care providers are approximately equally effective for conditions within their scope of practice.^{1,4,6-10}

Item C. This item allows additional treatment to assist the employee in the initial return to work, where the work activities place stress on the part of the body affected by the work injury. This information must be documented in the medical record to support additional treatment. Again, it is difficult to include more specific criteria, such as how much stress, without inadvertently excluding a circumstance where treatment may be appropriate. Similarly, it is difficult to identify a time limit for the initial return to work, since some employees may need more time to adjust than others, and some may initially return to work more slowly than others. This item simply provides a standard with which the parties, commissioner, and compensation judge may use as guidance, since successful return to work is a primary goal in workers' compensation. However, this item also requires the provider to document efforts made to promote employee independence and to avoid prolonged dependency on health care providers in a clinical setting.

Item D. This item allows treatment to continue past any time limits where the provider documents continuing effectiveness of the treatment. This is the same standard found in part 5221.6050, subp. 1, item B, which requires progressive improvement in two out of the three categories. For example, most but not every employee will recover within eight weeks of a back injury. However, if an employee is showing continuing improvement with passive care beyond 12 weeks, the treatment may be continued. This item requires specific documentation in the medical record of the continuing improvement.

Item E. This item allows additional treatment for an "incapacitating exacerbation." This again is not specifically defined for fear of excluding some necessary treatment or providing a "recipe" for ongoing treatment which may not be indicated. Therefore, a general standard is given which may be used as guidance by the parties and judges in individual cases. This item requires that treatment of the incapacitating exacerbation, whether it is a new injury or a continuation of a previous injury, must follow the parameters of the rules as well.

These departures were approved by the Medical Services Review Board and also

recommended by the passive care advisory group discussed under part 5221.6200, subpart 3.

Subpart 9. Prior notification; health care provider and insurer responsibilities.

This subpart establishes requirements for health care providers to notify the insurer of proposed treatment in certain circumstances; and establishes requirements for insurers to respond to the prior notification.

This rule is authorized by Minnesota Statutes § 176.83, subd. 5, which requires the Commissioner to adopt rules establishing standards and procedures for health care treatment. Statutory authority for these rules is also found in Minnesota Statutes § 176.83, subds. 1, 3 and 4 which authorize rules to implement Chapter 176, rules establishing standards for reviewing and evaluating clinical consequences of services, and rules establishing standards and procedures for determining whether charges for health services are excessive.

The purpose of subpart 9 is not to place the final treatment decision with the employer and insurer, but to promote communication among all parties in circumstances where the treatment is likely to involve an invasive inpatient procedure, where the treatment is costly, or where the treatment is proposed beyond the parameters in the rules. These procedures are likely to reduce litigation on the appropriateness of treatment, because the rules require discussion of such treatment before it is given, thus providing the parties with an opportunity to preauthorize the treatment, agree to alternate treatment, or obtain an opinion from another health care provider or compensation judge before the treatment is given. The prior notification and insurer response rules provide a structured system for ensuring documentation of medical necessity for the most costly treatment and treatment outside the parameters established in consultation with the medical community.

Item A. This item requires the provider to notify the insurer at least seven days before the specified treatment is initiated. This is a reasonable time frame, because prior notification is not required in an emergency. One week gives the insurer time to evaluate the proposed treatment and respond to the provider. Because Subpart 8 requires the insurer's response to be attached to a Medical Request in case of a dispute, it is important to allow the insurer enough time for a thoughtful response.

Some chronic management programs, and non-emergency inpatient surgery are subject to the prior notification requirements because these are costly procedures, and in the case of surgery, invasive. Medical equipment is also costly, and the insurer may be able to provide the equipment at a lower cost than if the employee were to purchase it retail. Surgery may involve the need for a second opinion under Minnesota Statutes § 176.135, subd. 1a. Additionally, prior notification allows parties to evaluate more than one alternative. For example, chronic management modalities include health clubs, work conditioning and work hardening, computerized exercise programs, pain clinics, and psychological counseling. More than one of these may be appropriate for the employee, and the insurer may be willing to pay for one modality and not another, thus avoiding litigation.

Prior notification is also required for treatment that departs from a treatment parameter. Treatment that departs from a parameter is deemed to be excessive unless one of the exceptions

in Subpart 8 applies. Therefore, the insurer must be able to participate in the discussion of ongoing treatment in these circumstances. One of the factors that courts have considered in determining whether treatment is compensable is whether alternative treatment has been tried. Horst v. Perkins Restaurant, 45 W.C.D. 9 (WCCA 1991). In some cases a departure may delay implementation of alternative treatment or even the next stage of treatment set forth in the rules (initial nonsurgical; surgical evaluation and chronic management). A case supporting the need for evaluating alternatives and demonstrating the concern over incurring expensive equipment before necessity is determined is Cotter v. Niro Atomizer, (WCCA, August 11, 1992)

Item B. This item sets forth the requirements for the prior notification. The provider's diagnosis and analysis are important to ensure that the provider and the insurer are applying the applicable parameter. For example, if they believe different parameters apply, further discussion is appropriate and will promote the resolution of disputes before treatment has been given and litigation ensues. The basis for a departure from a treatment plan and the anticipated effect of treatment on the employee's condition are required to give the insurer needed information to evaluate compensability, and again to head off disputes. Explanation of the treatment plan is consistent not only with past requirements of the workers' compensation courts, but also with standard medical practice. Field-Seifert v. Goodhue County. (WCCA, March 5, 1990).

Item C. This item requires the insurer to provide a toll-free telephone and facsimile number for the health care provider. This requirement is reasonable by analogy to the Minnesota Utilization Review Act, which requires a utilization review organization to provide a toll-free number for providers. Minnesota Statutes § 62M.10, subd. 1. It is appropriate because it promotes communication, and the insurer benefits from being informed of the nature and extent of the employee's medical treatment.

This item also requires the insurer to respond orally or in writing within seven working days to the request. It is reasonable to place the same time constraints on insurers as on health care providers for prior notification. Additionally, insurers and health care providers requested that the administrative notice and response periods remain consistent for ease in application. The rule also allows the insurer to respond orally or in writing; flexibility is appropriate to facilitate communication.

Item C also requires that any denial include notice to the employee and health care provider as to why the information provided by the health care provider does not support the treatment. This is consistent with Minnesota Statutes § 176.135, subd. 6 and Minn. Rules, part 5221.0600, which require notice to the employee and health care provider of denial of all or part of a charge. Requiring the insurer to give a substantive reason for the denial imposes the same requirement on insurers as item B does on health care providers: each party has the right to know the reason for the proposed action, which will facilitate communication and minimize litigation over whether treatment already given was necessary.

Subitem 1. This provides that if the insurer does not respond, treatment is authorized. The emergency rules provided that the insurer could still deny treatment if it had not responded; however, health care providers reasonably pointed out that this gives the insurer all the benefits of prior notification, but no incentive to comply, which is unfair to the provider and the employee. The rule does not prevent the insurer from raising the issue of whether prior

notification was received.

Subitem 2. This specifically provides that, in most cases, even if the insurer denies treatment, or requests a medical exam by the employer's physician, the health care provider may elect to provide the treatment, subject to a determination of compensability by the commissioner or compensation judge. Alternatively, the health care provider or employee may wish to file a medical request under subpart 7, for a determination prior to delivery of the treatment. This rule acknowledges that the health care provider retains ultimate responsibility for providing appropriate medical care; and the insurer retains the right to make compensability decisions. Therefore, while the rules promote communication about the medical treatment, the health care provider must make the final decision about whether to treat. The exceptions to this item, for non-emergency surgery and extended passive care, are discussed under the referenced subitems.

Subitem 3. This provides that the insurer may not later deny payment for the authorized treatment. This is reasonable because if the insurer had initially denied treatment, the provider or employee would have been able to petition the court or compensation judge for a determination prior to giving the treatment, or may have elected to discuss another alternative with the insurer.

Subitem 4. This clarifies and applies a statutory provision, Minnesota Statutes § 176.135, subd. 1a, which states that the insurer may require the employee to obtain a second opinion before the surgery. The rule states that when a second opinion is requested, the health care provider must wait with non-emergency inpatient surgery until the employee provides the insurer with the second opinion from a doctor of the employee's own choosing. That the employee may select the second opinion doctor is consistent with the decision of the Workers' Compensation Court of Appeals case in Bakke v. Monfort, Inc., 48 W.C.D 393 (1993).

The rule allows the health care provider to proceed with non-emergency surgery after the second opinion is communicated to the insurer, if the health care provider still feels it is appropriate, subject to a later determination by the court or compensation judge as to compensability. This rule affords the parties with information from the second opinion doctor prior to performing surgery as required by Minnesota Statutes § 176.135, subd. 1a.

Finally, subitem 4 provides that in cases of repeat surgery or implantation of a dorsal column stimulator, the surgery cannot be performed unless a confirming opinion supports the need. This is based on recommendation from the medical community and manufacturer of the implant devices that there is enough uncertainty about the routine need for these surgeries that a confirming opinion is medically appropriate. The high failure rate of repeat surgeries and the potential for unreimbursed expense of these procedures is illustrated in the case of Cook v. Lloyds Food Products, Slip op (WCCA, December 22, 1993).

Subitem 5. This reflects the insurer's right to obtain an examination of the employee by its own doctor under Minnesota Statutes § 176.155. If non-emergency surgery is proposed, the invasive nature and expense of surgery warrants the short delay pending the additional opinion. Once again, after the opinion is made available to the insurer, the health care provider may elect to perform the surgery, or may request a determination prior to the surgery from the commissioner or compensation judge. The 45 day time period is considered a reasonable time

for the insurer to schedule the exam and obtain a report, given that the surgery is delayed in the interim.

Subitem 6. This provides that if the insurer requests additional information in order to respond to the proposed treatment, the treatment must be delayed pending the additional information. This is analogous with Minnesota Statutes § 176.135, subd. 6, subitem 4, which applies to denials of payment for treatment. In either case, the statute and rule facilitate communication and resolution of disputes prior to litigation.

Subpart 10. Certified managed care plans. This subpart provides a managed care plan certified under Minnesota Statutes § 176.1351 may provide the prior notification for the health care provider or the insurer may delegate the responsibility for insurer responses to the managed care plan. The managed care plan in either event is bound by the same timeframes set forth in the rule. This rule acknowledges the role of managed care under Minnesota Statutes § 176.1351 and provides flexibility so that participating providers and insurers can communicate effectively.

Subpart 11. Outcome studies. The development of treatment parameters commits the Department of Labor and Industry to maintaining the currency and validity of those parameters. The ability to do outcome studies is central to that upkeep. This section authorizes the Department to gather the necessary information to perform those outcome studies. This will allow the Department to evaluate, on an ongoing basis, the efficacy of the treatment standards and propose needed changes.

Age, gender, and education are factors which may influence treatment outcomes and are usually included in studies of treatment outcome. Date of injury is necessary to evaluate the length of time of treatment. Employment status is one of the outcomes against which treatment will be measured, along with symptoms and functional status, because these are workers' compensation treatment rules and return to work is an important element. Information about other treatment given for the condition is needed to properly analyze the effect of the treatment being studied on the outcomes.

Part 5221.6100. PARAMETERS FOR MEDICAL IMAGING.

Subpart 1. General principles. Certain parameters for medical imaging are general to all treatment situations. They are gathered together under this subpart. The parameters written represent the consensus of the Medical Services Review Board and the majority opinion of the medical community. They are also similar to workers' compensation treatment parameters written in Massachusetts, Rhode Island and Colorado.¹¹⁻¹³ A history and physical is required before ordering an imaging study because these expensive procedures should not be used as a substitute for the clinician's personal evaluation since such studies are not warranted without the necessary clinical information to determine the most appropriate study and to interpret the results.

Item A. Effective imaging. This requires the health care provider to pick out the single most useful imaging technique as the first test. It requires the health care provider to obtain the results of that imaging study before ordering other imaging studies. This prevents unnecessary studies. It also ensures that imaging studies are being done solely in order to develop an

appropriate treatment plan. The rule prevents “shot gunning” in which a variety of imaging studies are ordered and obtained at one time as a convenience for the health care provider, even though some of them may turn out to be unnecessary.

Item B. Appropriate imaging. This rule is also written to eliminate unnecessary medical images. It prohibits the health care provider from ordering imaging studies to rule out unlikely etiologies for the condition being treated. This information is not used for the development of a treatment plan but is rather “defensive medicine” and the imaging study is just being obtained to protect the health care provider from any future malpractice claims. Careful history and physical examinations can provide the health care provider with sufficient information to eliminate unlikely etiologies. If legitimate diagnostic uncertainty persists, the history and physical examination will document the necessity for the imaging study.

Item C. Routine imaging. This prohibits the provider from having standing orders that result in medical imaging being obtained before the history and physical is done, and without regard to the development of a treatment plan. Medical images should be obtained to help diagnosis the condition and should be based on the results of the history and physical examination. Routine medical imaging rarely affects the final diagnosis and is not necessary for the development of a treatment plan.

Item D. Repeat imaging. This prohibits the health care provider from repeating a medical imaging study already obtained unless the repeat study is necessary for monitoring the condition in the special medically accepted circumstances listed in the rule, or developing an alternate treatment plan. This prevents medical imaging which is done as a default when the health care provider has no other idea about how to proceed. Allowance is made for repeating technically inadequate studies.

Item E. Alternative imaging. This is a further development of the prohibition on repeat imaging. It addresses the situation in which the health care provider orders another study of the same area with a different imaging technology. For instance, a CT scan of lumbar spine is followed by an MRI scan of the lumbar spine. Alternative imaging is appropriate for follow up of inconclusive findings. It is not appropriate for follow-up of negative findings in a case in which there is no change in the suspected etiology. It is allowed if the alternative imaging procedure is a better test of another suspected etiology.

Subpart 2. Specific imaging procedures for the low back. These parameters are meant to be used with the specific parameter for low back pain. In each case they reflect the medical literature^{1,5,10,14} and workers’ compensation parameters from other states¹¹⁻¹³ and represent the majority opinion of the medical community and the consensus of the Medical Services Review Board as to the appropriate indications for these specific diagnostic medical imaging procedures for the low back.

Item A. CT scanning. This item lists three situations in which CT scanning can be done at any time after injury.^{5,10,14,15} Otherwise CT scanning is not appropriate in the first eight weeks after the date of injury. During the first eight weeks after injury, 80 to 90 percent of patients recover fully; delaying CT scanning will eliminate unnecessary testing in individuals who will get well anyway. Since conservative care is the indicated care in the first eight weeks (except

in the three situations listed in this item), CT scan results are not needed to develop a treatment plan in that period. Treatment can be directed on the basis of the history and physical examination.

Item B. MRI scanning. This item lists three situations in which MRI scanning can be done at any time after injury. As with CT scanning, MRI scanning is not appropriate in the first eight weeks after the date of injury.^{5,10,14,15} During the first eight weeks after injury, 80 to 90 percent of patients recover fully; delaying MRI scanning will eliminate unnecessary testing in individuals who will get well anyway. Since conservative care is the indicated care in the first eight weeks (except in the three situations listed in this item), MRI scan results are not needed to develop a treatment plan in that period. Treatment can be directed on the basis of the history and physical examination.

Item C. Myelography. Myelography is not a preferred technique for routine imaging of the low back.¹⁰ It may be used if CT scanning or MRI scanning is not available. In addition, there are two specific situations in which myelography can be used as a follow-up to CT scanning or MRI scanning.

Item D. CT-myelography. CT-myelography is not a preferred technique for routine imaging of the low back. It is the initial choice in only one situation (subitem 1); otherwise, it can be used as a follow-up to CT scanning or MRI scanning in specified circumstances (subitems 2 through 5).

Item E. IV-enhanced CT scanning. IV-enhanced CT scanning is not a preferred technique for routine imaging of the low back and is only indicated if both CT-myelography and MRI scanning cannot be used.

Item F. Gadolinium enhanced MRI scanning. Gadolinium enhanced MRI scanning is not a preferred technique for routine imaging of the low back and is only indicated in five specific situations.

Item G. Discography. Discography is not a preferred technique for routine imaging of the low back and is only indicated in the specific situations listed.

Item H. CT discography. CT discography is not a preferred technique for routine imaging of the low back and is only indicated in the specific situations listed. It may be done as an immediate follow-up to discography so as to avoid a second injection, if the conditions of subitem 2 are met.

Item I. Nuclear isotope imaging. Nuclear isotope imaging is not indicated for the routine imaging of low back pain and is only indicated when certain specific diagnoses are suspected on the basis of other evidence.^{10,15} Nuclear isotope imaging should not be used to rule out a diagnosis for which there is no other evidence on history, physical examination, laboratory testing, or other imaging study.

Item J. Thermography. Thermography is not indicated for the diagnosis of low back pain in any circumstance.^{17,18} While thermographic changes may be present in cases of low back

pain, sciatica, and radiculopathy, they are not diagnostic and another imaging study is required anyway to make a structural diagnosis. In these cases the thermogram has added cost without contributing to the determination of a diagnosis or the creation of a treatment plan. If a thermogram is negative, this does not rule out the possibility of an important structural lesion in patients presenting with lower extremity symptoms suggestive of sciatica or radiculopathy; again, another imaging study will be required regardless of the findings on thermography.

Item K. AP and lateral x-rays. AP and lateral x-rays are over utilized in the initial evaluation of low back pain; they offer very little useful information except in select clinical circumstances. They are most often obtained "for the lawyers" rather than for the patient; and, they expose the patient to unnecessary radiation especially to the reproductive organs. Studies have questioned the use of these x-rays^{19,20} and it was the consensus of the MSRB that they were indicated only in the situations enumerated in subitems (a) to (e).

Item L. Oblique x-rays. Oblique x-rays are over-utilized even more than AP and lateral x-rays. They are often done as part of a pre-established "package" of x-rays including AP and lateral films.²¹ Even when AP and lateral films are appropriately ordered, there is often very little additional information, but a great deal of additional radiation, from the oblique films. The use of oblique films should be based on the findings on the AP and lateral films; this will limit their use to situations where they will add information necessary to making a diagnosis or establishing a treatment plan.

Item M. Electronic x-ray analysis. The consensus of medical opinion in the community and the opinion of the MSRB is that electronic x-ray analysis added no additional clinically important information not available from traditional radiographic interpretation. It does, however, add substantial cost and is not a cost-effective approach to low back pain.

Part 5221.6200. LOW BACK PAIN.

These parameters represent the appropriate approach to the entire episode of care for a patient with a new low back injury.^{6,10,22-24} They begin with parameters outlining the appropriate history, physical examination, and diagnostic work up. They then set out the initial approach to the patient with subsequent follow up, surgical treatment as needed, and rehabilitation if necessary.

Subpart 1. Diagnostic procedures.

Item A. As with any patient, the health care provider must perform a history and physical and diagnose the condition before initiating treatment. The clinical categories represent a distillation of numerous recommendations in the medical literature for grouping low back conditions.^{6,8-10,22,25,26} They bring together specific diagnoses which share common diagnostic and therapeutic approaches. The categories were reviewed extensively by the medical community and were approved by the Medical Services Review Board. ICD-9 codes are developed by the World Health Organization to be used as an internationally standardized system for diagnosis.

These rules do not intend to direct evaluation and treatment for all conditions, etiologies,

and diagnoses associated with patient complaints of discomfort in the lumbar area or radiating into the lower extremities from the back. A vast variety of problems can cause low back pain;^{2,3,9,10} most of these are rarely if ever seen as part of a workers' compensation claim. These rules are specifically addressed to the mechanical causes of low back pain that predominate in workers' compensation. In addition to excluded conditions not typically found in workers' compensation, one common problem in workers' compensation is excluded: these rules do not apply to fractures. The range of severity and complications in fractures was deemed to be too great to encompass in these rules.

Subitem 1. The first clinical category covers all complaints of low back pain confined to the lumbar area. Epidemiologic data indicates that these conditions behave similarly,⁷⁻¹⁰ in addition, the state of the art calls for similar medical interventions in these cases.

Subitems 2 and 3. The second and third clinical categories include all complaints which involve symptoms radiating into the leg. These patients may also have pain in the low back but that is not a necessary part of the presentation. Regardless of whether there is pain in the low back, patients with leg symptoms follow a different natural history¹⁰ and require somewhat different treatment at certain points in their course than those who have only low back pain. Subitems 2 and 3 are distinguished by an important severity indicator: progression of symptoms. Patients with leg symptoms that are becoming progressively worse require different, more immediate treatment similar to that for cauda equina syndrome than patients whose neurologic symptoms are stable.¹⁰

Subitem 4. Cauda Equina syndrome is an extremely rare but serious condition that requires emergency intervention. The natural history of untreated cauda equina is clinically distinct from the other clinical categories and there is a longstanding, well received consensus regarding the appropriate treatment of this condition.

Item B. The prescribed use of laboratory tests reflects common practice and the opinion of the Medical Services Review Board. Laboratory tests should be used to follow-up diagnostic possibilities raised by the history, physical examinations, or other testing. Laboratory tests should not be ordered routinely without regard to the facts in a particular case.

Item C. Please refer to the discussion of medical imaging in part 5221.6100, subs. 1 and 2.

Item D. The recommendations regarding electrodiagnostic testing reflect common medical practice in the opinion of the Medical Services Review Board. Only low back conditions which can affect the nerve roots can possibly be detected by a technique which tests the nerves and nerve roots, and therefore these tests are limited to patients in clinical categories (2) to (4). Physiologic studies show that there is at least a three week delay between nerve injury and the first detectable changes an EMG or nerve conduction testing, so testing is allowed only after 3 weeks, when it is most likely to be successful. Repeat testing is not appropriate without the development of new neurologic symptoms or signs because no new diagnostic information would be expected.

Item E. The consensus of expert opinion indicated no utility for the listed techniques in the

diagnosis of low back conditions covered by these rules.

Subitem 1. Surface EMG is not a standard medical test that has been validated in the peer reviewed literature as a diagnostic modality. Careful physical examination using well established techniques is able to provide the same information.

Item F. In general these rules attempt to limit specialized testing to special circumstances. The proliferation of this kind of technology into the initial care of persons with low back pain is not cost effective. These tests are inaccurate during the acute stage of injury because the level of pain can be expected to decrease with treatment. They are specifically used as components of chronic management under part 5221.6600. Eighty to ninety percent of episodes of low back pain are resolved within eight to twelve weeks even without treatment. These specialized techniques are appropriately confined to those individuals who do not follow the usual natural history of the disorder. These recommendations were approved by the Medical Services Review Board and physical therapy experts.

Item G. The medical literature indicates the importance of psychosocial problems in individuals who do not improve within the usual natural history of low back pain.^{1,7,10} These recommendations encourage health care providers to look for these problems which may interfere with recovery and address them in order to maximize the employee's recovery. These recommendations were approved by the Medical Services Review Board. The importance of considering psychological factors is noted in Torgerson v. ELO Engineering, (WCCA, March 16, 1992).

Item H. These recommendations reflect common medical practice, which is to limit diagnostic injections to only those cases where surgery is anticipated, the employee has failed to improve, or diagnosis is difficult. In other cases less invasive means of diagnosis are preferred, such as imaging.

Item I. The components of a functional capacity assessment were developed in consultation with occupational and physical therapy experts, and reflect national standards. As with computerized testing, these evaluations are expensive and are therefore not indicated during the initial non-surgical care of the acute back injury because most people will recover within eight to twelve weeks. It is the opinion of the MSRB and physical therapy experts that the physician directing the care during the initial non-surgical management should be able to determine the employee's capabilities during the acute phase of the injury. Therefore, only when the employee's condition has stabilized, and the employee's abilities are still unclear, is a functional capacities evaluation appropriate.

The functional capacities evaluation is not appropriate to establish baseline performance, because these are typically unnecessarily used to track the level of improvement, and the treatment plan is not dependent on the baseline results. A functional capacities evaluation is an end point evaluation to establish final activity abilities, and therefore only one is authorized per injury.

Item J. This item reflects that consultations with other providers may assist in diagnosis.

Subpart 2. General treatment parameters for low back pain. This outlines the general approach to the treatment of patients diagnosed as falling into clinical categories (1) to (4) using the approach to evaluation set out in subpart 1.

Item A. This item is necessary to provide an overview and instructions for the use of the parameters and directs the health care provider to the appropriate specific rules for each clinical category. It also reminds the provider to reassess the appropriateness of the clinical category at each visit and make changes in treatment as the clinical category is changed. Continuous evaluation of the diagnosis and effectiveness of treatment reflects common medical practice.

Item B. This item outlines the general approach to be taken for low back pain patients.^{6,8,10,22-24} In most cases the entire episode of care can be divided into three phases. The first phase is non-surgical management. As noted above, 80 to 90 percent of patients with low back pain recover in eight to twelve weeks even without treatment.^{5,10,14,15} It is expected that medical care provided under workers' compensation will be at least effective as the natural history of the untreated disease. Therefore it is expected that 80 to 90 percent of patients will do well with non-surgical management and this will be the only kind of care required. It is recognized that 10 to 20 percent of patients do not improve with non-surgical management. Therefore at some point these patients must be re-evaluated and decision must be made regarding invasive therapy. Even though these patients have not improved with non-surgical management it is not likely that all of these will be candidates for surgical management.

For those who are surgical candidates, surgery should be done in a timely manner. Others will not be surgical candidates and alternative forms of treatment will be required. Since 80 to 90 percent of patients are better within 8 to 12 weeks in most cases, decisions regarding surgical therapy are best postponed until 8 to 12 weeks of non-surgical management have been attempted.

Finally, for those patients who do not improve with surgery or who were not surgical candidates, alternative treatment must be provided. These individuals have chronic pain; they did not respond to traditional conservative management or indicated surgical treatment, so simply continuing those treatments will not be effective in curing their condition. The epidemiology of low back pain indicates that those individuals who have not recovered in 8 to 12 weeks are likely to have permanent or long term chronic complaints and that further attempts at cure will be unsuccessful.¹⁰ While acute pain is an indication of tissue damage and treatment is appropriately aimed at fixing the damage and restoring normal function, chronic pain is a derangement of the body's pain perception system. Treatment of chronic pain emphasizes minimizing the physiological and functional consequences of continued pain. At this point the focus of treatment changes from cure to rehabilitation. Rehabilitation is aimed at improving deconditioning, stiffness, weakness, incoordination, and anxiety that result from pain and prolonged inactivity due to pain. Rehabilitation emphasizes adaptation and the alternative modalities of treatment indicated in this stage of treatment are the well established techniques of rehabilitation medicine. This approach to low back pain reflects the medical literature,^{7,8,10,22,27,28} common medical usage, and is approved by the Medical Services Review Board.

Item C. This item allows the health care provider to refer the employee for a consultation at any time based on accepted medical practice. The emergency rules were interpreted by some

to limit the circumstances in which a consultation may be obtained. This is not the intent of the rules.

Subpart 3. Passive treatment modalities. Item A. This subpart sets out the definitions and conditions of use of the passive treatment modalities.^{5,6,10} These modalities may be used in combination or in sequence during the period of non-surgical management. The particular arrangement of modalities is at the discretion of the treating health care provider. Except as provided in item B, none of these modalities may be used in a clinical setting for more than 12 weeks during the period of initial treatment. This reflects the natural history of low back pain in which 80 to 90 percent of individuals are better in 8 to 12 weeks regardless of treatment. Since these treatments are directed at patients in the initial phase of treatment, if they have not had a positive effect in the first 8 to 12 weeks, they are not as effective as "no treatment." Patients who have failed to respond either have a problem requiring surgery or have developed a chronic condition more appropriately treated by rehabilitation.

During this initial period when the majority of patients are expected to have full resolution of symptoms, treatment is aimed at cure. Treatment that does not provide a cure fails to meet the goals of treatment in the initial period. Some other form of treatment should be tried in order to effect a cure. If all conservative treatments fail then surgery may be able to cure the condition. If neither conservative management nor surgery can cure the condition, statistics show that these patients are very likely to have chronic low back pain which will never be cured. Rehabilitation is the appropriate treatment in these situations.^{8,10}

For each of the modalities a time for treatment response, a maximum treatment frequency, and a maximum treatment duration are specified. These are based on recommendations by the North American Spine Society,⁵ as modified by the MSRBR after considering expert comments. The time for treatment response is the duration or number of treatments required to determine whether the treatment is going to be effective. After this duration or number of treatments there should be some improvement documented in the employee's symptoms, physical findings, or functional ability to indicate that the treatment is being effective. The maximum treatment frequency specifies the intensity with which the modality may be used. In many cases modalities are appropriately used at high frequency initially and then with decreasing frequency thereafter as the patient improves. If the intensity cannot be reduced then the treatment is not effective. Finally, the maximum duration specifies the total amount of calendar time over which this modality can be applied. This is determined at least in part by the natural history of low back pain. In some cases certain modalities are limited by side effects.

Limitations on passive care in patients with musculoskeletal injuries are proposed for a variety of reasons which reflect the current consensus in the medical literature and the health care provider community. First, there are no scientifically valid studies which show that long term passive care results in eventual recovery of function or cure of symptoms. Many studies exist which show the efficacy of short term treatment with passive modalities in acute cases. While the exact duration and numbers of treatment has varied between studies, the proposed durations and frequencies of treatment are large enough to accommodate the schedule of care proven useful in the literature.^{4-6,10,15,22-24,27-34} The proposed limitations also do not differ radically from many recommendations from professional organizations.³⁵⁻³⁸ However, it is a logical fallacy to expect a positive effect of long term treatment in chronic cases based on

outcomes of short term care in acute cases. In fact, in most therapeutic situations, the exact opposite is usually true; continued treatment without resolution is a sign of treatment failure. Since no studies demonstrate the efficacy of long term passive care in chronic cases, these proposed limitations do not deny the patient any reasonable or necessary treatment. The use of alternative rehabilitative treatment with chronic management modalities can provide relief of symptoms and improve functions and independence for employees with chronic pain.

Second, patients with musculoskeletal injuries who have not improved within the expected timelines are not suffering from their acute injuries but from the consequence of their acute injuries - usually permanent physical impairment or chronic pain syndrome, or both. Treatment for these consequences is different than the for the acute injury (see discussion in chronic management section). In this case, passive care is no longer reasonable or appropriate since the condition being treated has changed.

Third, epidemiologic data shows that prolonged inactivity is detrimental to the patient's vocational future. If a worker has not returned to work within 2 years of injury, the odds of ever working again at any job approach zero.^{8,10} Any treatment that promotes prolonged inactivity or disability is counterproductive to restoring the injured worker's function. Passive treatment continued after expected recovery periods can promote inactivity. Likewise, delay of necessary surgical intervention by prolonged passive treatment can lead to longer periods of disability. Given the importance of reestablishing activity in injured workers with prolonged symptoms, the proposed limitations are reasonable.

Item B. This item allows additional passive care beyond 12 weeks to be provided under specified circumstances. The 12 week passive care parameter in the emergency rules initially recommended by the Medical Services Review Board has been the subject of considerable controversy and debate. Therefore, the Department brought the issue back to the MSRB for further review, and the Board suggested that a group of health care providers and others knowledgeable in this aspect of workers' compensation be consulted on the various passive care proposals, to provide the commissioner and the MSRB with advice on the issues. Participants included a representative of the Minnesota Chiropractic Association; an employee; a self-insured employer; the Department's medical consultant; and three members of the Medical Services Review Board: a physical therapist, a neurologist and an occupational medicine physician. Also present were staff of the Department of Labor and Industry and a facilitator from the state Department of Administration. The names of the participants are attached in Appendix 4. This group met throughout the day on February 24, 1994. A consensus recommendation emerged from this process, which reflects sound medical and chiropractic practice, while addressing the concerns of employers and employees. This recommendation, reflected in item B, was considered an appropriate modification by the Medical Services Review Board and the Commissioner.

Item B specifies the two circumstances under which passive treatment beyond the 12 weeks is appropriate. As previously noted, most low back injuries resolve well within the 12 weeks; and most employees whose injuries have not resolved require rehabilitation with chronic management modalities. However, one of the primary goals of the workers' compensation system is to return the employee to work. Accordingly, under subitem 1, unit (a), if the employee has been released to work 12 additional passive care visits are allowed ever an

additional year to facilitate the return to work process. An additional 12 visits for passive care is also allowed under unit (a) in cases where the injury is serious enough that the employee is permanently totally disabled and unlikely to ever return to work, if the additional treatment is necessary to maintain function in activities of daily life.

Unit (b) provides that the additional 12 visits may not be given on a regularly scheduled basis, for example in order to extend the initial 12 continuous weeks of passive care. Rather, the treatment must be specifically tailored to the minimum amount needed to maintain function and employability. Regularly scheduled visits do not allow for an individual "need based" assessment, and may discourage employees from taking independent self-care measures or even from being careful not to overexert, thus causing reinjury.

Unit (c) requires the health care provider to document employee independence and decreased reliance on health care providers. During the return to work process additional treatment is intended to facilitate employment. As discussed under item B above, long term passive care has not been shown to increase the function or pain level, to the extent function is a measurement of pain. Accordingly, for long term care the chronic management modalities, which promote employee independence, are appropriate rather than continuous professional clinical intervention.

Unit (d) requires that the additional treatment must include active treatment, such as exercise. This reinforces concepts included elsewhere in the rules, such as Subpart 5 and the chronic management section in part 5221.6600. Exercise has been shown to be a key factor in the successful long term management of an musculoskeletal injury.^{7,8,10,27,39,40,41}

Units (e) and (f) require that the structure of the rules, requiring three stages of treatment, be adhered to, because consideration of alternative treatment and early intervention with chronic management modalities is important. Ongoing passive care is contraindicated and cannot be substituted were surgery or chronic pain treatment is necessary.

Subitem 2. This provides that further passive care beyond the provisions in Subitem 1 must be prior authorized by the insurer, commissioner or compensation judge. After the additional 12 treatments over 12 months have elapsed, it is certainly imperative to move on to chronic management unless it can be documented that the passive treatment is maintaining employability, or for a permanently totally disabled employee, function. This ensures a more intense and objective level of review at this point, so that needed alternative treatment or chronic management to promote independence is provided.

It should also be noted that the departures in part 5221.6050, subpart 8 are in addition to the passive care allowed by this Item B. Thus, if at any time during the additional 12 visit/12 month period the employee needs passive care due to a medical complication, an actual return to work where the injured body part is stressed, where the employee is continuing to improve or where the employee sustains an incapacitating exacerbation, further passive care may be provided (subject to the prior notification requirements in subpart. 9 of that section).

The passive care parameters attempt to balance the need for treatment where treatment is facilitating the employee's return to work, or cure of the condition, with the legislature's concern about escalating medical costs. The MSRB and other health care providers have determined that

this rule provides an appropriate balance.

Item C. Adjustment or manipulation. This refers to all types of chiropractic and osteopathic manipulations or adjustments. These limitations apply to any kind of practitioner using these types of treatments. The recommendations as to time for treatment response and optimum treatment frequency reflect recommendations in the chiropractic literature⁵ and the recommendations of the Medical Services Review Board. The maximum treatment duration reflects the natural history of low back pain as well as the chiropractic and medical literature and the recommendations of the Medical Services Review Board. Studies of chiropractic treatment reviewed by the Department show that chiropractic treatment which is effective, is effective within the first 3 months of treatment.⁴²⁻⁷³ No studies were found in the medical literature that showed prolonged periods of chiropractic treatment were effective.

Item D. Thermal treatment. These limitations follow the recommendations in the literature,^{5,6,10,27} and reflect current practice in the medical community. They were approved by the Medical Services Review Board. The second paragraph of this part indicates that the patient may use thermal modalities at home without any limitation as part of a program of self-care. Throughout these rules self-care by the patient is promoted. This frees the patient of dependency on health care providers and is cost effective so long as the quality of care provided by patients to themselves is at least as good as that provided by health care providers. In this situation it is clear that with training during the in-clinic phase of treatment, and with appropriate medical devices, the patient can provide self-care which is at least as good as that given by the health care provider. In fact, the patient is in a position to provide better health care since treatments can be given more often and as needed, as opposed to on a scheduled basis at the health care providers office.

Item E. Electrical muscle stimulation. See discussion under item D.

Item F. Mechanical traction. See discussion under item D.

Item G. Acupuncture. These recommendations reflect the opinion of the Medical Services Review Board. Very little medical literature is available on the cost effective application of acupuncture. Expert opinion was relied on.

Item H. Manual therapy. See discussion under item C.

Item I. Phoresis. Phoresis treatments are used to deliver steroid medication to injured soft tissues by means of ultrasonic pressure or electric gradient. These limitations reflect current practice in Minnesota. They were approved by the MSRB. They are based on concern for the development of local side effects with prolonged administration of steroids, such as thinning of the skin and weakening of tendons.

Item J. Bed rest. Well designed studies in the medical literature indicate that prolonged bed rest is detrimental to patients.^{7,74,75} These recommendations follow the results of those studies.

Item K. Spinal braces. Like prolonged bed rest, prolonged bracing can be detrimental to

the patient's long term prognosis. These recommendations reflect the opinion of the physical therapy community and were approved by the Medical Services Review Board.

Subpart 4. Active treatment modalities. This subpart sets out the definitions and conditions of use of the active treatment modalities. These modalities may be used in combination or in sequence with each other and with passive treatment modalities (subp. 3), injection modalities (subp. 5), and medications (subp. 10) during the period of non-surgical management. The particular arrangement of modalities is at the discretion of the treating health care provider, depending on the symptoms, and physical signs and preferences of the employee. Promotion of employee education and exercise is cost effective because such self-care is often as effective as clinical intervention. Self-care emphasizes patient independence and responsibility for symptom control and reinjury prevention.

Item A. Education. The medical literature^{8,10,27,76,77} indicates that education about the key elements of low back pain is important to recovery and prevention of re-injury, which is a significant problem in workers' compensation. Back schools have been shown to be cost effective means of treatment in number of studies. Three visits is thought to be the maximum amount needed to teach the employee about anatomy, physiology, posture, biomechanics and relaxation. These recommendations reflect the consensus of experts in the community and were approved by the Medical Services Review Board.

Item B. Posture and work method training. This item allows training on posture and biomechanics for specific work activities. This is included to allow additional training that will assist the employee in returning to work and preventing re-injury, which is key in workers' compensation.

Item C. Worksite analysis. Early return to activity has shown to be important for a successful outcome of treatment of low back pain. There is a consensus in the medical literature that early return to work is beneficial to patients with low back pain.^{8,10} Worksite analysis and modification encourages early return to work. This is a cost effective intervention and reflects the consensus of expert opinion in the community and the recommendation of the Medical Services Review Board.

Item D. Exercise. The medical literature on the treatment of low back pain is consistent in pointing out the efficacy of exercise.^{6-8,10,27,39-41,75,77} The recommendations here reflect the current practice in the community and the consensus of medical experts in the community. These recommendations were approved by the Medical Services Review Board. Again self-care is emphasized because the success of an exercise program depends on employee motivation. Objective evaluation and initial education is necessary to track the employee's initial progress and at specific intervals to facilitate employee motivation. However, indefinite education and objective evaluation is inappropriate; ultimately the success of the program must depend on the employee.

Subpart 5. Therapeutic injections. Injections can be useful in the treatment of low back pain as adjuncts to passive and active modalities during the period of non-surgical management.^{9,10}

For each of the modalities a time for treatment response, a maximum treatment frequency, and a maximum treatment duration are specified. These are based on recommendations by the North American Spine Society,⁵ as modified by the MSRB after considering expert comments. The time for treatment response is the duration or number of treatments required to determine whether the treatment is going to be effective. After this duration or number of treatments there should be some improvement documented in the employee's symptoms, physical findings, or functional ability to indicate that the treatment is being effective. The maximum treatment frequency specifies the intensity with which the modality may be used. In many cases modalities are appropriately used at high frequency initially and then with decreasing frequency thereafter as the patient improves. If the intensity cannot be reduced then the treatment is not effective. Finally, the maximum duration specifies the total amount of calendar time over which this modality can be applied. This is determined at least in part by the natural history of low back pain. In some cases certain modalities are limited by side effects.

Items A and B. These items list the temporary therapeutic injections and permanent lytic or sclerosing injections indicated in the treatment of low back pain.^{5,10,77} It specifies that the injections can only be used in conjunction with active treatment modalities, which promote patient education, exercise and self-care to minimize the development of dependency on injection treatment. Therapeutic injections of anesthetics and anti-inflammatory and permanent lytic or sclerosing injections are indicated for the relief of symptoms so that active treatment (such as exercise) can be maximized to improve long term outcomes. All limitations were approved by the MSRB.

Item C. There are no positive controlled trials in the medical literature or consensus, among local experts, for the use of prolotherapy and botulinum toxin injections in the treatment of low back pain. It also was the consensus recommendation of the MSRB that these modalities should not be allowed in the treatment of patients with low back pain.

Subpart 6. Surgery. As previously noted, some patients will not improve with initial management and subsequent evaluation will reveal a condition treatable by surgery. Specific surgical parameters are specified in subparts 11 to 13 and in part 5221.6500.

Item A. A period of post-operative treatment with active and passive modalities is often indicated to maximize the benefit of the surgery and allow the patient to recover as much function as possible. This item represents the current level of care in the community and these recommendations are the consensus of medical expertise and the recommendations of the physical therapy experts and the Medical Services Review Board.

Item B. Repeat surgery must meet the same criteria as a first surgery. Because of concerns about multiple surgeries, which may also be unsuccessful, the rule provides subsequent surgeries may be performed only after a second opinion, confirms the need, if requested by the insurer in accordance with part 5221.6050, subp. 9.

Item C. These spinal implant treatment modalities have very limited application because they are used to treat the symptom of pain rather than the underlying condition. The parameters for the use of these specialized techniques represents the consensus opinion of medical experts involved in the use of these devices, the manufactures of these devices, and the Medical Services

Review Board.

Subpart 7. Chronic management. Some patients will not improve with surgery or will not be candidates for surgery despite ongoing symptoms. These patients have chronic back pain and require a different approach to their treatment. Further management of these patients is based on rehabilitative techniques applicable to chronic musculoskeletal conditions covered by the parameters of 5221.6600.

Subpart 8. Durable medical equipment. This sets out indications and limitations on the use and prescription of durable medical equipment. Durable medical equipment is indicated when it promotes self-care at home and the patient's independence from in-clinic treatment. However, domestic equipment and furniture prescribed purely for convenience or enhanced comfort are not medically necessary.

Item A. Braces, corsets and supports may be prescribed at any time without limitation and can be used during initial management. These assist in keeping the employee functional and prevent re-injury as the employee's activity level increases.

Item B. Electric stimulation and mechanical traction devices may be prescribed for a preliminary period to determine their efficacy in relief of pain for the patient, consistent with the parameters in subpart 3, items E and F. If these modalities are useful they may be continued. Again, these modalities facilitate employee independence in controlling pain. Prior notification of the insurer for purchase or long term use is allowed because the insurer can provide equipment comparable to that prescribed by the health care provider; this is allowed to control long term costs through large purchasing agreements.

Item C. Purchase of exercise equipment is limited to the period of chronic management. Since most individuals improve with non-surgical management, which includes types of exercise that do not require expensive equipment, and some of those who do not improve with non-surgical treatment will improve with surgical management, it is not cost effective to purchase durable medical equipment for exercise prior to the patient entering into a program of chronic management. In chronic management it is expected that the patient will require exercise and conditioning for long periods of time. One option for reconditioning is a home exercise program supported with appropriate home exercise equipment. Once the patient is entered into such a program, the insurer is given the opportunity to provide the most cost effective piece of equipment and to utilize resources available at the employee's place of employment, if such is available and appropriate. This is allowed to control long term costs through large purchasing agreements or by avoiding duplication of investments. Specific documentation of the need for the equipment, the exercise activities, and the goals is required to minimize unstructured and unnecessary prescription of costly equipment.

Item D. Certain medical equipment and furniture is not considered appropriate medical treatment for low back conditions. These kinds of equipment are listed. These limitations represent the consensus of the treatment community and the Medical Services Review Board.

Subpart 9. Evaluation of treatment. This part specifies how the health care providers evaluate the effectiveness of treatment. Health care providers are asked to assess the treatment

plan at each patient visit; this represents current clinical practice. In regard to the modalities of subpart 3, 4, and 5, the assessment of the modality must be done no later than the time for treatment response. Treatment and modalities are evaluated according to three criteria: the patient's subjective symptoms, the physical findings on examination, and the patient's functional status. Explicit directions are provided for documenting changes in these criteria. Treatment or a modality is effective if it results in ongoing and progressive improvement in two of these three criteria.

If treatment or a modality is not effective it should be stopped or modified since it is not promoting improvement in the patient's condition.

The treating health care provider may delegate the evaluation of a treatment or modality to another health professional. For example, a physician could ask a physical therapist providing hot pack treatment to assess their effectiveness. However, the treating health care provider remains responsible for assuring that the evaluation is performed and appropriate action is taken since the treatment is being provided under his/her overall direction.

The rationale for this rule is discussed in more detail under part 5221.6050, subpart 1, item B.

Subpart 10. Scheduled and nonscheduled medication. This subpart outlines the indications and limitations for use of scheduled medications. It limits the use of narcotics to the first two weeks of treatment in patients with regional low back pain but does allow a longer period of treatment with narcotics for patients with radicular pain. This is based on the differing natural histories of regional low back pain versus radicular pain.^{8,10} Regional pain is expected to improve sufficiently within two weeks so that continued narcotic use is not indicated. Radicular pain is more severe and persistent. If need for narcotics continues past expected time frames then the diagnosis may be in error or there may be concurrent problems of chronic pain syndrome in which narcotics are contra-indicated.

This subpart allows that the use of non-scheduled medications, such as non-steroidal anti-inflammatory medication, may be appropriate at any time during the treatment and even after clinical treatment has been discontinued. Health care providers are required to demonstrate that medication is effective treatment and that the most cost effective regimen is being used. For example, it may not be cost-effective to simply provide medication for pain relief for a number of weeks in lieu of passive or active modalities, which will permanently improve the employee's functional level.

Subpart 11. Specific treatment parameters for regional low back pain. This subpart details the specific parameters for the treatment of regional low back pain through the entire episode of care. It coordinates the general requirements for care of low back pain with the specific parameters for the types of treatment modalities listed in subparts 3 to 10 for persons with regional low back pain.

Item A. This item indicates how the various component parts of the initial non-surgical management may be used together in the treatment of patients with regional low back pain.^{8,10,23,24,76} It specifies that any of the passive, active, and injection, equipment and

medication modalities may be used in sequence or simultaneously during this initial period. This allows the provider a great deal of flexibility in structuring a treatment program unique to each patient. Only certain kinds of injections are medically appropriate for patients with regional low back pain. The parameter also requires some kind of active modality (such as exercise) after the first week of treatment. This recommendation reflects common medical practice and the growing consensus in the medical literature that active treatment, such as patient education and exercise, is essential to recovery of low back pain.^{6-8,10,27,39-41,75,77} The item furthermore requires initial treatment to be cost effective; this is accomplished by providing treatment in the least intensive setting consistent with quality health care and by limiting initial passive treatment in a clinical setting to 12 weeks duration.

As noted under subpart 3, the 12 week duration for passive care was chosen after careful consideration of the natural history of low back pain and various treatment parameters from a variety of organizations and provider disciplines. The epidemiology of acute low back pain would indicate that 80 percent of individuals will have resolved their low back pain within 8 weeks of onset without any treatment at all. It is the Department's expectation that treatment for acute low back pain be at least as effective as no treatment. An additional four weeks of treatment beyond the eight weeks is allowed to take into account possible administrative delays in being able to set up various treatment plans and to maximize the patient's likelihood of recovery during this period. Additional treatment may be indicated if special circumstances exist, such as a basis for departure in part 5221.6050, subp. 8, or a release to work or permanent total disability status under subpart 3.

Item B. Subitem 1. The treatment parameters do recognize that some cases do not improve with initial non-surgical management and are appropriately treated with surgery.^{2,8,10,39,76} Since, however, such a high percentage of patients do recover without surgery it is deemed reasonable and appropriate that consideration of surgery be delayed, absent clear symptoms that indicate immediate surgery is necessary, until conservative non-surgical treatment has had an opportunity to improve the patient. If, on the other hand, conservative non-surgical management has failed, then no further delay is warranted in considering the patient for surgery. This item requires an initial evaluation at eight to 12 weeks; in response to inquiries about the emergency rules the rule specifies that surgery needed at a later date, due to a deteriorating condition, is not precluded.

Subitems 2 and 3. Consideration for surgery does require the use of advanced imaging techniques to detect and define structural lesions and these techniques are specifically allowed at this point. Since these imaging studies are only useful for detecting surgically treatable conditions they are not appropriate prior to this point since surgery is not the initial treatment option. The eight to twelve week time frame for consideration of surgery is consistent with part 5221.6100, subp. 2, items A and B, which provide that CT scans and MRIs are not indicated in the first eight weeks after an injury, absent specified symptoms. Likewise diagnostic blocks and injections are also allowed at this time, if needed, to help isolate which structural lesions seen on imaging studies are related to the patient's symptoms.

Subitem 4. The latest research in low back pain indicates that psychosocial factors play a very large part in determining who has chronic long term disabling back pain.^{1-3,8,10,27,77} Health care providers are therefore encouraged to consider psychosocial problems at this time in those

patients who have not improved as would be expected according to the natural history of the condition.

Subitem 5. Because of the consideration of surgical treatment and investigation of psychosocial factors, it is likely that specialty consultants may be necessary in order to develop the most appropriate treatment plan.

Subitem 6. Consistent with the recommendations of the MSRB and surgeons, the rules limit surgical intervention to arthrodesis procedures (fusions) and decompressions of lumbar nerve roots. Allowance is also made for dorsal column stimulators and morphine pumps for patients with previous failed back surgery. If surgery is the treatment of choice then it should be scheduled without any unnecessary delay. Once it has been determined that surgery is required, timely scheduling is appropriate to facilitate recovery as soon as possible. The surgical procedure must meet the specific requirements of part 5221.6500 and subpart 6.

Item C. The parameters also anticipate that some patients will not improve with surgery or will not be considered surgical candidates even though they have ongoing symptoms. Some further care is necessary in these cases. Again, however, the natural history of the condition is extremely important in determining what is reasonable and appropriate care for patients who have chronic symptoms of low back pain. It is the consensus of the Medical Services Review Board that treatment at this juncture should change in focus from attempts to cure or completely relieve the symptoms of low back pain, to attempts to rehabilitate the patient who is expected to continue to have low back pain complaints according to the natural history of the condition.^{7,10,27,77} The health care provider is therefore directed to consider a program of chronic management according to the parameters of 5221.6600.

Subpart 12. Specific treatment parameters for radicular pain. This subpart outlines the course of treatment for patients with radicular pain with no or static neurologic defect. This treatment involves the same three phases of treatment in the same order as indicated for regional low back pain.

Item A. The consensus of received opinion and the recommendation of the MSRB indicate that patients with non-progressive radicular pain should be treated conservatively in a manner consistent with the treatment for regional low back pain with some specific exceptions.^{8,10,15,22,78} The injections indicated for radicular pain only are epidural and nerve root blocks.^{5,10,77} These injections are directed at the anatomical structure presumed to be responsible for the radicular symptoms. For those patients who have both radicular pain and regional low back pain, the injections for regional low back pain may be used in addition to those for radicular pain, as indicated by standard medical practice.

Item B. Patients who fail conservative therapy should be considered for surgery in a manner consistent with the procedures for regional low back pain. The same types of surgery are permitted.

Item C. Some patients will develop chronic radicular problems despite all other appropriate conservative and surgical treatment and will require chronic management. These patients should be cared for according to the parameters of 5221.6600.

Subpart 13. Specific treatment parameters for cauda equina syndrome and radicular pain with progressive neurologic deficits. This subpart outlines the course of treatment for patients with progressive radicular pain or cauda equina syndrome. Treatment for these conditions may be dramatically different than that for patients with radicular pain with no or static neurologic defect depending on the severity of nerve involvement.^{2,8,10,15,22,78}

Item A. These patients may need early surgical intervention in order to provide the best possible care because the conditions may result in permanent incapacitating nerve damage with loss of sensory, motor and anatomic function. Therefore surgical evaluation and surgery are allowed at any time, based on the provider's best clinical judgment for each employee.

Item B. The health care provider can certainly elect a course of non-surgical care but it must meet the same guidelines as for other clinical categories of low back pain. If the provider has decided against early surgery, the condition is presumed to be no more severe than radicular pain with no or static neurologic defect and should be treated similarly.

Item C. If at the end of that course of initial non-surgical management and surgery or surgical evaluation the patient is still disabled from vocational and other activities then a period of chronic management may be indicated.

Part 5221.6205. NECK PAIN.

These parameters represent the appropriate approach to the entire episode of care for a patient with a new neck injury. As with low back conditions, the rules begin with parameters outlining the appropriate history, physical examination, and diagnostic work up. The rules then set out the initial approach to the patient with subsequent follow up, surgical treatment as needed, and rehabilitation if necessary. The rules for neck pain follow the same format as the rules for low back pain, and because the neck is part of the spine (cervical), are in many cases, identical to the low back parameters. Therefore, the rationale for identical rules is not repeated, and the reader is referred to the corresponding low back rule.

Subpart 1. Diagnostic procedures for neck injuries.

Item A. The clinical categories represent a distillation of numerous recommendations in medical literature for grouping neck conditions.^{10,79-81} They bring together specific diagnoses which share common diagnostic and therapeutic approaches. They were modelled after the clinical categories used in the low back pain parameters, where feasible. The categories were reviewed extensively by the medical community and were approved by the Medical Services Review Board. Please refer to Part 5221.6200, subpart 1, item A for further discussion of the components of this rule.

Item B. Laboratory tests. See discussion under 5221.6200.

Item C. Imaging. See discussion under 5221.6100, subp. 1. The Department and MSRB have not yet developed specific rules for imaging neck disorders. Therefore, until developed, only the general imaging rules in subpart 1 apply.

Item D. EMG and nerve conduction studies. See discussion under 5221.6200, subp. 1(D).

Item E. Miscellaneous tests. See discussion under 5221.6200, subp. 1(E).

Item F. Computerized testing. See discussion under 5221.6200, subp. 1(F).

Item G. Personality or psychosocial evaluations. See discussion under 5221.6200, subp. 1(G).

Item H. Diagnostic blocks or injections. See discussion under 5221.6200, subp. 1(H).

Item I. Functional capacity assessment. See discussion under 5221.6200, subp. 1(F).

Item J. Consultations. See discussion under 5221.6200, subp. 1(J).

Subpart 2. General treatment parameters for neck pain.

Item A. As with low back pain, this item sets out the format of the parameters for treatment of neck pain: rules for assigning a clinical category, general parameters for modalities and specific parameters for each clinical category.

Item B. This paragraph outlines the general approach to be taken with neck pain patients. As with other back pain, it is assumed that in most cases the entire episode of care can be divided into three phases.^{10,80-83} The first phase is non-surgical management, except where progressive neuropathy or myelopathy requires urgent evaluation. It is expected that the majority of patients will improve with conservative care. The natural history of neck pain is similar to low back pain.^{10,81} It is expected that some patients will not improve with non-surgical management, and therefore these patients must be re-evaluated and a decision must be made regarding invasive therapy. Even though these patients have not improved with non-surgical management it is not likely that all will be candidates for surgical management. For those who are surgical candidates, surgery should be done expeditiously and proper follow-up given to maximize success rates. For the others who are not surgical candidates, alternative forms of treatment will be needed. Since these patients did not respond to traditional conservative management and now have chronic neck pain, simply continuing the treatments provided in the initial period will not be cost effective. The natural history of neck pain indicates that these individuals are likely to have permanent or long term chronic complaints and that attempts at cure will be unsuccessful. Therefore, at this point the focus changes from cure to rehabilitation and the alternative modalities of treatment indicated are the techniques of rehabilitation medicine. Cure is aimed at the eradication of all symptoms and the restoration of pre-injury/illness function; rehabilitation accepts the presence of chronic symptoms and permanent impairments and is aimed at maximizing independence and performance within that context. This approach to treatment of neck pain is approved by the Medical Services Review Board.

Item C. This item reflects the standard medical practice of consultation between health care providers. That is, a provider need not wait until initial non-surgical treatment is completed before referring the employee for a second opinion where a complication or other uncertainty exists.

Subpart 3. Passive treatment modalities. Passive treatment modalities applied to the neck are subject to the same indications and limitations as when applied to other areas of the spine, such as the lumbar spine.^{10,80,81} See discussion under 5221.6200, subp. 3.

Subpart 4. Active treatment modalities. Active treatment modalities applied to the neck are subject to the same indications and limitations as when applied to other areas of the spine, such as the lumbar spine.^{10,80,81} See discussion under 5221.6200, subp. 4.

Subpart 5. Injections can be useful in the treatment of neck pain as adjuncts to passive and active modalities during the period of non-surgical management.^{10,81-83} See discussion under 5221.6200, Subp. 3 and 5. Sacroiliac injections are not included because they are anatomically specific to the low back.

Subpart 6. Surgery.

Item A. A period of post-operative treatment with active and passive modalities is the current standard of care in the community and these recommendations represent the consensus of medical expertise and the recommendations of the Medical Services Review Board.

Item B. Repeat surgery must meet the same criteria as first surgery, but must be confirmed by second opinion. Repeat surgery has a lower success rate than original surgery and often involves complicated pathophysiology.

Item C. These spinal implant treatment modalities have very limited application. They are used to treat the symptom of pain rather than the underlying condition. The parameters for the use of these specialized techniques represents the consensus opinion of medical experts involved in the use of these devices, the manufacturers of these devices, and the Medical Services Review Board.

Subpart 7. Chronic management. See discussion under 5221.6200, subp. 7.

Subpart 8. Durable medical equipment. See discussion under 5221.6200, subp. 8. This subpart differs from the low back parameter only in that prior notification of the insurer is not required for cervical traction, as it is for low back traction, because cervical traction does not require costly equipment.

Subpart 9. Evaluation of treatment. See discussion under 5221.6050, subp. 1(B).

Subpart 10. Medication. See discussion under 5221.6200, subp. 10.

Subpart 11. Specific treatment parameters for regional neck pain. See discussion under 5221.6200, subp. 11. Regional neck pain is similar to regional low back pain in severity and types of treatment modalities used in accepted medical practice.

Subpart 12. Specific treatment parameters for radicular pain, with no or static neurologic changes. See discussion under 5221.6200, subp. 12. This category of diagnoses is similar in severity and types of treatment modalities used to treat radicular pain caused by low back

injuries.

Subpart 13 and Subpart 14. Specific treatment parameters for radicular neck pain with progressive neurologic changes and specific treatment parameters for myelopathy. These conditions are equivalent in severity and urgency to radicular low back pain with progressive changes and cauda equina syndrome and require the same level of intensity in treatment and the same latitude in arranging the components of case.^{10,80} Again the concern is for the possibility of severe, and in this case wide spread, neurologic damage that can affect sensory, motor and autonomic function in both the upper and lower body. See discussion under 5221.6200, subp. 13.

Part 5221.6210. THORACIC BACK PAIN.

These parameters represent the appropriate approach to the entire episode of care for a patient with a thoracic back injury. As with the low back and neck sections, the rules begin with parameters outlining the appropriate history, physical examination, and diagnostic work up. The rules then set out the initial approach to the patient with subsequent follow up, surgical treatment as needed, and rehabilitation if necessary. Because the thoracic back injury is injury to another part of the spine, the parameters are very similar to the parameters for treatment of injuries to the neck and low back areas.¹⁰ Where the rules are the same as for low back, the rationale is not repeated.

Subpart 1. Diagnostic procedures.

Item A. See discussion under 5221.6200, subp. 1. The clinical categories consist of diagnoses unique to the thoracic spine, but the other requirements remain the same as for low back and cervical injuries.

Item B. Laboratory tests. See discussion under 5221.6200, subp. 1(B).

Item C. Medical imaging. See discussion under 5221.6205, subp. 1(C).

Item D. EMG and nerve conduction studies. Electrophysiologic testing of the thoracic nerves and nerve roots is technologically difficult and diagnostically suspect. It is not routinely done by electromyographers, and was not considered acceptable medical practice by commentators or the MSRB.

Item E. Miscellaneous tests. See discussion under 5221.6200, subp. 1(E).

Item F. Computerized testing. See discussion under 5221.6200, subp. 1(F).

Item G. Personality or psychosocial evaluations. See discussion under 5221.6200, subp. 1(G).

Item H. Diagnostic blocks or injections. See discussion under 5221.6200, subp. 1(H).

Item I. Functional capacity assessment. See discussion under 5221.6200, subp. 1(I).

Item J. Consultations. See discussion under 5221.6200, subp. 1(J).

Subpart 2. General treatment parameters.

Item A. Overview of rules. See discussion under 5221.6200, subp. 2, item A.

Item B. Three phases of treatment. This paragraph outlines the general approach to be taken to thoracic back pain patients. It is assumed that in most cases the entire episode of care can be divided into three phases. The first phase is non-surgical management. It is expected that the majority of patients will improve with conservative care. It is recognized that some patients do not improve with non-surgical management, and therefore, these patients must be re-evaluated and a decision must be made regarding invasive therapy. Even though these patients have not improved with non-surgical management it is not likely that all will be candidates for surgical management. For those who are surgical candidates, surgery should be done expeditiously and proper follow-up given to maximize successes. For others who are not surgical candidates, alternative forms of treatment will be needed. Since these patients did not respond to traditional conservative management and now have chronic thoracic back pain, simply continuing the treatments provided in the initial period will not be cost effective. The natural history of thoracic back pain indicates that these individuals are likely to have permanent or long term chronic complaints and that attempts at cure will be unsuccessful. Therefore, at this point the focus changes from cure to rehabilitation and the alternative modalities of treatment indicated are the techniques of rehabilitation medicine. This approach to treatment of thoracic back pain is approved by the Medical Services Review Board.

Subpart 3. Passive treatment modalities. Treatment modalities applied to the thoracic back area are subject to the same indications and limitations as when applied to other areas of the spine, such as neck and lumbar spine.¹⁰ See discussion under 5221.6200, subp. 3.

Subpart 4. Active treatment modalities. Treatment modalities applied to the thoracic back area are subject to the same indications and limitations as when applied to other areas of the spine, such as neck and lumbar spine.¹⁰ See discussion under 5221.6200, subp. 4.

Subpart 5. Therapeutic injections. Injections can be useful in the treatment of thoracic back pain as adjuncts to passive and active modalities during the period of non-surgical management.¹⁰ See discussion under 5221.6200, subp. 3 for the treatment response periods and maximum treatment frequency and duration and subp. 5 for items A to C. Sacroiliac injections are not included here because they are anatomically limited to the low back.

Subpart 6. Surgery.

Item A. A period of post-operative treatment with active and passive modalities is the current standard of care in the community and these recommendations represent the consensus of medical expertise and the recommendations of the Medical Services Review Board.

Item B. Repeat surgery must meet the same criteria as first surgery, but must be confirmed by a second opinion, if requested by the insurer, due to the higher rate of unsuccessful repeat surgeries and completed pathophysiology.

Item C. Dorsal column stimulators and morphine pumps have very limited application. They are used to treat the symptom of pain than the underlying condition. The parameters for the use of these specialized techniques represents the consensus opinion of medical experts involved in the use of these devices, the manufacturers of these devices, and the Medical Services Review Board.

Subpart 7. Chronic management. See discussion under 5221.6200, subp. 7.

Subpart 8. Medical equipment. See discussion under 5221.6200, subp. 8.

Subpart 9. Evaluation by health care provider. See discussion under 5221.6050, subp. 1(B).

Subpart 10. Medication. See discussion under 5221.6200, subp. 10.

Subpart 11. Specific parameters for regional thoracic back pain. Regional thoracic back pain is similar in severity and types of treatment modalities used, based on accepted medical practice, to regional low back pain. See discussion under 5221.6200.

Subpart 12. Specific parameters for radicular thoracic back pain. Thoracic back pain with radicular symptoms is similar in severity and types of treated modalities used, based on accepted medical practice, to low back pain with static neurologic changes. Progressive radicular syndromes do not occur within the thoracic area due to the limited function of thoracic nerves. See discussion under 5221.6200.

Subpart 13. Myelopathy. Myelopathy is equivalent in severity and urgency to cauda equina syndrome and requires the same level of intensity of treatment and the same latitude in arranging the components of care. See discussion under 5221.6200, subp. 13.

Part 5221.6300. UPPER EXTREMITY DISORDERS.

These parameters represent the appropriate approach to the entire episode of care for patients with selected upper extremity disorders. This part begins with parameters outlining the appropriate history, physical examination, and diagnostic work up. It then sets out the initial approach to the patient with subsequent follow up, surgical treatment as needed, and rehabilitation if necessary.

Subpart 1. Diagnostic procedures.

Item A. As with any patient, a history and physical and diagnosis is required before initial treatment. The clinical categories represent kinds of conditions that can affect the upper extremity; many of these conditions can occur as the result of cumulative trauma but can have other causes as well.^{84,85} The clinical categories group together specific diagnoses which share common therapeutic approaches. The clinical categories were reviewed extensively by the medical community and were approved by the Medical Services Review Board. The ICD-9 codes are developed by the World Health Organization to be used as an internationally standardized system for diagnosis.

The clinical categories represent the most commonly occurring disorders of the upper extremity. They are not exhaustive of all upper extremity disorders. Nor are the clinical categories mutually exclusive as in the neck, thoracic, and low back pain parameters. A patient may simultaneously have conditions properly assigned to different clinical categories, or other conditions, some of which can be assigned to a clinical category and some of which cannot. When a clinical category can be applied, the appropriate parameter governs the treatment of that condition. The rules are specifically addressed to typical workers' compensation upper extremity disorders.

Typical conditions are excluded, as are fractures, amputations and injuries with complete tissue description; the range and severity of these conditions is too great to encompass in the rules.

Subitem 1. Epicondylitis is an inflammation of the attachment of the forearm musculature to the humerus due to repetitive stress, or contusion. Medial and lateral epicondylitis have similar etiologies, treatment and prognosis.

Subitem 2. Tendinitis distal to the elbow is a group of disorders that can be caused by repetitive use of the wrist and hand, and have similar treatment and prognosis.

Subitem 3. Nerve entrapment syndrome includes carpal tunnel syndrome and other less frequent chronic compression syndromes of the nerves of the arm which can be caused by repetitive pressure on the nerve or repetitive use of surrounding anatomic structures which in turn compress the nerve. Similar treatment approaches are used for all of the conditions in this category: initial attempts to relieve compression with conservative treatment, followed by surgical release if initial treatment is unsuccessful.

Subitem 4. Muscle pain syndromes group together all conditions of the muscles of the upper extremity which can be the result of repetitive use. Conditions which arise entirely as the result of a single trauma are grouped together in subitem 6. Muscle pain syndromes share a similar etiology, prognosis, and treatment which is distinct from the other clinical categories.

Subitem 5. Shoulder impingement syndromes all share the same etiology; they are caused by compression of the soft tissues of the shoulder between the bones of the shoulder during movement. In all cases, treatment is directed at both the consequences and the underlying cause.

Subitem 6. Muscles and ligaments can be injured by sudden stretching. All of these types of injuries are grouped together in this category since the etiology and treatment are the same. Injuries in which the muscle or ligament has been completely torn are excluded since the range of severity and treatment is not uniform.

Item B. The prescribed use of laboratory tests reflects common practice and the opinion of the Medical Services Review Board. Laboratory tests should be used to follow-up diagnostic possibility raised by the history, physical examination, or other testing; they should not be ordered routinely without regard to the specific condition of the employee.

Item C. See discussion of medical imaging in part 5221.6100, subp. 1. Again, routine

medical imaging is not appropriate as a substitute for a history and an examination of the employee.

Item D. The recommendations regarding electrodiagnostic testing reflect common medical practice in the opinion of the Medical Services Review Board. Only conditions affecting the nerves of the arm can be detected by these techniques, so they are limited to nerve entrapment syndromes.

Item E. No consensus of expert opinion indicated any utility for the listed conditions.

Item F. It was the consensus of the MSRB that these procedures are an integral part of the physical examination and not separate diagnostic tests.

Item G. In general these rules attempt to limit specialized testing to special circumstances. The proliferation of this kind of technology into the initial care of persons with an upper extremity disorder is not cost effective. These specialized techniques are appropriately confined to those individuals who do not follow the usual natural history of the disorder. These recommendations were approved by the Medical Services Review Board and physical therapy experts. These tests are inaccurate during the acute stage of injury because the level of pain is expected to decrease with treatment. They are specifically allowed as a part of chronic management under part 5221.6600.

Item H. The medical literature indicates the importance of psychosocial problems in individuals who do not improve within the usual natural history of upper extremity disorders.⁸⁵ These recommendations encourage health care providers to look for these problems which may interfere with recovery and address them in order to maximize the employee's recovery. These recommendations were approved by the Medical Services Review Board.

Item I. These recommendations reflect common medical practice, which is to limit diagnostic injections to only those cases where surgery is anticipated, the employee has failed to improve, or diagnosis is difficult. In other cases less invasive means of diagnosis are preferred, such as imaging.

Item J. The components of a functional capacity assessment were developed in consultation with occupational and physical therapy experts, and reflect national standards. As with computerized testing, these evaluations are expensive and are therefore not indicated during the initial non-surgical care of the acute injury because most recover with initial non-surgical care. It is the opinion of the MSRB and physical and occupational therapy experts that the physician directing the care during the initial non-surgical management should be able to determine the employee's capabilities during the acute phase of the injury. Therefore, only when the employee's condition has stabilized, and the employee's abilities are still unclear, is a functional capacities evaluation appropriate.

The functional capacities evaluation is not appropriate to establish baseline performance, because these are typically unnecessarily used to track the level of improvement, and the treatment plan is not dependent on the baseline results. A functional capacities evaluation is an end point evaluation to establish final activity abilities, and therefore only one is authorized per

injury.

Item K. This item reflects that consultation with experts may be a valuable diagnostic tool.

Subpart 2. General treatment parameters for upper extremity disorders.

Item A. This item provides an overview and instructions for the use of the general and specific parameters and directs the health care provider to the appropriate specific rules for specific clinical categories. It also reminds the provider to reassess the appropriateness of the clinical category and make changes in treatment as the clinical category is changed. This reflects common medical practice. A change in clinical category does not allow the health care provider to repeat treatment already given unless it is directed to a previously untreated anatomic structure. Many modalities have wide anatomic application and are general treatments for a variety of conditions, e.g. hot packs. A hot pack to the arm would treat all existing tendon, muscle, nerve disorders in the area of application. A change of diagnosis from tendinitis of the forearm to muscle pain syndrome of the arm would not require another course of heat treatment since both structures have already been treated.

Item B. This paragraph outlines the general approach to be taken to patients with upper extremity disorders. It is assumed that in most cases the entire episode of care can usually be divided into the same three phases used for back disorders. The first phase is non-surgical management, and it is expected that the majority of patients will improve with conservative care. It is expected that some patients will not improve with non-surgical management, and therefore these patients must be re-evaluated and a decision must be made regarding invasive therapy. Even though these patients have not improved with non-surgical management it is not likely that all will be candidates for surgical management. For those who are surgical candidates, surgery should be done expeditiously and proper follow-up provided. For the others who are not surgical candidates, alternative forms of treatment will be needed. Since these patients did not respond to traditional conservative management and now have chronic pain, simply continuing the treatments provided in the initial period will not be cost effective. The natural history of chronic pain indicates that these individuals are likely to have permanent or long term complaints and that attempts at cure will be unsuccessful. Therefore, at this point the focus changes from cure to rehabilitation and the alternative modalities of treatment indicated are the techniques of rehabilitation medicine. This approach reflects the medical literature, common medical usage, and is approved by the Medical Services Review Board.^{84,85}

Item C. This item reflects the appropriate use of consultations in treatment.

Subpart 3. Passive treatment modalities. This subpart thus sets out the definitions and conditions of use of the passive treatment modalities. These modalities may be used in combination or in sequence during the period of non-surgical management. The particular arrangement of modalities is at the discretion of the treating health care provider to provide maximum flexibility in designing a treatment plan responsive to the needs of the individual employee. None of these modalities may be used in a clinical setting for more than 12 weeks during the period of initial treatment. This reflects the natural history of upper extremity disorders in which most individuals are better in eight to 12 weeks.^{84,85} Since these treatments are directed at patients in the initial phase of treatment, if they have not had a positive effect in

the first eight to 12 weeks, they are not as effective as "no treatment." Patients who have failed to respond either have a problem requiring surgery or have developed a chronic condition more appropriately treated by rehabilitation.

During the initial period when the majority of patients are expected to have full resolution of symptoms, treatment is aimed at cure. Treatment that does not provide a cure fails to meet the goals of treatment in the initial period; some other form of treatment should be tried in order to affect a cure. If all conservative treatment fails then surgery may be able to cure the condition. If neither conservative management nor surgery can cure the condition, these patients are very likely to have chronic pain which will never be cured. Rehabilitation is the appropriate treatment in these situations.

For each of the modalities the MSRB established a time for treatment response, a maximum treatment frequency, and a maximum treatment duration using the format developed by the North American Spine Society.⁵ The time for treatment response is the duration or number of treatments required to determine whether the treatment is going to be effective. After this duration or number of treatments there should be some improvement documented in the employee's symptoms, physical findings, or functional ability to indicate that the treatment is being effective. The maximum treatment frequency specifies the intensity with which the modality may be used. In many cases modalities are appropriately used at high frequency initially and then with decreasing frequency thereafter as the patient improves. If the intensity cannot be reduced then the treatment is not effective. Finally, the maximum duration specifies the total amount of calendar time over which this modality can be applied. This is determined at least in part by the natural history of upper extremity disorders. In some cases certain modalities are limited by side effects.

Item B. This item allows additional passive care beyond 12 weeks to be provided under specified circumstances. The 12 week passive care parameter in the emergency rules initially recommended by the Medical Services Review Board has been the subject of considerable controversy and debate. Therefore, the Department brought the issue back to the MSRB for further review, and the Board suggested that a group of health care providers and others knowledgeable in this aspect of workers' compensation be consulted on the various passive care proposals, to provide the commissioner and the MSRB with advice on the issues. Participants included a representative of the Minnesota Chiropractic Association; an employee; a self-insured employer; the Department's medical consultant; and three members of the Medical Services Review Board: a physical therapist, a neurologist and an occupational medicine physician. Also present were staff of the Department of Labor and Industry and a facilitator from the state Department of Administration. The names of the participants are attached in Appendix 4. This group met throughout the day on February 24, 1994. A consensus recommendation emerged from this process, which reflects sound medical and chiropractic practice, while addressing the concerns of employers and employees. This recommendation, reflected in item B, was considered an appropriate modification by the Medical Services Review Board and the Commissioner.

Item B specifies the two circumstances under which passive treatment beyond the 12 weeks is appropriate. As previously noted, most injuries resolve with non-surgical care; and most employees whose injuries have not resolved require rehabilitation with chronic management

modalities. However, one of the primary goals of the workers' compensation system is to return the employee to work. Accordingly, under subitem 1, unit (a), if the employee has been released to work 12 additional passive care visits are allowed over an additional year to facilitate the return to work process. An additional 12 visits for passive care is also allowed under unit (a) in cases where the injury is serious enough that the employee is permanently totally disabled and unlikely to ever return to work, if the additional treatment is necessary to maintain function in activities of daily life.

Unit (b) provides that the additional 12 visits may not be given on a regularly scheduled basis, for example in order to extend the initial 12 continuous weeks of passive care. Rather, the treatment must be specifically tailored to the minimum amount needed to maintain function and employability. Regularly scheduled visits do not allow for an individual "need based" assessment, and may discourage employees from taking independent self-care measures or even from being careful not to overexert, thus causing reinjury.

Unit (c) requires the health care provider to document employee independence and decreased reliance on health care providers. During the return to work process additional treatment is intended to facilitate employment. As discussed under item B above, long term passive care has not been shown to increase the function or pain level, to the extent function is a measurement of pain. Accordingly, for long term care the chronic management modalities, which promote employee independence, are appropriate rather than continuous professional clinical intervention.

Unit (d) requires that the additional treatment must include active treatment, such as exercise. This reinforces concepts included elsewhere in the rules, such as Subpart 5 and the chronic management section in part 5221.6600. Exercise has been shown to be a key factor in the successful long term management of an musculoskeletal injury.^{7,8,10,27,39,40,41}

Units (e) and (f) require that the structure of the rules, requiring three stages of treatment, be adhered to, because consideration of alternative treatment and early intervention with chronic management modalities is important. Ongoing passive care is contraindicated and cannot be substituted were surgery or chronic pain treatment is necessary.

Item C. Adjustment or manipulations. This refers to all types of chiropractic and osteopathic manipulations or adjustments. These limitations apply to any kind of practitioner using these types of treatments. The recommendations as to time for treatment response and optimum treatment frequency reflect recommendations in the chiropractic literature and the recommendations of the Medical Services Review Board. The maximum treatment duration reflects the natural history of upper extremity disorders and the recommendations of the Medical Services Review Board.

Item D. Thermal treatments. These limitations were approved by the Medical Services Review Board. The second paragraph of this part indicates that the patient may use thermal modalities at home without any limitation as part of a program of self-care. Throughout these rules self-care by the patient is promoted. This frees the patient of dependency on health care providers and is cost effective so long as the quality of care provided by patients to themselves is at least as good as that provided by health care providers. In this situation it is clear that with training during the in-clinic phase of treatment, and with appropriate medical devices, the patient

can provide self-care which is at least as good as that given by the health care provider. In fact, the patient is in a position to provide better health care since treatments can be given more often and as needed, as opposed to on a scheduled basis at the health care providers office.

Item E. Electrical muscle stimulation. See discussion under item D.

Item F. Acupuncture. These recommendations reflect the opinion of the Medical Services Review Board. Very little medical literature is available on the cost effective application of acupuncture. Expert opinion was relied on.

Item G. Phoresis. Phoresis treatments are used to deliver steroid medication to injured soft tissues by means of ultrasonic pressure or electric gradient. These limitations reflect current practice in Minnesota and the recommendations of the Minnesota Physical Therapy Association. They were approved by the Medical Services Review Board. They are based on concern for the development of local side effects with prolonged administration of steroids, such as thinning of the skin and weakening of tendons.

Item H. Manual therapy. See discussion under item C.

Item I. Splints, braces and casts. Like prolonged rest, prolonged bracing can be detrimental to the patient's long term prognosis.^{84,85} These recommendations reflect the opinion of the physical therapy community and were approved by the Medical Services Review Board.

Item J. Rest. Prolonged immobilization of extremities can have deleterious side effects. These rules are designed to provide appropriate rest of injured tissues while minimizing adverse side effects.^{84,85}

Subpart 4. Active treatment modalities. This subpart sets out the definitions and conditions of use of the active treatment modalities. These modalities may be used in combination or in sequence with each other and with passive treatment modalities (subp. 3), injection modalities (subp. 5), and medication (subp. 10) during the period of non-surgical management. The particular arrangement of modalities is at the discretion of the treating health care provider, depending on the symptoms, physical signs and preferences of the patient. Promotion of patient education and exercise is cost effective because such self-care is often as effective as clinical intervention. Self-care emphasizes patient independence and responsibility for symptom control and reinjury prevention.

Item A. Education. The medical literature indicates that education about the key elements of upper extremity disorders is important to recovery and prevention of reinjury, which is a significant problem in workers' compensation. Three visits is thought to be the maximum amount needed to teach the employee about anatomy, physiology, posture, biomechanics, and relaxation. These recommendations reflect the consensus of experts in the community and were approved by the Medical Services Review Board.

Item B. Posture and work method training. This item allows training on posture and biomechanics for specific work activities. This is included to allow additional training that will assist the employee in returning to work and preventing reinjury, which is key in workers'

compensation.

Item C. Worksite analysis. Early return to activity has been shown to be important for a successful outcome of treatment. Worksite analysis and modification encourages early return to work. This is a cost effective intervention and reflects the consensus of expert opinion in the community and the recommendation of the Medical Services Review Board.

Item D. Exercise. The recommendations here reflect the current practice in the community and the consensus of the medical experts in the community. These recommendations were approved by the Medical Services Review Board. Again self-care is emphasized, because the success of an exercise program depends on employee motivation. Objective evaluation and initial education is necessary to track the employee's initial progress and at specified intervals to facilitate employee motivation. However, indefinite education and objective evaluation is inappropriate. Ultimately the success of the program must depend on the employee.

Subpart 5. Therapeutic injections. Certain injections can be useful in the treatment of upper extremity as adjuncts to passive and active modalities during the period of non-surgical management. The injections listed are those recommended by the medical community, represented in the medical literature, and reviewed and approved by the MSRB.

Subpart 6. Surgery. For patients who do not improve with initial management, subsequent evaluation may reveal a condition treatable by surgery. A period of post-operative treatment with active and passive modalities is the current level of care in the community and these recommendations represent the consensus of medical expertise, and the recommendations of the Medical Services Review Board.

Subpart 7. Chronic management. Some patients will not improve with surgery or will not be candidates for surgery despite ongoing symptoms. These patients have conditions that require a different treatment approach. Further management of these patients is based on rehabilitative techniques applicable to chronic conditions as covered by the parameters of 5221.6600.

Subpart 8. Durable medical equipment. This sets out indications and limitations on the use and prescription of durable medical equipment. Durable medical equipment is indicated when it promotes self-care at home and the patient's independence from in-clinic treatment. However, domestic equipment and furniture prescribed purely for convenience or enhanced comfort are not medically necessary. Prior notification is required for items B and C because these are costly items.

Item A. Splints, braces, straps or supports may be prescribed at any time without limitation and can be used during initial management. These assist in keeping the employee functional and help prevent reinjury as the employee's activity level improves.

Item B. Electric stimulation and mechanical traction devices may be prescribed for a preliminary period to determine efficacy in relief of pain for the patient. If these modalities are useful they may be continued. Again, these modalities facilitate employee independence in controlling pain. The insurer can provide equipment comparable to that prescribed by the health care provider; this is allowed to control long term costs through large purchasing agreements.

Item C. Purchase of exercise equipment is limited to the period of chronic management. Since most individuals improve with non-surgical management, with types of exercise that do not require expensive equipment, and some of those who do not will improve with surgical management, it is not cost effective to purchase durable medical equipment for exercise prior to the patient entering into a program of chronic management. In chronic management it is expected that the patient will require exercise and conditioning for long periods of time. One option for reconditioning is a home exercise program supported with appropriate home exercise equipment. Once the patient is entered into such a program, the insurer is given the opportunity to provide the most cost effective piece of equipment and to utilize resources available at the employee's place of employment, if such is available and appropriate. This is allowed to control long term costs through large purchasing agreements or by avoiding duplication of investments. Specific documentation of the need for the equipment, the exercise activity and the goals is required to minimize unstructured and unnecessary prescription of costly equipment.

Item D. Certain medical equipment and furniture is not considered appropriate medical treatment for upper extremity conditions. These kinds of equipment are listed. These limitations represent the consensus of the treatment community and the Medical Services Review Board.

Subpart 9. Evaluation of treatment. This part specifies how the health care providers evaluate the effectiveness of treatment. Health care providers are asked to assess the treatment plan at each patient visit; this represents current clinical practice. In regard to the passive, active, and injection modalities of subpart 3, 4, and 5, the assessment of the modality must be done no later than the time for treatment response. Treatment and modalities are evaluated according to three criteria: the patient's subjective symptoms, the physical findings on examination, and the patient's functional status. Explicit directions are provided for documenting changes in these criteria. Treatment or a modality is effective if it results in ongoing and progressive improvement in two of these three criteria.

If treatment or a modality is not effective it should be stopped or modified since it is not promoting improvement in the patient's condition.

The treating health care provider may delegate the evaluation of a treatment or modality to another health professional. For example, a physician could ask a physical therapist providing hot pack treatments to assess their effectiveness. However, the treating health care provider remains responsible for assuring that the evaluation is performed and appropriate action is taken since the treatment is being provided under his/her overall direction. More detailed discussion of this rule is found in part 5221.6050, subp. 1(B).

Subpart 10. Scheduled and non-scheduled medication. This subpart outlines the indications and limitations for use of scheduled medications. It limits the use of narcotics to cases of severe pain, which are unusual in the listed upper extremity disorders. This subpart allows that the use of non-scheduled medications such as non-steroidal anti-inflammatory medication, may be appropriate at any time during the treatment and even after clinical treatment has been discontinued. Health care providers must demonstrate that the most cost effective regime is used--it may not be cost effective to prescribe medication in lieu of other treatment that would enable the employee to work.

Subpart 11. Epicondylitis. This subpart outlines the course of treatment for patients with epicondylitis. It indicates that in general patients will have a period of non-surgical management first, then diagnostic evaluation and surgical management if indicated, and finally chronic management if all else fails. The general parameters in subpart 3 to 10 are coordinated with these specific parameters. These specific recommendations represent the opinion of the MSRB and community experts.

Item A. The initial non-surgical management can include passive, active, injection, equipment and medication modalities. This allows the health care provider a great deal of flexibility in designing a treatment program unique to each patient. The use of passive modalities in a clinic setting or requiring attendance by a health care provider is limited to a period of 12 weeks. However, home use of modalities may continue for up to 12 months. This is based on the natural history of the condition which indicates that healing is slow and progress is not affected by further use of passive treatment in clinic. The useful passive and active modalities can be continued at home. As in other conditions active treatment such as education and exercise must be provided after the first week, because it is essential to full recovery.

Item B. If after 12 months of non-surgical management the patient continues to have symptoms and disability then surgical treatment can be considered. Invasive treatment is delayed because of the potential for delayed healing without surgery and the unpredictable response of this condition to surgery. As in other conditions, once the surgery is indicated it should be performed promptly. Diagnostic testing that has not already been performed may be an appropriate part of the surgical work-up. However, because healing is generally slow in these conditions repeat testing is unnecessary absent an objective change in the condition.

Item C. If the patient fails to improve with surgery or is not a surgical candidate then chronic management, with a focus on rehabilitation rather than cure, is indicated according to part 5221.6600.

Subpart 12. Tendonitis. This subpart specifies the course of treatment for tendonitis conditions. The outline of treatment is the same as for epicondylitis with certain specific exemptions. Patients with DeQuervain's syndrome, trigger finger or locked digits may go to surgical management earlier than 12 months; if their conditions do not respond quickly to conservative management they are not likely to improve without surgery. In addition, these exceptions are disabling conditions in which the surgery is a relatively minor procedure. Early surgery is efficient and cost-effective.

Subpart 13. Nerve entrapment syndromes. This outlines the treatment for patients with nerve entrapment syndromes. Again the pattern of treatment is similar to that for epicondylitis. Here the major difference is that the entire period of initial non-surgical management is reduced to 12 weeks and is coincidental with the period in which passive treatment modalities may be used. Similar to DeQuervain's syndrome, trigger finger, or locket digit, if conservative management is not successful early it is not likely to be successful if continued longer. Prolonged nerve compression can lead to permanent nerve damage and excessive disability. Early surgery is prudent and cost effective.

Subpart 14. Muscle pain syndromes. This sets out treatment for patients with muscle pain

syndromes. The pattern of treatment for these conditions is different than for epicondylitis, tendinitis, or nerve entrapment. No surgery is indicated for the treatment of these conditions. Treatment begins with a period of initial non-surgical management lasting up to 12 months. The use of passive modalities in a clinic setting is limited to 12 weeks; after that initial non-surgical management is based on self-care at home. These conditions are persistent and characterized by slow healing requiring prolonged courses of stretching and exercise which can be done at home. If after 12 months, the condition has not improved, chronic management is indicated.

Subpart 15. Shoulder impingement syndromes. This subpart outlines the course of treatment for patients with shoulder impingement syndromes. These conditions follow a pattern similar to epicondylitis but with shorter time lines. In these cases initial non-surgical management is indicated for up to six months. Passive use of modalities is limited to the first 12 weeks; after that initial non-surgical management is based on self care at home. After six months, the patient should be considered for surgery. If the patient fails surgery or is not a surgical candidate then chronic management is indicated. Two exceptions are allowed to this course of treatment; for patients with acute traumatic tear of the rotator cuff or acute rupture of the proximal biceps tendon immediate surgery may be indicated.

Subpart 16. Traumatic sprains and strains. This subpart outlines the course of treatment for patients with traumatic strains and sprains. The pattern of treatment is similar to muscle pain syndrome but with shorter time lines. These conditions usually heal quickly; therefore, initial non-surgical management is limited to 12 weeks. There are no proven surgical therapies unless there is complete tissue disruption. Cases with complete tissue disruption are not covered by these rules. If disability continues after 12 weeks of non-surgical management, chronic management is indicated.

Part 5221.6305 REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER AND LOWER EXTREMITIES.

These parameters represent the appropriate approach to the entire episode of care for patients with reflex sympathetic dystrophy (RSD), which is a complication of upper and lower extremity injuries. The parameters outline the appropriate history, physical examination and diagnostic findings in patients with reflex sympathetic dystrophy (RSD). The parameters then set out the initial approach to treatment, the indications for surgery, and referral to chronic management, if necessary.

Subpart 1. Scope.

Item A. Clinical categories. The patient's condition must meet these criteria to be treated under these parameters. The criteria are clinical indicators of RSD and are drawn from the medical literature⁸⁴⁻⁸⁸ and the expert opinion in the medical community. They are also the criteria for RSD used in the permanent partial disability schedule. (see, Part 5223.0400, subp. 6; 5223.0410, subp. 7; 5223.0420, subp. 6; and 5223.0430, subp. 6).

Item B. RSD is a special complication of extremity injuries. It occurs sporadically and unpredictably but is extremely disabling and has a very poor prognosis if not properly treated. The appearance of RSD requires a specific course of treatment for the RSD separate from the treatment that may have been given or will be given to the original injury. A diagnosis of RSD

does allow the health care provider to repeat certain modalities which may already have been used, but only for the part of the body affected by the RSD. For example, if an employee has bilateral arm injuries, but only one develops RSD, then only the arm affected by RSD may receive additional treatment under this item.

Item C. Since RSD can involve dysfunction in the control of local skin temperature, examination of the skin temperature can be indicated in the diagnosis and follow-up RSD. This can be accomplished by traditional physical examination techniques, such as touch, or thermography can be substituted. Since thermography is being substituted for part of the examination already incorporated into the office visit, no separate reimbursement is allowed.

Subpart 2. Initial non-surgical management. All patients with RSD begin with non-surgical management; treatment during this phase is limited to the passive, active, and injection modalities listed.⁸⁴⁻⁸⁸ The modalities listed and the indications for their use represent the consensus opinion of the MSRB after reviewing recommendations and comments from experts in the medical community.

Item A. Therapeutic injections. Since inappropriate and continuous activity of the sympathetic nerve is the underlying problem in RSD, blockade of that nerve activity is essential to relief of the syndrome.⁸⁴⁻⁸⁸ If counter stimulation fails to block sympathetic activity (Item B) then injection of an anaesthetizing agent is necessary if there are substantial functional limitations. Injections should be repeated until the condition resolves or until there is no further improvement with successive injections. This represents the medical literature, received opinion from experts in the medical community, and the opinion of the Medical Services Review Board.

Item B. Passive treatment. Only these four passive treatment modalities are believed to be effective in the treatment of RSD. This represents the medical literature,⁸⁶⁻⁸⁸ received opinion from experts in the medical community, and the opinion of the Medical Services Review Board. The treatment response, frequency and duration times are the same as for upper extremity disorders, as established by the MSRB based on the format developed by the North American Spine Society.⁵

Subitem 1. Thermal treatment reduces subjective discomfort, improves local blood flow, and helps, with active exercise, to reverse functional loss.

Subitem 2. Desensitizing procedures reduce discomfort and act as counter stimulation to reduce excess sympathetic activity.

Subitem 3. Electrical stimulation reduces discomfort and acts as counter stimulation to reduce excess sympathetic activity.

Subitem 4. Acupuncture reduces discomfort and acts as counter stimulation to reduce excess sympathetic activity.

Item C. Active treatment. Exercise not only helps to limit and reverse functional loss but also acts as a powerful counter stimulation to reduce excess sympathetic activity. As with the other conditions in these rules, exercise is essential to recovery and therefore must be included

after the first week of treatment.

Item D. Oral medication. No limits are placed on the use of medications because of the range of severity and anatomic/physiologic involvement in RSD makes it difficult to predict accurately medication needs.

Subpart 3. Surgery. There are limited surgical options in RSD; these parameters represent the consensus of the Medical Services Review Board.

Item A. Sympathectomy is indicated only if sympathetic nerve interruption by injection has been effective, but the condition continues to relapse or the relief with injection was incomplete.

Item B. These treatment modalities have very limited application. They are used to treat the symptom of pain rather than the underlying condition. The parameters for the use of these specialized techniques represents the consensus opinion of medical experts involved in the use of these devices, the manufactures of these devices, and the Medical Services Review Board.

Subpart 4. Chronic management. If all else fails, patients will need chronic management for injury pain and limitation of functions. The focus of treatment changes from cure to rehabilitation at this point, as discussed more fully under other sections.

Part 5221.6400 INPATIENT HOSPITALIZATION.

Subpart 1. General Principles.

Items A and B. Rules for inpatient hospitalization were modeled after parameters currently being used in Washington State for workers' compensation.⁸⁹ These were also found to be compatible with those used in many private insurance schemes. Because many outpatient procedures are performed in hospitals, the rules only apply if the employee spends a night at the hospital. The rules require prior notification of the insurer for inpatient hospital admissions except in emergency situations. Emergency hospitalization is of course allowed without prior notification. The health care provider, however, is obligated to inform the insurer within 2 business days following an emergency admission. The existence of an emergency is subject to retrospective review; however, it is acknowledged that it may be necessary to hospitalize a person for evaluation or testing to diagnose an emergency condition. For example, chest pain may be a muscle spasm, heartburn, or an imminent heart attack.

Item C. Patients are allowed only ward or semi-private accommodations, as this is the accepted medical and general health insurance standard, absent a unique condition that requires a private room (for example, infectious isolation).

Item D. Hospital admission before elective surgical procedures is allowed only if medically necessary to stabilize the patient. In keeping with current medical and health insurance practice, pre-operative examination and work-up is almost always able to be done as an out-patient.

Item E. In keeping with current medical practices, hospitalization solely for bed rest, medication, or physical therapy is not indicated unless the patient is unable to perform the

activities of daily life and participate in their own treatment and self-care. In such cases, which are rare, the employee may need hospitalization for assistance with eating, toileting and other essential functions of living.

Items F and G. In keeping with current medical practice, discharge from the hospital must be at the earliest possible date consistent with proper health care, due to the extremely high cost of inpatient hospitalization. Further treatment will be provided in an outpatient setting or in a lower cost inpatient setting such as a nursing home or convalescent center.

The same prior notification procedures are required for admission to a convalescent center or a nursing home.

Subpart 2. Specific requirements for hospital admission for patients with low back pain. These parameters are also modeled after those used in Washington state for workers' compensation patients.⁸⁹ They represent current medical practice and the consensus of the Medical Services Review Board. For patients who have incapacitating pain as evidenced by their inability to perform self-cares, hospitalization may be appropriate for specific treatment directed at controlling the pain and allowing patients to resume self-care. The rule requires that intensive medical intervention must be necessary for mobilization. This is because less intensive measures can be obtained on an outpatient or home treatment basis and hospitalization would be unnecessary for this level of care. Hospitalization is limited to those needing intensive medical care for basic functioning.

Items B, C and D. Hospitalization for patients with low back pain is also indicated for appropriate surgery and for the evaluation and treatment of cauda equina syndrome or progressive neurological deficit since emergency surgery may be required in either of these cases.

Part 5221.6500. GENERAL PARAMETERS FOR SURGICAL PROCEDURES.

General parameters are provided for all surgical procedures. Due to the high cost of surgery and hospitalization, all elective inpatient surgeries require prior notification. This correlates with all non-emergency inpatient hospitalizations, which also require prior notification. For emergency surgery, post-operative review will be done to determine reasonableness and necessity. As with hospitalization, emergency surgery may include surgery that is necessary to determine whether an emergency situation exists.

Subpart 2. Spinal surgery. Specific requirements for various spinal surgery procedures are provided. They are modeled after protocols used in Washington State for workers' compensation patients.⁹⁰⁻⁹² They have been reviewed and approved by the Medical Services Review Board after solicitation of extensive comments from the medical community, and reflect accepted surgical practice in Minnesota. For each surgical procedure the rules stipulate the diagnosis for which these procedures are appropriate and the indications in those diagnoses for which these procedures are reasonable and necessary treatment. The indications refer to necessary clinical findings, medical imaging findings, and response to previous treatment.

Subpart 3. Upper extremity surgery. This subpart provides specific requirements for

certain selected surgical procedures of the upper extremity.^{92,93} See discussion under subpart 2.

Subpart 4. Lower extremity surgery. This subpart provides specific requirements for certain selected surgical procedures of the lower extremity.^{92,94} See discussion under subpart 2.

Part 5221.6600 CHRONIC MANAGEMENT.

This part lists the modalities used in the third phase of treatment for individuals who did not improve with initial non-surgical management, or surgical treatment, or who were not surgical candidates but have ongoing problems. For each of the modalities there is a descriptive definition which sets out the components of these rehabilitative programs. The program must have all of the components listed in the definition. Then there are indications for the use of this kind of modality which indicate which kinds of patients and under which circumstances these modalities are considered to be cost effective. Then there are specifications regarding the requirements of the program. These are particular conditions posed on the program in order to treat patients. Finally, there is the treatment period which sets out the intensity and duration of treatment for each of these modalities. The parameters represent the consensus of medical experts using these modalities along with the opinion of the Medical Services Review Board. All of these modalities are designed to make the patient independent in their own self-care by giving them the resources they need to deal productively with their underlying condition. The programs combine a program of physical conditioning with ancillary interventions to restore as much function as possible. It is not the intent of any of these modalities to cure or resolve the underlying problem but rather to rehabilitate the individual and return them to the maximum possible function.

Subpart 1. Scope. Chronic management is recommended for all physical injuries after all other specific treatment has been received.^{7,10,22,77,80,84,85,95} At this point, the patient is dealing with permanent impairments or chronic pain, or both. Continued treatment aimed at the original injury will not improve the patient's underlying condition; that has already been tried and has failed. So it is necessary to rehabilitate the patient, regardless of the nature of the original injury. Rehabilitation helps the patient recondition or deal with the impairment or live with the chronic pain.

The goals of chronic management were proposed by health care providers from chronic pain treatment programs and was adopted by the MSRB. It reflects the current philosophy of medical rehabilitation. Again, promotion of independence from providers is reflected in workers' compensation caselaw, and encourages the employee to manage the condition more effectively and quickly than in a clinical setting. The goal of improving function is self-evident.

Item A. Psychological evaluation may be indicated because chronic pain and impairment can both be complicated and exacerbated by psychological distress and disorder. Therefore it is important to address these issues in order to maximize the efficacy of treatment. This is another factor utilized by the WCCA in determining the reasonableness of treatment.

Item B. Treatment programs need to be individualized and more than one of the allowable modalities may be applicable. This allows maximum flexibility in designing an individualized treatment plan.

Item C. Experience with chronic pain shows that continued treatment with painkilling narcotics, injections or passive treatment modalities prevents significant improvement in functional status, without providing any long-term relief for the pain. In fact, some patients require increasing amounts of treatment the longer the treatment is passive in nature. The chronic management modalities provide relief by promoting increased activity, function and independence, consistent with the factors identified by the Workers' Compensation Court of Appeals in Field-Seifert v. Goodhue County, (WCCA, March 1, 1990); and Horst v. Perkins Restaurant, 45 W.C.D. 9 (1991).

Chronic pain is paradoxical in several respects. First, it is often not associated with obvious or demonstrable tissue pathology, or it persists long after normal healing would have occurred. Second, it gets gradually worse with prolonged rest rather than better, so that patients report a slow, steady decline in their condition over time if pain is allowed to limit activity. Third, the amount of passive treatment needed for pain relief either increases with time, or remains fairly constant at high levels in patients with chronic pain as opposed to diminishing requirements in typical acute pain.

Patients with chronic pain and physical impairment get gradually worse with time unless active treatments are initiated to counteract the loss of function. These active treatments, such as exercise, cannot only restore and maintain function but can provide pain control similar to that achieved with medication and passive treatment modalities.

Item D. Patients are referred for chronic management if all relevant, necessary, and appropriate acute treatment has been provided; therefore, no further diagnostic work-up is indicated.

Item E. Since rehabilitation and patient independence are goals of chronic management, the continued use of narcotics and other scheduled medications as pain killers are contraindicated for the reasons specified in item C.

Subpart 2. Chronic Management Modalities. This subpart specifies the indications for treatment of a chronic condition. Prior notification is required of health clubs, computerized exercise programs, work conditioning and work hardening programs, chronic pain programs and psychological treatment. These can be costly, and the need for and likely success of the programs may be difficult to establish.

Item A. Exercise performed by the patient is the key to most programs of chronic management. It counteracts the debilitating effect of the self-limiting of activity by chronic pain. It trains and conditions the body so as to overcome physical impairment. And it helps modulate pain thresholds. One to three visits for education and monitoring is thought by practitioners to be enough time to get the employee started on the program.

Item B. Some patients require exercise equipment and facilities not readily available for use at home, or for structured program for a limited time before graduating to a home program. In these cases, exercise is best done at a health club. The rule requires strict documentation of the goals of the program and documentation of attendance and progress. Experience has shown that many people have difficulty maintaining motivation. Requiring the provider to specify the

medical reconditioning goals, and the employee to document attendance is simply documentation of the treatment plan and progress to promote treatment only when it is needed and effective. The importance of documenting the treatment plan and details of what is to be accomplished at a health club is supported by Sheehan v. Perkins, (WCCA, July 22, 1993); and Johnson v. American Red Cross, (WCCA, June 3, 1993). The rule allows for treatment of 13 weeks, at which point the continuing need and employee compliance must be reevaluated. Allowing the use of an employer exercise facility is a cost-effective alternative to a health club membership fee and should not inconvenience the employee since it is located at the place of employment.

Item C. Some patients need intensive exercise of isolated muscle groups. This is best achieved using specialized therapy equipment which isolates the muscles needing exercise, stabilizes the rest of the body, and then allows carefully graduated and controlled exercise with quantitative feedback to the patient and therapist to guide the exercising. For the same reasons specified in item B, the rules require specific documentation of the medical goals and employee compliance.

Item D. The definition and goals of work hardening and work conditioning programs are derived from the guidelines of the Commission for the Accreditation of Rehabilitation Facilities (CARF), a national voluntary organization which establishes and enforces quality standards for physical rehabilitation. These national recommendations were modified for use in Minnesota workers' compensation by the Minnesota Physical Therapy Association and approved by the MSRB. The indications for work hardening and work conditioning are distinguished by documentation of the need for behavioral and vocational assistance. Since work conditions only addresses physical and functional needs, the more expensive work hardening is not needed unless behavioral and vocational needs are also documented.

Work hardening and work conditioning are specialized exercise programs which allow the patient to gradually acclimate to work activities, building up physical, behavioral, and psychological tolerance to work in controlled circumstances under the guidance and supervision of a trained therapist or interdisciplinary team. Again, specific documentation of indications and compliance is required. Since the purpose of these programs is to maximize the return to work, it is a necessary element of the program that work restrictions be identified at completion of the program. This also ensures that an additional charge may not be assessed for a functional capacity assessment under part 5221.6200, subp. 1, item I, which yields the same information.

Item E. The definition and goals of chronic pain programs are derived from the guidelines of CARF and Minnesota health care providers specializing in chronic pain treatment. Chronic pain treatment is a holistic approach to all of the problems created by chronic pain for patients with the most advanced and complicated problems. The definition of chronic pain is set forth in pat 5221.6040. The program requirements in item 2 reflect the current standard of chronic pain programs. It is important for both the physical and psychological conditions to be evaluated at the onset of treatment to tailor the treatment to the employee's underlying problems and to avoid misdiagnosis. The treatment periods in item 3 reflect the current standard duration of treatment for these programs. There is no indication that if an employee completes a pain management program, repeating the program will provide additional benefit. If the program was proving ineffective it should be discontinued before completion.

Item F. Individual or group psychotherapy is used to address the psychological complications of physical impairment or chronic pain. This treatment is not meant to resolve or treat pre-existing or concurrent psychological disorders but to remove or minimize any psychological barriers to recovery from the physical injury.

Part 5221.8900. DISCIPLINARY ACTION; PENALTIES.

Disciplinary Action. This part sets forth the administrative procedure for investigation of complaints and the application of discipline for medical providers under Minnesota Statutes § 176.103, which establishes a double track procedure depending on the nature of the violation.

Subpart 1. Discipline. This subpart sets forth the scope and statutory reference for disciplinary actions against health care providers. The two procedural tracks depend on whether the violation is for a treatment parameter in part 5221.6010 to 5221.6600 or other violation of the workers' compensation law, order or rule.

Subpart 2. Complaints. This subpart specifies that complaints about activities or services of rehabilitation providers shall be made in writing to the commissioner. This is because it is important to maintain documentation about the specific violation alleged and the attendant facts. However, because there are some people who are unable to submit a written complaint, the rules allow the agency to assist a complainant in the documentation. The proposed rule also specifies that presiding officials and other employees in the workers' compensation system may file a complaint, because often it is these people who become aware of a violation in the course of litigation or other assistance to the parties.

Subpart 3. Review and investigation. This subpart sets forth the standard that the commissioner shall review all complaints to determine if the complaint alleges a violation of the workers' compensation law, rules, or orders. In the process of an investigation, the commissioner may dismiss complaints or refer a matter outside the Department's jurisdiction to a forum or agency that has jurisdiction. For example, some cases are more appropriately addressed by the provider's licensing agency, particularly if the violation has implications outside the workers' compensation system. Most professional organizations, including the Minnesota Chiropractic Association, the Minnesota Medical Association and the Minnesota Physical Therapy Association have a peer review system. Therefore, the rules allow the agency to refer the matter for peer review in the course of an investigation.

Due to concern expressed by health care providers that good faith provision of treatment that is outside the treatment parameters may result in referral to a prosecuting authority for fraud, the rules clarify that delivery of treatment outside the parameters does not in itself equal fraud; rather the commissioner must suspect that the elements of theft or fraud have been met before referral to a prosecutorial agency.

The rule further identifies the two-track procedural system, set forth in Minnesota Statutes § 176.103, depending on the nature of the violation.

Subpart 4. Cooperation with disciplinary proceedings. This subpart sets forth the expectation that a health care provider who is the subject of a complaint investigated by the

commissioner shall fully cooperate with the investigation, including responding to questions raised in the course of the investigation and providing copies of records, reports, logs, data and costs and other information as requested by the commissioner. This is a reasonable condition of reimbursement from the workers' compensation system. There is no provision in Chapter 176 that allows health care providers to charge, or the commissioner to pay for the medical records needed to review the case when a provider is being investigated. Requiring a health care provider to cooperate does not, however, preclude representation by an attorney during the course of the investigation

Subpart 5. In-person meeting. This subpart sets forth the administrative procedure of scheduling a meeting as a method of conferring with the parties to a complaint when this is deemed appropriate for the clarification or settlement of issues. Such a meeting may be conducted for the purpose of obtaining information, instructing the parties to a complaint, or for the purpose of resolving issues. This is an important part of the process, either as part of the investigation, to educate the provider, to reach an agreement on the issues, or to narrow the issues for hearing. Proceeding directly to hearing in every case would be counter-productive, because it is anticipated that most providers will be able to reach an agreement with the agency on the conduct in question.

Subpart 6. Resolution by written agreement. This subpart sets forth the commissioner's authority to enter into stipulated agreements regarding discipline with complaint subjects in lieu of initiating contested case proceedings. Many conduct matters can be resolved through education or by agreement of the parties, and therefore provision is made for stipulated agreements and letters of instruction. This is consistent with a primary goal of the disciplinary system, which is to promote compliance with the workers' compensation laws and rules, not only to sanction.

Subpart 7. Inappropriate, unnecessary, or excessive treatment. This subpart governs the procedures for violation of the treatment standards under Minnesota Statutes § 176.103, subd. 2.

Item A. This sets forth the criteria for referral to the Medical Services Review Board for a hearing on whether the treatment was excessive. The first criterion is that the matter requires medical expertise beyond the agency's general scope; the reason for referring cases to the MSRB is because that Board is established to provide the Department with the medical expertise of its members.

The second element is, where possible, that a final determination must be made in the workers' compensation system that the medical treatment was excessive. Although Minnesota Statutes § 176.103 seems to suggest that the MSRB should view all such cases, the MSRB only meets for an evening once per month, and it would be impossible for them to consider all cases where excessive treatment is suspected. The Department of Labor and Industry receives an average of 436 medical requests per month, the majority of which involve the reasonableness of treatment. There remain a number of procedures in the workers' compensation system for determining these individual cases of excessive treatment.

For example, if an insurer suspects excessive treatment, its remedy is to deny payment

under Minnesota Statutes § 176.136, subd. 2 and 176.135, subd. 5. The employee or health care provider may then file a Medical Request or Claim Petition under Minnesota Statutes § 176.106; 176.305; or 176.2615. The rules therefore clarify the distinction between adjudicating the compensability of disputed medical treatment in a given case and sanctioning a health care provider for excessive treatment.

The third element, in subitem 3, requires a pattern of providing excessive treatment for three or more employees before referral is made to the Medical Services Review Board. This is consistent with the legislative intent that the disciplinary system not replace the adjudication of liability for medical treatment in a given case. The legislature did not intend, and the MSRB does not have the resources to initiate a hearing in every case where a compensation judge has denied payment for treatment based on the treatment rules. For instance, the health care provider may not have been familiar with the rules or there may have been good faith issues over the application of a departure from the rules. Sanctioning the health care provider absent a pattern is not a wise use of resources.

Item B. This specifies the statutory sanctions that may be imposed by the commissioner after a finding by the Medical Services Review Board of excessive treatment. Because there are likely to be so many fact specific cases, it is not possible to list with specificity when each of the sanctions may apply. However, it is clear from the rule that the sanction will be more severe with the severity of the violation.

Item C. This item references the health care provider's right to request that the Court reconsider the sanction, or to appeal the sanction in accordance with the statutory procedure. Including a reference to the statutory procedure is appropriate to inform health care provider's of these rights, since few providers have easy access to Minnesota Statutes.

Subpart 8. Violation of statutes and rules other than those involving inappropriate, unnecessary or excessive treatment.

This rule describes the second procedural track for sanctioning a health care provider, specifically when there is a violation of a statute or rule other than a treatment parameter. For example, rule 5221.4020 requires a health care provider to participate in return to work planning. Under Minnesota Statutes § 176.103, subd. 3, the hearing for failure to do so would first be held by an administrative law judge. After the hearing the Medical Services Review Board will decide the sanction. Again, this rule is included to clarify the difficult-to-comprehend statutory distinction between violations.

Subpart 9. Penalties. This subpart cross references other rules which provide for a penalty in specific circumstances. This rule is appropriate to inform health care providers of other sanctions and also to clarify that the sanctions are not mutually exclusive. For example, if a provider fails to provide a necessary report in a single case, the statutory penalty under Minnesota Statutes § 176.231 may be assessed. If a health care provider repeatedly refuses to file the report in a number of cases, the MSRB may elect a more serious sanction or even disqualify the provider from receiving payment for services under Chapter 176.

WORKERS' COMPENSATION
MEDICAL SERVICES REVIEW BOARD
APRIL, 1994

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Appendix 2

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Appendix 3

Legislative History

Senate File 1877, 1878, 1879 and 1880 were four separate workers' compensation bills authored by Senator Chmielewski, which were eventually consolidated into S.F. 2107. Senate File 1877 was the bill containing workers' compensation medical cost containment provisions, including the relative value fee schedule and managed care. Senate File 2107 was amended on the Senate floor to include the amendments to Minn. Stat. § 176.83, subd. 5, and was passed by the Senate on April 14, 1992. Senate File 2107 was signed by the Governor on April 28, 1992. Senate File 2107 was substituted for H.F. 1952 on the floor of the House and passed. Senate File 2107 is codified at Chapter 510 of the 1992 session laws.

Appendix 4

Passive Care Advisory Group Participants

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David Ketroser, M.D. - Neurologist; Member Medical Services Review Board

Steven Bolles, D.C. - Chairperson, Legislative Committee, Minnesota Chiropractic Association

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