



**Medical Services Review Board
April 17, 2008
Minutes**

Members Present:

Beth Baker, M.D.
Barbara Baum
Sharon Ellis, R. N.
Barb Gibson, M.D.
Rose Hatmaker
Charles Hipp, M.D.
Robin Peterson, PT

Members Excused:

Philip Bachman, M.D.
Michael Goertz, M.D.
Kathi Hendrickson, R.N.
Elizabeth Shogren, R.N.
Andrew Schmidt, M.D.
Jon Talsness, M.D.
Andrea Trimble Hart

Members Absent:

Jeffrey Bonsell, D.C.
Gregory Hynan, D.C.
Reed Pollack

Staff:

Kate Berger
Debbie Caswell
Penny Grev
William Lohman, M.D.
Lisa Wichterman
Jana Williams

Visitors:

Chuck Cochrane; MNAJ
Judy Hawley, PT; MN Amer. Physical
Therapy Assn
Nilani Jayatilaka, MN Medical Association
Jen Samuels; Medical Advanced Pain
Specialists

The meeting was called to order by Chairperson Beth Baker. A quorum was present. Members and staff introduced themselves. Barbara Gibson was introduced as a new member and will serve as a physician alternate.

Approval of the January 17, 2008, Minutes

Sharon Ellis made a motion to approve the January 17, 2008, minutes as presented. Charles Hipp seconded the motion. All voted in favor of the motion and it passed.

Assistant Commissioner Announcements and Update

Penny Grev, Director of the department's Benefit Management and Resolution unit, gave an update on legislation in Patricia Todd's absence. She noted the Workers' Compensation Advisory Council (WCAC) bill was at the legislature and reviewed the key points. The bill passed through the Senate and is at the House for approval and then it will go to the governor.

Grev reported that the commissioner formed three main WCAC Work Groups and one subcommittee. They will look at key areas under discussion this year that need more work before they are brought forth by the WCAC.

- The Billing and Auditing Work Group will be an interaction between payers and providers to provide information about what can or cannot be repriced. This should eliminate some billing hassles. Their recommendations are due to the WCAC by September 1, 2008.
 - The Billing and Auditing Subgroup for the Repricing Industry will establish a code of conduct as it applies to Minnesota's workers' compensation system and make reform-based recommendations to the Billing and Auditing Work Group by July 1, 2008.
- The Employer Choice Work Group will make recommendations for reform to the WCAC by October 1. It will focus on employer choice workers' compensation and continuation of health care after FMLA standards have been met. They will explore whether that will work in Minnesota and whether it would be more efficient.
- The Vocational Rehabilitation Work Group will review the current practices of QRCs, a professional code of conduct and doing the right things the right way at the most efficient cost. Their recommendation is due by August 1, 2008.

Summaries from the meetings of these work groups will be available online at http://www.doli.state.mn.us/wcac_workgroups.html for those interested in what is happening.

Grev introduced Lisa Wichterman. She was hired to fill the Program Administrator position vacated by Julie Marquardt. Wichterman will be the department's contact for medical issues.

Baker noted that the RVUs can be updated when the WCAC bill passes. The conversion factor will be adjusted if necessary so that change to updated RVUs is revenue neutral. The RVUs will be updated at least every three years using a simpler rulemaking process to change the tables for the RVUs. Another major medical change is that providers in other states will be reimbursed at the rate payable in their state for workers' compensation medical services.

Treatment Parameters
Spinal Cord Stimulators and Morphine Pumps

Lohman proposed that members vote on each recommendation as a separate motion and all agreed. The comments received at the meeting and the actions to be taken are listed in the table below.

	Comment	Action Taken
p. 1 l. 31	What are the psychological contraindications?	No change. While guidelines state that "evident unresolved major psychiatric comorbidity" is a contraindication, specific disorders are not identified. This is a clinical judgment made on an individualized basis given all of the clinical facts of the case.

Lohman reviewed the draft rules for Intrathecal Drug Delivery Systems. He explained his research and reviewed the comments and recommendations on his handout. Lohman pointed out his handout in the packets

with information about the pool of articles and the results of the review. He quoted the authors where possible and the references are active links so that the information can be verified. All authors found that there is a role for the use of intrathecal delivery systems. This information will be posted on the department's Web site for members' review when it is completed. This information was provided for discussion; decisions will be made at a later date when the members have been able to review the completed research and report.

Lohman reviewed a handout about the trial period for intrathecal drug delivery systems. He presented draft language and reviewed DLI's recommendation regarding the appropriate trial period and which intrathecal medications are allowed, for discussion at the next meeting. Lohman asked that any comments be sent to him to be put into a grid so that the Board can deal with each recommendation specifically.

Lohman asked for discussion. Baker noted she has only seen one-day trial periods. Lohman thought the longer trial periods were in a hospital environment where you see three to eight-day trial periods. The tendency was to have a shorter trial period for outpatients. There were no other comments.

A visitor, Charles Cochrane, from the Minnesota Association for Justice, asked about the use of the term "second opinion" in the draft and whether DLI was using that term as it was defined in the workers' compensation statute. Kate Berger noted that the proposed rule would require a second opinion when a spinal cord stimulator or intrathecal drug delivery system has been recommended. This would not be an optional second opinion as referenced in the statute. Cochrane then asked who decides who will do the second opinion. Lohman responded that the treatment parameter rules do not specify in other sections where a second opinion is required. Any recommendations or comments on this issue should be emailed to Lohman at bill.lohman@state.mn.us. The matter will be discussed again and the Board will be asked to make an explicit recommendation.

Old Business

Lohman stated that the PPD rules are on the list of rules to be moved forward. They are going through them to correct punctuation and the incorrect changes. The proposed low back language was left out.

Lohman reviewed two treatment parameter rules that have been completed. DLI is going forward with the rules for choice of nonsteroidal anti-inflammatories, muscle relaxants, and opioid analgesics. One change was made, for internal reasons; the proposed rules on long-term use of opiates are not ready yet so the cross-reference to those rules had to be removed from the proposed rules on choice of opioid analgesics. Lohman pointed out the handout on the medication draft rules and reviewed C (3) on page two where the following will replace the cross-reference to the proposed rule on long term use of opiates:

- (3) Oral opioid analgesics prescribed more than 12 weeks after the injury may be for more than one month of medication per prescription if there has been a clinical evaluation to confirm the need for and efficacy of the prescription and a clinical evaluation at least every six months thereafter during continued use of opiate analgesics.

Lohman asked for MSRB approval of this language to replace the previous language.

Hipp made a motion to approve the language as presented. Barbara Baum seconded the motion. All voted in favor of the language.

Lohman reviewed the draft rules with changes to the current treatment parameters. He noted the proposed language on page 4, line 46, which states, "A functional capacity evaluation is not appropriate to establish baseline performance before treatment, or to evaluate change in performance during a course of treatment." Robin Peterson expressed concern that they not limit workers' access to treatment. Lohman asked for recommendations. Discussion occurred and it was agreed that Peterson and Baum would make a recommendation to Lohman and they would work together to come up with some alternative language for consideration at the next meeting.

Lohman asked for any additional input at the meeting and noted that DLI will now be drafting Statements of Need and Reasonableness (SONARs) for the PPD changes, the medication choice rules and the changes to the current treatment parameters as the next step in the rulemaking process.

Baker asked what issues the MSRB would discuss after spinal cord stimulators. Lohman responded that the lineup the board had discussed was prolotherapy and botox injections next. Then, in response to issues brought to DLI, the department recommended that traction and TENS technologies be evaluated after that. Then, as recommended by the board, the MSRB wanted to look at epidurals, facet joint, and intradiscal injections.

Hipp made a motion to adjourn the meeting at 5:17 p.m. Rose Hatmaker seconded the motion. All voted in favor of the motion and it passed.

Respectfully submitted,



Debbie Caswell
Executive Secretary

dc/s

Comments Received and Recommendations Re: Proposed Rules for Spinal Cord Stimulators

Comment	Recommendation
p. 1 1.31 What are the psychological contraindications?	No change. While guidelines state that "evident unresolved major psychiatric comorbidity" is a contraindication, specific disorders are not identified. This is a clinical judgment made on an individualized basis given all of the clinical facts of the case.

1 **5221.6030 INCORPORATION BY REFERENCE.**

2 The ICD-9-CM diagnostic codes referenced in parts 5221.6010 to 5221.6600 are contained in the
3 ~~fourth edition of the~~ International Classification of Diseases, Clinical Modification, 9th Revision, 1994,
4 and corresponding annual updates. This document is subject to annual revisions and is incorporated by
5 reference. It is published by the United States Department of Health and Human Services, Health Care
6 Financing Administration, and may be purchased through the Superintendent of Documents, United
7 States Government Printing Office, Washington, D.C. 20402. It is available through the Minitex
8 interlibrary loan system.

9
10 **5221.6040 DEFINITIONS.**

11 **For text of subpart 1, see M.R.**

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

16 **For text of subs 3 to 10, see M.R.**

17 Subp. 10a. Narcotic. "Narcotic" is as defined in Minnesota Statutes, section 152.01, subdivision 10.

18 **For text of subp 11 to 13, see M.R.**

19
20 **5221.6050 GENERAL TREATMENT PARAMETERS; EXCESSIVE TREATMENT;**
21 **PRIOR NOTIFICATION.**

22 Subpart 1. **General.**

23 **For text of item A, see M.R.**

24 B. The health care provider must evaluate at each visit whether initial nonsurgical treatment for the
25 low back, cervical, thoracic, and upper extremity and reflex sympathetic dystrophy conditions specified
26 in parts 5221.6200, 5221.6205, 5221.6210, and 5221.6300, and 5221.6305, is effective according to
27 subitems (1) to (3). No later than any applicable treatment response time in parts 5221.6200 to
28 ~~5221.6300~~ 5221.6305, the health care provider must evaluate whether the passive, active, injection, or
29 medication treatment modality is resulting in progressive improvement as specified in subitems (1) to
30 (3):

31 **For text of subitems (1) and (3), see M.R.**

32 **For text of item C, see M.R.**

33 **For text of subs 2 to 9, see M.R.**

34 Subp. 9. **Prior notification; health care provider and insurer responsibilities.** Prior notification
35 is the responsibility of the health care provider who wants to provide the treatment in item A. Prior
36 notification need not be given in any case where emergency treatment is required.

37 **For text of subitems (3) and (4), see M.R.**

38 **For text of items A to B, see M.R.**

39 C. The insurer must provide a toll-free facsimile and telephone number for health care providers to
40 provide prior notification. The insurer must respond orally or in writing to the requesting health care
41 provider's prior notification of proposed treatment in item A within seven working days of receipt of the
42 request. Within the seven days, the insurer must either approve the request, deny authorization, request
43 additional information, request that the employee obtain a second opinion, or request an examination by
44 the employer's physician. A denial must include notice to the employee and health care provider of the
45 reason why the information given by the health care provider in item B does not support the treatment
46 proposed, along with notice of the right to review of the denial under subitem (3).

47 **For text of subitems (1) to (4), see M.R.**

1 (5) If prior notification of surgery is required under item A, subitem (3), the insurer may require
2 that the employee obtain a second opinion from a physician of the employee's choice under Minnesota
3 Statutes, section 176.135, subdivision 1a. If within seven working days of the prior notification the
4 insurer notifies the employee and health care provider that a second opinion is required, the health care
5 provider may not perform the nonemergency surgery until the employee provides the second opinion
6 to the insurer. Except as otherwise provided in parts 5221.6200, subpart 6, items B and C;
7 5221.6205, subpart 6, items B and C; 5221.6210, subpart 6, items B and C; 5221.6300, subpart 6,
8 item B; and 5221.6305, subpart 3, item B, if the insurer denies authorization within seven working
9 days of receiving the second opinion, the health care provider may elect to perform the surgery, subject
10 to a determination of compensability by the commissioner or compensation judge under subpart 7.

11 **For text of subitems (6) and (7), see M.R.**

12 **For text of subs 10 and 11, see M.R.**

13
14 **5221.6100 PARAMETERS FOR MEDICAL IMAGING.**

15 **For text of subpart 1, see M.R.**

16 Subp. 2. **Specific imaging procedures for low back pain.** Except for the emergency evaluation of
17 significant trauma, a health care provider must document in the medical record an appropriate history
18 and physical examination, along with a review of any existing medical records and laboratory or
19 imaging studies regarding the patient's condition, before ordering any imaging study of the low back.

20 **For text of item A, see M.R.**

21 B. Magnetic resonance imaging (MRI) scanning is indicated any time that one of the following
22 conditions is met:

23 (1) when cauda equina syndrome is suspected;

24 (2) for evaluation of progressive neurologic deficit;

25 (3) when previous spinal surgery to the lumbar spine has been performed and there is a need to
26 differentiate scar due to previous surgery from disc herniation, tumor, or hemorrhage; or

27 (4) suspected discitis.

28 Except as specified in subitems (1) to (4), MRI scanning is not indicated in the first eight weeks after
29 an injury.

30 Magnetic resonance imaging scanning is indicated after eight weeks if the patient continues with
31 symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition
32 prevents the resumption of the regular activities of daily life including regular vocational activities.

33 C. Myelography is indicated in the following circumstances:

34 (1) may be substituted for otherwise indicated CT scanning or MRI scanning in accordance with
35 items A and B, if those imaging modalities are not locally available;

36 (2) in addition to CT scanning or MRI scanning, if there ~~are~~ is progressive neurologic deficits ~~or~~
37 ~~changes~~ deficit and CT scanning or MRI scanning has been negative; or

38 (3) for preoperative evaluation in cases of surgical intervention, but only if CT scanning or MRI
39 scanning have failed to provide a definite preoperative diagnosis.

40 D. Computed tomography myelography is indicated in the following circumstances:

41 (1) the patient's condition is predominantly sciatica, and there has been previous spinal surgery to
42 the lumbar spine, and tumor is suspected;

43 (2) the patient's condition is predominantly sciatica and there has been previous spinal surgery to
44 the lumbar spine and MRI scanning is equivocal;

45 (3) when spinal stenosis is suspected and the CT or MRI scanning is equivocal;

46 (4) in addition to CT scanning or MRI scanning, if there ~~are~~ is progressive neurologic ~~symptoms or~~
47 ~~changes~~ deficit and CT scanning or MRI scanning has been negative; or

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1 (5) for preoperative evaluation in cases of surgical intervention, but only if CT scanning or MRI
2 scanning have failed to provide a definite preoperative diagnosis.

3 E. Intravenous enhanced CT scanning is indicated only if there has been previous spinal surgery to
4 the lumbar spine, and the imaging study is being used to differentiate scar due to previous surgery from
5 disc herniation or tumor, but only if intrathecal contrast for CT-myelography is contraindicated and
6 MRI scanning is not available or is also contraindicated.

7 F. Gadolinium enhanced MRI scanning is indicated when:

8 (1) there has been previous spinal surgery to the lumbar spine, and the imaging study is being used
9 to differentiate scar due to previous surgery from disc herniation or tumor;

10 **For text of subitems (2) to (5), see M.R.**

11 G. Discography is indicated when:

12 **For text of subitem (1), see M.R.**

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

15 **For text of items H to M, see M.R.**

16
17 **5221.6200 LOW BACK PAIN.**

18 Subpart 1. **Diagnostic procedures for treatment of low back injury.** A health care provider shall
19 determine the nature of the condition before initiating treatment.

20 **For text of items A to H, see M.R.**

21 I. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a
22 patient's ability to perform work tasks. The components of a functional capacity assessment or
23 evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material
24 handling, assessment of functional mobility, and measurement of postural tolerance. A functional
25 capacity assessment or evaluation is an individualized testing process and the component tests and
26 measurements are determined by the patient's condition and the requested information. Functional
27 capacity assessments and evaluations are performed to determine and report a patient's physical
28 capacities in general or to determine work tolerance for a specific job, task, or work activity.

29 **For text of subitems (1) and (2), see M.R.**

30 (3) A functional capacity evaluation is not appropriate to establish baseline performance before
31 treatment, or to evaluate change in performance during a course of treatment.

32 **For text of subitem (4), see M.R.**

33 **For text of item J, see M.R.**

34 **For text of subpart 2, see M.R.**

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

36 **For text of items A to D, see M.R.**

37 E. Electrical muscle stimulation includes, but is not limited to, muscle stimulation, low volt therapy,
38 sine wave therapy, stimulation of peripheral nerve, galvanic stimulation, TENS, interferential, and
39 microcurrent techniques.

40 **For text of subitems (1) and (2), see M.R.**

41 F. Mechanical traction: is the therapeutic use of mechanically induced tension created by a pulling
42 force to produce a combination of distraction and gliding to relieve pain and increase flexibility.
43 Mechanical traction may be continuous, static, intermittent, inversion, gravity, or positional.
44 Mechanical traction includes, but is not limited to, intersegmental motorized mobilization, vertebral
45 axial decompression, autotraction (active), and 90/90.

46 **For text of subitems (1) and (2), see M.R.**

47 G. Acupuncture treatments. ~~Endorphin-mediated analgesic therapy includes classic acupuncture~~

1 and acupressure:

2 For text of subitems (1) to (3), see M.R.

3 H. Manual therapy includes soft tissue and joint mobilization, therapeutic massage, and, but is not
4 limited to, manual traction, myofascial release, joint mobilization and manipulation, manual lymphatic
5 drainage, soft-tissue mobilization and manipulation, trigger point therapy, acupressure, muscle
6 stimulation - manual (nonelectrical), and any form of massage:

7 For text of subitems (1) to (3), see M.R.

8 For text of items I to K, see M.R.

9 For text of subp 4 to 7, see M.R.

10 Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only in the
11 situations specified in items A to D. The health care provider must provide prior notification as
12 required in items B and C according to part 5221.6050, subpart 9.

13 For text of items A to C, see M.R.

14 D. The following durable medical equipment is not indicated for home use for any of the low back
15 conditions specified in subpart 1, item A:

16 For text of subitems (1) and (2), see M.R.

17 For text of subp 9, see M.R.

18 Subp. 10. **Scheduled and nonscheduled medication.** ~~Prescription of controlled substance~~
19 ~~medications scheduled under Minnesota Statutes, section 152.02, including without limitation,~~
20 ~~narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated~~
21 ~~in the treatment of patients with regional low back pain after the first two weeks.~~

22 ~~—Patients with radicular pain may require longer periods of treatment. The health care provider must~~
23 ~~document the rationale for the use of any scheduled medication.~~

24 ~~—Treatment with nonscheduled medication may be appropriate during any phase of treatment and~~
25 ~~intermittently after all other treatment has been discontinued. The prescribing health care provider must~~
26 ~~determine that ongoing medication is effective treatment for the patient's condition and that the most~~
27 ~~cost-effective regimen is used.~~

28 Prescription of medications may be indicated during any phase of treatment. Prescription of
29 nonsteroidal anti-inflammatory drugs, opioid analgesics, and muscle relaxants must comply with all of
30 the standards in part 5221.6XXX.

31 For text of subps 11 to 13, see M.R.

32
33 **5221.6205 NECK PAIN**

34 Subpart 1. **Diagnostic procedures for treatment of neck injury.** A health care provider shall
35 determine the nature of the condition before initiating treatment.

36 For text of items A to H, see M.R.

37 I. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a
38 patient's ability to perform work tasks. The components of a functional capacity assessment or
39 evaluation include, but are not necessarily limited to, neuromusculoskeletal screening, tests of manual
40 material handling, assessment of functional mobility, and measurement of postural tolerance. A
41 functional capacity assessment or evaluation is an individualized testing process and the component
42 tests and measurements are determined by the patient's condition and the requested information.
43 Functional capacity assessments and evaluations are performed to determine a patient's physical
44 capacities in general or to determine and report work tolerance for a specific job, task, or work activity.

45 For text of subitems (1) and (2), see M.R.

46 (3) A functional capacity evaluation is not appropriate to establish baseline performance before
47 treatment, or to evaluate change in performance during a course of treatment.

1 (4) Only one completed functional capacity evaluation is indicated per injury.

2 **For text of item J, see M.R.**

3 **For text of subp 2, see M.R.**

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

5 **For text of items A to D, see M.R.**

6 E. Electrical muscle stimulation includes, but is not limited to, muscle stimulation, low volt therapy,
7 sine wave therapy, stimulation of peripheral nerve, galvanic stimulation, TENS, interferential, and
8 microcurrent techniques.

9 **For text of subitems (1) and (2), see M.R.**

10 F. Mechanical traction: is the therapeutic use of mechanically induced tension created by a pulling
11 force to produce a combination of distraction and gliding to relieve pain and increase flexibility.
12 Mechanical traction may be continuous, static, intermittent, inversion, gravity, or positional.
13 Mechanical traction includes, but is not limited to, intersegmental motorized mobilization, vertebral
14 axial decompression, autotraction (active), and 90/90.

15 **For text of subitems (1) and (2), see M.R.**

16 G. ~~Acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture~~
17 ~~and acupressure:~~

18 **For text of subitems (1) to (3), see M.R.**

19 H. ~~Manual therapy includes soft tissue and joint mobilization, therapeutic massage, and, but is not~~
20 ~~limited to, manual traction, myofascial release, joint mobilization and manipulation, manual lymphatic~~
21 ~~drainage, soft-tissue mobilization and manipulation, trigger point therapy, acupressure, muscle~~
22 ~~stimulation - manual (nonelectrical), and any form of massage:~~

23 **For text of subitems (1) to (3), see M.R.**

24 **For text of items I to K, see M.R.**

25 **For text of subp 4 to 7, see M.R.**

26 **Subp. 8. Durable medical equipment.** ~~Durable medical equipment is indicated only as specified in~~
27 ~~items A to D. The health care provider must provide prior notification as required in items B and C~~
28 ~~according to part 5221.6050, subpart 9:~~

29 **For text of items A to C, see M.R.**

30 D. ~~The following durable medical equipment is not indicated for home use for any of the neck pain~~
31 ~~conditions specified in subpart 1, item A:~~

32 **For text of subitems (1) and (2), see M.R.**

33 **For text of subp 9, see M.R.**

34 **Subp. 10. Scheduled and nonscheduled medication.** ~~Prescription of controlled substance~~
35 ~~medications scheduled under Minnesota Statutes, section 152.02, including without limitation,~~
36 ~~narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated~~
37 ~~in the treatment of patients with regional low back pain after the first two weeks.~~

38 ~~—Patients with radicular pain may require longer periods of treatment. The health care provider must~~
39 ~~document the rationale for the use of any scheduled medication.~~

40 ~~—Treatment with nonscheduled medication may be appropriate during any phase of treatment and~~
41 ~~intermittently after all other treatment has been discontinued. The prescribing health care provider must~~
42 ~~determine that ongoing medication is effective treatment for the patient's condition and that the most~~
43 ~~cost-effective regimen is used.~~

44 Prescription of medications may be indicated during any phase of treatment. Prescription of
45 nonsteroidal anti-inflammatory drugs, opioid analgesics, and muscle relaxants must comply with all of
46 the standards in part 5221.6XXX

47 **For text of subps 11 to 14, see M.R.**

1
2 **5221.6210 THORACIC BACK PAIN.**

3 Subpart 1. **Diagnostic procedures for treatment of thoracic back injury.** A health care provider
4 shall determine the nature of the condition before initiating treatment.

5 **For text of items A to I, see M.R.**

6 I. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a
7 patient's ability to perform work tasks. The components of a functional capacity assessment or
8 evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material
9 handling, assessment of functional mobility, and measurement of postural tolerance. A functional
10 capacity assessment or evaluation is an individualized testing process and the component tests and
11 measurements are determined by the patient's condition and the requested information. Functional
12 capacity assessments and evaluations are performed to determine and report a patient's physical
13 capacities in general or to determine work tolerance for a specific job, task, or work activity.

14 **For text of subitems (1) and (2), see M.R.**

15 (3) A functional capacity evaluation is not appropriate to establish baseline performance before
16 treatment, or to evaluate change in performance during a course of treatment.

17 (4) Only one completed functional capacity evaluation is indicated per injury.

18 **For text of item J, see M.R.**

19 **For text of subp 2, see M.R.**

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

21 **For text of items A to D, see M.R.**

22 E. Electrical muscle stimulation includes, but is not limited to, muscle stimulation, low volt therapy,
23 sine wave therapy, stimulation of peripheral nerve, galvanic stimulation, TENS, interferential, and
24 microcurrent techniques.

25 **For text of subitems (1) and (2), see M.R.**

26 F. Mechanical traction: is the therapeutic use of mechanically induced tension created by a pulling
27 force to produce a combination of distraction and gliding to relieve pain and increase flexibility.
28 Mechanical traction may be continuous, static, intermittent, inversion, gravity, or positional.
29 Mechanical traction includes, but is not limited to, intersegmental motorized mobilization, vertebral
30 axial decompression, autotraction (active), and 90/90.

31 **For text of subitems (1) and (2), see M.R.**

32 G. Acupuncture treatments. ~~Endorphin-mediated analgesic therapy includes classic acupuncture~~
33 ~~and acupressure.~~

34 **For text of subitems (1) to (3), see M.R.**

35 H. Manual therapy ~~and massage~~ includes soft tissue and joint mobilization, therapeutic massage,
36 and, but is not limited to, manual traction, myofascial release, joint mobilization and manipulation,
37 manual lymphatic drainage, soft-tissue mobilization and manipulation, trigger point therapy,
38 acupressure, muscle stimulation - manual (nonelectrical), and any form of massage:

39 **For text of subitems (1) to (3), see M.R.**

40 **For text of items I to K, see M.R.**

41 **For text of subp 4 to 7, see M.R.**

42 Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only in certain
43 specific situations, as specified in items A to D. The health care provider must provide the insurer with
44 prior notification as required by items B and C, according to part 5221.6050, subpart 9.

45 **For text of items A to C, see M.R.**

46 D. The following durable medical equipment is not indicated for home use for any of the thoracic
47 back pain conditions specified in subpart 1, item A:

DRAFT RULES – FOR DISCUSSION PURPOSES ONLY: 02-07-08

1 **For text of subitems (1) and (2), see M.R.**

2 **For text of subp 9, see M.R.**

3 **Subp. 10. Scheduled and nonscheduled medication.** ~~Prescription of controlled substance~~
4 ~~medications scheduled under Minnesota Statutes, section 152.02, including without limitation,~~
5 ~~narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated~~
6 ~~in the treatment of patients with regional low back pain after the first two weeks.~~

7 ~~Patients with radicular pain may require longer periods of treatment. The health care provider must~~
8 ~~document the rationale for the use of any scheduled medication.~~

9 ~~Treatment with nonscheduled medication may be appropriate during any phase of treatment and~~
10 ~~intermittently after all other treatment has been discontinued. The prescribing health care provider must~~
11 ~~determine that ongoing medication is effective treatment for the patient's condition and that the most~~
12 ~~cost-effective regimen is used.~~

13 Prescription of medications may be indicated during any phase of treatment. Prescription of
14 nonsteroidal anti-inflammatory drugs, opioid analgesics, and muscle relaxants must comply with all of
15 the standards in part 5221.6XXX

16 **For text of subs 11 to 13, see M.R.**

17
18 **5221.6300 UPPER EXTREMITY DISORDERS.**

19 **Subpart 1. Diagnostic procedures for treatment of upper extremity disorders (UED).** A health
20 care provider shall determine the nature of an upper extremity disorder before initiating treatment.

21 **For text of items A to D, see M.R.**

22 E. The following diagnostic procedures or tests are not indicated for the diagnosis of upper
23 extremity disorders any of the clinical categories in item A:

24 **For text of subitems (1) to (3), see M.R.**

25 **For text of items F to K, see M.R.**

26 **For text of subp 2, see M.R.**

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

28 **For text of items A to D, see M.R.**

29 E. Electrical muscle stimulation includes, but is not limited to, muscle stimulation, low volt therapy,
30 sine wave therapy, stimulation of peripheral nerve, galvanic stimulation, TENS, interferential, and
31 microcurrent techniques.

32 **For text of subitems (1) and (2), see M.R.**

33 F. Acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and
34 acupressure:

35 **For text of subitems (1) to (3), see M.R.**

36 **For text of item G, see M.R.**

37 H. Manual therapy includes soft-tissue and joint mobilization and therapeutic massage, but is not
38 limited to, manual traction, myofascial release, joint mobilization and manipulation, manual lymphatic
39 drainage, soft-tissue mobilization and manipulation, trigger point therapy, acupressure, muscle
40 stimulation - manual (nonelectrical), and any form of massage:

41 **For text of subitems (1) to (3), see M.R.**

42 **For text of items I and J, see M.R.**

43 **For text of subp 4 to 7, see M.R.**

44 **Subp. 8. Durable medical equipment.** Durable medical equipment is indicated only in the
45 situations specified in items A to D. The health care provider must provide the insurer with prior
46 notification as required in items B and C and part 5221.6050, subpart 9.

47 **For text of items A to C, see M.R.**

1 D. The following durable medical equipment is not indicated for home use for the upper extremity
2 disorders specified in subparts 11 to 16 subpart 1, item A:

3 **For text of subitems (1) and (2), see M.R.**

4 **For text of subp 9, see M.R.**

5 **Subp. 10. Scheduled and nonscheduled medication.** ~~Prescription of controlled substance~~
6 ~~medications scheduled under Minnesota Statutes, section 152.02, including without limitation,~~
7 ~~narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated~~
8 ~~in the treatment of patients with regional low back pain after the first two weeks.~~

9 ~~Patients with radicular pain may require longer periods of treatment. The health care provider must~~
10 ~~document the rationale for the use of any scheduled medication.~~

11 ~~Treatment with nonscheduled medication may be appropriate during any phase of treatment and~~
12 ~~intermittently after all other treatment has been discontinued. The prescribing health care provider must~~
13 ~~determine that ongoing medication is effective treatment for the patient's condition and that the most~~
14 ~~cost-effective regimen is used.~~

15 Prescription of medications may be indicated during any phase of treatment. Prescription of
16 nonsteroidal anti-inflammatory drugs, opioid analgesics, and muscle relaxants must comply with all of
17 the standards in part 5221.6XXX

18 **For text of subps 11 to 16, see M.R.**

19
20 **5221.6305 COMPLEX REGIONAL PAIN SYNDROME (CRPS) / REFLEX SYMPATHETIC**
21 **DYSTROPHY OF THE UPPER AND LOWER**
22 **EXTREMITIES.**

23 **Subpart 1. Scope.**

24 A. This clinical category encompasses

25 (1) any condition diagnosed as reflex sympathetic dystrophy, causalgia, complex regional pain
26 syndrome, Sudek's atrophy, algoneurodystrophy, or shoulder-hand syndrome, including, but not limited
27 to, ICD-9-CM codes 337.9, 354.4, and 733.7; or

28 (2) any condition of the upper or lower extremity characterized by concurrent presence in the
29 involved extremity of five of the following conditions: edema; local skin color change of red or purple;
30 osteoporosis in underlying bony structures demonstrated by radiograph; local dyshidrosis; local
31 abnormality of skin temperature regulation; reduced passive range of motion in contiguous joints; local
32 alteration of skin texture of smooth or shiny; or typical findings of reflex sympathetic dystrophy on
33 bone scan; or ~~This clinical category includes, but is not limited to, the diagnoses of reflex sympathetic~~
34 dystrophy, causalgia, complex regional pain syndrome, Sudek's atrophy, algoneurodystrophy, and
35 shoulder-hand syndrome, and including, but not limited to, ICD-9-CM codes 337.9, 354.4, and 733.7.

36 (3) any condition of the upper or lower extremity that develops after trauma or nerve injury
37 and is characterized by continuing pain, allodynia or hyperalgesia that is non-anatomic in
38 distribution and disproportionate to the original injury and to stimulation, and the patient has or
39 has had edema, vasomotor abnormality, or sudomotor abnormality on examination, and there is
40 no other explanation for the degree of pain and dysfunction.

41
42 **For text of items B and C, see M.R.**

43 **Subp. 2. Initial nonsurgical management.** Initial nonsurgical management is appropriate for all
44 patients with reflex sympathetic dystrophy and must be the first phase of treatment. Any course or
45 program of initial nonsurgical management is limited to the modalities specified in items A to D.

46 A. Therapeutic injection modalities. The only injections allowed for reflex sympathetic dystrophy
47 are sympathetic block, intravenous infusion of steroids or sympatholytics, or epidural block.

DRAFT RULES – FOR DISCUSSION PURPOSES ONLY: 02-07-08

1 (1) Unless medically contraindicated, sympathetic blocks or the intravenous infusion of steroids or
2 sympatholytics must be used if reflex sympathetic dystrophy has continued for four weeks and the
3 employee remains disabled as a result of the reflex sympathetic dystrophy.

4 (a) Time for treatment response: within 30 minutes.

5 (b) Maximum treatment frequency: can repeat an injection at a site to a limb if there was a
6 positive response to the first injection. If subsequent injections demonstrate diminishing control of
7 symptoms or fail to facilitate objective functional gains, then injections must be discontinued. No more
8 than three injections to different sites limbs are reimbursable per patient visit.

9 (c) Maximum treatment duration: may be continued as long as injections control symptoms and
10 facilitate objective functional gains, if the period of improvement is progressively longer with each
11 injection.

12 (2) Epidural block may only be performed in patients who had an incomplete improvement with
13 sympathetic block or intravenous infusion of steroids or sympatholytics.

14 **For text of items B and C, see M.R.**

15 ~~D. Oral medications may be indicated in accordance with accepted medical practice. Prescription of~~
16 ~~medications may be indicated during any phase of treatment. Prescription of nonsteroidal anti-~~
17 ~~inflammatory drugs, opioid analgesics, and muscle relaxants must comply with all of the standards in~~
18 ~~part 5221.6XXX~~

19 **For text of subps 3 and 4, see M.R.**

20
21 **5221.6600 CHRONIC MANAGEMENT.**

22 Subpart 1. **Scope.** This part applies to chronic management of all types of physical injuries, even if
23 the injury is not specifically governed by parts 5221.6200 to 5221.6500. If a patient continues with
24 symptoms and physical findings after all appropriate initial nonsurgical and surgical treatment has been
25 rendered, and if the patient's condition prevents the resumption of the regular activities of daily life
26 including regular vocational activities, then the patient may be a candidate for chronic management.
27 The purpose of chronic management is twofold: the patient should be made independent of health care
28 providers in the ongoing care of a chronic condition; and the patient should be returned to the highest
29 functional status reasonably possible.

30 **For text of item A, see M.R.**

31 B. Any of the chronic management modalities of subpart subparts 2 and 3 may be used singly or in
32 combination as part of a program of chronic management.

33 **For text of items C and D, see M.R.**

34 E. A program of chronic management must include appropriate means by which use of scheduled
35 medications can be discontinued or severely limited except as provided in subpart 3.

36 **For text of subp 2, see M.R.**

MEDICATIONS
DRAFT RULES – FOR DISCUSSION PURPOSES ONLY: 02/05/08

1 5221.6XXX Medications

2
3 Subpart 1. Subparts 2 to 4 do not require a health care provider to prescribe any class of drugs in
4 the treatment of any patient.

5
6 Subpart 2. Nonsteroidal anti-inflammatory drugs (NSAIDs). Non-steroidal anti-inflammatory
7 drugs are drugs with analgesic, antipyretic and anti-inflammatory effects. The term "non-
8 steroidal" is used to distinguish these drugs from steroids. NSAIDs act as inhibitors of the
9 enzyme cyclooxygenase. For the purposes of this rule NSAIDs include diflunisal but not other
10 salicylates or acetaminophen. NSAIDs can be divided into two groups, nonselective NSAIDs
11 and COX-2 inhibitors. Examples of nonselective NSAIDs include diclofenac, diflunisal,
12 etodolac, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketorolac,
13 meclofenamate, mefenamic acid, meloxicam, nabumetone, naproxen, oxaprozin, piroxicam,
14 sulindac, and tolmetin. An example of a COX-2 inhibitor is celecoxib.

15
16 A. NSAIDs are indicated for the symptomatic relief of acute and chronic musculoskeletal pain.
17 NSAIDs must be prescribed at the lowest clinically effective dose, as determined by the
18 prescribing health care provider, but not to exceed the manufacturer's maximum daily dosage.

19
20 B. When treating musculoskeletal pain, a generic nonselective-NSAID is indicated unless a
21 COX-2 inhibitor is indicated as specified in item C.

22 (1) When a nonselective NSAID is used, treatment must begin with one of the following:
23 generic ibuprofen, generic naproxen, or generic diclofenac. If there is a medical
24 contraindication documented by the prescribing health care provider to each of the
25 medications in this item, then treatment may begin with any other generic nonselective
26 NSAID.

27 (2) Other generic nonselective-NSAIDs are not indicated unless one-week trials of each
28 of ibuprofen, diclofenac, and naproxen have been ineffective in reducing the patient's
29 pain by at least 50% as determined by the prescribing health care provider.

30 (3) Nonselective-NSAIDs that are not available as generics are not indicated

31
32 C. A COX-2 inhibitor may be indicated instead of a nonselective NSAID for

33 (1) patients over 60 years of age;

34 (2) patients with a history of gastrointestinal bleed or peptic ulcer disease; or,

35 (3) patients with a history of gastrointestinal side effects with nonselective-NSAID use.

36 However, for any patient meeting any of the criteria of subitems 1 through 3 who is taking
37 aspirin or who is at an increased risk of cardiovascular disease, a COX-2 inhibitor is not
38 indicated and a nonselective NSAID is indicated as allowed in items A and B, together with
39 gastroprotective medication.

40
41 D. NSAIDs are indicated only for the shortest duration needed as determined by the prescribing
42 health care provider.

43 (1) NSAIDs prescribed within the first four weeks after the date of injury are limited to no
44 more than 2 weeks of medication per prescription or refill.

45 (2) NSAIDs prescribed more than 4 weeks after the date of injury may not be for more
46 than one month of medication per prescription or refill.

MEDICATIONS
DRAFT RULES – FOR DISCUSSION PURPOSES ONLY: 02/05/08

1 (3) NSAIDs prescribed more than 12 months after the date of injury may not be for more
2 than three months of medication per prescription or refill.
3

4 Subpart 3. Opioid Analgesics. An opioid is any agent that binds to opioid receptors. There are
5 three broad classes of opioids: opium alkaloids, such as morphine and codeine; semi-synthetic
6 opioids such as heroin and oxycodone; and fully synthetic opioids such as pethidine and
7 methadone. Opioid analgesics include codeine, hydrocodone, levorphanol, methadone, morphine,
8 hydromorphone, and oxycodone.
9

10 A. Opioid analgesics are indicated for the symptomatic relief of acute and chronic pain that has
11 been inadequately relieved by non- opioid medications. Opioid analgesics must be prescribed at
12 the lowest clinically effective dose, as determined by the prescribing health care provider.
13

14 B. When treating pain, a generic oral opioid analgesic is indicated.

15 (1) When an oral opioid analgesic is used for the symptomatic relief of acute or chronic
16 pain, treatment must begin with one of the following: generic codeine, generic
17 hydrocodone, generic oxycodone, or generic morphine, unless there is a medical
18 contraindication documented by the prescribing health care provider. If there is a medical
19 contraindication documented by the prescribing health care provider to each of the
20 medications in this item, then treatment may begin with any other generic oral opioid
21 analgesic.

22 (2) Other generic opioid analgesics are not indicated for oral use for the symptomatic
23 relief of acute or chronic pain unless one-week trials of each of codeine, hydrocodone,
24 oxycodone, and morphine have been ineffective in reducing the patient's pain by at least
25 50% as determined by the prescribing health care provider.

26 (3) Generically available combinations of an oral opioid and a non-opioid analgesic may
27 be prescribed instead of that opioid analgesic as otherwise allowed under subitems 1 and
28 2.

29 (4) Oral opioid analgesics that are not available as generics and combinations of an oral
30 opioid analgesic and a non-opioid analgesic that are not available as generics are not
31 indicated.
32

33 C. A course of oral opioid analgesics or combination of an oral opioid and a non-opioid analgesic
34 is limited as provided in subitems 1, 2 and 3.
35

36 (1) Oral opioid analgesics prescribed within the first four weeks after the date of injury
37 are limited to no more than 2 weeks of medication per prescription.

38 (2) Oral opioid analgesics prescribed more than 4 weeks after the date of injury may not
39 be for more than one month of medication per prescription.

40 **(3) Oral opioid analgesics prescribed more than 12 weeks after the**
41 **injury may be for more than one month of medication per prescription**
42 **if there has been a clinic evaluation to confirm the need for and efficacy**
43 **of the prescription and a clinical evaluation at least every six months**
44 **thereafter during continued use of opiate analgesics.**
45

MEDICATIONS

DRAFT RULES – FOR DISCUSSION PURPOSES ONLY: 02/05/08

1 D. Meperidine is not indicated in the treatment of acute or chronic pain.

2
3 E. Transcutaneous opioid analgesics are only indicated in patients with a documented disorder
4 that prevents adequate oral dosing.

5
6 F. Oral transmucosal and buccal preparations are only indicated for the treatment of breakthrough
7 pain and only in patients with a documented disorder that prevents adequate dosing with
8 swallowed medications.

9
10 Subpart 4. Muscle Relaxants. A muscle relaxant is a drug which decreases the tone of a muscle.
11 For the purposes of this rule muscle relaxants include carisoprodol, chlorzoxazone,
12 cyclobenzaprine, metaxalone, methocarbamol, orphenadrine, and tizanide but not other
13 medications that may be used to treat spasticity.

14
15 A. Muscle relaxants are indicated for the symptomatic relief of acute and chronic
16 musculoskeletal pain. Muscle relaxants must be prescribed at the lowest clinically effective dose,
17 as determined by the prescribing health care provider, but not to exceed the manufacturer's
18 maximum daily dosage.

19
20 B. When treating musculoskeletal pain, a generic muscle relaxant is indicated.

21 (1) When a muscle relaxant is used, treatment must begin with one of the following:
22 generic carisoprodol, generic chlorzoxazone, generic cyclobenzaprine, generic
23 methocarbamol, or generic tizanide. If there is a medical contraindication documented by
24 the prescribing health care provider to each of the medications in this item, then treatment
25 may begin with any other generic muscle relaxant.

26 (2) Metaxalone and orphenadrine are not indicated unless one-week trials of each of
27 carisoprodol, chlorzoxazone, cyclobenzaprine, methocarbamol, and tizanide have been
28 ineffective in reducing the patient's pain by at least 50% as determined by the prescribing
29 health care provider.

30 (3) Generically available combinations of a muscle relaxant and an analgesic may be
31 prescribed instead of that muscle relaxant as otherwise allowed under subitems 1 and 2.

32 (4) Muscle relaxants that are not available as generics, and combinations of a muscle
33 relaxant and an analgesic that are not available as generics, are not indicated.

34
35 C. A course of muscle relaxants or combination of a muscle relaxant and an analgesic is limited
36 as provided in subitems 1, 2 and 3.

37 (1) Muscle relaxants prescribed within the first four weeks after the date of injury are
38 limited to no more than 2 weeks of medication per prescription or refill.

39 (2) Muscle relaxants prescribed more than 4 weeks after the date of injury are limited to
40 no more than one worth of medication per prescription or refill.

41 (3) Treatment with muscle relaxants for more than three consecutive months is not
42 indicated.

43
44 D. Benzodiazepines are not indicated as muscle relaxants for the symptomatic relief of acute and
45 chronic musculoskeletal pain.

MEDICATIONS
DRAFT RULES – FOR DISCUSSION PURPOSES ONLY: 02/05/08

1 MR 5221.6200 Subpart. 10. Scheduled and nonscheduled medication. Prescription of controlled
2 substance medications scheduled under Minnesota Statutes, section 152.02, including without
3 limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications
4 are not indicated in the treatment of patients with regional low back pain after the first two
5 weeks.

6
7 Patients with radicular pain may require longer periods of treatment.
8

9 The health care provider must document the rationale for the use of any scheduled medication.
10 Treatment with nonscheduled medication must comply with all of the applicable standards in
11 part 5221.6XXX may be appropriate during any phase of treatment and intermittently after all
12 other treatment has been discontinued. The prescribing health care provider must determine that
13 ongoing medication is effective treatment for the patient's condition and that the most cost-
14 effective regimen is used.

15
16 5221.6205 subpart 10. Scheduled and nonscheduled medication. Prescription of controlled
17 substance medications scheduled under Minnesota Statutes, section 152.02, including without
18 limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications
19 are not indicated in the treatment of patients with regional low back pain after the first two
20 weeks.

21
22 Patients with radicular pain may require longer periods of treatment.
23

24 The health care provider must document the rationale for the use of any scheduled medication.
25 Treatment with nonscheduled medication must comply with all of the applicable standards in
26 part 5221.6XXX may be appropriate during any phase of treatment and intermittently after all
27 other treatment has been discontinued. The prescribing health care provider must determine that
28 ongoing medication is effective treatment for the patient's condition and that the most cost-
29 effective regimen is used.

30
31 5221.6210 subpart 10. Scheduled and nonscheduled medication. Prescription of controlled
32 substance medications scheduled under Minnesota Statutes, section 152.02, including without
33 limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications
34 are not indicated in the treatment of patients with regional low back pain after the first two
35 weeks.

36
37 Patients with radicular pain may require longer periods of treatment.
38

39 The health care provider must document the rationale for the use of any scheduled medication.
40 Treatment with nonscheduled medication must comply with all of the applicable standards in
41 part 5221.6XXX may be appropriate during any phase of treatment and intermittently after all
42 other treatment has been discontinued. The prescribing health care provider must determine that
43 ongoing medication is effective treatment for the patient's condition and that the most cost-
44 effective regimen is used.
45

MEDICATIONS

DRAFT RULES – FOR DISCUSSION PURPOSES ONLY: 02/05/08

1 5221.6300 Subpart 10. Scheduled and nonscheduled medication. Prescription of controlled
2 ~~substance medications scheduled under Minnesota Statutes, section 152.02, including, without~~
3 ~~limitation, narcotics, is indicated only for the treatment of severe acute pain. Therefore, these~~
4 ~~medications are not routinely indicated in the treatment of patients with upper extremity~~
5 ~~disorders.~~ The health care provider must document the rationale for the use of any scheduled
6 medication. Treatment with nonscheduled medication must comply with all of the applicable
7 standards in part 5221.6XXX may be appropriate during any phase of treatment and
8 intermittently after all other treatment has been discontinued. The prescribing health care
9 provider must determine that ongoing medication is effective treatment for the patient's condition
10 and the most cost-effective regimen is used.

11
12 5221.6040 Subpart X. Medical Contraindication: A condition which makes the use of a
13 particular treatment or medication inadvisable because of an increased risk of harm to the patient.