5219.0200 SCOPE.

This chapter governs reimbursement for copies of existing medical records related to a current claim for compensation under Minnesota Statutes, chapter 176, when requested by any person or business entity from a health care provider as defined in Minnesota Statutes, section 176.011, subdivision 12a.

5219.0500 INDEPENDENT MEDICAL EXAMINATION FEES.

[For text of subp 1, see M.R.]

Subp. 2. **Definition.** For purposes of this part, the language contained in Minnesota Statutes, section 176.136, subdivision 1c: "for, or in connection with, independent or adverse medical examinations requested by any party" means charges by a health care provider as defined by Minnesota Statutes, section 176.011, subdivision 12a, with regard to examinations conducted pursuant to Minnesota Statutes, section 176.155, subdivision 1, for:

[For text of items A to J, see M.R.]

Subp. 3. **Charges.** Charges by a health care provider as defined by Minnesota Statutes, section 176.011, subdivision 12a, for or in connection with independent medical examinations pursuant to Minnesota Statutes, section 176.155, must not exceed the cost specified in items A to J.

[For text of items A to J, see M.R.]

[For text of subp 4, see M.R.]

5221.0100 DEFINITIONS.

[For text of subps 1 and 1a, see M.R.]

Subp. 1b. **Appropriate record.** "Appropriate record" is a legible medical record or report that substantiates the nature and necessity of a service being billed and its relationship to the work injury.

[For text of subp 2, see M.R.]

Subp. 3. **Charge.** "Charge" means the payment requested by a provider on a bill for a particular service. This chapter does not prohibit a provider from billing usual and customary charges that are in excess of the amount listed in the fee schedule.

Subp. 4. **Code.** "Code" means the alphabetic, numeric, or alphanumeric symbol used to identify a specific health care service, place of service, or diagnosis as described in items A to G.

[For text of item A, see M.R.]

B. "CPT code" means a numeric code included in the Current Procedural Terminology Coding System manual, incorporated by reference in part 5221.0405, item B. A CPT code is used to identify a specific medical service, article, or supply.

C. "HCPCS code" means a numeric or alphanumeric code included in the Centers for Medicare and Medicaid Services' Common Procedure Coding System. An HCPCS code is used to identify a specific medical service, article, or supply. HCPCS level I codes are the numeric CPT codes listed in the CPT manual, incorporated by reference in part 5221.0405, item B. HCPCS level II codes are alphanumeric codes created for national use. HCPCS level II codes are listed in the HCPCS manual, incorporated by reference in part 5221.0405, item C.

[For text of item D, see M.R.]

E. "Place of service code" means the code used to identify the type of facility and classification of service as inpatient or outpatient service on the uniform billing claim formats required by Minnesota Statutes, sections 62J.50 to 62J.61, and the corresponding uniform companion guides adopted by the Minnesota Department of Health under Minnesota Statutes, section 62J.61.

F. "Procedure code" means a numeric or alphanumeric code used to identify a particular health care service. Procedure codes used in this chapter include CPT codes, HCPCS codes, revenue codes, Codes on Dental Procedures and Nomenclature (CDT codes), and codes in the National Drug Code Directory (NDC).

G. "Revenue code" means a numeric or alphanumeric code included in the UB-04 Data Specifications manual, incorporated by reference in part 5221.0405, item E. Revenue codes are used in institutional settings such as hospitals to identify an individual or group of medical services, articles, or supplies.

[For text of subps 5 and 6, see M.R.]

Subp. 6a. **Conversion factor.** "Conversion factor" means the dollar value of the maximum fee payable for one relative value unit of a compensable health care service delivered under Minnesota Statutes, chapter 176, as specified in part 5221.4020, subpart 1b.

[For text of subps 6b to 9, see M.R.]

Subp. 10. **Medical fee schedule.** "Medical fee schedule" means the list of codes, service descriptions, and corresponding dollar amounts allowed under Minnesota Statutes, section 176.136, and parts 5221.4005 to 5221.4070.

[For text of subps 10a to 11a, see M.R.]

Subp. 12. **Provider.** "Provider" means a health care provider as defined in Minnesota Statutes, section 176.011, subdivision 12a.

[For text of subps 13 to 15, see M.R.]

5221.0200 AUTHORITY.

This chapter is adopted under the authority of Minnesota Statutes, sections 175.171; 176.135, subdivisions 2 and 7; 176.136; 176.231; and 176.83.

5221.0405 INCORPORATIONS BY REFERENCE.

The following documents are incorporated by reference to the extent cited in this chapter. Many of these documents may be accessed through the Internet by contacting the organization listed.

[For text of item A, see M.R.]

B. The Physician's Current Procedural Terminology, (CPT manual) 2016 Professional Edition, and any subsequent revisions. CPT codes are subject to frequent change. The manual is published by and may be purchased from the American Medical Association, Order Department: P.O. Box 930876, Atlanta, GA, 31193-0876, or from the American Medical Association Web site at https://commerce.ama-assn.org/store/. It is available through the Minitex interlibrary loan system.

C. The alphanumeric Healthcare Common Procedure Coding System (HCPCS manual), 2016 edition and any subsequent revisions. It is subject to frequent change. It is published by the Practice Management Information Corporation (PMIC) under the authority of the Centers for Medicare and Medicaid Services and may be purchased from medical bookstores, or through PMIC, 200 West 22nd Street, #253, Lombard, IL 60148, (800) 633-7467, or www.pmiconline.com. It is available through the Minitex interlibrary loan system and on the Centers for Medicare and Medicaid Services Web site at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

D. The Codes on Dental Procedures and Nomenclature (CDT code), 2016, and any subsequent revisions. The CDT code is published by the American Dental Association and may be purchased from its Web site at http://www.ada.org/en/store. It is available through the Minitex interlibrary loan system.

E. The UB-04 Data Specifications Manual (UB-04 Manual), 2016, and any subsequent revisions adopted by the National Uniform Billing Committee (NUBC). It is subject to frequent change. It is published by and may be purchased from the American

Hospital Association. It is available through the Minitex interlibrary loan system and on the American Hospital Association's Web site at http://www.ahaonlinestore.com.

F. The National Drug Code Directory, published, maintained, and distributed by the federal Department of Health and Human Services, U.S. Food and Drug Administration. The directory is available for viewing or printing free of charge on the Internet at the U.S. Food and Drug Administration's Web site at http://www.fda.gov/cder/ndc/. The directory is subject to frequent change and amendments to the directory are also incorporated by reference into this chapter.

5221.0410 REQUIRED REPORTING AND FILING OF MEDICAL INFORMATION.

[For text of subps 1 and 2, see M.R.]

Subp. 3. **Maximum medical improvement.** For injuries occurring on or after January 1, 1984, or upon request for earlier injuries, the health care provider must report to the self-insured employer or insurer, maximum medical improvement, when ascertainable, on the health care provider report form or in a narrative report. "Maximum medical improvement" is a medical and legal concept defined by Minnesota Statutes, section 176.011, subdivision 13a.

[For text of items A and B, see M.R.]

C. If the employer or insurer does not serve a notice of intention to discontinue benefits or a petition to discontinue benefits under Minnesota Statutes, section 176.238, at the same time a narrative maximum medical improvement report is served, then the report must be served with a cover letter containing the information in subitems (1) to (6). Serving the cover letter with the maximum medical improvement report does not replace the notice of intention to discontinue benefits or petition to discontinue benefits required by Minnesota Statutes, section 176.238. The cover letter must include:

(1) information identifying the employee by name, worker identification number (WID) or Social Security number, and date of injury;

[For text of subitems (2) to (4), see M.R.]

(5) the definition of maximum medical improvement as defined by Minnesota Statutes, section 176.011, subdivision 13a; and

[For text of subitem (6), see M.R.]

[For text of subps 4 to 8, see M.R.]

5221.0500 EXCESSIVE CHARGES; LIMITATION OF PAYER LIABILITY.

[For text of subp 1, see M.R.]

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.

[For text of item A, see M.R.]

B. Except as provided in items C to F, if the maximum fee for service, article, or supply is not limited by parts 5221.4005 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.

[For text of subitem (1), see M.R.]

(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), based on no more than two years of billing data immediately preceding the date of service, for each service, article, or supply if the database for the service meets all of the following criteria:

[For text of units (a) to (c), see M.R.]

C. Payment for services, articles, and supplies provided to an employee while an outpatient at a hospital shall be as provided in parts 5221.4005 to 5221.4070, except as provided in Minnesota Statutes, section 176.136, subdivision 1b. 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. Payment for services, articles, and supplies provided to an employee who is an inpatient at a hospital shall be as provided in Minnesota Statutes, sections 176.136, subdivision 1b, and 176.1362.

[For text of items E and F, see M.R.]

[For text of subp 3, see M.R.]

5221.0700 PROVIDER RESPONSIBILITIES.

Subpart 1. **Usual charges.** No provider shall submit a charge for a service that exceeds the amount that the provider charges for the same type of service in cases unrelated to workers' compensation injuries.

[For text of subp 1a, see M.R.]

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 in the formats prescribed in subparts 2a, 2b, 2c, and 2d, 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:

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

(3) services performed by a health care provider at a hospital, 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

[For text of subitem (4), see M.R.]

B. Charges must be submitted to the payer in the manner required by subparts 2a, 2b, 2c, and 2d, 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.

[For text of item C, see M.R.]

Subp. 2a. **ASC X12 Health Care Claim: Professional (837) format.** Except as provided in subparts 2b, 2c, and 2d, charges for all services, articles, and supplies that are provided for a claimed workers' compensation injury must be submitted to the payer electronically in the ASC X12 Health Care Claim: Professional (837) format required by Minnesota Statutes, sections 62J.50 to 62J.61, and the corresponding uniform companion guide adopted by the Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61.

Subp. 2b. **ASC X12 Health Care Claim: Institutional (837) format.**

A. Hospitals licensed under Minnesota Statutes, section 144.50, must submit charges electronically in the ASC X12 Health Care Claim: Institutional (837) format required by Minnesota Statutes, sections 62J.50 to 62J.61, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61.

B. When the billing format in item A provides only summary information, an itemized listing of all services and supplies provided during the inpatient hospitalization must be attached, except as otherwise provided in Minnesota Statutes, section 176.1362. The itemized list must include:

(1) 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;

(2) the charge for each service;

(3) the number of units of each service provided; and

(4) 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/outpatient pharmacy must be submitted to the payer electronically in the National Council for Prescription Drug Programs (NCPDP) Version D, Release 0 format required by Minnesota Statutes, sections 62J.50 to 62J.61, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61.

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 this subpart or subpart 2a.

C. Charges for drugs dispensed by a hospital may be submitted according to the applicable requirements of this subpart or subpart 2b.

D. The terms "community/outpatient 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. 2d. **ASC X12 Health Care Claim: Dental (837) format.** Charges for dental services must be submitted to the payer electronically in the ASC X12 Health Care Claim: Dental (837) format required by Minnesota Statutes, sections 62J.50 to 62J.61, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61.

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-04 Data Specifications 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 that is assigned a "D," "F," "G," or "H" status as described in part 5221.4020, subpart 2a, item D. 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 the Code on Dental Procedures and Nomenclature (CDT code) as published by the American Dental Association.

Inpatient services shall be coded using the same codes, formats, and details that are required for billing for hospital inpatient services by the Medicare program as required by Minnesota Statutes, section 176.1362, subdivision 1, paragraph (c).

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 5221.4005 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 that is outside the provider's scope of practice, nor shall a provider use a procedure code for a service that is outside the 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.

[For text of subitems (2) to (6), see M.R.]

[For text of subps 4 and 5, see M.R.]

5221.4005 INSTRUCTIONS FOR APPLICATION OF FEE SCHEDULE.

Subpart 1. **Workers' compensation medical fee schedule; incorporation of Medicare National Physician Relative Value Files.** The workers' compensation medical fee schedule consists of items A and B:

A. the tables in the Medicare National Physician Fee Schedule Relative Value File and the Geographic Practice Cost Indices File most recently incorporated by reference by the commissioner by publishing in the State Register pursuant to Minnesota Statutes, section 176.136, subdivision 1a; and

[For text of item B, see M.R.]

Subp. 2. **Effective date.** The medical fee schedule applies to treatment provided on or after the effective date of:

A. the most recent fee schedule tables adopted pursuant to Minnesota Statutes, section 176.136, subdivision 1a, as described in subpart 1; and

B. corresponding rules in parts 5221.4005 to 5221.4061 to implement the fee schedule tables.

[For text of subp 3, see M.R.]

5221.4035 FEE ADJUSTMENTS FOR MEDICAL/SURGICAL SERVICES.

[For text of subps 1 and 2, see M.R.]

Subp. 3. **Services not included in global surgical package.** The services listed in items A to O are not included in the global surgical package. These services may be coded and paid for separately. Physicians must use appropriate modifiers as set forth in this subpart.

[For text of items A to N, see M.R.]

O. Surgeries for which services performed are significantly greater or more complex than usually required must be coded with CPT modifier 22 added to the CPT code for the procedure. Additional requirements for use of this modifier are in subitems (1) to (5).

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

(4) The maximum fee for a surgical procedure that has satisfied all of the requirements for use of CPT modifier 22 is up to 125 percent of the maximum fee calculated under part 5221.4020, subpart 1b, for that CPT code.

[For text of subitem (5), see M.R.]

[For text of subps 4 to 10, see M.R.]

5221.4050 PHYSICAL MEDICINE AND REHABILITATION PROCEDURE CODES.

[For text of subps 1 to 2d, see M.R.]

Subp. 3. **Additional payment instructions.** The instructions and examples in items A to D are in addition to CPT code descriptions found in the CPT manual. Additional instructions include both general instructions for a group of codes as well as specific instructions for an individual specific code.

[For text of items A and B, see M.R.]

C. Additional specific instructions for therapeutic procedure codes 97110 to 97546.

CPT Code	CPT Description	Specific Instructions and Examples
97110	Therapeutic exercises	Examples include, but are not limited to, any type of range of motion, stretching, or strengthening exercises; e.g., stabilization and closed kinetic chain exercises, passive range of motion, active and assistive range of motion, progressive resistive exercises, prolonged stretch, isokinetic, isotonic, or isometric strengthening exercises.
97112	Neuromuscular reeducation	Examples include, but are not limited to, facilitation techniques, NDT, Rood, Brunnstrom, PNF, and FeldenKrais.
97113	Aquatic therapy	This code applies to any water-based exercise program such as Hubbard Tank or pools.

97140	Manual therapy	In addition to the services included in the CPT manual incorporated by reference in part 5221.0405, item D, this code also includes, but is not limited to: myofascial release, joint mobilization and manipulation, manual lymphatic drainage, manual traction, soft tissue mobilization and manipulation, trigger point therapy, acupressure, muscle stimulation - manual (nonelectrical), and transverse friction massage. This code is not paid when reported with any of the osteopathic manipulative treatment (OMT) (98925-98929) or chiropractic manipulative treatment (CMT) (98940- 98943) codes on the same regions(s)/body part on the same day. This code may be paid when reported with CMT or OMT codes only if used on a different region(s)/ body part on the same day and must be accompanied by CPT modifier 59 which identifies a distinct procedural service.
97150	Group therapeutic	Therapeutic procedure(s) for a group is used when two or more patients are present for the same type of service such as instruction in body mechanics training, or group exercises when participants are doing same type exercises, etc. There is no time definition for this code. Providers may charge only one unit, regardless of size of group, number of areas treated, or length of time involved.
97760	Orthotic training	This code applies to fabrication, instruction in use, fitting, and care and precautions of the orthotic.
97530	Therapeutic activities	This code is used for treatment promoting functional use of a muscle, muscle group, or body part. This code is not to be used for PROM, active assistive ROM, manual stretch, or manual therapy. Examples for use of code: A patient has had rotator cuff repair. When treatment incorporates functional motion of reaching to increase range of motion and strength, 97530 should be used. A patient has a herniated disc. When treatment incorporates instruction in body mechanics and positioning and simulated activities to improve functional performance, 97530 should be used.

97537	Community/ work	Community/work reintegration training includes jobsite analysis.
97545	Work hardening/ conditioning	Work hardening/conditioning units are for the initial two hours each visit. Codes 97545 and 97546 refer to services provided within a work hardening or work conditioning program described in part 5221.6600, subpart 2, item D.
97546	Work hardening/ conditioning	Work hardening/conditioning additional units are for each additional hour each visit. Refers to time beyond initial two hours of work conditioning or work hardening.

[For text of item D, see M.R.]

5221.4060 CHIROPRACTIC PROCEDURE CODES.

[For text of subps 1 to 2d, see M.R.]

Subp. 3. **Select chiropractic procedure code descriptions, instructions, and examples.** The following instructions and examples are in addition to CPT code descriptions found in the CPT manual. Additional instructions include both general instructions for a group of codes as well as specific instructions for an individual specific code.

[For text of items A and B, see M.R.]

C. Additional specific instructions for therapeutic procedure codes 97110 to 97546.

CPT Code	CPT Description	Specific Instructions and Examples
97110	Therapeutic exercises	Examples include, but are not limited to, any type of range of motion, stretching, or strengthening exercises; e.g., stabilization and closed kinetic chain exercises, passive range of motion, active and assistive range of motion, progressive resistive exercises, prolonged stretch, isokinetic, isotonic, or isometric strengthening exercises.

97112	Neuromuscular reeducation	Examples include, but are not limited to, facilitation techniques, NDT, Rood, Brunnstrom, PNF, and FeldenKrais.
97113	Aquatic therapy	This code applies to any water-based exercise program such as Hubbard Tank or pools.
97140	Manual therapy	In addition to the services included in the CPT manual incorporated by reference in part 5221.0405, item D, this code also includes, but is not limited to: myofascial release, joint mobilization and manipulation, manual lymphatic drainage, manual traction, soft tissue mobilization and manipulation, trigger point therapy, acupressure, muscle stimulation - manual (nonelectrical), and transverse friction massage. This code is not paid when reported with any of the osteopathic manipulative treatment (OMT) (98925-98929) or chiropractic manipulative treatment (CMT) (98940-98943) codes on the same region(s)/body part on the same day. This code may be paid when reported with CMT or OMT codes only if used on a different region(s)/body part on the same day and must be accompanied by CPT modifier 59 which identifies a distinct procedural service.
97150	Group therapeutic	Therapeutic procedure(s) for a group is used when two or more patients are present for the same type of service such as instruction in body mechanics training, or group exercises when participants are doing same type exercises, etc. There is no time definition for this code. Providers may charge only one unit, regardless of size of group, number of areas treated, or length of time involved.
97760	Orthotic training	This code applies to fabrication, instruction in use, fitting, and care and precautions of the orthotic.

97530	Therapeutic activities	This code is used for treatment promoting functional use of a muscle, muscle group, or body part. This code is not to be used for PROM, active assistive ROM, manual stretch, or manual therapy. Examples for use of code: A patient has had rotator cuff repair. When treatment incorporates functional motion of reaching to increase range of motion and strength, 97530 should be used. A patient has a herniated disc. When treatment incorporates instruction in body mechanics and positioning and simulated activities to improve functional performance, 97530 should be used.
97537	Community/ work	Community/work reintegration training includes jobsite analysis.
97545	Work hardening/ conditioning	Work hardening/conditioning units are for the initial two hours each visit. Codes 97545 and 97546 refer to services provided within a work hardening or work conditioning program described in part 5221.6600, subpart 2, item D.
97546	Work hardening/ conditioning	Work hardening/conditioning additional units are for each additional hour each visit. Refers to time beyond initial two hours of work conditioning or work hardening.

[For text of item D, see M.R.]

[For text of subp 4, see M.R.]

5221.4070 PHARMACY.

Subpart 1. **Substitution of generically equivalent drugs.** A generically equivalent drug must be dispensed according to Minnesota Statutes, section 151.21.

Subp. 1a. **Definitions.** The terms in this part have the following meanings.

A. "Community/outpatient pharmacy" has the meaning given in part 6800.0100, subpart 2.

[For text of items B to D, see M.R.]

E. "Pharmacy" has the meaning given in Minnesota Statutes, section 151.01, and includes:

(1) community/outpatient pharmacies;

(2) hospital pharmacies; and

(3) persons or entities that the pharmacy has designated by contract or other means to act on its behalf to submit its charges to the workers' compensation payer.

F. "Practitioner" has the meaning given in Minnesota Statutes, section 151.01, and includes persons or entities that the practitioner has designated by contract or other means to act on its behalf to submit its charges to the workers' compensation payer.

G. "Usual and customary charge" has the meaning given in part 5221.0500, subparts 1, item B, and 2, item B, subitem (1).

H. "Workers' compensation payer" or "payer" means any of the following entities:

(1) the workers' compensation insurer or self-insured employer liable for a claim under Minnesota Statutes, chapter 176;

(2) the special compensation fund liable for a claim under Minnesota Statutes, section 176.183, where the employer was uninsured at the time of the injury; or

(3) any other person or entity that the workers' compensation payer has designated by contract or other means to act on its behalf in paying drug charges, or determining the compensability or reasonableness and necessity of drug charges under Minnesota Statutes, chapter 176.

Subp. 2. **Procedure code; usual and customary charge.**

A. Providers must use the procedure codes in the National Drug Code Directory maintained and published by the federal Department of Health and Human Services,

United States Food and Drug Administration. Procedure codes are not required for over-the-counter drugs.

[For text of item B, see M.R.]

Subp. 3. **Maximum fee.**

A. Except as provided in subparts 4 and 5 and Minnesota Statutes, section 176.136, subdivision 1b, the workers' compensation payer's liability for compensable prescription drugs dispensed for outpatient use by a hospital pharmacy, practitioner, or community/outpatient pharmacy shall be limited to the lower of:

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

B. Except as provided in subparts 4 and 5 and Minnesota Statutes, section 176.136, subdivision 1b, the workers' compensation payer's liability for compensable over-the-counter drugs dispensed for outpatient use by a hospital pharmacy, practitioner, or community/outpatient pharmacy shall be, on the date the drug was dispensed, the lower of:

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

C. Except as provided in subpart 5, the workers' compensation payer's liability for compensable prescription drugs provided to an inpatient by a hospital is governed by Minnesota Statutes, sections 176.136, subdivision 1b, and 176.1362. The maximum fee for drugs dispensed for use at home, to an inpatient being discharged, is governed by item A or B, or subpart 4, as applicable.

Subp. 4. **Maximum fee for electronic transactions.**

A. The maximum fee specified in this item applies only if the requirements of item B or D are met. Except as provided in subpart 5, the workers' compensation payer's liability under items B and D for compensable drugs dispensed for outpatient use by a large hospital pharmacy, a practitioner, or a community/outpatient pharmacy shall be, on the date the drug was dispensed, the lower of:

(1) the average wholesale price (AWP) of the drug minus 12 percent, and a professional dispensing fee of $3.65 per prescription filled;

[For text of subitems (2) and (3), see M.R.]

B. The maximum fee specified in item A applies if:

(1) the pharmacy or practitioner electronically requests authorization for payment of the drug from the workers' compensation payer, according to the referral certification and authorization standards that apply to outpatient pharmacies in the NCPDP Version D, Release 0 format, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61; and

(2) the workers' compensation payer, electronically and in real time, authorizes payment for the drug according to the referral certification and authorization standards in the NCPDP Version D, Release 0 format, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61.

[For text of item C, see M.R.]

D. If the requirements in item B have not been met, the maximum fee specified in item A also applies if all of the following requirements are met:

(1) the pharmacy or practitioner requests electronic authorization according to the referral certification and authorization standards in the NCPDP Version D, Release 0 format, and the corresponding uniform companion guide adopted by the Minnesota Department of Health under Minnesota Statutes, sections 62J.536 and 62J.61;

[For text of subitems (2) to (4), see M.R.]

[For text of item E, see M.R.]

[For text of subp 5, see M.R.]

EFFECTIVE DATE. The adopted rules are effective upon publication in the State Register.