

Workers' Compensation Fees for Medical Services

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Medical Billing and Payment Selected Statutes and Rules

Minn. Stat. 176.136 Medical Fee Review.

Subd 1. Schedule.

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

Subd. 1a. Relative value fee schedule.

- (a) The liability of an employer for services included in the medical fee schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee, whichever is lower. The commissioner shall adopt permanent rules regulating fees allowable for medical, chiropractic, podiatric, surgical, and other health care provider treatment or service, including those provided to hospital outpatients, by implementing a relative value fee schedule. The commissioner may adopt by reference, according to the procedures in paragraph (h), clause (2), the relative value fee schedule tables adopted for the federal Medicare program. The relative value fee schedule must contain reasonable classifications including, but not limited to, classifications that differentiate among health care provider disciplines. The conversion factors for the original relative value fee schedule must reasonably reflect a 15 percent overall reduction from the medical fee schedule most recently in effect. The reduction need not be applied equally to all treatment or services, but must represent a gross 15 percent reduction.
- (b) Effective October 1, 2005, the commissioner shall remove all scaling factors from the relative value units and establish four separate conversion factors according to paragraphs (c) and (d) for each of the following parts of Minnesota Rules:
 - (1) medical/surgical services in Minnesota Rules, part 5221.4030, as defined in part 5221.0700, subpart 3, item C, subitem (2);
 - (2) pathology and laboratory services in Minnesota Rules, part 5221.4040, as defined in part 5221.0700, subpart 3, item C, subitem (3);
 - (3) physical medicine and rehabilitation services in Minnesota Rules, part 5221.4050, as defined in part 5221.0700, subpart 3, item C, subitem (4); and
 - (4) chiropractic services in Minnesota Rules, part 5221.4060, as defined in part 5221.0700, subpart 3, item C, subitem (5).

- (c) The four conversion factors established under paragraph (b) shall be calculated so that there is no change in each maximum fee for each service under the current fee schedule, except as provided in paragraphs (d) and (e).
- (d) By October 1, 2006, the conversion factor for chiropractic services described in paragraph (b), clause (4), shall be increased to equal 72 percent of the conversion factor for medical/surgical services described in paragraph (b), clause (1). Beginning October 1, 2005, the increase in chiropractic conversion factor shall be phased in over two years by approximately equal percentage point increases.
- (e) When adjusting the conversion factors in accordance with paragraph (g) on October 1, 2005, and October 1, 2006, the commissioner may adjust by no less than zero, all of the conversion factors as necessary to offset any overall increase in payments under the fee schedule resulting from the increase in the chiropractic conversion factor.
- (f) The commissioner shall give notice of the relative value units and conversion factors established under paragraphs (b), (c), and (d) according to the procedures in section [14.386, paragraph \(a\)](#). The relative value units and conversion factors established under paragraphs (b), (c), and (d) are not subject to expiration under section [14.386, paragraph \(b\)](#).
- (g) The conversion factors shall be adjusted as follows:
 - (1) After permanent rules have been adopted to implement this section, the conversion factors must be adjusted annually on October 1 by no more than the percentage change computed under section [176.645](#), but without the annual cap provided by that section.
 - (2) Each time the workers' compensation relative value fee schedule tables are updated under paragraph (h), the commissioner shall adjust the conversion factors so that, for services in both fee schedules, there is no difference between the overall payment in each category of service listed in paragraph (b) under the new schedule and the overall payment for that category under the workers' compensation fee schedule most recently in effect. This adjustment must be made before making any additional adjustment under clause (1).
- (h) The commissioner shall give notice of the adjusted conversion factors and updates to the relative value fee schedule as follows:
 - (1) The commissioner shall annually give notice in the State Register of the adjusted conversion factors and any amendments to rules to implement Medicare relative value tables incorporated by reference under this subdivision. The notices of the adjusted conversion factors and amended rules to implement the relative value tables are subject to the requirements of section [14.386, paragraph \(a\)](#). The annual adjustments to the conversion factors and the medical fee schedules adopted under this section, including all previous fee schedules, are not subject to expiration under section [14.386, paragraph \(b\)](#).
 - (2) The commissioner shall periodically, but at least once every three years, update the workers' compensation relative value tables by incorporating by reference the relative value tables in the national physician fee schedule relative value file established by the Centers for Medicare and Medicaid Services. The commissioner shall publish the notices of the incorporation by reference in the State Register at least 60 days before the tables are to become effective for purposes of payment under this section. Each notice of incorporation must state the date the incorporated tables will become effective and must include information on how the Medicare relative value tables may be obtained. The published notices of incorporation by reference and the incorporated tables are not rules subject to section [14.386](#) or other

provisions of chapter 14, but have the force and effect of law as of the date specified in the notices.

Subd. 1b. Limitation of liability.

- (a) The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a small hospital shall be the hospital's usual and customary charge, unless the charge is determined by the commissioner or a compensation judge to be unreasonably excessive. A "small hospital," for purposes of this paragraph, is a hospital which has 100 or fewer licensed beds.
- (b) The liability of the employer for the treatment, articles, and supplies that are not limited by subdivision 1a or 1c or paragraph (a) shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower. On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph.
- (c) The limitation of liability for charges provided by paragraph (b) does not apply to a nursing home that participates in the medical assistance program and whose rates are established by the commissioner of human services.
- (d) An employer's liability for treatment, articles, and supplies provided under this chapter by a health care provider located outside of Minnesota is limited to the payment that the health care provider would receive if the treatment, article, or supply were paid under the workers' compensation law of the jurisdiction in which the treatment was provided.

Subd. 1c. Charges for independent medical examinations.

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

Subd. 2. Excessive fees.

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

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

Subd. 3. Report.

The commissioner shall contract with a review organization as defined in section [145.61](#) for the purposes listed in section [145.61, subdivision 5](#), and report to the legislature on January 15 of every odd-numbered year, regarding the delivery of medical and health care services, including rehabilitation services, under the workers' compensation laws of this state.

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

MN Rules 5221.0300 Purpose.

This chapter is intended to prohibit health care providers treating employees with compensable injuries from receiving excessive reimbursement for their services. This chapter defines the payer's maximum liability for medical services, articles, and supplies. This chapter also governs health care provider communication with parties; required reporting of medical, disability, and billing information under Minnesota Statutes, chapter 176; change of health care provider; and criteria for determining, serving, and filing maximum medical improvement.

MN Rules 5221.0500 Excessive Charges; Limitation of Payer Liability.

Subp. 1. **Excessive health care provider charges.** A billing charge for services, articles, or supplies provided to an employee with a compensable injury is excessive if any of the conditions in items A to I apply to the charge. A payer is not liable for a charge which meets any of these conditions.

- A. the charge wholly or partially duplicates another charge for the same service, article, or supply, such that the charge has been paid or will be paid in response to another billing; or
- B. the charge exceeds the provider's current usual and customary charge, as specified in subpart 2, item B, for the same or similar service, article, or supply in cases unrelated to workers' compensation injuries; or
- C. the charge is described by a billing code that does not accurately reflect the actual service provided; or
- D. the service does not comply with the treatment standards and requirements adopted under Minnesota Statutes, section [176.83](#), subdivision 5, concerning the reasonableness and necessity, quality, coordination, level, duration, frequency, and cost of services; or
- E. the service was performed by a provider prohibited from receiving reimbursement under Minnesota Statutes, chapter 176, pursuant to Minnesota Statutes, sections [176.83](#), [176.103](#), [176.1351](#), and [256B.0644](#); or
- F. the service, article, or supply is not usual, customary, and reasonably required for the cure or relief of the effects of a compensable injury or is provided at a level, duration, or frequency that is excessive, based on accepted medical standards for quality health care and accepted rehabilitation standards under Minnesota Statutes, section [176.136](#), subdivision 2, clause (2); or
- G. the service, article, or supply was delivered in violation of the federal Medicare anti-kickback statutes and regulations as specified in part [5221.0700](#), subpart 1a; or
- H. where approval for a change of doctor is required by part [5221.0430](#) for the provider submitting the charge, and approval has not been obtained from the payer, commissioner, or compensation judge; or

- I. the service is outside the scope of practice of the particular provider or is not generally recognized within the particular profession of the provider as of therapeutic value for the specific injury or condition, under Minnesota Statutes, section [176.136](#), subdivision 2, clause (3).

Subp. 2. **Limitation of payer liability.** A payer is not liable for health care charges which are excessive under subpart 1. If the charges are not excessive under subpart 1, a payer's liability for payment of charges is limited as provided in items A to F.

- A. If the medical fee schedule applies to the service according to part [5221.4000](#), subpart 3, the payer's liability shall be limited to the maximum amount allowed for any service, article, or supply in the medical fee schedule in effect on the date of the service, or the provider's usual and customary fee, whichever is lower.
- B. Except as provided in items C to F, if the maximum fee for service, article, or supply is not limited by parts [5221.4000](#) to [5221.4070](#), the payer's liability for payment shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charge for similar treatment, articles, or supplies furnished to an injured person when paid for by the injured person, whichever is lower.
 - (1) A usual and customary charge under Minnesota Statutes, section [176.136](#), subdivision 1b, paragraphs (a) and (b), means the amount actually billed by the health care provider to all payers for the same service, whether under workers' compensation or not, and regardless of the amount actually reimbursed under a contract or government payment system.
 - (2) A prevailing charge under Minnesota Statutes, section [176.136](#), subdivision 1b, paragraph (b), is the 75th percentile of the usual and customary charges as defined in subitem (1) in the previous calendar year for each service, article, or supply if the database for the service meets all of the following criteria:
 - (a) the database includes only Minnesota providers, with at least three different, identifiable providers of the same provider type, distinguished by whether the service is an inpatient hospital service, or an outpatient physician, pathology, laboratory, chiropractic, physical therapy or occupational therapy service, or provider of other similar service, article, or supply;
 - (b) there are at least 20 billings for the service, article, or supply; and
 - (c) the standard deviation is less than or equal to 50 percent of the mean of the billings for each service in the data base or the value of the 75th percentile is not greater than or equal to three times the value of the 25th percentile of the billings.
- C. Under Minnesota Statutes, section [176.136](#), subdivision 1b, paragraph (a), payment for services, articles, and supplies provided to an employee while an inpatient or outpatient at a hospital with 100 or fewer licensed beds shall be 100 percent of the usual and customary charge as defined in item B, unless the charge is determined by the commissioner or compensation judge to be unreasonably excessive. The payer's liability for services provided by a nursing home that participates in the medical assistance program shall be the rate established by the commissioner of human services.
- D. Under Minnesota Statutes, section [176.136](#), subdivision 1b, 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 [5221.4000](#) to [5221.4070](#) is limited to 85 percent of the hospitals usual and customary, or

prevailing charge, as described 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.

- E. Charges for cost of copies of medical records and postage are governed by parts [5219.0100](#) to [5219.0300](#) and are not subject to the 85 percent reimbursement limit specified in item B. Travel expenses incurred by an employee for compensable medical services shall be paid at the rate equal to the rate paid by the employer for ordinary business travel expenses, or the rate paid by the state of Minnesota under the commissioner's plan for employment-related travel, whichever is lower. Reimbursement for employee travel expenses is not subject to the 85 percent reimbursement limit specified in item B.
- F. Charges for supplementary reports that are not required reports under part [5221.0410](#), subpart 7, and charges for return to work services under part [5221.0420](#), subpart 3, are not subject to the 85 percent reimbursement limit specified in item B.

Subp. 3. **Collection of excessive charges.** A provider may not collect or attempt to collect payment from an injured employee, or any other source, charges for a compensable injury which the payer has determined are excessive under subpart 1 or which exceed the maximum amount payable specified in subpart 2, unless payment is ordered by the commissioner, compensation judge, or Workers' Compensation Court of Appeals. Unless the provider or the employee has filed a claim for a determination of the amount payable with the commissioner, the health care provider must remove the charges from the billing statement. If a dispute exists as to whether an employee's injury is compensable under Minnesota Statutes, chapter 176, and the employee has general health insurance, payment of medical bills is governed by Minnesota Statutes, section [176.191](#), subdivision 3.

MN Rules 5221.0600 Payer Responsibilities.

Subp. 1. **Compensability.** This chapter does not require a payer to pay a charge for a service that is not for the treatment of a compensable injury or a charge that is the primary obligation of another payer.

Subp. 2. **Determination of excessiveness.** Subject to a determination of the commissioner or compensation judge, the payer shall determine whether a charge or service is compensable by evaluating the charge and service according to the conditions of excessiveness and payer liability specified in part part [5221.0500](#), subparts 1 and 2, and Minnesota Statutes, section [176.136](#), subdivision 2. If the payer determines that the provider has assigned an incorrect code for a service, the payer may determine the correct code for the service and evaluate liability for payment on the basis of the correct code.

Subp. 3. **Determination of charges.** As soon as reasonably possible, and no later than 30 calendar days after receiving the bill, the payer shall:

- A. pay the charge or any portion of the charge that is not denied;
- B. deny all or a portion of a charge on the basis that the injury is noncompensable; the charge is excessive or noncompensable under Minnesota Statutes, section [176.136](#), subdivision 2; or part [5221.0500](#), subparts 1 and 2; or the charges are not submitted on the appropriate billing form prescribed in part [5221.0700](#); or
- C. request specific additional information to determine whether the charge or the condition is compensable. The payer shall make a determination as set forth in items A and B no later than

30 calendar days following receipt of the provider's response to the initial request for specific additional information.

Subp. 4. Notification. Within 30 calendar days of receipt of the bill, the payer shall provide written notification to the employee and provider of denial of part or all of a charge, or of any request for additional information. Written notification shall include:

- A. the basis for denial of all or part of a charge that the payer has determined is not for a compensable injury under part [5221.0100](#), subpart 6;
- B. the basis for denial or reduction of each charge and the specific amounts being denied or reduced for each charge meeting the conditions of an excessive or noncompensable charge under part [5221.0500](#), subparts 1 and 2, or Minnesota Statutes, section [176.136](#), subdivision 2;
- C. denial of a charge for failure to submit it on the billing form prescribed in part [5221.0700](#), subpart 2; and
- D. a request for an appropriate record or the specific information requested to allow for proper determination of the bill under this part.

The payer shall specify the applicable rule, part, and subpart in this chapter supporting its denial or reduction of a charge. A general statement that a service or charge "exceeds the fee schedule or treatment parameters" is not adequate notification.

If payment is denied under item B, C, or D, the payer shall reconsider the charges in accordance with this rule as soon as reasonably possible, and no later than 30 calendar days after receipt of additional relevant information or documents. Notice of denial of part or all of a charge shall be given by the payer consistent with the guidelines in this subpart.

Subp. 5. Penalties. Failure to comply with the requirements of this part may subject the payer to the penalties provided in Minnesota Statutes, sections [176.221](#), [176.225](#), and [176.194](#).

Subp. 6. Collection of excessive payment. Any payment made to a provider which is determined to be wholly or partially excessive, according to the conditions prevailing at the time of payment, may be collected from the provider by the payer in the amount that the reimbursement was excessive. The payer must demand reimbursement of the excessive payment from the provider within one year of the payment.

MN Rules 5221.0700 Provider Responsibilities.

Subp. 1. Usual charges. No 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' compensation injuries.

Subp. 1a. Conflicts of interest. All health care providers subject to this chapter are bound by the federal Medicare antikickback statute in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and regulations adopted under it, pursuant to Minnesota Statutes, section [62J.23](#). Any medical services or supplies provided in violation of these provisions are not compensable under Minnesota Statutes, chapter 176.

Subp. 2. Submission of information. Providers except for hospitals must supply with the bill a copy of an appropriate record that adequately documents the service and substantiates the nature and necessity of the service or charge. Hospitals must submit an appropriate record upon request by the payer. All charges billed after January 1, 1994, for workers' compensation health care services, articles, and supplies, except for United States government facilities rendering health care services

for veterans must be submitted to the payer on the forms prescribed in subparts 2a, 2b, and 2c, and in accordance with items A to C.

- A. Charges for services, articles, and supplies must be submitted to the payer directly by the health care provider actually furnishing the service, article, or supply. This includes but is not limited to the following:
 - (1) diagnostic imaging, laboratory, or pathology testing not actually performed by the health care provider, or employee of the health care provider, who ordered the test;
 - (2) equipment, supplies, and medication not ordinarily kept in stock by the hospital or other health care provider facility, purchased from a supplier for a specific employee;
 - (3) services performed by a health care provider at a small or large hospital, as defined in part [5221.0500](#), subpart 2, items C and D, if the provider has an independent practice, except that a hospital may charge for services furnished by a provider who receives at least a base payment from the hospital, which is paid regardless of the number of patients seen; and
 - (4) outpatient medications dispensed by a licensed pharmacy pursuant to an order written by a health care provider, as described in this subpart, including both prescription and nonprescription medications.
- B. Charges must be submitted to the payer in the manner required by subparts 2a, 2b, and 2c within 60 days from the date the health care provider knew the condition being treated was claimed by the employee as compensable under workers' compensation. Failure to submit charges within the 60 days is not a basis to deny payment, but is a basis for disciplinary action against the provider under Minnesota Statutes, section [176.103](#). Failure to submit claims within the time frames specified in Minnesota Statutes, section [62Q.75](#), subdivision 3, may result in denial of payment.
- C. This part does not limit the collection of other information the provider may be required to report under any other state or federal jurisdiction.

Subp. 2a. Centers for Medicare and Medicaid Services CMS 1500 form. Except as provided in subparts 2b and 2c, charges for all services, articles, and supplies that are provided for a claimed workers' compensation injury must be submitted to the payer on the CMS 1500 form. Charges for dental services may be submitted on the dental claim form required by Minnesota Statutes, section [62J.52](#), subdivision 3. The CMS 1500 form must be filled out in accordance with Minnesota Statutes, section [62J.52](#), and directions set forth in the "Minnesota Standards for the Use of the CMS 1500 Claim Form" manual adopted by the Department of Health under Minnesota Statutes, section [62J.61](#).

Subp. 2b. Uniform billing claim form UB-92 (CMS 1450). Hospitals licensed under Minnesota Statutes, section [144.50](#), must submit itemized charges on the uniform billing claim form, UB-92, (CMS 1450). The UB-92 form must be filled out according to Minnesota Statutes, section [62J.52](#), and the "Minnesota UB-92 manual" published by the Minnesota Hospital Association.

When the UB-92 form provides only summary information, an itemized listing of all services and supplies provided during the inpatient hospitalization must be attached to the UB-92 form. The itemized list must include:

- A. 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 must be itemized;
- B. the charge for each service;
- C. the number of units of each service provided; and
- D. the date each service was provided.

Subp. 2c. Submission of drug charges.

- A. Itemized charges for drugs dispensed for a claimed workers' compensation injury by a licensed community/retail pharmacy must be submitted to the payer on a pharmacy billing form that includes the data elements required by Minnesota Statutes, section [62J.52](#), subdivision 4, or according to the electronic transaction standards that apply to retail pharmacies specified in Code of Federal Regulations, title 45, part 162, as amended.
- B. Charges for drugs dispensed by a practitioner as defined in Minnesota Statutes, section [151.01](#), subdivision 23, who is permitted to dispense drugs under Minnesota Statutes, chapter 151, may be submitted to the payer according to the applicable requirements of any of the following: subpart 2a; Minnesota Statutes, section [62J.535](#); or one of the billing methods described in item A.
- C. Charges for drugs dispensed by a hospital may be submitted according to the applicable requirements of any of the following: subpart 2b; Minnesota Statutes, section [62J.535](#); or one of the billing methods described in item A.
- D. In addition to the requirements of subpart 3 and part [5221.4070](#), all bills or claims for reimbursement of drug charges under this part must include the following information:
 - (1) the workers' compensation file number (the employee's social security number), if provided by the employee;
 - (2) the employee's name and address;
 - (3) the insurer's name and address;
 - (4) the date of the injury;
 - (5) the name of the health care provider who ordered the drug;
 - (6) the name and quantity of each drug provided;
 - (7) the prescription number for the drug;
 - (8) the date the drug was provided;
 - (9) the total charge for each drug provided;
 - (10) the name, address, and telephone number of the pharmacy or practitioner that provided the drug; and
 - (11) the pharmacy's or practitioner's usual and customary charge for the drug at the time it is dispensed.
- E. The terms "community/retail pharmacy," "dispense," "drug," "practitioner," and "usual and customary charge" in this subpart have the meanings given to them in part [5221.4070](#), subpart 1a.

Subp. 3. Billing code.

- A. The provider shall undertake professional judgment to assign the correct approved billing code, and any applicable modifiers, in the CPT, HCPCS, NDC, or UB-92 manual in effect on the date the service, article, or supply was rendered, using the appropriate provider group designation, and according to the instructions and guidelines in this chapter. No provider may use a billing code which is assigned a "D," "G," "H," or "I" status in part [5221.4030](#). Where several component services which have different CPT codes may be described in one more comprehensive CPT code, only the single CPT code most accurately describing the procedure performed or service rendered may be reported.
Dental procedures not included in CPT or HCPCS shall be coded using any standard dental coding system.
- B. The codes for services in parts [5221.4030](#) to [5221.4070](#) may be submitted with two-digit or two-letter suffixes called "modifiers" as defined in part [5221.0100](#), subpart 10a. Except as

otherwise specifically provided in parts [5221.4000](#) to [5221.4070](#), the use of a modifier does not change the maximum fee to be calculated according to part [5221.4020](#).

C. Provider group designation.

- (1) General. The provision of services by all health care providers is limited and governed by each provider's scope of practice as stated in the applicable statute. A provider shall not perform a service which is outside that provider's scope of practice, nor shall a provider use a procedure code for a service which is outside that provider's scope of practice. Services delivered at the direction and under the supervision of a licensed health care provider listed in this item are considered incident to the services of the licensed provider and are coded as though provided directly by the licensed provider. Services delivered by support staff such as aides, assistants, or other unlicensed providers are incident to the services of a licensed provider only if the licensed provider directly responsible for the unlicensed provider is on the premises at the time the service is rendered. Hospital charges are governed by part [5221.0500](#), subpart 2, items C and D. Outpatient charges by hospitals with more than 100 licensed beds are subject to the maximum fees in parts [5221.4000](#) to [5221.4070](#).
- (2) Medical and surgical services. Procedure codes for medical and surgical services and supplies are listed in part [5221.4030](#). These include services delivered by the following types of providers or services provided incident to the services of the following types of providers: medical physicians, surgeons, osteopathic physicians, podiatrists, dentists, oral and maxillofacial surgeons, optometrists, opticians, speech pathologists, licensed psychologists, social workers, nurse practitioners, clinical nurse specialists, and physician's assistants.
- (3) Pathology and laboratory services. Procedure codes for services and supplies provided by a pathologist or by a technician under the supervision of a physician are listed in part [5221.4040](#).
- (4) Physical medicine and rehabilitation services. Procedure codes for services and supplies provided by a physician, an osteopathic physician, a physical therapist, an occupational therapist, a physical therapist assistant under the direction and supervision of a physical therapist, or a certified occupational therapy assistant under the direction and supervision of an occupational therapist, or provided incident to the services of a physician, an osteopathic physician, a physical therapist, or an occupational therapist are listed in part [5221.4050](#).
- (5) Chiropractic services. Procedure codes for services and supplies provided by a chiropractor or provided incident to a chiropractor's services are listed in part [5221.4060](#).
- (6) Pharmacy services. Procedure codes for drugs dispensed pursuant to the order of a health care provider, are described in part [5221.4070](#).

Subp. 4. **Cooperation with payer.** Pursuant to Minnesota Statutes, section [176.138](#), providers shall comply within seven working days with payers' proper written requests for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of compensability or excessiveness.

MN Rules 5221.4020 Determining Fee Schedule Payment Limits.

Subp. 2. **Key to abbreviations and terms and payment instructions.**

C. Column 3 identifies the status of the code.

- (1) "A" status indicates an active code. These services are separately paid under the medical fee schedule. The maximum fee for this service is calculated according to the formula in subpart 1 and as adjusted by other instructions in this subpart.
- (2) "B" status indicates a bundled code. Payment for covered services are always bundled into payment for other services. There is no separate payment for these services even if an RVU is listed. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident. An example is a telephone call from a hospital nurse regarding care of a patient.
- (3) "C" status indicates a coverage status that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section [176.135](#), the maximum fee for the service is governed by part [5221.0500](#), subpart 2, items B to F, and Minnesota Statutes, section [176.136](#), subdivision 1b.
- (4) "D" status indicates an invalid or deleted CPT or HCPCS code. Another CPT or HCPCS code must be used to describe the service. No payment is allowed for codes with a "D" status even if a positive RVU is listed.
- (5) "E" status indicates a coverage status that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section [176.135](#), the maximum fee for the service is governed by part [5221.0500](#), subpart 2, items B to F, and Minnesota Statutes, section [176.136](#), subdivision 1b, if the code has an RVU of zero. If a positive RVU is listed, the liability for the service is limited to the listed RVU.
- (6) "G" and "I" status indicates an invalid CPT or HCPCS code and "H" status indicates an invalid modifier code. Another code must be used to describe these services. No payment is allowed for codes with a "G," "H," or "I" status even if a positive RVU is listed.
- (7) "N" status indicates a code that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section [176.135](#), the liability for the service is governed by part [5221.0500](#), subpart 2, items B to F, and Minnesota Statutes, section [176.136](#), subdivision 1b, if the code has an RVU of zero. If a positive RVU is listed, the liability for the service is limited to the listed RVU.
- (8) "P" status indicates a bundled or excluded code.
 - (a) If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. An example is an elastic bandage furnished by a physician incident to physician service.
 - (b) If the item or service is covered as other than incident to a physician service, such as colostomy supplies, it may be paid for separately. If the item or service is not provided incident to the services of a licensed provider, the maximum fee for the service is governed by any listed positive RVU or, if there is a zero RVU listed, by part [5221.0500](#), subpart 2, items B to F, and Minnesota Statutes, section [176.136](#), subdivision 1b.
- (9) "R" status indicates a coverage status that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section [176.135](#), the maximum fee for the service is governed by part [5221.0500](#), subpart 2, items B to F, and Minnesota Statutes, section [176.136](#), subdivision 1b, if the code has an RVU of zero. If a positive RVU is listed, the liability for the service is limited to the listed RVU.
- (10) "T" status indicates injections. There are RVUs listed for these services, but they are only paid if there are no other services payable under the fee schedule billed on the same date by the same provider. If any other services payable under the fee schedule are billed on

the same date by the same provider, these services are bundled into the physician services for which payment is made. Payment for the injected material is separate from the injection services and is governed by part [5221.0500](#), subpart 2, items B to F.

- (11) "X" status indicates a code that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section [176.135](#), the maximum fee for the service is governed by part [5221.0500](#), subpart 2, items B to F, and Minnesota Statutes, section [176.136](#), subdivision 1b, if the code has an RVU of zero. If a positive RVU is listed, the liability for the service is limited to the listed RVU.

Calculating a maximum fee under the fee schedule formula (MN Rules 5221.4020 Subp. 1)

Where the RVU tables apply to a service, use this basic formula:

$$\text{maximum fee} = \text{relative value unit (RVU)} \times \text{conversion factor (CF)}$$

Example:

Service 99201 on a service date of November 1, 2008

$$\text{Maximum fee} = (\text{RVU}) \times (\text{CF})$$

$$\text{Maximum fee} = 0.84 \times \$80.74$$

$$\text{Maximum fee} = \$67.82$$

Effective date	Medical Surgical services in M.R. 5221.4030	Pathology Laboratory services in M.R. 5221.4040	Physical Medicine Rehabilitation services in M.R. 5221.4050	Chiropractic services in M.R. 5221.4060
10/1/2006	\$76.87	\$64.19	\$66.64	\$55.35
10/1/2007	\$77.56	\$64.77	\$67.24	\$55.85
10/1/2008	\$80.74	\$67.43	\$70.00	\$58.14

1. First check the fee schedule status code (column 3) to determine payment eligibility for the code (refer to 5221.4020, subp. 2, item C. to decode the status codes- see reverse side).
2. For this service, an outpatient office visit coded as 99201, the status code is "A." It is allowed separate payment under the rule cited above.
3. Determine the RVU (column 5). In this example it is 0.84.
4. Determine the conversion factor that applies to the date of service and the category of service. The service date in this example is November 1, 2008. The code is listed in the medical surgical services section of the fee schedule (5221.4030).
5. Plug the numbers into the formula and do the arithmetic.

I. Procedure code numbers 99201 to 99449 relate to evaluation and management services.											
(1) CPT/HCPCS	(2) Tech/Prof	(3) Status	(4) Description	(5) Office RVU	(6) Facility RVU	(7) Global Package	(8) Multi Procedure	(9) Bilat Procedure	(10) Assist Surg	(11) Co-Surgery	(12) Team Surg
(1) Office or other outpatient services, new patient:											
99201		A	Office/outpatient visit	0.84	0.61	XXX	0	0	0	0	0

5221.4020, subp. 2

C. Column 3 identifies the status of the code.

- (1) "A" status indicates an active code. These services are separately paid under the medical fee schedule. The maximum fee for this service is calculated according to the formula in subpart 1 and as adjusted by other instructions in this subpart.
- (2) "B" status indicates a bundled code. Payment for covered services are always bundled into payment for other services. There is no separate payment for these services even if an RVU is listed. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident. An example is a telephone call from a hospital nurse regarding care of a patient.
- (3) "C" status indicates a coverage status that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the maximum fee for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b.
- (4) "D" status indicates an invalid or deleted CPT or HCPCS code. Another CPT or HCPCS code must be used to describe the service. No payment is allowed for codes with a "D" status even if a positive RVU is listed.
- (5) "E" status indicates a coverage status that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the maximum fee for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b, if the code has an RVU of zero. If a positive RVU is listed, the liability for the service is limited to the listed RVU.
- (6) "G" and "I" status indicates an invalid CPT or HCPCS code and "H" status indicates an invalid modifier code. Another code must be used to describe these services. No payment is allowed for codes with a "G," "H," or "I" status even if a positive RVU is listed.
- (7) "N" status indicates a code that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the liability for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b, if the code has an RVU of zero. If a positive RVU is listed, the liability for the service is limited to the listed RVU.
- (8) "P" status indicates a bundled or excluded code.
 - (a) If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. An example is an elastic bandage furnished by a physician incident to physician service.
 - (b) If the item or service is covered as other than incident to a physician service, such as colostomy supplies, it may be paid for separately. If the item or service is not provided incident to the services of a licensed provider, the maximum fee for the service is governed by any listed positive RVU or, if there is a zero RVU listed, by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b.
- (9) "R" status indicates a coverage status that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the maximum fee for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b, if the code has an RVU of zero. If a positive RVU is listed, the liability for the service is limited to the listed RVU.
- (10) "T" status indicates injections. There are RVUs listed for these services, but they are only paid if there are no other services payable under the fee schedule billed on the same date by the same provider. If any other services payable under the fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made. Payment for the injected material is separate from the injection services and is governed by part 5221.0500, subpart 2, items B to F.
- (11) "X" status indicates a code that is unique to the federal Medicare fee schedule. If the service is compensable for workers' compensation under Minnesota Statutes, section 176.135, the maximum fee for the service is governed by part 5221.0500, subpart 2, items B to F, and Minnesota Statutes, section 176.136, subdivision 1b, if the code has an RVU of zero. If a positive RVU is listed, the liability for the service is limited to the listed RVU.

Minnesota Workers Compensation Health Care Charges: A Payment Reference Guide

Type of Charges	Payment Standard
<p>Services provided by a Minnesota small hospital (licensed by the Minnesota Department of Health as a hospital with 100 or fewer hospital beds).</p> <p>(Minn. Stat. 176.136 Subd. 1b(a))</p>	<p>100% of the hospital's usual and customary charge,¹ unless "unreasonably excessive."</p>
<p>Inpatient treatment, articles and supplies at a large hospital (one with more than 100 licensed beds).</p> <p>(Minn. Stat. 176.136 Subd. 1b(b))</p>	<p>Apply the <u>85% standard.</u>¹</p>
<p>Charges not listed above or below.</p> <p>(See "Applying the Workers' Compensation RVU Fee Schedule" handout.)</p>	<p>The lower of the provider's usual and customary charge charge¹ or the maximum rate according to the relative value fee schedule rules in MN Rules 5221.4000 to 5221.4062, and the pharmacy fee schedule rules in MN Rules 5221.4070.</p> <p>If the service code is not listed in an applicable relative value fee schedule table then apply the <u>85% standard.</u>¹</p>
<p>Services provided by a provider located outside of Minnesota.</p> <p>(Minn. Stat. 176.136 Subd. 1b(d))</p>	<p>Payment is limited to the payment that the health care provider would receive if the treatment, articles, or supply were paid under the workers' compensation law of the jurisdiction in which the treatment was provided.</p>
<p>Independent medical examination (IME).</p> <p>(Minn. Stat. 176.136 Subd. 1c)</p>	<p>Payment is determined by the IME payment rules (MN Rules 5219.0500).</p> <p>The amounts listed in the rule are subject to annual adjustments in the same manner as the conversion factor of the relative value fee schedule.</p>

¹ **The 85% standard** is the **lower of 85% of the provider's usual and customary charges or 85% of the prevailing charge** for similar treatment, articles or supplies. MN Rules 5221.0500 Subp. 2 delineates the database standards that must be used to establish a prevailing charge. Subp. 2 also defines "usual and customary charge" as "the amount actually billed by the health care provider to all payers for the same service, whether under workers' compensation or not, and regardless of the amount actually reimbursed under a contract or government payment system."

<p>Services provided by a Minnesota nursing home that participates in a medical assistance program.</p> <p>(Minn. Stat. 176.136 Subd. 1b(c))</p>	<p>The rate established by the Commissioner of Human Services.</p>
<p>Travel expenses incurred by an employee for compensable medical services.</p> <p>(MN Rules 5221.0500 Subp. 2E)</p>	<p>The rate paid by the employer for ordinary business travel expenses, or the rate paid by the state of Minnesota under the commissioner's plan for employment-related travel, whichever is lower.</p>
<p>Charges for supplementary reports that are not required by Minn. R. 5221.0410, subp. 7, and charges for return to work services under 5221.0420, subp. 3.</p> <p>(MN Rules 5221.0500 Subp. 2F)</p>	<p>Charges for these reports are not subject to the relative value fee schedule or the 85% standard in footnote 1.</p>
<p>Charges for cost of copies of medical records and postage are governed by MN Rules 5219.0100 to 5219.0300.</p> <p>(MN Rules 5221.0500 Subp. 2E)</p>	<p>MN Rules 5219.0300</p> <p>Subp. 1. First copy of appropriate record. For the first copy of the appropriate record as defined in 5221.0100, subp.1a...a charge not to exceed 75 cents per page is reasonable. This amount applies whether the record is provided with the billing, under separate cover, or in response to a request by the payer for an appropriate record which has not been submitted with the bill.²</p> <p>Subp. 2. Other copies. For all other copies ...not specifically addressed in subpart 1 or in Minnesota Statutes, section 176.155, or any other Minnesota statute or rule, a charge is reasonable if the total charge for each submission following a request does not exceed the sum of \$10 as a retrieval fee and 75 cents per page.</p> <p>Subp. 3. Postage and other charges. The health care provider may charge actual postage, any applicable Minnesota sales tax, and notary fees, if notarization is requested.</p>

² "Appropriate record is a legible medical record or report which substantiates the nature and necessity of a service being billed and its relationship to the work injury."

APPLYING THE WORKERS' COMPENSATION RVU FEE SCHEDULE

What is the relative value fee schedule?

The relative value fee schedule is authorized by Minn. Stat. 176.136 Subd. 1. The schedule itself is found in MN Rules 5221.4000 to 5221.4062.

The relative value fee schedule contains codes and descriptions of services, relative value units, and additional descriptive information for each service, and the conversion factor(s) (MN Rules 5221.4000). Depending on the date and type of service, four conversion factors are specified in MN Rules 5221.4020 Subp. 1.

When does the relative value fee schedule apply to a charge?

The relative value fee schedule applies to a charge for a particular health care service if:

- The charge is not paid by another method (the relative value fee schedule does not apply to large hospital inpatient; small hospital inpatient or outpatient; nursing home fees set by DHS; or outpatient pharmacy charges).
- The medical service is compensable under Minnesota Statutes, section 176.135;
- The service conforms to a billing code listed in the CPT, HCPCS, or UB-92 manual in effect on the date the service was rendered; and
- The billing code for the service is listed under the appropriate provider group designation for the health care provider that rendered the service (which is described in MN Rules 5221.0700 Subp. 3).

When the relative value fee schedule applies to a charge, how is the maximum reimbursement for a charge calculated?

A. Using the relative value fee schedule in effect on the date the service was rendered, determine if the service code is listed in a relative value fee schedule table. Make certain that you are using the proper table that applies to the provider that rendered service based on the provider group designations in MN Rules 5221.0300 Subp. 3.

B. If the service code is listed in a table that corresponds to the provider type:

Determine whether the status code permits payment. See MN Rules 5221.4020 Subp. 2C.

- If the status code permits payment, calculate the maximum fee using the listed RVU, and according to the payment indicators in the table.
 - Then determine whether any adjustments should be made to the maximum fee (see table below).
 - Compare the provider's charge to the maximum fee; and pay the lower of the two.
- If the status code indicates the provider has used an incorrect service code, payer may assign the correct code and pay accordingly, with notice to provider.
- If the status code permits payment but the RVU is zero, pay under the 85% standard.¹
- If the status code prohibits payment, properly notify the provider of this.

C. If the service code is not listed in a table that corresponds to the provider type, pay under the 85% standard.¹

D. Properly notify the provider of the basis for reduction, denial, or reassignment of another service code.

Services listed in a table in:	May also have rules that adjust or limit the maximum fee in:
5221.4030-Medical/Surgical Codes	5221.4033-Outpatient Limitation for Medical/Surgical Facility Fee 5221.4035-Fee Adjustments for Med/Surgical Services
5221.4040-Pathology/Laboratory Codes	5221.4041-Fee Adjustments for Professional/Technical Path & Lab Services
5221.4050-Physical Medicine/Rehabilitation Codes	5221.4051-Fee Adjustments for Physical Medicine Services
5221.4060-Chiropractic Codes	5221.4061-Fee Adjustments for Chiropractic Services 5221.4062-Professional/Technical Components for Chiropractic Services

¹ **The 85% standard** is the *lower of* 85% of the provider's usual and customary charges or 85% of the prevailing charge for similar treatment, articles or supplies. MN Rules 5221.0500 Subp. 2 delineates the database standards that must be used to establish a prevailing charge. Subp. 2 also defines "usual and customary charge" as "the amount actually billed by the health care provider to all payers for the same service, whether under workers' compensation or not, and regardless of the amount actually reimbursed under a contract or government payment system."

**Example: Calculating a Prevailing Charge
under MN Rules 5221.0500 Subp. 2B**

Sample Data Set One for service "X".			
<ul style="list-style-type: none"> • Code not listed in the fee schedule • Service provided by an outpatient provider, billed on CMS 1500 • All charges in data set are for the same CPT code 			
Provider	Zip Code	Charge	Service Year
A	55106	\$71.13	2008
A	55106	\$71.13	2008
A	55106	\$71.13	2008
B	55101	\$67.75	2008
B	55101	\$67.75	2008
B	55101	\$67.75	2008
B	55101	\$67.75	2008
B	55101	\$67.75	2008
B	55101	\$67.75	2008
B	55101	\$67.75	2008
B	55101	\$67.75	2008
B	55101	\$67.75	2008
B	55101	\$67.75	2008
C	55135	\$69.27	2008
D	55570	\$61.14	2008
E	55406	\$44.33	2008
E	55406	\$44.33	2008
F	55443	\$40.21	2008
G	55815	\$75.63	2008
H	55814	\$65.21	2008
H	55814	\$65.21	2008
H	55814	\$65.21	2008
I	55121	\$50.97	2008
J	55346	\$53.49	2008
75 th Percentile:			\$67.75
25 th Percentile:			\$61.14
Ratio of the 75 th to 25 th percentile:			1.1
Mean:			\$62.98
Standard Deviation (SD):			\$10.06
Ratio of the SD to the Mean			16%

Sample Data Set Two for service "X".			
<ul style="list-style-type: none"> • Code not listed in the fee schedule • Service provided by an outpatient provider, billed on CMS 1500 • All charges in data set are for the same CPT code 			
Provider	Zip Code	Charge	Service Year
A	55106	\$57.65	2008
A	55106	\$57.65	2008
A	55106	\$57.65	2008
B	55101	\$93.13	2008
B	55101	\$93.13	2008
B	55101	\$93.13	2008
B	55101	\$93.13	2008
B	55101	\$93.13	2008
B	55101	\$93.13	2008
B	55101	\$93.13	2008
B	55101	\$93.13	2008
B	55101	\$93.13	2008
B	55101	\$93.13	2008
C	55135	\$29.27	2008
D	55570	\$31.14	2008
E	55406	\$32.33	2008
E	55406	\$32.33	2008
F	55443	\$30.21	2008
G	55815	\$30.29	2008
H	55814	\$30.11	2008
H	55814	\$30.11	2008
H	55814	\$30.11	2008
I	55121	\$30.97	2008
J	55346	\$33.49	2008
75 th Percentile:			\$93.13
25 th Percentile:			\$30.29
Ratio of the 75 th to 25 th percentile:			3.1
Mean:			\$55.49
Standard Deviation (SD):			\$28.79
Ratio of the SD to the Mean			52%

MN Rules 5221.0500 Subp. 2B(2)

- (2) A prevailing charge under Minnesota Statutes, section 176.136, subdivision 1b, paragraph (b), is the 75th percentile of the usual and customary charges as defined in subitem (1) in the previous calendar year for each service, article, or supply if the database for the service meets all of the following criteria:
- (a) the database includes only Minnesota providers, with at least three different, identifiable providers of the same provider type, distinguished by whether the service is an inpatient hospital service, or an outpatient physician, pathology, laboratory, chiropractic, physical therapy or occupational therapy service, or provider of other similar service, article, or supply;
 - (b) there are at least 20 billings for the service, article, or supply; and
 - (c) the standard deviation is less than or equal to 50 percent of the mean of the billings for each service in the data base or the value of the 75th percentile is not greater than or equal to three times the value of the 25th percentile of the billings.

Sample Data Set One

A prevailing charge is established (\$67.65), because all requirements of MN Rules 5221.0500 Subp. 2B(2) have been met	
Database requirement from rule	Has this requirement been met?
“the usual and customary charges...in the previous calendar year”	Yes, the charges in the database are from 2008 and the comparison is being made in 2009.
“the database includes only Minnesota providers”	Yes, one way we may see this is the zip codes are all Minnesota zip codes.
“with at least three different, identifiable providers...”	Yes, there are 10 different providers in the data set.
“of the same provider type distinguished by whether the service is an inpatient hospital service, or an outpatient physician, pathology, laboratory, chiropractic, physical therapy or occupational therapy service”	Yes, the bills were all on CMS 1500 forms, indicating they were all outpatient services and for the billed service CPT code.
“there are at least 20 billings for the service, article, or supply”	Yes, there are at least 20 bills listed in the database.
the standard deviation is less than or equal to 50 percent of the mean of the billings for each service in the data base or the value of the 75th percentile is not greater than or equal to three times the value of the 25th percentile of the billings	Yes. Although only one need be true, both are true here. <ul style="list-style-type: none"> • Is the ratio of the standard deviation to the mean (SD/M) less than or equal to 50% (0.50)? Yes, the ratio in this data set is: $\\$10.06 / \\$62.98 = 16\% (0.16)$. • Is the ratio of 75th to 25th percentile (75th/25th) less than 3.0? Yes, the ratio in this data set is: $\\$67.65 / \\$61.14 = 1.1$

Sample Data Set Two

A prevailing charge is not established, because all requirements of MN Rules 5221.0500 Subp. 2B(2) have not been met.	
Database requirement from rule	Has this requirement been met?
“the usual and customary charges...in the previous calendar year”	Yes, the charges in the database are from 2008 and the comparison is being made in 2009.
“the database includes only Minnesota providers”	Yes, one way we may see this is the zip codes are all Minnesota zip codes.
“with at least three different, identifiable providers	Yes, there are 10 different providers in the data set.
“of the same provider type distinguished by whether the service is an inpatient hospital service, or an outpatient physician, pathology, laboratory, chiropractic, physical therapy or occupational therapy service”	Yes, the bills were all on CMS 1500 forms, indicating they were all outpatient services and for the billed service CPT code.
“there are at least 20 billings for the service, article, or supply”	Yes, there are 20 bills listed in the database.
the standard deviation is less than or equal to 50 percent of the mean of the billings for each service in the data base or the value of the 75th percentile is not greater than or equal to three times the value of the 25th percentile of the billings	No. One must be true, but neither one is true. <ul style="list-style-type: none"> • Is the ratio of the standard deviation to the mean (SD/M) less than or equal to 50% (0.50)? No, the ratio in this data set is: $\\$28.79 / \\$55.49 = 52\% (0.52)$. • Is the ratio of 75th to 25th percentile (75th/25th) less than 3.0? No, the ratio in this data set is: $\\$93.13 / \\$30.29 = 3.1$