11-1900-8006-1

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE-HEARINGS

FOR THE MINNESOTA DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Permanent Rules Relating to Workers' Compensation: Managed Care; Independent Medical Examination Fees; Rules of Practice; Relative Value Medical Fee Schedule and Medical Rules of Practice; and Independent Contractors (Minnesota Rules Chapters 5218, 5219, 5220, 5221, and 5224).	SECOND REPORT OF THE CHIEF ADMINISTRATIVE LAW-JUDGE RELATING TO RELATIVE VALUE MEDICAL FEE SCHEDULE AND MEDICAL RULES OF PRACTICE

The above-entitled matter came on for review by the Chief Administrative Law Judge pursuant to the provisions of Minn. Stat. 14.15, subds. 3 and 4, which provide:

> Subd. 3. Findinq of substantial change. If the [administrative law judge's] report contains a finding that a rule has been modified in a way which makes it substantially different from that which was originally proposed, or that the agency has not met the requirements of sections 14.131 to 14.18, it shall be submitted to the chief administrative law judge for approval. If the chief administrative law judge approves the finding of the administrative law judge, the chief administrative law judge shall advise the agency and the revisor of statutes of actions which will correct the defects. The agency shall not adopt the rule until the chief administrative law judge determines that the defects have been corrected.
>
> Subd. 4. Need or resonableness not established If the chief administrative law judge determines that the need for or reasonableness of the rule has not been established pursuant to section 14.14, subdivision 2, and if the agency does not elect to follow the suggested actions of the chief administrative law judge to correct that defect, then the agency shall submit the proposed rule to the legislative commission to review administrative rules for the commission's advice and comment. The agency shall not adopt the rule until it has received and considered the advice of the commission. However, the agency is not required to delay adoption longer than 30 days after the commission has received the agency's submission. Advice of the commission shall not be binding on the agency.

Based upon a review of the record in this proceeding, the Chief Administrative Law Judge hereby approves the Report of the Administrative Law

Judge in all respects.

In order to correct the defects enumerated by the Administrative Law Judge, the agency shall either take the action recommended by the Administrative Law Judge or reconvene the rule hearing if appropriate. If the agency chooses to reconvene the rule hearing, it shall do so as if it is initiating a new rule hearing, complying with all substantive and procedural requirements imposed on the agency by law or rule.

If the agency chooses to take the action recommended by the Administrative Law Judge, it shall submit to the Chief Administrative Law Judge a copy of the rules as initially published in the State Register, a copy of the rules as proposed for final adoption in the form required by the State Register for final publication, and a copy of the agency's Findings of Fact and Order Adopting Rules. The Chief Administrative Law Judge will then make a determination as to whether the defects have been corrected and whether the modifications in the rules are substantial changes.

Should the agency make changes in the rules other than those recommended by the Administrative Law Judge, it shall also submit the complete record to the Chief Administrative Law Judge for a review on the issue of substantial change.

Dated: October 26th 1993.

KEVIN E. JOHNSON
Chief Administrative Law Judge

11-1900-8006-1

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE MINNESOTA DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Permanent Rules Relating to Workers' Compensation: Managed Care; Independent Medical Examination Fees; Rules of Practice; Relative Value Medical Fee Schedule and Medical Rules of Practice; and Independent Contractors (Minnesota Rules Chapters 5218, 5219, 5220, 5221, and 5224).	SECOND REPORT OF THE ADMINISTRATIVE LAW JUDGE RELATING TO RELATIVE VALUE MEDICAL FEE SCHEDULE AND MEDICAL-RULES OF PRACTICE

The above-entitled matter came on for hearing before Administrative Law Judge Barbara L. Neilson on July 27, 1993, at 9:00 a.m. in Rooms C-14 and C-15 of the St. Paul Civic Center, 144 West Fourth Street, St. Paul, Minnesota. The hearing continued on July 28, 29, and 30, 1993.

This Report is part of a rulemaking proceeding held pursuant to Minn. Stat. □□ 14.131 to 14.20 (1992) to hear public comment, determine whether the Minnesota Department of Labor and Industry (hereinafter referred to as "the Department") has fulfilled all relevant substantive and procedural requirements of law applicable to the adoption of the rules, assess whether the proposed rules are needed and reasonable, and determine whether or not modifications to the rules proposed by the Department after initial publication are substantially different from those originally proposed.

Six separate sets of rules were consolidated for consideration in this rulemaking proceeding. The rules relate to the following subjects:

1. Independent Contractor Rules (Minn. Rules pt. 5224.0010);

2. Independent Medical Examination Fees (Minn. Rules pt. 5219.0500);

3. Managed Care Plans for Workers' Compensation (Minn. Rules pts. 5218.0010 through 5218.0900);

4. Relative Value Medical Fee Schedule (Minn. Rules pts. 5221.4000 through 5221.4070);

5, Medical Rules of Practice (Minn. Rules pts. 5221.0100 through 5221.0700);

6. Workers' Compensation Rules of Practice (Minn. Rules pts. 5220.0105 through 5220.2960.

Although, for convenience, the proposed rules were heard in a continuous proceeding, each set of rules is independent of and severable from the others. The First Report of the Administrative Law Judge dated October 4, 1993, encompassed the proposed rules relating to Independent Contractors, Independent Medical Examination Fees, and Managed Care Plans. This Second Report will encompass the Relative Value Medical Fee Schedule and the Medical Rules of Practice. The Workers' Compensation Rules of Practice will be discussed in a report to be issued at a later date.

Gilbert S. Buffington, Assistant Attorney General, 520 Lafayette Road, Suite 200, St. Paul, Minnesota 55155, and Penny Johnson, Assistant General Counsel, Department of Labor and Industry, 443 Lafayette Road, St. Paul, Minnesota 55155, appeared on behalf of the Department. The Department's hearing panels for the rules relating to the Relative Value Fee Schedule and the Medical Rules of Practice consisted of Leo Eide, Assistant Commissioner of the Department; Kathryn Berger, Attorney with the Department's Legal Services Division; Patricia "Kate" Kimpan, Acting Director of the Department's Research and Education Unit; Monica Ryan and Sandra Keogh, Medical Policy Analysts with the Department's Rehabilitation and Medical Affairs Unit; and William Lohman, M.D., Medical Consultant for the Department.

Approximately 150 persons attended the hearing and 138 signed the hearing register. Many of the attendees gave testimony about these rules. The Department submitted changes to the proposed rules at the hearing. The Administrative Law Judge received 20 agency exhibits and 5 public exhibits as evidence during the hearing. The hearing continued until all interested persons, groups or associations had an opportunity to be heard concerning the adoption of these rules,

The record remained open for the submission of written comments until August 19, 1993, 20 calendar days after the date on which the hearing concluded. Pursuant to Minn. Stat. 14.15, subd. 1 (1992), five working days were allowed for the filing of responsive comments. At the close of business on August 26, 1993, the rulemaking record closed for all purposes. The comment period set in this rulemaking proceeding is the maximum allowed under Minnesota law.

The Administrative Law Judge received numerous written comments from interested persons during the comment period. The Department submitted written comments responding to matters discussed at the hearing and comments filed during the 20-period. In its written comments, the Department proposed further amendments to the rules.

The agency must wait at least five working days before taking any final action on the rules; during that period this report must be made available to all interested persons upon request.

Pursuant to the provisions of Minn. Stat. 14.15, subd. 3 and 4, this Report has been submitted to the Chief Administrative Law Judge for his approval. If the Chief Administrative Law Judge approves the adverse findings of this Report, he will advise the agency of actions which will correct the defects and the agency may not adopt the rule until the Chief Administrative Law Judge determines that the defects have been corrected. However, in those instances where the Chief Administrative Law Judge identifies defects which

relate to the issues of need or reasonableness, the agency may either adopt the Chief Administrative Law Judge's suggested actions to cure the defects or, in the alternative, if the agency does not elect to adopt the suggested actions, it must submit the proposed rule to the Legislative Commission to Review Administrative Rules for the Commission's advice and comment.

If the agency elects to adopt the suggested actions of the Chief Administrative Law Judge and makes no other changes and the Chief Administrative Law Judge determines that the defects have been corrected, then the agency may proceed to adopt the rule and submit it to the Revisor of Statutes for a review of the form. If the agency makes changes in the rule other than those suggested by the Administrative Law Judge and the Chief Administrative Law Judge, then it shall submit the rule, with the complete record, to the Chief Administrative Law Judge for a review of the changes before adopting it and submitting it to the Revisor of Statutes.

When the agency files the rule with the Secretary of State, it shall give notice on the day of filing to all persons who requested that they be informed of the filing.

Based upon all the testimony, exhibits and written comments, the Administrative Law Judge makes the following:

FINDINGS OF FACT

Procedural Requirements

1. The Procedural Findings set forth in paragraphs I through 4 of the First Report of the Administrative Law Judge are hereby incorporated herein by reference.

Small-Business Consideration in rulemaking

2. Minn. Stat. § 14.115, subd. 2 (1992), requires state agencies proposing rules that may affect small businesses to consider methods for reducing adverse impact on those businesses. In its Notice of Hearing, the Department acknowledged that the relative value fee schedule and the Medical Rules of Practice would affect small business health care providers. The Department further contended that the proposed rules are exempt from the small business requirements under Minn. Stat. § 14.115, subd. 7. Subdivision 7(3)

exempts from the small business consideration requirements certain "service businesses regulated by government bodies for standards and costs, such as nursing homes, long-term care facilities, hospitals, providers of medical care, day care centers, group homes, and residential care facilities." Minn. Stat. 14.115, subd. 7(3) (1992). The Administrative Law Judge agrees that the proposed rules fall within this exemption because the Department regulates providers of workers' compensation services for both standards and costs.

Fiscal Note

3. Minn. Stat. 14.11, subd. 1 (1992), requires agencies proposing rules that will require the expenditure of public funds in excess of $100,000.00 per year by local public bodies to publish an estimate of the total cost to local public bodies for a two-year period immediately following adoption of the rules. In its Notice of Hearing, the Department stated that

the proposed Relative Value Medical Fee Schedule and Medical Rules of Practice will not require public spending greater than $100,000.00 in either of the two years following their promulgation. Ex. D. No one disputed the Department's assessment. The Administrative Law Judge concludes that the Department is not required to publish a fiscal notice under Minn. Stat. 14. 1, subd. 1 (1992).

Impact on Agricultural Land

4. Minn. Stat. 14.11, subd. 2 (1992), requires that agencies proposing rules that have a "direct and substantial impact on agricultural land in the stated comply with the requirements set forth in Minn. Stat. 17.80 to 17.84 (1992). Because the proposed rules will not have an impact on agricultural land within the meaning of Minn. Stat. 14.11, subd. 2 (1992), these provisions do not apply to this rulemaking proceeding.

Outside-Information-Solicited

5. During the past three years, the Department has published several notices in the State Register soliciting outside information and opinions. Three comments were submitted regarding the Medical Rules of Practice. Ex. F-3. Twelve comments addressing the Relative Value Medical Fee Schedule were received. Ex. F-4. One comment was submitted which appears to relate to the Department's emergency treatment standard rules. Ex. F-5. Rules relating to treatment standards are not included in this rulemaking proceeding.

In formulating the proposed rules, the Department conducted various studies and consulted with the Medical Services Review Board, an advisory group made up of medical providers, employers insurers, self-insurers, and a public member. Hearing Transcript at 371-73.1 Departmental representatives discussed drafts of the proposed rules with groups of health care providers, insurers, employers, and several professional organizations, including the Minnesota Medical Association, the Minnesota Chiropractic Association, the Physical Therapy Association, the Minnesota Hospital Association, and medical management and records organizations. T. 373. The Department also held open

meetings in Richfield, Minnesota, on July 16 and 17, 1992, to obtain input on changes or additions to any aspect of the workers' compensation rules. More than 25 members of the public made presentations at the open meetings. Ex. L.

Thirteen members of the Minnesota House of Representatives submitted a comment during the rulemaking process indicating, inter alia, that none of the proposed rules had been considered by the Advisory Council on Workers' Compensation. While the duties of the Advisory Council include advising the Department and carrying the purposes of Chapter 176, and the input of Council members could obviously be of assistance in establishing rule requirements, the Commissioner is not required by statute to submit proposed rules to the Advisory Council. lag Minn. Stat. □ 175.007 (1992).

Hereinafter, citations to the hearing transcript will be indicated by a reference to "T. [page number]."

Analysis_of the Proposed Rules

6. The Administrative Law Judge must determine, inter alia, whether the need for and reasonableness of the proposed rules has been established by the Department by an affirmative presentation of fact. The Department prepared a Statement of Need and Reasonableness ("SONAR") in-support of the adoption of each of the proposed rules. At the hearing, the Department primarily relied upon the SONAR for that rule as its affirmative presentation of need and reasonableness for each rule. Each SONAR was supplemented by the comments made by the Department at the public hearing and its written post-hearing comments.

The question of whether a rule is reasonable focuses on whether it has a rational basis. The Minnesota Court of Appeals has held a rule to be reasonable if it is rationally related to the end sought to be achieved by the statute. Broen Memorial Home v. Minnesota Department of human Services 364 N.W.2d 436, 440 (Minn. Ct. App. 1985); Blocher Qutdoor Advertising-Co. v. Minnesota Department of Transportation 347 N.W.2d 88, 91 (Minn. Ct. App. 1984). The Supreme Court of Minnesota has further defined the burden by requiring that the agency "explain on what evidence it is relying and how the evidence connects rationally with the agency's choice of action to be taken." Manufactured Housing Institute v. Pettersen, 347 N.W.2d 238, 244 (Minn. 1984). An agency is entitled to make choices between possible standards as long as the choice it makes is rational. If commentators suggest approaches other than that selected by the agency, it is not the proper role of the Administrative Law Judge to determine which alternative presents the "best" approach.

This Report is generally limited to a discussion of the portions of the proposed rules that received significant critical comment or otherwise need to be examined. Because some sections of the proposed rules were not opposed and

were adequately supported by the SONAR, a detailed discussion of each section of the proposed rules is unnecessary. The Administrative Law Judge specifically finds that the Department has demonstrated the need for and reasonableness of the provisions of the Relative Value Fee Schedule rules and Medical Rules of Practice that are not discussed in this Report by an affirmative presentation of facts, that such provisions are specifically authorized by statute, and that there are no other problems that prevent their adoption.

Where changes are made to the rule after publication in the State Register, the Administrative Law Judge must determine if the new language is substantially different from that which was originally proposed. Minn. Stat. § 14.15, subd. 4. The standards to determine if the new language is substantially different are found in Minn. Rules pt. 1400.1100. Any language proposed by the Department in the Relative Value Fee Schedule rules or the Medical Rules of Practice which differs from the rules as published in the State Register and is not discussed in this Report is found not to constitute a substantial change.

The Administrative Law Judge notes that several members of the public submitted comments which appear to relate to the Department's emergency treatment standard rules. Because the treatment standard rules are not at issue in this proceeding, those comments will not be discussed in the Reports issued by the Administrative Law Judge. In addition, a few commentators asked

the Judge to make determinations regarding coverage or reimbursement questions. It would not be appropriate for the Judge to address these matters.

Format of Rule Report

7. As discussed above, the proposed rules in this rulemaking proceeding are actually divisible into six disparate rules within five discrete rule sections. To retain some degree of control over the voluminous comments and myriad issues raised by the rules, both the Department and the Judge have treated each rule separately within this proceeding. This Second Report of the Administrative Law Judge will address, in separate sections, only the proposed rules relating to the Relative Value Medical Fee Schedule and the Medical Rules of Practice. A later report will discuss the Workers' Compensation Rules of Practice.

RULES RELATING TO RELATIVE VALUE MEDICAL-FEE SCHEDULE

Statutory Authority for the Proposed Relative Value Medical Fee Schedule Rules

8. The Department relies upon Minn. Stat. □□ 176.136 and 176.83, subd. 4 (1992), as its authority for promulgation of the rules relating to the relative value medical fee schedule. Minn. Stat. □ 176.136, subd. 1, authorizes the Commissioner to adopt rules establishing "procedures for determining whether or not the charge for a health service is excessive" and limiting "the charges allowable for medical, chiropractic, podiatric, surgical, hospital and other health care provider treatment or services" compensable under the workers' compensation laws. Minn. Stat. □ 176.136, subd. la (1992), specifically empowers the Commissioner to adopt a "relative value fee schedule":

> The liability of an employer for services included in the medical fee schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee, whichever is lower. The medical fee schedule effective on October 1, 1991, shall remain in effect until the commissioner adopts a new schedule by permanent rule. The commissioner shall adopt permanent rules regulating fees allowable for medical, chiropractic, pediatric, surgical, and other health care provider treatment or service, including those provided to hospital outpatients, by implementing a relative value fee schedule to be effective on October 1, 1993. The

commissioner may adopt by reference the relative value fee schedule adopted for the federal Medicare program or a relative value fee schedule adopted by other federal or state agencies. The relative value fee schedule shall contain reasonable classifications including, but not limited to, classifications that differentiate among health care provider disciplines. The conversion factors for the original relative value fee schedule must reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in effect. The

> reduction need not be applied equally to all treatment or services, but must represent a gross 15 percent reduction.
>
> After permanent rules have been adopted to implement this section, the conversion factors must be adjusted annually on October 1 by not more than the percentage change computed on Section 176.645, but without the annual cap provided by that section. The commissioner shall annually give notice in the State Register of the adjusted conversion factors. This notice shall be in lieu of the requirements of Chapter 14.

Minn. Stat. 176.83, subd. 4 (1992), confers upon the Commissioner the authority to adopt rules "establishing standards and procedures for determining whether or not charges for health services or rehabilitation services rendered under this chapter are excessive."

Based upon these statutory provisions, the Administrative Law Judge concludes that the Department has the statutory authority to adopt a Relative Value Fee Schedule for workers' compensation health care services charges.

Nature of the-Proposed Rules Relating to the Relative Value Medical Fee Schedule

9. The Department promulgated its first permanent rules setting forth a medical fee schedule in 1984, pursuant to authority granted by statute. In 1985, the governing statute was amended to allow the Department to annually update the permanent rules without going through formal rulemaking procedures. See Minn. Stat. 176.136, subd. 5. The Department has revised its maximum fee schedule each year since 1984. SONAR at 1.

In 1990, the Department conducted several studies to evaluate the effectiveness of the existing medical fee schedule in containing costs and to assess the likelihood that increased cost savings would be realized if a resource-based relative value fee schedule were implemented. The Department provided the following explanation of such an approach in its SONAR:

> A Resource-Based Relative Value Fee Schedule establishes maximum fees for medical services based on the value of the service in comparison to a standard or base service. The value of the service reflects the time and intensity of physician work expended in providing the service, as well as associated practice costs, such as overhead and malpractice expenses. The base service is assigned a relative value unit of 1.O. Service which require more medical resources than the base service are assigned

higher relative value units such as 2.0, while service which require fewer resources are assigned lower relative value units, such as 0.50.

The maximum fee for a service listed in a Relative Value Fee Schedule is determined by multiplying the relative value unit for the service by a dollar amount, referred to as a conversion factor. For example, if the conversion factor is set at $50.00, then the maximum fee

> for a service whose relative value unit is 1.0, is $50.00, while that for a service whose relative value unit is 2.0, is $100.00. The relative value units assigned to a given service are intended to be permanent, because the amount of provider resources required for the service, as compared to other services, is generally consistent over time . . . . By contrast, the conversion factor is intended to change over time.

SONAR at 4. In 1992, the Minnesota Legislature enacted legislation that directed the Department to implement a relative value fee schedule.

Proposed rules pts. 5221.4000 through 5221.4070 consist of new rules relating to the relative value fee schedule that are designed to replace the existing medical fee schedule. The services and procedures encompassed under the proposed rules are divided into four provider groups: medical/surgical; pathology/laboratory; physical medicine/rehabilitation; and chiropractic. The proposed rules include guidelines for application of the relative value fee schedule, a delineation of the employer's liability for services included in the fee schedule, and a formula for determining the payment limits under the relative value fee schedule and the conversion factor to be used. The proposed rules contain separate listings of procedure codes in the medical/surgical, physical medicine/rehabilitation, chiropractic, and pathology/laboratory classifications; a description of fee adjustments for services in each category and for certain services which combine professional and technical care; outpatient limitations for medical/surgical services; and rules pertaining to fees charged by pharmacies.

Modifications to the PropQsed Rules Made by the

10. At the time of and subsequent to the hearing on this matter, and after a review of all the written submissions, the Department has made three additional modifications to the proposed rules. These modifications are as follows:

> 5221.4041 FEE ADJUSTMENTS FOR PROFESSIONAL/TECHNICAL COMPONENTS FOR PATHOLOGY/LABORATORY SERVICES
>
> Subpart 1. General. Fees for pathology and laboratory services shall be adjusted when the

professional and technical components of the service are performed by different individuals or entities. The professional component of the service represents the care rendered by the health care provider, such as examination of the patient, performance and supervision of the procedure, and consultation with other practitioners. The technical component of the service represents all other costs associated with the service, such as the cost of equipment, the salary of technicians, and supplies normally used in delivering the service.

The maximum fee for the professional component of the service is calculated according to the following formula: Maximum fee = .75 25 x (total TVUs x CF). The billing

code for the professional component of the service is the specific procedure code plus the modifier 26.

The maximum fee for the technical component of the service is calculated according to the following formula: Maximum fee = _.25 .75 x (total RVUs x CF). The billing code for the technical component of the services is the specific procedure code plus the modifier TC.

5221.4034 FEE ADJUSTMENTS FOR MEDICAL/SURGICAL SERVICES

Subpart 1. Global surgery fee.

E. ZZZ: these procedures are part of other services and fall within the global definition of the major service.

5221.4070 PHARMACY

Subpart 1. Substitution of generically equivalent drugs. A generically equivalent drug as defined in Minnesota Statutes, section 151.21, subdivision 2, must be dispensed in place of the ordered drug if:

C. The charge for the substituted equivalent drug is less than the charge for the drug originally ordered.

The Department announced the modifications to parts 5221.4041 and 5221.4034 of the proposed rules at the hearing. These modifications were made in response to prehearing comments by Elaine McLinden and James M. Miller of StrategiCare Consulting Group and are necessary to correct errors in the proposed rules. The Department modified part 5221.4070 of the proposed rules to clarify that a generic drug does not need to be substituted unless its cost is less than that of the specific drug ordered. If the generic drug costs the same as the ordered drug, the ordered drug should be dispensed. These modifications were made to correct errors and to clarify the intent of the proposed rules. The Administrative Law Judge finds that the need for and reasonableness of these modifications has been demonstrated and that none of these modifications constitute a substantial change from the rules as initially proposed.

Overview of Appraoch taken by the Department

11. In these proposed rules, the Department seeks to replace its existing medical fee schedule, which is a charge-based schedule that sets the maximum price per service offered, with a resource-based relative value fee schedule. The relative value fee schedule proposed by the Department refers to the "CPT/HCPCS" code applicable to the particular medical service, article, or supply (i.e., a numeric code included in the Current Procedural Terminology Coding System manual or the United States Health Care Financing Administration's Common Procedure Coding System); contains a brief narrative

description of the medical service; identifies a "Tech/Prof. MOD," if applicable (i.e., the modifier for technical or professional components of the procedure); specifies the status of the service or article (i.e., indicates whether separate payment for that item is authorized); sets forth the total "RVU" (relative value units) assigned to the procedure; and identifies the "Global Period" applicable to the procedure (i.e.,-indicates whether the global surgery package applies).

As explained in its SONAR and at the hearing (see SONAR at 5-16 and T. 455-82), the Department took the following steps in formulating the proposed rules. First, the Department selected four provider groups: medical/surgical (services provided primarily by or under the direction of physicians and surgeons); physical medicine and rehabilitation (services provided primarily by or under the direction of physical therapists and occupational therapists); chiropractic (services provided by or under the direction of a chiropractor); and pathology and laboratory (services provided by a pathologist or technician working under the supervision of a physician). The Department then utilized a data base obtained from State Fund Mutual Insurance Company consisting of all bills submitted to State Fund Mutual between January 1, 1991, and June 30, 1991, to calculate a target expenditure for each provider group that reflected a fifteen percent overall reduction from the 1991 expenditures for that group. This was accomplished by applying the 1991 fee schedule to bills that fell in each of the four categories (taking into consideration the global surgical package and multiple procedure adjustment rules applied under the 1991 fee schedule), summing the payments at either the billed amount or the maximum amount under the 1991 fee schedule (whichever was lower), arriving at a total expenditure amount for each of the four groups, and then reducing that amount by fifteen percent to delineate a target expenditure amount for each of the four groups.

The Department next utilized the relative value units ("RVUs") established by Medicare for particular services or established new RVUs itself

under the methodology used by Medicare, where appropriate. The Medicare Fee Schedule contains RVUs for approximately 7,500 medical services and was developed after extensive research by the Harvard School of Public Health and the Health Care Financing Administration ("HCFA") of the U.S. Department of

2The Medicare relative value fee schedule includes RVUs for all of the services in the workers' compensation medical/surgical and physical medicine data bases. All of the most recent Medicare RVUs are included in the proposed rules with respect to medical/surgical and physical medicine services. The Medicare schedule, however, provides an RVU for only one chiropractic service and includes RVUs for only a small number of pathology/laboratory services. Accordingly, the Department was required to develop additional RVUs for chiropractic and pathology/laboratory services. SONAR at 8, 14, 16. To arrive at the RVUs for these services, the Department used charge data in the State Fund Mutual data base for these services and the methodology used by Medicare for calculating RVUs for services which were not individually surveyed. SONAR at 14, 16. Under this methodology, the median charge for each service in the data base was divided by the median charge for the base service, or anchor. The result was then multiplied by the total RVU for the anchor service to arrive at a RVU for all services in the proposed schedule. id.

Health and Human Services. The Department used the Medicare RVS which became effective on January 1, 1993, which are the most current RVUs available. For each included service, the Medicare schedule assigns RVUs for the three component parts of (1) practitioner work (the time, mental effort, stress, technical skill and physical effort involved in the service); (2) practice expense (overhead costs such as rent, staff salaries, equipment and supplies); and (3) malpractice insurance costs. The Department adjusted these RVUs for use in the Minnesota workers' compensation fee schedule through application of a geographic adjustment which used the same fo 3 mulae and values Medicare uses to determine actual Minnesota payment amounts. The Department calculated a total RVU for each service to be covered in the proposed rules by adding together the three geographically-adjusted component RVUS. This total RVU is listed in the Department's proposed relative value fee schedule.

The Department next calculated the conversion factor to be used, i.e., a dollar figure which, when multiplied by the RVUs for a particular service, would determine the maximum reimbursement amount for the service. With respect to its base group (the medical/surgical group), the Department determined, after assigning the geographically-adjusted Medicare RVUs to the workers' compensation services in the data base and applying the Medicare global surgery and multiple procedure adjustments, that the conversion factor should be $52.05. In essence, the Department applied the Medicare RVUs to the sample obtained from State Fund Mutual and solved for the conversion factor. The Department decided that a single conversion factor of $52.05 should be used for II provider groups rather than requiring the use of a separate conversion factor with respect to each of the groups. Therefore, the Department further adjusted the RVUs used for physical medicine, chiropractic services, and pathology and laboratory services in order to accommodate the use of a single conversion factor. The adjustment factor was 0.81 for physical medicine, 0.572 for chiropractic services, and 0.835 for pathology and laboratory services.

The RVUs contained in the relative value fee schedule proposed by the

Department have already been geographically adjusted. In addition, the RVUS for the physical medicine, chiropractic, and pathology/laboratory groups have already been adjusted to accommodate the single conversion factor. As a result, the values in the fee schedule can be multiplied by the $52.02 conversion factor to calculate the maximum reimbursable amount for services performed by each of the four provider groups.

The testimony and comments regarding the proposed rules focused upon several distinct issues. Each of these issues will be discussed in the Findings below.

3This adjustment was necessary because the average physicians' costs per medical services are slightly lower than the nationwide averages on which the Medicare RVUs are based. The Minnesota RVUs are approximately ninety-eight percent of the Medicare RVUS.

Targeted Reduction in Actual Costs

12. David Ketroser, M.D., representing the Minnesota Medical Association, and Joe Wild, a disabled employee who has been involved in the workers' compensation system, questioned whether the State Fund Mutual data base utilized by the Department was a statistically reliable sample of all workers' compensation claims. The Department indicated that State Fund Mutual accounted for approximately eight percent of Minnesota's insured workers' compensation market in 1991 and was the largest insurer of workers' compensation claims in Minnesota during that year. The Department reviewed all bills submitted to State Fund Mutual during a six-month period. SONAR at 9-10. More than 100,000 individual bills were involved. T. 468. The Department indicated that an eight percent sample "is a fairly large sample of data" and that it was a "sufficiently large sample to ensure that the bills [the Department] used were representative of the types and numbers of services typically provided in workers' compensation." It.; SONAR at 9. Susan Witcraft, the expert witness retained by the Minnesota Chapter of the American Physical Therapists Association, agreed that the State Fund data base "did not appear to be a biased data base" and "was sufficiently large [to be] representative." T. 579-80. Accordingly, the Department's use of the State Fund Mutual data base in formulating the proposed relative value fee schedule was not inappropriate.

13. The Minnesota Chapter of the American Physical Therapists Association (hereinafter referred to as MN-APTA), represented by Thomas E. Harms, Hessian, McKasy & Soderberg, presented testimony at the hearing and submitted post-hearing comments arguing that flaws in the Department's analysis and methodology undermined the legitimacy of the proposed relative value fee schedule. MN-APTA asserted through its expert actuary, Susan Witcraft, that the Department used the "wrong starting point" in analyzing the individual State Fund Mutual bills by using the lesser of the 1991 maximum fee schedule amount or the actual fee billed and that the reductions in fees imposed by the Department's proposed relative value fee schedule thus are more severe than the Legislature intended. MN-APTA contended that the Department

should have merely used the maximum fee schedule amounts when performing these underlying calculations. If the MN-APTA approach had been followed, the actual total expenditures and the resulting fifteen percent reduction expenditures (the "target" expenditures) in each category would have been higher, and the conversion factor selected by the Department to achieve the target expenditure also would have been higher. MN-APTA argues that the directive in Minn. Stat. 176.136, subd. la (1992), that "[t]he conversion factors for the original relative value fee schedule must reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in effect" clearly and unambiguously calls for the approach it promotes. Drs. Stark, Perra, Transfeldt and Akins agreed with the argument made by MN-APTA, as did Dr. Heithoff and John Penn of The Center for Diagnostic Imaging and Suzanne Veenhuis, Associate Legal Counsel, and Molly Sigel, Associate Director of State Legislation of the Minnesota Medical Association.

In response, the Department argued that it correctly applied Minn. Stat. 176.136, subd. la (1992), in calculating the fifteen percent reduction from the 1991 fee schedule by summing payments in the State Fund Mutual data base at either the maximum fee or the provider's actual charge and by applying other adjustments set forth in the fee schedule. The Department emphasizes that the statute does not refer to a reduction in the published maximum fees

but instead refers to a fifteen percent reduction from the "medical fee schedule" and mandates a "overall" reduction" and a "gross" reduction. The Department asserts that the 1991 medical fee schedule includes not only the published maximum fees but also rules of application that are necessary for determining the amount to be paid to the provider. The Department argued that an approach in which "real world" expenditures are-examined is necessary and appropriate, particularly where 4 roviders are required to bill their usual and customary amounts and frequently bill less than the maximum fee schedule amount. In support of its approach, the Department submitted a description of the history of the 1992 legislation, copies of portions of the minutes of the Senate Employment Committee, and several versions of the proposed relative value fee schedule legislation.

14. Minn. Stat. 176.136, subd. la (1992), provides in relevant part as follows:

> The liability of an employer for services included in the medical fee schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee, whichever is lower. The medical fee schedule effective on October 1, 1991, shall remain in effect until the commissioner adopts a new schedule by permanent rule. The commissioner shall adopt permanent rules regulating fees allowable for medical, chiropractic, podiatric, surgical, and other health care provider treatment or service, including those provided to hospital outpatients, by implementing a relative value fee schedule to be effective on October 1, 1993. The commissioner may adopt by reference the relative value fee schedule adopted for the federal Medicare program or a relative value fee schedule adopted by other federal or state agencies. The relative value fee schedule shall contain reasonable classifications including, but not limited to, classifications that differentiate among health care provider disciplines. The conversion factors for the original relative value fee schedule must reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in effect. The reduction need not be applied equally to all treatment or services, but must represent a gross 15 percent reduction.

(Emphasis added.) The statute unfortunately does not contain a definition of

" medical fee schedule." It is, however, clear that the statute is referring
to the 1991 medical fee schedule. The existing rules of the Department of
Labor and Industry relating to the 1991 fee schedule define "medical fee

4In its August 26, 1993, submission, the Department indicates that approximately forty percent of the charges in the State Fund data base for
medical/surgical, chiropractic, and physical medicine services were submitted
at levels below the maximum fee amounts.

schedule" to mean "the list of codes, service descriptions, and corresponding dollar amounts allowed under Minnesota Statutes, section 176.136, subdivisions I and 5, and parts 5221.1000 to 5221.3500." Minn. Rules 5221.0100, subp. 10 (1991). Minn. Rules pt. 5221.1000, subp. 3 (1991), specifies that "[t]he instructions in this part and this chapter govern the use and application of fees in this chapter." Among those instructions is the requirement in Minn. Rules pts. 5221.0500(D) and 5221.0700, subp. 1, that providers must submit their usual and customary charges in order to avoid a determination that the charge is excessive.

It is a well-established canon of statutory construction that, "[w]hen the words of a law in their application to an existing situation are clear and free from all ambiguity, the letter of the law shall not be disregarded under the pretext of pursuing the spirit." Minn. Stat. 645.16 (1992). The term "medical fee schedule" as used in the statute clearly refers to the Department's 1991 medical fee schedule, and the rules setting forth the 1991 schedule clearly incorporate the "usual and customary charge" restriction. The Administrative Law Judge concludes that the term "medical fee schedule" as used in the statute is unambiguous when viewed in the context of the underlying rules to which it refers. The statutory mandate to achieve "a 15 percent overall reduction from the medical fee schedule most recently in effect" requires a reduction in the actual amounts expended through application of the entire panoply of rules governing the application of that medical fee schedule, not merely a reduction in the 1991 published maximum amounts. As Administrative Law Judge Bruce D. Campbell held in a workers' compensation rulemaking proceeding earlier this year:

> The Department is not free to disregard the duty imposed upon it by the Legislature to reduce costs. The Department is not free to reevaluate the policy choices that are inherent in the legislative directive. Cost containment in the area of social benefit programs is a

well recognized and judicially sanctioned policy objective. King v. Smith, 392 U.S. 309, 334 (1967); Norton v. Weinberger, 364 F. Supp. 1117, 1129 (D. Md. 1973), vacated on other-grounds, 418 U.S. 902 (1974); Baker v. City of Concord, 916 F.2d 744, 751, 751 (lst Cir. 1990); Metrolina Family Practice Group v. Sullivan , 767 F. Supp. 1314, 1321 (W.D.N.C. 1989); Whitney v. Heckler, 780 F.2d 963, 969 (11th Cir. 1986); New York State Society- of Orthopaedic_Surgeons v. Gould, 796 F. Supp. 67, 74 (E.D.N.Y. 1992); Association of American Phvsicians and Surgeons v. Weinberger, 395 F. Supp. 125, 140 (N.D. Ill. 1975), aff'd, 423 U.S. 975 (1975).

5Minn. Rules pt. 5221.0700, subp. 1, provides that "[n]o provider shall submit a charge for a service which exceeds the amount which the provider charges for the same type of service in cases unrelated to workers' compensa- tion injuries." Minn. Rules pt. 5221.0500(D) specifies that a charge will be deemed excessive if it "exceeds the provider's current charge for the same type of service in cases unrelated to workers' compensation injuries

In the Matter of the Proposed Workers' Compensation Rules, OAH Docket No. 2-1900-7263-1 at 25 (Report issued May 11, 1993). The Department has shown that the methodology it employed in analyzing the State Fund Mutual data to arrive at target expenditures did not conflict with the governing statute.

Selection of Four Provider Groups

15. The Minnesota Medical Association expressed support for the Department's decision to apportion the fifteen percent reduction equally among the four provider groups identified by the Department (medical/surgical, physical medicine and rehabilitation, chiropractic, and pathology and laboratory). The Minnesota Chiropractic Association ("MCA") objected to the Department's decision to develop a separate fee schedule and different coding system for chiropractic services on the grounds that the Department's approach is unreasonable, arbitrary, and discriminatory. The MCA contends that the Department has unfairly abandoned its past practice of listing each provider group separately in the fee schedule in favor of its current approach, under which all health care provider groups other than chiropractors are allowed to bill under the physical medicine classification. In testimony at the hearing, Scott Mayer, Executive Director of the MCA, asserted that the chiropractic classification is not analogous to the others because it is the only one based upon the provider group rather than the service provided. The MCA indicated that the maximum rate at which chiropractors may be reimbursed for administering a hot pack is $10.93 compared to $18.74 for all other providers and contended that the maximum rate at which chiropractors may be reimbursed for manipulating a patient's spine is $22 compared to $168 for those seeking reimbursement under the medical/surgical classification. Mr. Mayer testified that the adjustments applied by the Department to the RVUs of chiropractic services are unreasonable because " there is no evidence indicating that the cost, education or expertise of all of the other providers exceeds that of a

chiropractor." T. 527; July 27, 1993, submission at 4. The MCA objected that the Department had singled out one provider group to receive reimbursements that are across the board lower than any other provider group. T. 528. The MCA later indicated that it is not opposed to " a reasonable 'adjustment factor' which establishes separate reimbursement fees for chiropractors so long as they are based on the value of the service as reflected by the time

and intensity of work in providing the service. August 17, 1993, submission of MCA at 3. The MCA asserted that twenty-four of twenty-five states with workers' compensation fee schedules that responded to a survey by the MCA permit chiropractors to obtain reimbursement under the same CPT codes used by other providers. Moreover, all states responding to the survey that use a relative value fee schedule reimburse identically for all provider groups providing the same service. The MCA urged the Department to eliminate the separate classification for chiropractic services and allow doctors of chiropractic to bill under the physical medicine classification.

The Department offered the following explanation for its decision to select the four provider groups:

> These four groups reflect rational, historical distinctions. The primary type of provider in each group corresponds to a separate health care discipline, or group of related disciplines, with distinctive identifying features, such as education and licensure requirements, individual professional association and unique statutory

> scopes of practice. Three of the four groups - physical and occupational therapists, chiropractors and physicians are presently listed as distinct provider groups in the existing fee schedule. Services by these providers constitute 97 percent of the workers' compensation nonhospital bills in the State Fund Data Base described below.

SONAR at 8. While the Department acknowledged that other provider groups could have been created and included as separate groups in the fee schedule, it indicated that all other providers collectively account for less than three percent of workers' compensation nonhospital billings and that the administrative burdens associated with such an approach would be extensive and would outweigh potential benefits to users of the fee schedule. Id.

The Department argued that it is reasonable to require that chiropractors share in the fifteen percent reduction on an equitable basis because they account for more than 38 percent of all non-hospital workers' compensation charges. Ex. R-7; Department's August 19, 1993, submission. The Department asserted that the vast majority of physicians' services will be billed under the medical/surgical and pathology/laboratory classifications and that the majority of services in the physical medicine category will be provided by physical therapists, who cannot bill under any other category. Id. With respect to the particular examples offered by the MCA, the Department indicated that the medical/surgical code for manipulation of the spine involved the manipulation of the spine in an open surgical procedure with the patient under anesthesia and thus is not analogous to the service performed by a chiropractor. The Department pointed out that regional manipulation under the physical medicine classification will result in a maximum reimbursement of $16, slightly less than the maximum reimbursement provided for chiropractors. T. 540-542. The Department admitted that there was a discrepancy in the maximum reimbursement applicable to the application of a hot pack under the physical medicine codes and under the chiropractic codes, but explained that the discrepancy is based upon actual charges by the two providers and reflects

historical distinctions in the marketplace. T. 529-532; Department's August 19, 1993, submission.

16. Minn. Stat. 176.136, subd. la (1992), specifies that the "relative value fee schedule shall contain reasonable classifications including, but not limited to, classifications that differentiate among health care provider disciplines." The Department has demonstrated that its selection of the four provider classifications was reasonably based upon the prevalence of services offered by such providers within the workers' compensation system and that the classifications chosen reasonably reflect the differing scope of practice of such providers. The Administrative Law Judge thus finds that the Department has shown the need for and reasonableness of its selection of the four classifications.

Selection of Single Conversion Factor for All Provider Groups and Adjustment of RVUs for Chiropractic Services. Physical Medicine--and Pathology and Laboratory Services

17. MN-APTA asserted that the Department, by adopting a single conversion factor and making an adjustment to the RVUS in the physical medicine codes, made an arbitrary change in the Medicare approach. Ms.

Witcraft asserted that the Department in so doing had introduced "a .81 MICOR [make it come out right] factor for physical therapists" and argued that this was an unjustified change in the Medicare RVU. T. 573. The crux of MN-APTA's disagreement with the Department's approach is not with the mathematics used by the Department but with the Department's policy decision to create separate budgets for each provider group. T. 584. In its lost-hearing submissions, MN-APTA argued that the Department did not adequately explain why it adjusted the Medicare program in a way that was economically prejudicial to the physical therapists and asserted that the approach was unreasonable, contrary to law, and reflected the Department's abandonment of the value differentials established by the Medicare program. MN-APTA further contends that the adoption of the adjustment factors is not justified by the permission given by the statute to differentiate among health care provider disciplines.

The Department pointed out during the hearing that, despite the reference in the statute to "conversion factors" in the plural, the agency decided for administrative convenience to use the conversion factor developed in the base medical/surgical group for all provider groups and make one-time adjustments to the RVUs of the other provider groups. T. 465-66. Ms. Kimpan explained:

> [T]hat adjustment has no effect in terms of what the maximum reimbursement for any particular service would be. What it means is the $52 conversion factor that we determined for med/surg is a higher conversion factor than these other groups would have attained on their own. so instead of adjusting the conversion factor for the other groups, we made that adjustment to the RVUs and have frozen that adjustment so that the $52 conversion factor can be used by all groups, and any inflation in the conversion factor into the future would then apply to all groups.
>
> It's important to note here that the relationships that HCFA has published within a particular provider group, the relationship of one physical medicine service to another is intact. It is indeed HCFA's relationship. The actual numbers are different to use the relatively high conversion factor accomplished with the medical/ surgical analysis. I will go into more detail about

> these, but in the big picture we set the conversion factor based on the bulk of the services, the medical/surgical, and then in order to use that conversion factor we adjusted the RVUs to accomplish the ability to use one for administrative ease.

T. 466-67. See also SONAR at 13, 15, 16.

In its post-hearing submissions, the Department contended that the RVU adjustments made in the proposed rules are reasonable and consistent with the requirements set forth in Minn. Stat. 176.136, subd. la (1992), that the relative value fee schedule contain reasonable provider classifications. The Department argued that, while the Legislature authorized the Commissioner to adopt the Medicare fee schedule, wholesale adoption of unadjusted Medicare RVUs was not possible given the statutory requirements that the schedule "contain reasonable classifications including, but not limited to

classifications that differentiate among health care provider disciplines" and utilize conversion factors that reflect a fifteen percent overall reduction from the 1991 medical fee schedule. The Department stressed that physical therapists comprise more than twelve percent of all non-hospital workers' compensation charges, have been assigned separate reimbursement categories in prior fee schedules, and have separate professional registrations and a unique scope of practice. Under these circumstances, the Department asserts that it is reasonable to consider physical therapists a separate provider group that should share equitably in the fifteen percent reduction.

18. The Administrative Law Judge concludes that the Department's decision to apply the fifteen percent reduction to each of the four major provider groups is a reasonable application of the statutory provision. The statute clearly authorizes the Department to utilize different conversion factors for the various classifications, thereby approving reimbursement distinctions between provider groups. The use of RVU adjustment factors for the non-medical/surgical groups accomplishes the same end result as the use of separate conversion factors for those groups, while having the advantage of allowing the Department and providers to use a single conversion factor each year. The Department's approach preserves the Medicare relative value relationships within each group. The Department has shown that the use of a single conversion factor for all groups and RVU adjustments for the non-medical/surgical groups is needed and reasonable and consistent with the authorizing statute.

19. Christopher Roe, Associate Counsel of the American Insurance Association, and Allan Syc, Assistant General Counsel of Kemper National Insurance Company, suggested that the conversion factor of $52.05 be reduced to make reimbursement in workers' compensation consistent with reimbursement levels in other major insurance programs. They pointed out that the conversion factor selected by the Department is sixty percent higher than the Medicare conversion factor and argued that, while the unique aspects of workers' compensation may justify a somewhat higher rate, the rate should be

lower than that set by the Department. The Department responded that it selected the single conversion factor of $52.05 in order to accomplish a fifteen percent overall reduction, as mandated by the Legislature. The approach urged by the AIA and Kemper would bring about a much more severe cost reduction that would not be consistent with the governing statute.

Adoption of RVUs and Global and Multiple Procedures Policies

20. The Minnesota Medical Association; William H. Call, M.D., Gary E. Wyard, M.D., and John A. Wilson, M.D., of Orthopaedic Consultants; L.L. Ault, M.D., of Orthopaedic Surgery; Diane Zoeller of Anesthesia Associates; Penny Scherkenbach of the Minneapolis Clinic of Neurology; and Kenneth B. Heithoff, M.D., and John C. Penn, President/CEO of The Center for Diagnostic Imaging ("CDI") objected to particular aspects of the proposed relative value fee schedule. The Minnesota Medical Association expressed serious concern that the fee schedule may not offer adequate reimbursement for a number of medical services and was particularly concerned about the cuts in physical medicine. Dr. Ault indicated that Medicare was an inappropriate fee schedule for workers' compensation. Drs. Wyard and Wilson asserted that the Medicare RVUs adopted by the Department are too low to adequately reimburse doctors for their services given the complex nature of the treatment and the additional administrative burdens imposed on workers' compensation providers.

Dr. Call argued that the adoption of the multiple procedures formula and the global pricing policy will have a severe impact on hand and upper extremity surgeons. He indicated that the application of the global pricing policy and the fee reductions will result in a twenty-five to thirty percent reduction in compensation for common hand and upper extremity procedures done by orthopedic surgeons and that, as a result of such reductions, many physicians will choose to cease their involvement in the workers' compensation system. He recommended that the RVUs for forearm, wrist and hand procedures be increased overall by fifteen percent to avoid a further reduction of already low fees and that the global pricing policy be restricted to fourteen days. Ms. Zoeller urged the Department to reevaluate the pain management codes and the RVUs assigned to them because they were grossly undervalued. Ms. Scherkenbach requested that the Department reconsider RVUs for certain procedures, reevaluate the physical medicine and rehabilitation procedure codes, and add additional pathology and clinic laboratory codes to the schedule. CDI estimated that more than a fifteen percent reduction is imposed with respect to certain radiological services.

The Department stressed in its post-hearinq response that the RVUs in the proposed rules were derived from the Medicare relative value fee schedule and that the Medicare schedule was adopted after extensive consultation with and surveys of orthopedic surgeons and other providers. The RVUs contained in the schedule resulted from efforts to reflect the resources that are necessary to provide a particular service. The Medicare RVUs relating to the physician work component were not based solely on Medicare covered services. Because the Medicare RVUs were developed as part of a single analysis and the values are related to each other, any changes made by the Department in one set of RVUs would necessitate changes in other values. The Department pointed out that the Legislature did not adopt Medicare's reimbursement rate, "perhaps because there is additional administrative activity required for workers' compensation patients." Department's August 19, 1993, submission. The Department further explained that the legislative mandate to achieve a fifteen

percent overall reduction from the 1991 medical fee schedule required the Department to adopt a conversion factor which differed from that used by Medicare. Id. Although particular services in the medical/surgical classification may not be reduced evenly, the statute specifically provides that the fifteen percent reduction need not be applied equally to all services or treatment.

21. The Minnesota Legislature specifically authorized the Department to adopt the relative value fee schedule adopted for the federal Medicare program and expressly provided that the fifteen percent reduction "need not be applied equally to all treatment or services." Minn. Stat. 176.136, subd. la (1992). The Department has demonstrated that its adoption of the Medicare relative value fee schedule, including the RVUs and global and multiple procedures policies, is needed and reasonable.

Impact of Emeraency Treatment Standards Rules

22. MN-APTA and practicing physical therapists Robin Saunders, Susan Isernhagen, and Dennis Isernhagen argued that the proposed relative value fee schedule would in effect penalize physical therapists for following the Department's emergency rules relating to treatment parameters. They contended that the proposed fee schedule would impose reductions ranging from nineteen

percent to forty-six percent for "active" services that are encouraged by the emergency rules, and asserted that it was unreasonable for the Department to fail to take the impact of the treatment rules into consideration when establishing the fee schedule. T. 563, 578, 580; Public Ex. 5. Ms. Saunders testified that the resources needed to do active treatment modalities such as exercise, education, body mechanics, and training-are greater than those required for passive modalities. She stated that the total impact of the proposed fee schedule on her practice would be a nearly thirty-five percent reduction in her usual and customary charges. T. 623-24. Susan and Dennis Isernhagen agreed that the proposed rules would establish economic incentives to perform passive rather than active therapies, contrary to the approach taken in the emergency rules.

The Minnesota Medical Association also expressed concern that the proposed relative value fee schedule increases payment for passive spine care while decreasing payment for active spine care, contrary to the intent of the treatment standards. The MMA proposed that the proposed rules be modified to "increase the fees for active spine care, at the expense of the fees for passive care."

The Department contends in response to the above comments that it properly did not apply the emergency rules pertaining to treatment standards to services in the data base in determining the fifteen percent reduction. The Department denies that the fee schedule reflects any bias against treatments that should be emphasized under the treatment standards rules. The fee schedule was constructed by Medicare to reflect the costs of providing services; the RVUs are designed to "correct[] for historical patterns of overcharging for some services while undercharging for others. Those corrections are made independent of the treatment standards which are interventions at the level of the entire course of treatment." Department's August 26, 1993, response at 17. The Department asserts that the fee schedule

applies to individual services and does not attempt to control the cost of an entire course of treatment, while the treatment standards apply to the entire course of treatment given a patient and attempt to control the number and mix of services provided, thereby reducing the entire cost of the whole course of treatment. Id. at 16. The Department contends that "[t]here is absolutely no inherent contradiction in simultaneously requiring not only that a particular service be appropriate for a particular patient in a particular situation, but that the price be reasonable . . . . [T]he therapists have a duty and obligation under their practice act to provide the correct treatment and . . . the workers' compensation payor has an obligation to pay a reasonable fee." id. at 17.

In the Department's view, "[t]here is absolutely no need to incorporate an analysis of the impact of the treatment standards on the incomes of physical therapists since the effect of the treatment standards is to eliminate unreasonable and unnecessary treatment which would not have been reimbursed under any circumstances." Id. at 16-17. The Department indicated that Ms. Saunders' anticipated reduction in income is attributable in part to her patient mix and the effect of the Legislature's imposition of a two-year freeze on medical fees. Although the Department acknowledges that providers whose practices have focused upon the provision of the services which are reduced more than fifteen percent will see greater reductions in their incomes than other providers, it emphasized that the Legislature specifically allowed the Department to reduce the fees paid for some services in excess of fifteen

percent. The Department asserted that it issued treatment standards precisely to counterbalance the inevitable economic incentives created by the fee schedule. It. at 18. The Department further emphasized that the proposed schedule would reimburse physical therapy services at a level sixty percent greater than Medicare, thereby affording physical therapists fees that are 50 to 100 percent higher than in many other payment systems. Id

23. The Administrative Law Judge finds that the proposed relative value fee schedule is not rendered unreasonable by the Department's failure to take its treatment rules into consideration when formulating the fee schedule. The fee schedule and the emergency rules serve entirely separate purposes. The fee schedule merely defines the maximum price for a particular service and does not provide guidance regarding whether the service is in fact appropriate. There is no inherent conflict between the proposed relative value fee schedule and the emergency rules, and the Department is under no requirement to consider the impact of the emergency rules in formulating the fee schedule.

Outpatient Limitation for Medical/surgical Services

24. Proposed Rule part 5221.4033 identifies a series of medical/surgical services that are deemed to be "predominantly performed in office settings" and requires that "no additional facility fees are payable unless it is medically necessary to perform the procedure in a nonoffice setting." David Feinwachs of the Minnesota Hospital Association pointed out that hospital data was not included in the data base for development of the relative value fee schedule and asserted that hospitals will receive a reduction substantially greater than fifteen percent of their charges under the proposed fee schedule. In response, the Department asserts that, pursuant to Minn. Stat. 176.136, subd. la (1992), the relative value fee schedule is to apply to hospital outpatient services. Although hospitals were excluded from the 1991 medical fee schedule under Boedingheimer v. Lake County Transportation, 485 N.W.2d 917 (Minn. 1992), hospital outpatient services "are

now on the same footing as other similar outpatient services." Department's August 26, 1993, submission at 24. The Department further explained that bills for services in the State Fund Mutual data base which occurred in an outpatient setting of a hospital were retained for analysis as long as the provider on the bill was something other than "hospital." In addition, entitles such as stand-alone physical therapy practices that are owned by hospitals were included as long as the bills were submitted by physical therapists rather than hospitals.

25. HealthSpan Health Systems Corporation, a nonprofit organization providing hospitals and related services, represented by John Diehl, Larkin, Hoffman, Daly & Lindgren, also filed comments objecting to this portion of the proposed rules. HealthSpan asserted that the proposed rule exceeds the Department's statutory authority because, pursuant to Minn. Stat. 176.136, subd. la (1992), only individual "health care providers" (not hospitals) are to be governed by the Department's relative value fee schedule and because a "usual and customary charge" approach is applicable to treatment, articles and supplies provided by hospitals under Minn. Stat. 176.136, subd. lb. HealthSpan also argues that the Department's approach is arbitrary and

capricious and emphasized that the Department has not provided a reasonable explanation for its failure to follow the Medicare system.6 Finally, HealthSpan asserts that the proposed rule fails to put outpatient facilities on sufficient notice when the use of the facility will be considered "medically necessary" and they will be reimbursed, thereby depriving such facilities of due process, and that the effect of the proposed rule will be to prohibit the use of the facility for the listed procedures by those in the workers' compensation system.

The Department argues that the rules are authorized by Minn. Stat. 176.136, subd. la (1992), which specifically requires the inclusion of outpatient services in the fee schedule, and Minn. Stat. 176.83, subd. 4 (1992), which empowers the Commissioner to promulgate rules establishing "standards and procedures for determining whether or not charges for health services . . . are excessive," and requires that the procedures set by the Commissioner '"include standards for evaluating hospital care . . . ." The Department justifies the proposed rule's departure from the Medicare approach by asserting that it is reasonable to place responsibility upon the hospital to monitor the necessity of treatment provided in its facility since the hospital is the entity that controls the facility and would collect a fee for unnecessary services.

26. The Administrative Law Judge finds that the proposed rule has been shown to be needed and reasonable to ensure that services that are typically provided in a physician's office are not unnecessarily performed in hospital settings and thereby subject to inappropriate additional charges. Because the Legislature directed the Commissioner to adopt permanent rules regulating fees allowable for treatment or service "provided to hospital outpatients," the proposed rules are within the scope of the Commissioner's rulemaking authority. The language of the proposed rule is not unduly vague. Facilities will be able to determine whether the use of the hospital setting is appropriate by consulting with the provider and by seeking prior authorization from the insurer. Moreover, if a dispute regarding medical necessity later

arises, the facility may request review by a Compensation Judge. The Judge thus concludes that the proposed rule does not bring about a denial of due process rights.

Regulation of Pharmacy Fees

27. The Minnesota Medical Association asserted that the Department lacks statutory authority to regulate pharmacy fees and thus objected to part 5221.4061 of the proposed rules. Ralph Siverson, Pharmacist, urged that the current approach of reimbursing pharmacists at 85 percent of their usual and customary charges be changed to a fairer approach. In its SONAR, the

6As the Department explains in its SONAR, "The Medicare rule, which addresses only the physician's fees, reduces the physician's fee for the service when performed in an outpatient setting, in an amount equal to 50 percent of the practice expense portion of the relative value unit for service . . . . Medicare pays the associate facility fee charged by the outpatient hospital SONAR at 23.

Department explained that the proposed rule was prompted by hardships experienced by pharmacies under the current approach:

> Because pharmacy services were not included in the 1991 medical fee schedule, the services have been subject to payment limitations imposed by the 1992 legislation, codified at Minnesota Statutes, section 176.136, subdivision lb(b), which provides that services, articles and supplies not included in the fee schedule are reimbursed at 85 percent of the usual and customary or prevailing charge. In the fall and winter of 1992, when payers began applying this discount to bills received, providers of pharmacy services contacted the Department and described the hardships these discounts worked on their operations. Because the profit margin for pharmacies is typically small, representatives for pharmacists affected by this statute stated that they were delivering pharmacy services to workers' compensation recipients at a loss. Thus, the absence of a rule providing fee limits for pharmacy services was, in effect, serving to discourage providers of pharmacy services from treating individuals who had been injured on the job.

SONAR at 33-34. The proposed rules limit an employer's liability for compensable prescription medications to the sum of the average wholesale price of the medication on the date the medication was dispensed and a professional dispensing fee of $5.14 per medication, and limit liability for compensable nonprescription medications to the lower of the actual retail price of the medication or the sum of the average wholesale price of the medication on the date the medication was dispensed and a professional dispensing fee of $5.14 per medication. BlueCross/BlueShield urged the Department to further reduce the compensable amount for prescription medication to the sum of the average wholesale price less ten percent and to limit the professional dispensing fee to $3.25, and proposed that nonprescription medications be reduced to the lower of the actual retail price or the sum of the average wholesale price less ten percent or the maximum cost reimbursement program cost of the medication and a professional dispensing fee of $3.25. The Department declined to make this change. It noted that its determination of the reasonable cost of pharmacy services was based on a study conducted by the Pharmaceutical Economics Research Center at Purdue University.

28. Minn. Stat. □□ 176.136, subd. 1, and 176.83, subd. 5 (1992), empower

the Commissioner to adopt rules and procedures for determining whether a charge for a health service is excessive. Such authority reasonably extends to the setting of a maximum fee for compensable prescription and nonprescription medications. The compensation levels set have been shown to adequately recompense pharmacists while controlling costs. The proposed rules have thus been shown to be needed and reasonable.

Additional Comments

29. The Minnesota Medical Association suggested that proposed rule part 5221.4000 be modified to require that the Department monitor the Medicare relative value fee schedule and make changes to the rules as Congress makes changes in the Medicare fee schedule. The Department declined to make the

suggested modification. While the Department may consider this suggestion and it would not be a substantial change in the proposed rules to adopt the recommended modification, the proposed rules are not unreasonable or defective due to their failure to incorporate the modification.

30. Subpart 2F of proposed rule part 5221.4030 sets forth procedure codes for numbers 70010 to 79440, relating to radiology procedures. For each procedure, there are three possible charges: (1) the charge for the plain code without a modifier; (2) the code modified by the number "26"; and (3) the code modified by "TC" (Technical Component). Andrea J. Linner, Chief Corporate Counsel for State Fund Mutual Insurance Company, pointed out that the rules do not describe the specific activities that are appropriately associated with "TC" and "26." State Fund suggested that the "TC" modifier be described to include the room and equipment charges as well as the actual technician time. State Fund further recommended that, where the CPT code is described as "supervision and interpretation only," payment for the "TC" modifier be indicated for support staff services only and payment for the "26" modifier be indicated for radiologists' interpretation only.

The Department pointed out in its post-hearing response that the definition of "TC" and "26" modifiers are included in part 5221.4032 of the proposed rules. The Department did not specifically discuss the language modifications suggested by State Fund Mutual and did not make any changes to the descriptions of "TC" and "26.uThe proposed rules are not rendered unreasonable by the Department's failure to make the recommended modifications.

31. Joe Wild raised questions about the lack of a cap on the conversion factor adjustments to be made by the Department in future years. The Department explained in response that Minn. Stat. 176.136, subd la (1992) provides that the conversion factors must be adjusted annually by no more than the percentage change computed under Minn. Stat. 176.645, but excepts the adjustment from the annual cap otherwise provided by section 176.645. The proposed rules thus are consistent with the authorizing statute in not imposing a cap on the annual adjustments to the conversion factor.

32. With respect to part 5221.4040 of the proposed rules, State Fund

Mutual Insurance Company pointed out that not all CPT codes relating to laboratory procedures which were included in the 1991 fee schedule were incorporated in the new relative value fee schedule and suggested that they be included. The Department stated in response that these codes were not included because there is no medical relative value unit assigned and the Department had insufficient data to develop a charge-based relative value for these codes. The Department indicated that, if sufficient data becomes available, it will be able to develop relative values for these services. The Department's approach is reasonable in light of the lack of sufficient data to develop RVUs for these codes.

33. State Fund Mutual Insurance Company suggested that part 5221.4060 of the proposed rules (relating to chiropractic procedure codes) include descriptions of what constitutes a "brief examination," "intermediate exam," "extended exam," "initial office visit," and "subsequent office visit," and that clarifying language be added concerning conjunctive therapy modalities, secondary manipulations, and payment for therapies. In response, the Department indicated that item E of part 5221.0405 of the proposed Medical Rules of Practice incorporates by reference the Medicare coding system, which includes a description of the chiropractic codes.

Overall Assessment of-Proposed Rules

34. In order for the Department to demonstrate the reasonableness of its proposed rules,it need only advance facts in the hearing record sufficient to show that the measures it proposes are rationally related to the end it seeks to achieve. Broen Memorial Home v. Minnesota Department of human Services , 364 N.W.2d 436, 440 (Minn. Ct. App. 1985). The Department must demonstrate that it has made a reasoned determination. Manufactured-Housing institute v. Pettersen, 347 N.W.2d 238, 246 (Minn. 1984). As discussed above, if the choice made by the agency is rational, the Administrative Law Judge may not properly require that the agency adopt another approach because it appears to be a better alternative. As Judge Campbell noted in his consideration of an analogous workers' compensation rule proceeding:

> The principles derived from these decisions [i.e., cases in which similar cost containment proposals have been challenged on federal constitutional grounds] may be summarized as follows: absent some particular contract or statute, neither a provider nor a participant has a right to a specified level of benefits or compensation; the governmental authority has broad discretion in adopting cost containment measures which involve no obvious invidious discrimination; and a classification adopted by the governmental authority will be sustained if it does not relate to a "suspect class" and bears Qme rational relationship to the end to be achieved -- cost containment. With respect to a provider, it is under no legal obligation to participate in the program and, if it does so, it accepts reasonable cost containment measures. [Citations omitted.] The same principles developed in the area of social benefit legislation apply to workers' compensation legislation and rules. See, Richardson v. Belcher, 404 U.S. 78, 83-84 (1971); Estridge v. Stovall 704 S.W.2d 653, 655 (Ky. App. 1986).

In the Matter of the Proposed Workers' Compensation Rules, OAH Docket No. 2-1900-7263-1 at 26 (Report issued May 11, 1993) (emphasis in original).

As discussed in various Findings set forth above, the Judge has concluded that the methodology employed by the Department in arriving at its proposed relative value fee schedule comports with the governing statute. The RVUs

were reasonably derived from those assigned by HCFA for use in the Medicare system, as expressly permitted by the Legislature, or through the Department's application of the Medicare methodology. The provider classifications, single conversion rate, and adjustment factors reflected in the proposed fee schedule are rationally related to the goal of producing the fifteen percent reduction in 1991 expenditures required by the Legislature. The data and analysis provided by the Department establish a rational basis for the relative value fee schedule rules. The rules as a whole bear a rational relationship to the goal of cost containment. The Administrative Law Judge thus concludes that the Department has demonstrated the need for and reasonableness of its proposed rules relating to the relative value fee schedule and that there are no other problems preventing their adoption.

MEDICAL RULES OF PRACTICE

Statutory Authority

35. In its SONAR, the Department cites a variety of statutes as the basis for its authority to adopt medical rules of practice. Ole SONAR at 7-8. Minn. Stat. □ 175.171(2) and (3) (1992) authorizes the Department to "adopt reasonable and proper rules relative to the exercise of its powers and duties" and "collect, collate, and publish statistical and other information relating to the work under its jurisdiction . . . ." Minn Stat. □□ 176.101, subd. 3e(f) (1992) empowers the Commissioner to adopt rules to "assure proper application" of the statutory provisions relating to the cessation of temporary total compensation, maximum medical improvement, and the offer of a "suitable job." The Commissioner is also authorized to adopt rules establishing standards and criteria under which physicians podiatrists, or chiropractors are selected or under which changes in such providers are allowed under Minn. Stat. □□ 175.135, subd. 2, and 176.83, subd. 8 (1992). Minn. Stat. □ 176.135, subd. 7 (1992), requires the Commissioner to prescribe a billing form to be used by health care providers. Pursuant to Minn. Stat. □□ 176.231, subds. 3, 4, 5, 6, and 7, and 176.83, subd. 5a (1992), the Commissioner is authorized to require the filing of prescribed medical report forms by health care providers, insurers, and employers. Finally, Minn. Stat. □ 176.83, subds. 1, 3, 4, 5, and 7 (1992), further authorizes the Commissioner to adopt rules to implement the provisions of Chapter 176 of the Minnesota Statutes, specifically including rules "establishing standards for reviewing and evaluating the clinical consequences of services" provided by qualified rehabilitation consultants, rehabilitation service providers, and health care providers; rules "establishing standards and procedures for determining whether or not charges for health services or rehabilitation services . . . are excessive"; rules "establishing standards and procedures for health care provider treatment"; and rules "necessary for implementing and administering" the statutory provisions relating to the payment and discontinuance of

compensation. The Administrative Law Judge concludes that the Department has the general statutory authority to adopt medical rules of practice for workers' compensation.

Nature of the Proposed Rule

36. The Department first adopted permanent rules relating to workers' compensation medical services in 1984. These rules, which were last revised in 1989, govern the relationship between health care providers and the workers' compensation system, particularly in the areas of measuring the appropriate ongoing treatment of injured workers and controlling the method by which providers are reimbursed. The adoption of a relative value medical fee schedule necessitates some revisions and amendments in the medical rules of practice to assist in administering the new fee schedule and to reflect the new approach to payment of care provided to injured workers. The Department also seeks to amend the rules in order to address perceived problems regarding the timely and adequate submission of information by health care providers, "doctor shopping" and delays in employees' return to work, confusion over billing and payment responsibilities of payers and providers, and limiting paperwork requirements while ensuring adequate and timely information on claims.

In the proposed rules, the Department seeks to replace the Physician Report and the Maximum Medical Improvement Report required by the existing rules with a single revised Health Care Provider Report; describe considerations for applying the concept of maximum medical improvement; require the filing of a new Report of Work Ability; address the obligation of providers to participate in return to work planning; establish criteria to be used when a change of doctor is requested; amends current provisions regarding excessive charges and the payer's maximum liability; clarify the responsibilities of payers to promptly review and pay medical bills and keep providers and employees informed of their actions; require the reporting of medical information; establish data collection, retention, and reporting requirements; and implement federal antikickback requirements.

Proposed_Rule Part 5221.0100 - Definitions

37. The proposed rules add several new definitions and amend various other definitions contained in the existing rules. Jeannine Churchill, Vice President Workers' Compensation, BlueCross/BlueShield of Minnesota, argued that the rule on pharmaceutical reimbursement should use the National Drug Code listing rather than the HCPCS Code (i.e., the code included in the U.S. Health Care Financing Administration's Common Procedure Coding System) and urged the Department to include in the proposed rules a definition of "NDC Code." In response, the Department pointed out that the definition of .procedure code" contained in subpart 4(F) of the proposed rules indicates that the references to "procedure codes" contained in Chapter 5221 include "prescription numbers." Following the hearing, the Department modified proposed rule 5221.0700, subp. 2c(H) to refer to the "prescription number" for the medication rather than the "procedure code." This modification was made to clarify the rule and does not constitute a substantial change from the rule as originally proposed. The Department may wish to consider adding a definition of "prescription number" to the proposed rules to ensure that pharmacists are aware of the precise meaning of the term. Such an addition would not constitute a substantial change.

The definitions contained in part 5221.0100 of the proposed rules have been shown to be needed and reasonable as modified.

Proposed Rule Part 5221.0100 - Scope

38. In part 5221.0400 of the proposed rules, the Department seeks to amend the current rule to provide that "employees as defined in Minnesota Statutes, section 176.011, subdivision 9" are subject to Chapter 5221 of the rules. In its SONAR, the Department indicates that this amendment is proposed to reflect the employee's obligation to provide the Report of Work Ability form to employers or insurers and QRCS. No one objected to the proposed amendment. The Department has demonstrated that its proposed amendment to the first sentence of part 5221.0400 is needed and reasonable.

39. The Department also proposes to add a new second sentence to part 5221.0400 specifying that Chapter 5221 "shall be applied in all relevant determinations made by compensation judges at the department and the Office of Administrative Hearings, and by the commissioner." John C. Wallraff, Assistant Chief Administrative Law Judge, Workers' Compensation Section, Office of Administrative Hearings, filed comments objecting to the proposed

amendment. In its SONAR, the Department stated that this language was added "to reinforce that the provisions apply to all disputes in the workers' compensation system" and "is necessary for consistency and predictability throughout the system." SONAR at 8.

The Administrative Law Judge concludes that the Department has not established the need for inclusion of this sentence in the rules. It is a well-established principle that an agency is bound by its own rules. See G. Beck, L. Bakken, and T. Muck, Minnesota Administrative Procedure, 16.3 (1987). It thus is unnecessary for the rules to restate that the Commissioner and the Department must apply the rules in relevant situations. Moreover, pursuant to Minn. Stat. 176.371 (1992), the decisions of Compensation Judges must "include a determination of all contested issues of fact and law and an award or disallowance or other order as the pleadings, evidence, this chapter and rule require." To the extent a rule is relevant in a particular case, the statute thus requires that it be applied. The statement in the proposed rules is superfluous under these circumstances. To correct this defect in the rules, the Department should delete the second sentence from part 5221.0400.

Proposed Rule Part 5221.04Q5 Incorporations_by_Reference

40. Proposed rule part 5221.0405 incorporates five documents into the rules by reference. These documents are the International Classification of Diseases, Clinical Modification, 9th revision, 1991 (ICD-9-CM); the Federal Health Care Financing Administration claim form (HCFA-1500)(U2)(12-90); the Uniform Billing Claim form (UB-92, HCFA-1450); the Physician's Current Procedural Terminology (CPT manual), 4th edition, 1993; and the Health Care Financing Administration Common Procedural Coding System (HCPCS manual). These documents are referenced throughout the rules. At the hearing and in its post-hearing comments, the Department indicated that the HCPCS manual has undergone a recent revision and proposed to change the rule to refer to the 1993 edition rather than the 1989 edition. T. 379; Department's August 19, 1993, submission at 5.

Minn. Stat. 14.07, subd. 4 (1992), sets forth various requirements that must be satisfied for an agency to incorporate by reference into its rules the text from publications and documents. The proposed rules comply with these requirements. The modification proposed by the Department incorporates the most up-to-date information into the rule. The proposed rule, as modified, has been shown to be needed and reasonable. The modification does not constitute a substantial change.

Proposed Rule Part 5221.0410 - Required Reporting and Filing of Medical Information

41. Proposed rule 5221.0410 is composed of eight subparts relating to information health care providers are required to give to the employer, the insurer, or the Commissioner. Subparts 2, 3, 4, and 6 will be discussed below. The remainder of the subparts did not receive substantial critical comment and have been shown to be needed and reasonable.

Subpart 2 - Health Care Provider Report

42. Subpart 2 of the proposed rules requires health care providers to file an extensive report concerning the examination, diagnosis, medical history, prognosis, work ability, permanent partial disability rating, and

maximum medical improvement of an injured employee within ten days of receipt of a request for information from an employer, insurer, or the Commissioner. The report may be filed either on a specified form or in a narrative format. The information required in subpart 2 has been shown to be needed and reasonable to facilitate the proper management and monitoring of claims and ensure that information regarding the injury, treatment, and ability to work is received promptly following a request for such information. The proposed rules would also reduce paperwork burdens by not eliminating the requirement in the existing rules that a report automatically be filed regarding every injured worker treated.

Subpart 3_-_Maximum Medical improvement

43. Maximum medical improvement ("MMI") is defined in Minn. Stat. 176.011, subd. 25 (1992), to mean "the date after which no further significant recovery from or significant lasting improvement to a personal injury can reasonably be anticipated, based upon reasonable medical probability." The date on which MMI is reached is important because it affects the employee's entitlement to benefits. The employee's temporary total compensation ceases ninety days after he or she has reached MMI and has been served with a written medical report, or ninety days after the end of an approved retraining program, whichever is later. Minn. Stat. 176.101, subd. 3e (1 992) .

Subpart 3 of the proposed rules requires health care providers to report orally or in writing to the insurer or self-insured employer when an employee has reached maximum medical improvement. Pursuant to the proposed rules, this reporting requirement is mandatory with respect to injuries occurring on or after January 1, 1984, and the information must be provided upon request with respect to earlier injuries. The proposed rules quote the statutory definition of MMI; set forth in item A a list of factors to be considered by the health care provider in assessing whether MMI has been reached in general injury situations; specify in item B a list of factors to be considered in

determining MMI in situations where more than one year has elapsed since the date of a defined musculoskeletal injury; and require in item C that insurers serve notice of MMI on employees. Items A, B, and C are discussed in the paragraphs below.

Items A and B

44. Pursuant to item A of subpart 3 of the proposed rules, health care providers would consider the following factors as an indication that MMI has, been reached:

(a) there has been no significant lasting improvement in the employee's condition, and significant recovery or lasting improvement is unlikely, even if there is ongoing treatment;

(b) all diagnostic evaluations and treatment options that may reasonably be expected to improve or stabilize the employee's condition have been exhausted, or declined by the employee;

(c) any further treatment is primarily for the purpose of maintaining the employee's current condition or is considered palliative in nature; and

(d) any further treatment is primarily for the purpose of temporarily or intermittently relieving symptoms.

Item A further provides that the following factors should be considered by the health care provider as an indication that MMI has not been reached:

(a) the employee's condition is significantly improving or likely to significantly improve, with or without additional treatment;

(b) there are diagnostic evaluations that could be performed that have a reasonable probability of changing or adding to the treatment plan leading to significant improvement; or

(c) there are treatment options that have not been applied that may reasonably be expected to significantly improve the employee's condition.

Item A also defines "the employee's condition" and "functional status" in a fashion which was "based on recommendations of the health care providers on the workers' compensation Medical Services Review Board and members of the Medical Committee of the International Association of Industrial Accident Boards and Commissions." SONAR at 12.

45. Item B of the proposed rules imposes a different approach for determining whether MMI has been reached with respect to certain injuries of the musculoskeletal system. Item B does not apply where "the injury is a spinal cord injury resulting in permanent paralysis, a head injury with loss of consciousness, or where surgery has been performed within the previous six months." In such instances, the factors listed in item A above are to be used to determine MMI. In addition, since item B applies only when more than one year has elapsed since the date of the injury, the factors listed in item A will be applied to assess whether MMI has been reached during the first year following the date of a covered musculoskeletal injury.

When more than one year has elapsed since the date of the covered musculoskeletal injury and the employee has not shown either a decrease in his

or her estimated permanent partial disability rating or a significant improvement in work ability over a three-month period, item B requires that the employee be presumed to have reached MMI. These two factors--whether a decrease is anticipated in the employee's estimated permanent partial disability rating or whether a significant improvement is anticipated in the employee's work ability--are to be the only factors in determining MMI at that point. The employee can rebut the presumption by showing that a decrease in the permanent partial disability rating or a significant improvement in the work ability has occurred or is likely to occur beyond this three-month period.

After the hearing, the Department modified item B.7 Is modified, item B provides as follows:

> This item applies to musculoskeletal injuries that fall within any category under parts 5223.0070; 5223.0080; 5223.0110 to 5223.0150 and 5223.0170 for dates of injury before July 1, 1993, and that fall within any category under parts 5223.0370 to 5223.0390 and parts 5223.0440 to 0550 for dates of injury on or after July 1, 1993. When more than one year has elapsed since the date of a musculoskeletal injury that falls within the above categories, the only factors in determining maximum medical improvement shall be whether a decrease is anticipated in the employee's estimated permanent partial disability rating or a significant improvement is anticipated in the employee's work ability as documented on the report of work ability described in subpart 6. If medical reports show no decrease in the employee's estimated permanent partial disability or no significant improvement in the employee's work ability in any three-month period later than one year after the injury, the employee is presumed to have reached maximum medical improvement. This presumption can only be rebutted by a showing that a decrease in the employee's permanent partial disability rating or significant improvement in the work ability has occurred or is likely to occur beyond this three-month period. The medical reports relied upon as establishing maximum medical improvement under this item, must be served on the employee in accordance with item C.

The Department explained that the modifications were made to the first two sentences of the proposed rule due to the adoption of a new permanent partial disability schedule effective July 1, 1993. Because two permanent partial disability schedules may apply depending on the date of the injury, a change in the language of the rule was necessary to reflect the new permanent partial disability schedule and correcting the old schedule references. The Department proposed modifications to the third and final sentences of item B in order to clarify that medical reports must establish that no decrease in the employee's estimated permanent partial disability or improvement in work ability has occurred during the three month period and to specify that the employee must be served with the medical reports and will thus be afforded an opportunity to challenge the presumption.

7Item B was modified in the Department's August 19, 1993, submission as well as in its August 26, 1993, submission. The August 26 submission did not accurately reflect the changes made in the August 19 submission. The Judge assumes that the Department intended to propose that the language be modified as set forth in both submissions. The language quoted in the text above reflects that assumption.

46. Andrea J. Linner, Chief Corporate Counsel for State Fund Mutual Insurance Company ("State Fund"), expressed support for the MMI rule and stated that it would be beneficial to the workers' compensation system. Michael B. Bloom, Gordon-Miller-O'Brien, Attorneys, asserted that the rules relating to MMI are not within the Department's rulemaking authority. Mr. Bloom argued based upon the decision of the Minnesota Supreme Court in Hammer v. Mark Hagen Plumbing & Heating, 435 N.W.2d 525, 529 (Minn. 1989), that a finding of MMI is legal in nature and rests with the Compensation Judge in each individual case, not with the health care provider. Mr. Bloom contended that the proposed rules attempt to change in a substantive way the definition of MMI and argued that the Department's rulemaking authority is limited to the promulgation of rules that are merely procedural in nature. John C. Wailraff, Assistant Chief Administrative Law Judge, Workers' Compensation Division, Office of Administrative Hearings, also objected that the MMI provision attempted to make a substantive change in the law.

John G. Engberg, Peterson, Engberg & Peterson, representing the Minnesota AFL-CIO, commented that the specification of procedures to determine MMI would encroach upon the judgment of the treating medical provider. Daniel C. Berglund, Falsani, Balmer, Berglund & Merritt, asserted that the definition of MMI is not consistent with the statute or current case law and urged that the solution to the confusion in this area should come from the Legislature rather than the Department. Thirteen members of the Minnesota House of Representatives (Patrick W. Beard, Irv Anderson, David Battaglia, Jim Farrell, Thomas Huntley, Alice Johnson, Mary Murphy, Walter Perlt, James Rice, Tom Rukavina, John Sarna, Kathleen Sekhon, and Stephen Wenzel) objected to the Department's "attempt to legislate via rule" through promulgation of rules setting forth MMI standards.

47. The Department argued in response that its rulemaking authority is not limited to the promulgation of rules that are merely procedural in nature. The Department relies primarily upon Minn. Stat. □ 176.101, subd. 3e, which permits the Commissioner to "adopt rules to assure [the] proper application" of the MMI statutory provisions, and 176.83, subd. 1, which

provides the Commissioner with authority to 'amend or repeal rules to implement the provisions of [Chapter 176 of the Minnesota Statutes]." Citing Minnesota-Dakotas Retail Hardware Assiciation v. State, 279 N.W.2d 360, 364 (Minn. 1979), and Minn. Stat. 14.02, subd. 4 (1992), the Department argues that agencies may promulgate rules that make statutory definitions more specific.

In support of the need for and reasonableness of the proposed MMI rules, the Department indicated that the Supreme Court in Hammer had determined that MMI is "both a medical and legal concept" and that, in cases in which there is a dispute regarding MMI, a Compensation Judge must make the final determination. SONAR at 12; Department's August 19, 1993, submission at 1. The Department stressed that the Court in Hammer had noted with approval the Department's analysis of MMI factors to be considered as set forth in the Department's Health Care Provider's Guide to the Minnesota-Workers' Compensation System. Id.; Hammer, 435 N.W.2d at 639. The Department determined that MMI rules were appropriate because the handbook is out of date in other areas and did not incorporate more recent case law regarding the MMI concept. SONAR at 12.

The Department indicated that the proposed rules attempt to "clarify for health care providers, employers and insurers what it is [sic] meant by ,maximum medical improvement' as stated by the Minnesota Supreme Court." Id. The Department further stated that, "although workers' compensation judges and providers will continue to make determinations on an individual basis, these rules are expected to provide general guidelines for providers to use in making determinations of maximum medical improvement." Id. The Department asserted that the proposed rules are needed and reasonable to promote the recognition of MMI by health care providers, promote uniformity among providers in making the MMI determination by "helping them understand what factors they need to focus on, what are the demonstrable and observable facts that serve as the foundation for an opinion" of MMI, and promote timeliness by avoiding delays due to ignorance by providers regarding what MMI is. T. 428-29. Item A is designed to "codif[y] the current case law . . . so that it is accessible and understandable by health care providers" and clarifies that providers must consider functional status including the individual's ability to do work. T. 429-30.

The Department asserted that item B of the proposed rules (which engendered the most controversy among those who were interested in the rules) is necessary "because, despite medical evidence that MMI is generally reached well within one year for these injuries, the workers' compensation system continues to receive disputes about MMI issues beyond this time period, resulting in unnecessary litigation and delay in benefit resolution." Id. The Department explained that it selected the one-year time period "because, from a medical perspective, maximum improvement of a musculoskeletal injury is almost always reached sooner than one year." SONAR at 13. The Department asserts that the one-year standard is supported by the Department's emergency rules on treatment standards, which were approved by the Minnesota Medical Association and the workers' compensation Medical Services Review Board, as well as by The Minnesota Chiropractic Assocation Standards of Practice and relevant medical literature, including P. Reed, The Medical Disability

Advisor; Workplace Guidelines-for Disability Duration (1991). SONAR at 14.
The one-year period was also supported by expert medical testimony provided by William Lohman, M.D., at the hearing. T. 431-37. Dr. Lohman indicated that "[i]njuries to bones, ligaments, tendons and muscles physiologically are known in experimental situations to heal within six to 12 weeks" and that "the epidemiology and natural history of untreated low back pain would indicate that 90 percent of the people who have low back pain who receive no treatment at all are completely well within eight to 12 weeks." T. 432.
Non-musculoskeletal injuries and musculoskeletal injuries that are by their nature less predictable are explicitly excluded from item B and are dealt with under the general approach of item A. T, 436-37.

48. The Minnesota Administrative Procedure Act specifies that an agency shall adopt rules "only pursuant to authority delegated by law and in full compliance with its duties and obligations." Minn. Stat. □ 14.05, subd. 1 (1992). To assist in determining whether an agency has statutory authority to promulgate a particular rule, courts and commentators have assessed whether the challenged rule is procedural, interpretative, or legislative in nature.
G. Beck, L. Bakken, & T. Muck, Minnesota Administrative Procedure □ 19.2 at 344 (1987). Procedural rules are generally viewed as those which "describe the methods by which the agency will carry out its appointed functions"; interpretative rules "interpret and apply the provisions of the statute under

which the agency operates"; and legislative rules are substantive rules which "have been defined as 'the product of an exercise of delegated legislative power to make law through rules.'" Id. at 344-45, citing F. Cooper, State Administrative Law 173-76 (1965).8 While an agency's authority to promulgate legislative rules must be specifically stated in the governing statute, it "has been recognized by commentators and suggested by dicta in a Minnesota case that the power to promulgate interpretative rules need not be expressed but, rather, may be inferred from an agency's authority to enforce a law." Id. at 345, 347, citing Minnesota-Dakotas Retail Hardware Association v. State 279 N.W.2d 360, 365 (1979), and K. Davis, Administrative Law of-the Seventies 5.03 (1976).

The Legislature has granted specific statutory authority to the Department to adopt rules relating to MMI. Minn. Stat. 176.101, subd. 3e (1992), states in pertinent part that "[t]he commissioner shall monitor application of this subdivision and may adopt rules to assure its proper application." Subdivision 3e of the statute states, inter alia, that the employee's temporary total compensation shall cease ninety days after the employee reaches MMI and a medical report to that effect is served on the employee and also describes the impact that the offer or procurement of a "suitable job" prior to the end of the ninety-day period will have on the employee's benefits. The Department also has been granted general authority to adopt rules to "implement the provisions of" Chapter 176. Minn. Stat. 176.83, subd. 1 (1992).

The Department's rulemaking authority to ensure the proper application of the MMI provision and implement the provisions of the workers' compensation laws cannot properly be viewed to be limited to mere procedural matters. An "agency's authority to regulate has been held to include the authority to restrict or prohibit, and within the designated area of its regulation, the agency has implied power to formulate the necessary classifications and definitions." G. Beck et al., Minnesota Administrative Law 24.2 at 400 (1987), citing Manufactured Housing Institute v. Pettersen 347 N.W.2d 238,

242 (Minn. 1984); State v. Hopf, 323 N.W.2d 746, 752 (Minn. 1982); Blocher Outdoor-Advertising Co. v. Minnesota Department of Transportation, 347 N.W.2d 88, 91 (Minn. Ct. App. 1984)."

8Although historically interpretative rules were viewed as lacking the force and effect of law, the Minnesota Administrative Procedure Act was amended in 1981 to clearly specify that "[e]very rule, regardless of whether it might be known as a substantive, procedural, or interpretative rule, which is [adopted in accordance with the Act] shall have the force and effect of law . . . ." Minn. Stat. 14.38, subd. 1 (1992).

9For example, in Blocher, the Minnesota Court of Appeals upheld a rule promulgated by the Department of Transportation which specified that billboard permits could be issued only if a commercial or industrial activity was conducted on the site during normal business hours and on a regularly scheduled basis for at least 150 days during a calendar year. The general statutory requirement was that such permits be available only if a commercial or industrial activity was "actually" conducted on the site. The statute also prohibited the location of billboards on sites used for "transient or temporary activities." The Court of Appeals held that the rule was "a minimal requirement and not overly restrictive." Id. at 91. The Court of Appeals also held that the Department of Transportation could have properly denied the permit by making a case-by-case determination and relying upon the statute alone.

Regardless of whether the proposed rules are properly viewed as "legislative" or "interpretative" in nature, however, it is clear that they must not conflict with the language of the statute or be contrary to legislative intent. Can Manufacturers Institute, Inc. v. State, 289 N.W.2d 416 (Minn. 1979); accord State v. Hopf, 323 N.W.2d 746, 752 (Minn. 1982); Buhs v. State, 306 N.W.2d 127, 131 (Minn. 1981). The Department thus does not have the authority to "define" MMI independently of the statutory definition if the definition set forth in the proposed rule is inconsistent with the statute. J. C. Penny Co. v. Commissioner of Economic Security Penn , 353 N.W.2d 243, 246 (Minn. Ct. App. 1984).

The statutory definition of MMI contains a number of concepts which would benefit from clarification. "Reasonably anticipated significant recovery" or "significant lasting improvement based on reasonable medical probability" are such concepts. The Department has demonstrated that health care providers lack specific training regarding when MMI is reached and that delays have resulted in reporting MMI in part due to provider uncertainties regarding the meaning of the term. Further definition of those terms thus has been shown to be needed.

In the proposed rules, the Department has taken the definition of MMI provided in the statute and placed it in the context of what rehabilitative health care is intended to provide in the workers' compensation system. The factors set forth in item A are restatements of or logical extensions of the statutory definition of MMI. There is no evidence that the factors specified in item A for consideration by health care providers go beyond the statute or restrict its application or that they depart from relevant case law.

Item B of the proposed rules establishes a new approach to be followed with respect to covered musculoskeletal injuries. Pursuant to that approach, there would be a rebuttable presumption that MMI has been reached if there is

no decrease in the employee's estimated permanent partial disability or no significant improvement in the employee's work ability in any three-month period occurring later than one year after the injury. Commentators who opposed the one-year MMI standard did not introduce any evidence that one year is in fact inadequate to treat the bulk of the covered musculoskeletal injuries. Employees will be able to rebut the presumption by showing that a decrease in the employee's PPD rating or significant improvement in work ability has occurred or is likely to occur beyond the three month period.

A rule may properly declare that a rebuttable presumption will be established if certain factors are present. Juster Brothers, Inc. v. Christqau, 7 N.W.2d 501, 507 (Minn. 1943). While it is true that the statute does not expressly authorize the use of a rebuttable presumption, the use of such a device under circumstances where there has been no decrease in PPD or increase in work ability is consistent with the statutory intent to provide rehabilitative care to injured workers and terminate that care when it is no longer productive. No commentator has alleged that the proposed rule will result in the discontinuance of benefits to an employee who would have otherwise been entitled to continued benefits if the statutory definition alone had been applied. The statute defines MMI as "the date after which no further significant recovery from or lasting improvement to a personal injury can reasonably be anticipated, based on reasonable medical probability."

Minn. Stat. § 176.011, subd. 25 (1992). If, in fact, an employee cannot produce a medical opinion that states that a reduction of PPD or increase of work ability has occurred or is likely to occur in order to rebut the presumption established by rule, it would appear that MMI has been reached regardless of whether the rule or the statute is applied.

49. The Department has shown that items A and B are needed and reasonable to efficiently implement the statutory definition of MMI, clarify when MMI is reached with respect to general injury situations and covered musculoskeletal injuries, and prevent uncertain cases from going on indefinitely. The proposed rules do not conflict with or narrow the statutory definition of MMI and are within the Department's rulemaking authority. No specific case citations were provided in support of the commentators' assertion that the MMI factors specified in the proposed rules are inconsistent with judicial interpretations of the statutory definition of MMI. The proposed rules are consistent with the case law cited by the Department in its SONAR at 13-14, and the Judge is not aware of any conflicting cases. The modifications made following the hearing clarify the rule and do not result in a rule which is substantially different from the rule as originally published in the State Register. The Judge thus concludes that item B does not conflict with the workers' compensation statute or the statutory definition of MMI.

Item C

50. The workers' compensation statute requires that the insurer serve the affected employee with notice of a determination that MMI has been reached. Minn, Stat. § 176.101, subd. 3e (1992). Item C of subpart 3 of the proposed rules addresses situations in which the health care provider has submitted the information about MMI in a narrative report, which is then served on the employees. Such reports will not contain information included on the standard forms (such as the Health Care Provider Report form, the Notice of Intention to Discontinue form or the Petition to Discontinue form) which explains the significance of a finding of MMI. Pursuant to the proposed rules, insurers will be required in such situations to send a cover letter containing information specified in the proposed rules, including notification that there may be an impact on the employee's temporary total disability benefits.

Following the hearing, the Department modified item C(4) of the proposed rules to require the inclusion of "a statement that the attached report indicates that in the opinion of the health care provider, the employee reached maximum medical improvement by the specified date; or an explanation that the attached reports indicate the employee has reached maximum medical improvement under the circumstances specified in item B."

The proposed rule, as modified, has been shown to be needed and reasonable to avoid confusion and ensure that employees are given adequate information.

Subpart A --Permanent Partial Disability

51. Subpart 4 requires a health care provider to render an opinion on partial permanent disability "when ascertainable, but no later than the date of maximum medical improvement." The Department explained that reports have

been received of health care providers routinely delaying the issuance of ratings of even minimal permanent partial disability. SONAR at 18. This practice increases costs to the workers' compensation system and delays the proper payment of benefits to injured workers.

The Minnesota AFL-CIO objected to the requirement as being beyond the Department's statutory authority and not medically prudent or practical in all cases. No statute has been cited that conflicts with the Department's approach to the reporting of permanent partial disability, nor have any practical problems been explained which would prevent PPD from being assessed at the time MMI is reached. In its post-hearing response, the Department asserts that the rule is reasonable from a medical standpoint "because if the employee is not likely to continue improving a rating of permanent disability should be able to be made. If it is too early for a rating to be ascertained, the employee has not likely reached MMI." Department's August 26, 1993, submission at 7.

As discussed above, the Department has specific authority to adopt rules requiring the reporting of medical and other data necessary to implement the workers' compensation laws and to require reports from health care providers related to the nature and extent of the injury and disability. Minn. Stat. 176.83, subd. 5a and 15, and 176.231 (1992). At present, the physician's report form used by the Department requests both PPD and MMI opinions from health care providers. Department's August 26, 1993, submission at 7. The Administrative Law Judge is not aware of any reason why permanent partial disability should not be ascertainable at the time MMI is reached. Subpart 4 has been shown to be needed and reasonable, as proposed.

Subpart 6 - Report of Work Ability

52. Subpart 6 of the proposed rules requires that the injured employee's primary health care provider must submit a Report of Work Ability to the employee. The report must be submitted within ten days of a request by

an insurer or at other intervals specified in the rules, unless there are no work restrictions or the restrictions are permanent and have been reported previously. The Report of Work Ability must be provided either on the form prescribed by the Commissioner or in a report that contains the same information required in the form. The report must indicate whether the employee is able to work without restrictions, able to work with restrictions, or unable to work, the date any restriction of work activity is to begin and the anticipated ending or review date, and the date of the next scheduled visit. The employee must submit the report to the employer or the insurer and QRC "promptly upon receipt." This reporting requirement is a new requirement "which is intended to properly communicate to employers and insurers the information necessary to plan return to work for an injured worker." SONAR at 18.

53. Michael B. Bloom, Gordon-Miller-O'Brien, asserted that the Department lacked statutory authority to require submission of a Report of Work Ability. Mr. Bloom asserts that Minn. Stat. 176.231, subd. 5, provides only that the Commissioner "shall prescribe forms for use in making the reports required by this section," and emphasizes that the only reports required by that section are a First Report of Injury, a doctor's report, and supplementary reports. Mr. Bloom further argued that the Commissioner has exceeded his authority by requiring that the Report of Work Ability be

provided at the request of insurers and at a frequency which does not adhere to the ten-day period set forth in Minn. Stat. 176.231, subd. 3. Mark J. Fellman of Sieben, Polk, LaVerdiere, Jones & Hawn objected to the ten-day time limit for the submission of the Report of Work Ability as being too burdensome for health care providers. Mr. Fellman also suggested that such a report would be requested at the whim of insurers and suggested that the rule was unnecessary since the insurer has access to the worker's medical records.

54. Pursuant to Minn. Stat. 176.231, subds. 3 and 4 (1992), the Commissioner is authorized to request information from health care providers relating to "the nature and extent of the injury and disability and the treatment provided for the injury or disability," "require the filing of supplementary reports of accidents as is deemed necessary to provide information required by law," and request "supplementary reports related to the current nature and extent of the employee's injury, disability, or treatment." These provisions do not limit the inquiry to the employee's first visit to the provider. Minn. Stat. 176.231, subd. 5 (1992), specifies that the Commissioner "shall prescribe forms for use in making the reports required in this section." Minn. Stat. 176.231, subd. 6 (1992), imposes on the Commissioner the duty to "keep fully informed of the nature and extent of all injuries compensable under this chapter, their resultant disabilities, and of the rights of employees to compensation'" and authorizes the Commissioner to request written reports from physicians who have examined or treated an employee or have special knowledge relating to an injury which may be compensable under Chapter 176. The Administrative Law Judge thus concludes that the Department has broad statutory authority to require information concerning the treatment of injured workers, including information concerning their ability to work, that is not limited to the narrow strictures urged by opponents to the rule,

The proposed rules require that the Report of Work Ability be submitted

within ten days of a request by an insurer or at other intervals which range from every visit (if visits are less frequent than once every two weeks), every two weeks (if visits are more frequent than once every two weeks), or upon expiration of the ending or review date of the restriction specified in a previous report. The ten-day limit is apparently derived from Minn. Stat. 176.231, subd. 3, which requires the submission of reports within ten days of a request by the Commissioner or an authorized representative of the Commissioner. Under these rules, the Department has in effect authorized insurers to request the Report of Work Ability. Pursuant to the other time intervals set forth in the rule, the health care provider will not be required to provide a Report of Work Ability more frequently than every two weeks and in many cases the report will be prepared less often.

The Administrative Law Judge thus concludes that the Commissioner has authority to promulgate the proposed rules requiring a Report of Work Ability and that the rules are needed and reasonable to assist in return to work planning and to ensure that the employee is aware of the provider's opinion concerning his or her condition and ability to work. While administrative burdens are associated with the imposition of new reporting requirements, this burden is not unreasonable when compared to the benefit derived to the worker.

Subpart 7 - Charge for Required Reporting

55. Subpart 7 clarifies that, while no charge may be assessed by health care providers for completion of a Health Care Provider Report, the Report of Work Ability, or narrative or other reports prepared in lieu of such reports, providers may charge a reasonable amount for requested supplementary reports. State Fund Mutual Insurance Company suggested that the proposed rules specify maximum amounts that may be charged for such reports. The Department declined to make the requested modification based on its view that Providers would be more prompt in providing these supplementary reports if they are permitted to charge their usual and customary fee for preparing the reports. The Department also indicated that it would not be feasible to set such maximum fees because the reports are infrequently requested and the amount of time and expertise required to prepare the reports varies depending upon the nature of the inquiry. Subpart 7 has been shown to be needed and reasonable as proposed.

Proposed Rule Part 5221.0420 - Health Care Provider Participation with return to Work Planning

56. Under proposed rule part 5221.0420, health care providers must participate and cooperative in return to work planning. Subpart I of the proposed rules requires that the health care provider "release the employee to return to work, with restrictions if necessary, at the earliest appropriate time." In situations in which the QRC has not requested an opinion regarding whether the physical requirements of a proposed job are within the employee's restrictions, the provider is required to respond within ten calendar days of receipt of a similar request by the employee, employer, or insurer. That opinion can be provided in writing, by telephone, or in person. The health care provider has the option of requiring a written description of the job and may agree to review a videotape of the job. Subpart 2 of the proposed rules

identifies and also places certain limitations upon the circumstances under which the provider must respond to a QRC's request for communication. Subpart 3 specifies that health care providers may not require prepayment for communications required by the proposed rules and must bill the employer and insurer for the service.

State Fund Mutual expressed its support for the proposed rule. The Minnesota Medical Association objected to the ten-day requirement as unreasonable. Since Minn. Stat. § 176.101, subd. 3e (1992), provides the employer and insurer only ninety days after MMI to make a suitable job offer and affords the employee only fourteen days to decide whether to accept such an offer, the ten-day period is appropriate. As the Department points out in its SONAR, "[t]he 10 day time frame will allow the employee an opportunity to discuss a job offer with a health care provider prior to making a decision about accepting or rejecting the job." SONAR at 23. The Department has demonstrated that it is needed and reasonable to require the health care provider to provide an opinion on the suitability of a proposed job in light of the worker's medical restrictions in a prompt fashion. The rule is crafted to impose as light a burden on the provider as is possible given the statutory mandate.

Proposed Rule 5221.0430 - Change of Health Care Provider

Subpart_l -_Primary Health_Care Provider

57. Proposed rule 5221.0430, subpart 1, codifies the Department's current practice, which is to allow employees to have only one primary health care provider at a time. A provider is considered the primary health care provider if the employee receives medical care from that provider on at least two occasions after the injury and if that provider "directs and coordinates the course of medical care provided to the employee." Subpart 2 indicates when changes of a primary health care provider can occur. Jnlimited changes are possible if the employee and payer agree on the changes. Only where the change is opposed does the subpart have an effect on the choice of primary health care provider.

The Minnesota AFL-CIO commented that it was concerned that the definition of "primary health care provider" would exclude the individual's long term health care provider. Assuming that the employee wishes to select his or her long term health care provider and that individual is willing to direct and coordinate the care provided to the employee, the proposed rule should not interfere with that choice. Subpart I has been shown to be needed and reasonable.

Subpart_2_-_ChAnge of-Health Care Provider

58. Under subpart 2, an injured worker may change primary providers once during the first sixty days after treatment for the injury begins, without approval from any source. Transfers that are beyond the control of the worker, such as the primary provider no longer offering care or referring the worker to another provider, do not exhaust the employee's right to a change of provider without approval under this provision. After sixty days, a change in primary health care provider may only be accomplished with the approval of the insurer, the Department, or a Compensation Judge. Employees covered by managed care plans are governed by Minn. Stat. □ 176.1351, subd. 2(11), Minn. Rules Chapter 5218, and the procedures of their plans.

State Fund supported the limitations on changes of health care providers as "reasonable and likely to result in cost savings to the system overall." The Minnesota AFL-CIO expressed concern that the proposed rules setting forth standards to govern changes in health care providers are unduly restrictive and exceed the scope of the statute. Daniel C. Berglund, Falsani, Balmer, Berglund & Merritt, also argued that the proposed rules are inconsistent with the statute.

Minn. Stat. § 176.135, subd. 2 (1992), governs changes in the primary health care providers of employees who are not covered under a managed care plan. The statute provides in pertinent part that "[t]he commissioner shall adopt rules establishing standards and criteria to be used when a dispute arises over a change of physicians, podiatrists, or chiropractors in the case that either the employee or the employer desire a change." Minn. Stat. § 176.83, subd. 8 (1992), further authorizes the Commissioner to promulgate "[r]ules establishing standards or criteria under which a physician, podiatrist, or chiropractor is selected or under which a change of physician, podiatrist, or chiropractor is allowed under section 176.135, subdivision 2." The Commissioner thus is granted express statutory authority to establish the

standards by which a change-of-provider dispute will be resolved. The approach adopted by the Department in subpart 2 is needed and reasonable to protect the employee's right to exercise one free choice to change to another health care provider while imposing reasonable limitations on the time within which such a change may occur.

Subpart-! --Unauthorized Change: Prohibited Payment

59. As originally proposed, subpart 3 provided that, if the employee or health care provider failed to obtain the required approval of a change in provider before treatment was commenced, the treatment rendered prior to approval would be deemed inappropriate and would not be compensable unless the insurer agreed to pay. Mark Fellman, Sieben, Polk, LaVerdiere, Jones & Hawn, commented that necessary treatment should be compensated regardless of whether or not a change of doctor is authorized. The Minnesota Medical Association asserted that the rule was unfair to providers who are acting in good faith and are unaware that they are treating compensable injuries.

The Department agreed with the MMA that the provider should not be penalized for the worker's failure to obtain required approval before the commencement of treatment, and modified the subpart following the hearing. As modified, the first sentence of subpart 3 provides that, "[i]f the employee or health care provider fails to obtain approval of a change of provider before commencing treatment where required by this part, the insurer is not liable for the treatment rendered prior to approval unless the insurer has agreed to pay for the treatment." The proposed rules as modified would allow the health care provider to seek payment from the employee under such circumstances. Subpart 3 is needed and reasonable to establish incentives for employees to adhere to the change of provider procedures. The modification does not result in a substantial change from the rule as originally proposed.

Supart 4 - Change of Primary Provider Not Approved

60. After the passage of the first sixty days following initiation of medical treatment or after the employee has exercised the right to change

providers once, any dispute regarding a further change of healthcare provider must be resolved by the Department, a certified managed care organization (if applicable), or a Compensation Judge. The proposed rule states that a party's request to change primary providers "may not [be] approved . . . where:

> A. a significant reason underlying the request is an attempt to block reasonable treatment or to avoid acting on the provider's opinion concerning the employee's ability to return to work;
>
> B. the change is to develop litigation strategy rather than to pursue appropriate diagnosis and treatment;
>
> C. the provider lacks the expertise to treat the employee for the injury;
>
> D. the travel distance to obtain treatment is an unnecessary expense and the same care is available at a more reasonable location;

E. at the time of the employee's request, no further treatment is needed; or

F. for another reason, the request is not in the best interest of the employee and the employer.

The Minnesota AFL-CIO asserted that the additional limitations on changes of providers set forth in subpart 4 are unduly restrictive and beyond the scope of the statutes related to permitted health care providers. As discussed in Finding 58 above, Minn. Stat. □□ 176.135, subd. 2, and 176.83, subd. 8 (1992), provide express authority for the promulgation of rules establishing standards or criteria under which a change of provider is to be allowed.

The existing rules specify that, if the adverse party "fail[s] to respond to the proposed change of physician within 20 days of the filing of the M-10 form, the change must be granted unless the change is clearly not in the best interest of the employee." Minn. Rules pt. 5220.2620, subp. 7 (1991). At the hearing and in its SONAR, the Department indicated that the proposed rules are designed to more clearly identify the situations in which a change in provider should not be approved, based on decisions from previous cases. T. 393; SONAR at 26. The sixth factor set forth in the rule reflects the general test contained in the existing rule that a change of doctor should not be allowed if it is not in the best interest of the parties. SONAR at 26. The Department stated that the list is not intended to be exhaustive and acknowledged that other factors may also be significant. Id.

The Department has shown that, where the listed factors are present, approval for a change of provider should be denied. While the sixth criterion, that the request is not "in the best interest of the employee and the employer," is somewhat vague, the "best interests" approach is utilized in the current rules, which were found to be needed and reasonable in a previous rulemaking proceeding. In addition, because the sixth factor is meant to be a "general test," SONAR at 26, it is unlikely that the rule "could be significantly more precise in this kind of regulatory scheme." Cap MAnufacturers-Institute. Inc..v. State, 289 N.W.2d 416, 423 (Minn. 1979).

The use of the word "may" in the rule suggests, however, that the request may be approved even where the factors set forth in the rule are found to be present. The use of the term "may" instead of "shall" in this circumstance may create unfettered discretion and permit decisionmakers to treat persons who are in similar situations differently. The Department has not shown that the decisionmaker should have the discretion to grant the requested change despite the presence of the listed criteria in a particular case. The use of "may" is a defect in the rules. The defect may be corrected by changing "may" to "shall." The suggested modification would not result in a rule that is substantially different from that originally proposed.

Proposed Rule 5221.0500 - Excessive Charge and Limitation of Payer Liability

Subpart 1 - Excessive Health Care Provider Charges

61. Subpart I of proposed rule 5221.0500 alters the existing rule pertaining to excessive charges by health care providers. Subpart I specifies

that a billing charge is excessive of any of the conditions set forth in items A to IIO are applicable, and payers are expressly relieved from liability for charges which are excessive. Charges are deemed excessive if the charge: (1) is duplicative; (2) exceeds the provider's usual and customary charge in other contexts; (3) uses an improper billing code; (4) is for a service that does not comply with the Department's treatment standards; (5) is for a service that was performed by a prohibited provider; (6) is for a service that is not usual, customary, and reasonably required or is provided at a level, duration, or frequency that is excessive; (7) is for a service that violates the Medicare antikickback standards; (8) is submitted by a provider for whom proper approval for change of provider was not obtained; or (9) is for a service that is outside the provider's scope of practice.

The Minnesota Hospital Association strenuously objected to the excessive charge provision as being unreasonable. The Association argued that the rule expands the conditions under which the payer may refuse to make payment to a provider and will require that hospital providers "render service completely at their own peril." The Association asserted that payers improperly use the existing denial of payment provisions to delay payment or coerce "discounts" from health care providers. The Association also contends that the rule will add to a "staggering backlog of cases currently pending appeal." It recommended that the proposed rule be modified to include the requirement that carriers provide hospitals and other providers with a toll free number and a system whereby prior authorization can be given to providers. The Association and HealthSpan also suggested that insurers be required to pay the submitted bill and then undertake an appeal to resolve the dispute. While the Department modified the managed care rules to require provision of a toll-free number, it did not modify the rules regarding non-managed-care plan situations.

Minn. Stat. 176.136, subd. 2 (1992), precludes any payment in excess of the amount the employer or insurer determines is reasonable, subject to the

provider's appeal. Minn. Stat. 176.135, subd. 6 (1992), requires denial of all or part of a charge if that charge is excessive, not compensable, not properly submitted, or inadequately supported by medical documentation. Because the rule cannot properly require payment prohibited by statute, the Department declined to modify the rule as suggested by the Minnesota Hospital Association. The Department has demonstrated that the rule is needed and reasonable as proposed. The rule is not rendered unreasonable by its failure to require that insurers provide a toll-free number.

62. The Minnesota Medical Association objected to the inclusion of the antikickback provision set forth in subpart 1, item G. The Department maintains that Minn. Stat. 62J.23 governs all health care providers. Subdivision I of that statute provides in pertinent part:

> The commissioner of health shall adopt rules restricting financial relationships or payments or payment arrangements involving health care providers under which

10As originally proposed, the rule referred to items A to "G." This typographical error was corrected by the Department in its post-hearing submissions. The correction does not constitute a substantial change.

> a provider benefits financially by referring a patient to another provider, recommending another provider, or furnishing or recommending an item or service. The rules must be compatible with, and no less restrictive than, the federal Medicare antikickback statute

Chapter 62J does not exempt workers' compensation providers from the antikickback restrictions. The Department has demonstrated that its rule conforms to the statutory approach set out in Minn. Stat. 62J.23 (1992) and that item G is needed and reasonable.

Subpart 2 Limitation of Payer Liability

63. Subpart 2 of the proposed rules describes the payer's liability for payment where charges are not excessive under subpart 1. The proposed rules specify that the payer's liability is limited to the maximum amount allowed under the relative value fee schedule or the provider's usual and customary fee, whichever is lower. If the service is not included in the fee schedule, the payer's liability is limited to eighty-five percent of the provider's usual and customary charge or the prevailing charge for similar treatment, whichever is lower. The proposed rule includes definitions of "usual and customary charge" and "prevailing charge." The proposed rule also reiterates the statutory requirements for hospital and nursing home charges.

In order to reduce costs, State Fund recommended that "usual and customary" be defined as "the lowest amount actually billed by the health care provider to any payer for the same service, whether workers' compensation or not, and regardless of the amount actually reimbursed under a contract or government payment system." The Department declined to adopt State Fund's suggestion on the ground that such an approach "would be equally difficult to administer and determine, because some provider's bills may reflect the contracted amount in cases outside the workers' compensation system. It is likely that the term "usual and customary" means the typical charge, not the lowest charge, in response to a specific contract." Department's August 19,

1993, submission at 3. The Department stressed that providers are required by law to bill the same amount for a service regardless of whether the payer is workers' compensation, a government agency, or a third party administrator. The Department has demonstrated that its interpretation of "usual and customary" is needed and reasonable.

64. State Fund suggested that subpart 2D limit the amount to be charged by large hospitals (those with more than 100 beds) for outpatient procedures not encompassed within the relative value fee schedule to eighty-five percent of the hospital's usual and customary or prevailing charge. This change was suggested to apply the fifteen percent reduction required by Minn. Stat. 176.136, subd. lb(b) (1992) to certain charges not otherwise covered in the rules. The Department agreed that the suggested approach conformed to the statute's intent and modified item D in its post-hearing comments as follows:

> Under Minnesota Statutes, section 176.136, subdivision lb, paragraph (b), payment for services, articles, and supplies provided to an employee who is an inpatient at a hospital with more than 100 licensed beds shall be limited to 85 percent of the hospital's usual and customary charge as defined in item B, or 85 percent of

> the prevailing charge as defined in item B, whichever is lower. Outpatient charges for hospitals with more than 100 beds are limited by the maximum fees for any service set forth in parts 5221.4000 to 5221.4070. For hospitals with more than 100 beds, liability for outpatient charges that are not included in parts 5221.400O to 5221 4070 is limited to 85 percent of the hospital's usual and customary, or prevailing charge, as defined in item B. A hospital charge is considered an inpatient charge if the employee spent either the night before or the night after the service in the hospital, and there is an overnight room charge.

Subpart 2D, as modified, is needed and reasonable to conform the rule to statutory requirements. The modification made by the Department does not constitute a substantial change.

Proposed Rule 5221,0600 - Payer Responsibilities

65. The proposed rules amend the existing rule on payer responsibility to clarify the payer's responsibility to review and pay medical bills in a prompt fashion and to keep the employee and health care provider informed of its determinations. The proposed rule adds new language permitting payers to determine the correct code for a service if an incorrect code has been assigned and evaluate liability for payment on the basis of the correct code. L.L. Ault, M.D., of Orthopaedic Surgery, P.A. objected to allowing payers to change the service codes. In its SONAR, the Department explained that payers need the ability to correct code errors in order to carry out the fee schedule requirements, SONAR at 29, The Department pointed out that notice of any reduction in payment resulting from the recoding must be given to the provider and the employee under subpart 4. The Department has shown that proposed rule 5221.0600 is needed and reasonable to clarify the payer's responsibilities and to provide incentives to health care providers to submit proper codes.

Proposed Rule 5221.0650 - Data Collection, Retention and Reporting Requirements

66. As originally proposed, subpart 3 of the proposed rules required that workers' compensation insurers, self-insurers, group self-insurers, adjusters, and third party administrators collect and store specified types of

data for ten years from the date the service or supply was provided. Christopher Roe of the American Insurance Association ("AIA") argued that the ten-year retention period was too long and was inconsistent with national standards. AIA also asserted that it is unreasonable to require insurers to have a computerized data collection system in place by January 1, 1994. In response, the Department asserted that ten years of treatment history is required to adequately monitor and evaluate long-term cases, but acknowledged that ten years from the date of service was a "complicated and unwieldy" standard. The Department also indicated that the January 1, 1994, date was not intended for data collection, although it recognized that a date should be specified for compliance. Department's August 19, 1993, submission at 4. The Department proposed to modify the language of subpart 3 to provide that the "[d]ata described in subpart 4 shall be collected and stored by the parties listed in subpart 1, beginning July 1, 1994, for all medical services and supplies provided to an employee under Minnesota Statutes, chapter 176, for

ten years from the date of injury or four years from the date the claim is closed, whichever is later." The rule, as modified, has been shown to be needed and reasonable. The compliance date selected by the Department affords affected insurers eight months' lead time. The modification does not result in a prohibited substantial change.

67. AIA pointed out that the rules are not consistent with national standards and suggested that the Department work with the International Association of Industrial Accident Boards and Commissions (IAIABC) in its development of a national uniform medical data reporting system. The Department stated in its post-hearing response that there is no standard yet existing for the type of data required by the rule. The Department indicated that it is working with the IAIABC to develop recommendations for electronic data reporting and is interested in facilitation electronic data interchange once national standards have been set. Until such national standards are established, the approach adopted in the proposed rules is needed and reasonable.

Proposed Rule 5221.0700 - Provider Responsibilities

68. Proposed rule part 5221.0700 amends the current rule setting forth the responsibilities of providers in submitting claims for payment. A new subpart la is added which states that all health care providers subject to the rules are bound by the federal Medicare antikickback statute and regulations adopted thereunder and that services or supplies provided in violation of these provisions are not compensable under the workers' compensation laws. The basis for this provision was discussed and approved in Finding 62 above The proposed rules modify subpart 2 to clarify when appropriate records must be submitted and to require greater specificity from providers in information submitted to support outside testing, specially-ordered equipment, hospital services, or outpatient medications. The proposed rules also require the use of two uniform billing forms. Subpart 2a requires nonhospital providers to submit the HCFA 1500 claim form, and subpart 2b requires hospitals to use the

uniform billing claim form UB-92 (HCFA 1450). The rules include instructions for completing the uniform billing forms.

69. The Minnesota Hospital Association urged that billing data be standardized and that the use of the HCFA 1450 form not be compromised by requiring additional information to be submitted with the form. The MHA emphasized that such additional information must be added manually and will preclude the electronic submission of bills. The Association also asserted that the proposed rules will make the submission of outpatient claims more difficult by requiring item-by-item reporting with approved billing codes, modifiers, and the date each service was provided, and emphasized that many emergency room services do not have CPT/HCPCS codes used in the relative value fee schedule. The Department pointed out in response that workers' compensation insurers are required to examine provider charges prior to payment. Further, Minn. Stat. 176.135, subd. 7 (1992), requires that health care providers submit to insurers "an itemized statement of charges on a billing form prescribed by the commissioner." The Department has the authority to specify what information should be included on the form and what, if any, additional information must accompany the form.

70. Following the hearing, the Department proposed several minor modifications to subparts 2b. Subpart 2b, item 11, subitem (1) was modified to require that the UB-92 (HCFA 1450) form include the following information:

"where a code is assigned to a service, the approved procedure codes and modifiers appropriate for the service, in accordance with subpart 3. Charges for supplies need not be coded, but a description and charge for specific articles and supplies billed must be itemized." Subpart 2b, item 16 was modified to refer to the "CPT-4" code rather than the "ICD 9 CM" code. These changes clarify the rules and facilitate the reporting of relevant information. The reporting requirements are needed and reasonable, as modified. The modifications do not constitute substantial changes.

71. Subpart 2c governs charges submitted for outpatient or independent pharmacy medications. MMA asserted that the Department lacked statutory authority to adopt this rule. This assertion was not explained or supported by statutory citation. The Department has in the past limited the amount that can be charged for pharmaceuticals for workers' compensation treatment. The information originally required "the procedure code for the medication" under item H. As discussed in Finding 37, above, the Department modified the item to require "the prescription number of the medication" The Department also modified the first paragraph of subpart 2c to provide that "itemized charges for all hospital outpatient and independent pharmacy medications provided for a claimed workers' compensation injury must be submitted to the payer on a claim form" which includes the information set forth in items A through K. These modifications clarify the rule relating to pharmacy charges and do not result in a rule that is substantially different from that originally proposed. The Department has demonstrated that subpart 2c, as modified, is needed and reasonable.

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Minnesota Department of Labor and Industry gave proper notice of this rulemaking hearing.

2. The Department has substantially fulfilled the procedural

requirements of Minn. Stat. □□ 14.14, subds. 1, la, and 2 (1992), and all other procedural requirements of law or rule so as to allow it to adopt the proposed rules,

3. The Department has demonstrated its statutory authority to adopt the proposed rules, and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. □□ 14.05, subd. 1, 14.15, subd. 3, and 14.50 (i) and (ii) (1992), except as noted in Finding 60 above.

4. The Department has demonstrated the need for and reasonableness of the proposed rules by an affirmative presentation of facts in the record within the meaning of Minn. Stat. □□ 14.14, subd. 2 and 14.50 (iii) (1990), except as noted in Finding 39 above.

5. The additions and amendments to the proposed rules which were suggested by the Department after publication of the proposed rules in the State Register do not result in rules which are substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. □ 14.15, subd. 3 (1992), and Minn. Rules pts. 1400.1000, subp. I and 1400.1100 (1991).

6. The Administrative Law Judge has suggested action to correct the defects cited at Conclusions 3 and 4 as noted at Findings 39 and 60.

7. Due to Conclusions 3, 4 and 6, this Report has been submitted to the Chief Administrative Law Judge for his approval pursuant to Minn. Stat. 14.15, subd. 3 (1992).

8. Any Findings which might properly be termed Conclusions and any Conclusions which might properly be termed Findings are hereby adopted as such.

9. A Finding or Conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the Department from further modification of the proposed rules based upon an examination of the public comments, provided that no substantial change is made from the proposed rules as originally published, and provided that the rule finally adopted is based upon facts appearing in this rule hearing record.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS HEREBY RECOMMENDED that the proposed rules be adopted except where specifically otherwise noted above.

Dated this 18th day of October, 1993.

BARBARA L. NEILSON
Administrative Law Judge

Reported: Transcript prepared by Angela D. Sauro
Court Reporter
Kirby Kennedy & Associates
(Relative Value Medical Fee Schedule Rules and
Medical Rules of Practice - two volumes)