

Minnesota State Register

Published every Monday (Tuesday when Monday is a holiday)



**Proposed, Adopted, Emergency, Expedited, Withdrawn, Vetoed Rules;
Executive Orders; Appointments; Commissioners' Orders; Revenue Notices;
Official Notices; State Grants & Loans; State Contracts;
Non-State Public Bids, Contracts and Grants**

**Monday 23 September 2019
Volume 44, Number 13
Pages 401 - 434**

Exempt Rules

Exempt rules are excluded from the normal rulemaking procedures (*Minnesota Statutes* §§ 14.386 and 14.388). They are most often of two kinds. One kind is specifically exempted by the Legislature from rulemaking procedures, but approved for form by the Revisor of Statutes, reviewed for legality by the Office of Administrative Hearings, and then published in the State Register. These exempt rules are effective for two years only.

The second kind of exempt rule is one adopted where an agency for good cause finds that the rulemaking provisions of *Minnesota Statutes*, Chapter 14 are unnecessary, impracticable, or contrary to the public interest. This exemption can be used only where the rules:

- (1) address a serious and immediate threat to the public health, safety, or welfare, or
- (2) comply with a court order or a requirement in federal law in a manner that does not allow for compliance with *Minnesota Statutes* Sections 14.14-14.28, or
- (3) incorporate specific changes set forth in applicable statutes when no interpretation of law is required, or
- (4) make changes that do not alter the sense, meaning, or effect of the rules.

These exempt rules are also reviewed for form by the Revisor of Statutes, for legality by the Office of Administrative Hearings and then published in the *State Register*. In addition, the Office of Administrative Hearings must determine whether the agency has provided adequate justification for the use of this exemption. Rules adopted under clauses (1) or (2) above are effective for two years only. The Legislature may also exempt an agency from the normal rulemaking procedures and establish other procedural and substantive requirements unique to that exemption.

KEY: Proposed Rules - Underlining indicates additions to existing rule language. ~~Strikeouts~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **Adopted Rules** - Underlining indicates additions to proposed rule language. ~~Strikeout~~ indicates deletions from proposed rule language.

Department of Labor and Industry

Adopted Exempt Permanent Rules Relating to Workers' Compensation; 2019 Adjustments to Relative Value Fee Schedule Conversion Factors and Amendments to Rules Implementing the Workers' Compensation Relative Value Fee Schedule Tables

5221.4020 DETERMINING FEE SCHEDULE PAYMENT LIMITS.

Subpart 1. [Repealed, 35 SR 227]

Subp. 1a. [Repealed, 35 SR 227]

Subp. 1b. **Conversion factors and maximum fee formulas.**

[For text of item A, see Minnesota Rules]

B. The conversion factors for services, articles, and supplies included in parts 5221.4030 to 5221.4061 are as provided in Minnesota Statutes, section 176.136, subdivision 1a, as follows:

[For text of subitems (1) to (7), see Minnesota Rules]

- (8) for dates of service from October 1, 2017, to September 30, 2018, the conversion factors are:

[For text of units (a) to (c), see Minnesota Rules]

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: \$49.44; and

(9) for dates of service from October 1, 2018, to September 30, 2019, the conversion factors are:

[For text of units (a) to (c), see Minnesota Rules]

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: \$49.66; and

(10) for dates of service from October 1, 2019, to September 30, 2020, the conversion factors are:

(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: \$70.24;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: \$59.57;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: \$58.16; and

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: \$50.25.

Subp. 1c. **Sample calculation.** The following is a sample calculation for determining the maximum fee, excluding any applicable adjustments in parts 5221.4030 to 5221.4061, for a new patient office examination (procedure code 99201) in a clinic based on the 2016 2019 National Physician Fee Schedule Relative Value April July (RVU16B RVU19 C) Release:

.48 [Work RVU (.48) * Work Geographic PCI (1)]
+ .714 .76836 [Nonfacility PE RVU (.76) * PE GPCI (1.021.011)]
+ .01595 .0181 [MP RVU (.05) * MP GPCI (.319 .362)]
= 1.20995 1.26646 [Total RVU]
* \$60.00 [Conversion factor for example only]
= \$72.597 \$75.9876 [Maximum fee]
= \$72.60 \$75.99 [Maximum fee, rounded]

Subp. 2. [Repealed, 35 SR 227]

[For text of subparts 2a to 4, see Minnesota Rules]

5221.4035 FEE ADJUSTMENTS FOR MEDICAL/SURGICAL SERVICES.

[For text of subparts 1 to 4, see Minnesota Rules]

Subp. 5. **Coding and payment for multiple surgeries and procedures.** Part 5221.4020, subpart 2a, item S, and column S in the tables incorporated by reference in part 5221.4005, subpart 1, item A, describe codes subject to the multiple procedures payment restrictions. Multiple surgeries are separate surgeries performed by a single physician on the same patient at the same operative session or on the same day for which separate payment may be allowed.

[For text of items A to E, see Minnesota Rules]

F. For diagnostic imaging procedures with an indicator of 4 in column S, special rules for the technical component (TC) and professional component (PC) of diagnostic imaging procedures apply if the procedure is billed with another diagnostic imaging procedure with indicator 88 in column AB. If the procedure is furnished by the same provider, or different providers in the same group practice, to the same patient in the same session on the same day as another procedure with indicator 88, the procedures must be ranked according to the maximum fee for the technical component and professional component, calculated according to the formula in part 5221.4020, subpart 1b. The technical component

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with the highest maximum fee is paid at 100 percent, and the technical component of each subsequent procedure is paid at 50 percent. The professional component with the highest maximum fee is paid at 100 percent, and the professional component of each subsequent procedure is paid at 75.95 percent. For example (for illustrative purposes):

	Unadjusted Maximum Fee, Procedure 1	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
PC	\$ 68 <u>\$100</u>	\$ 102 <u>\$80</u>	\$ 152 <u>\$160</u>	$\$102 + (.75 \times \$68)$ $\$176 (\$100 + (.95 \times \$80))$
TC	\$ 476 <u>\$500</u>	\$ 340 <u>\$400</u>	\$ 646 <u>\$700</u>	$\$476 + (.50 \times \$340)$ $\$700 (\$500 + (.50 \times \$400))$
Global	\$ 544 <u>\$600</u>	\$ 816 <u>\$480</u>	\$ 799 <u>\$860</u> (\$600 $+ (.75 \times \$80)$ $+ (.50 \times \$400)$)	$\$102 + (.75 \times \$68) + \$476 +$ $(.50 \times \$340)$ $\$876 (\$600 + (.95 \times \$80) +$ $(.50 \times \$400))$

[For text of items G to J, see Minnesota Rules]
[For text of subparts 6 to 10, see Minnesota Rules]

5221.4050 PHYSICAL MEDICINE AND REHABILITATION PROCEDURE CODES.

[For text of subparts 1 to 2c, see Minnesota Rules]

Subp. 2d. **List of physical medicine and rehabilitation procedure codes.** The physical medicine and rehabilitation conversion factor in part 5221.4020, subpart 1b, item B, applies to the health care providers listed in part 5221.0700, subpart 3, item C, subitem (4), when they provide, within their scope of practice, the services, articles, or supplies identified by procedure codes ~~9700+~~ 97010 through 97799, 97810 through 97814, and V5336 to V5364 in the Medicare Physician Fee Schedule tables described in part 5221.4005.

[For text of subpart 3, see Minnesota Rules]

5221.4060 CHIROPRACTIC PROCEDURE CODES.

Subpart 1. **Key to abbreviations and terms.** For descriptions of columns, abbreviations, and terms, see part 5221.4020, subpart 2a.

Subp. 2a. [Repealed, 25 SR 1142]

Subp. 2b. [Repealed, 30 SR 291]

Subp. 2c. [Repealed, 35 SR 227]

Subp. 2d. **List of chiropractic procedure codes.** The chiropractic conversion factor in part 5221.4020, subpart 1b, item B, applies to the health care providers listed in part 5221.0700, subpart 3, item C, subitem (5), when they provide, within their scope of practice, services, articles, or supplies identified by any of the following procedure codes in the Medicare Physician Fee Schedule tables described in part 5221.4005:

A. radiologic examination procedure codes from ~~72010~~ 72020 to ~~73630~~ 73660;

B. pathology and laboratory procedure codes 81000 and 81002;

C. physical medicine and rehabilitation procedure codes from 97010 to 97150 and 97530 to 97799;

[For text of items D to G, see Minnesota Rules]
[For text of subparts 3 and 4, see Minnesota Rules]

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5221.4061 FEE ADJUSTMENTS FOR CHIROPRACTIC SERVICES.

[For text of subparts 1 to 2, see Minnesota Rules]

Subp. 3. **Diagnostic imaging procedures.** For diagnostic imaging procedures with an indicator of 4 in column S, special rules for the technical component and professional component (PC) apply if the procedure is billed with another diagnostic imaging procedure with indicator 88 in column AB. If the procedure is furnished by the same provider, or different providers in the same group practice, to the same patient in the same session on the same day as another procedure with indicator 88, the procedures must be ranked according to the maximum fee for the technical component and professional component, calculated according to the formula in part 5221.4020, subpart 1b. The technical component with the highest maximum fee is paid at 100 percent, and the technical component of each subsequent procedure is paid at 50 percent. The professional component with the highest maximum fee is paid at 100 percent, and the professional component of each subsequent procedure is paid at 75.95 percent. For example (for illustrative purposes):

	Unadjusted Maximum Fee, Procedure 1	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
PC	\$68 <u>\$100</u>	\$102 <u>\$80</u>	\$152 <u>\$160</u>	\$102 + (.75 x \$68) \$176 (\$100 + (.95 x \$80))
TC	\$476 <u>\$500</u>	\$340 <u>\$400</u>	\$646 <u>\$700</u>	\$476 + (.50 x \$340) \$700 (\$500 + (.50 x \$400))
Global	\$544 <u>\$600</u>	\$816 <u>\$480</u>	\$799 <u>\$860</u> (\$600 + (.75 x \$80) + (.50 x \$400))	\$102 + (.75 x \$68) + \$476 + (.50 x \$340) \$876 (\$600 + (.95 x \$80) + (.50 x \$400))

EFFECTIVE DATE. The amendments to Minnesota Rules, parts 5221.4020, 5221.4035, 5221.4050, 5221.4060, and 5221.4061, are effective for services provided on or after October 1, 2019.