CHAPTER 5218

DEPARTMENT OF LABOR AND INDUSTRY

MANAGED CARE FOR INJURED WORKERS

5218.0010 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 5218.0010 to 5218.0900 have the meanings given them in this part.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Labor and Industry or a designee.

Subp. 3. **Emergency care.** "Emergency care" means those medical services that are required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency, but is necessary to determine whether an emergency exists.

Subp. 4. **Employee.** "Employee" means an employee entitled to treatment of a personal injury under Minnesota Statutes, section 176.135.

Subp. 5. **Health care provider.** "Health care provider" has the meaning given in Minnesota Statutes, section 176.011, subdivision 24.

Subp. 6. **Insurer.** "Insurer" means the insurer providing workers' compensation insurance required by Minnesota Statutes, chapter 176, and includes a self-insured employer except as otherwise provided in part 5218.0200, subpart 4.

Subp. 7. **Managed care plan.** "Managed care plan" means a plan certified by the commissioner that provides for the delivery and management of treatment to injured employees under Minnesota Statutes, sections 176.135 and 176.1351.

Subp. 8. **Participating health care provider.** "Participating health care provider" means any person, provider, company, professional corporation, organization, or business entity with which the managed care plan has contracts or other arrangements for the delivery of medical services or supplies to injured employees.

Subp. 9. **Payer.** "Payer" refers to any entity responsible for payment and administration of a workers' compensation claim under Minnesota Statutes, chapter 176.

Subp. 10. **Primary treating health care provider.** "Primary treating health care provider" means a physician, chiropractor, osteopath, podiatrist, or dentist directing and coordinating the course of medical care to the employee.

Subp. 11. **Revocation.** "Revocation" means the termination of a managed care plan's certification to provide services under parts 5218.0010 to 5218.0900.

Subp. 12. **Suspension.** "Suspension" means the managed care plan's authority to enter into new or amended contracts with insurers has been suspended by the commissioner for a specified period of time.

Statutory Authority: *MS s 176.1351*

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5218.0020 AUTHORITY.

Parts 5218.0010 to 5218.0900 are adopted under the commissioner's rulemaking authority under Minnesota Statutes, section 176.1351, subdivision 6.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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5218.0030 PURPOSE AND SCOPE.

The purpose of parts 5218.0010 to 5218.0900 is to establish procedures and requirements for certification as a managed care plan relating to the management and delivery of medical services to injured employees within the workers' compensation system under Minnesota Statutes, sections 176.135, subdivision 1, paragraph (f), and 176.1351. No person or entity shall hold itself out to be a workers' compensation managed care entity unless the entity is a certified managed care plan under this chapter.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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5218.0040 PROVISIONAL CERTIFICATION.

A managed care plan provisionally certified under the emergency rules may continue to operate with the provisional certification under parts 5218.0010 to 5218.0900, provided that the managed care plan must submit a new application by January 28, 1994. To maintain certification, a certified managed care plan must submit an annual report required by part 5218.0300, subpart 2.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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5218.0100 APPLICATION FOR CERTIFICATION.

Subpart 1. **Certification.** Except as provided in part 5218.0200, subpart 4, any person or entity may make written application to the commissioner to provide managed care to injured employees for injuries and diseases compensable under Minnesota Statutes, chapter 176, under a plan certified by the commissioner. To obtain certification of a plan, an application shall be submitted on a form provided by the commissioner which shall include items A to N, and other matters related to parts 5218.0010 to 5218.0900.

A. One clean copy suitable for imaging plus one identical copy of the application must be submitted. Portions of the application which the managed care plan believes is subject to trade secret protection under Minnesota Statutes, section 13.37, must be clearly marked, separated and justified in accordance with part 5218.0800, subpart 2, item B.

B. The plan must provide the information in subitems (1) to (6). An individual may act in more than one capacity:

(1) the names of all directors and officers of the managed care plan;

(2) the title and name of the person to be the day-to-day administrator of the managed care plan;

(3) the title and name of the person to be the administrator of the financial affairs of the managed care plan;

(4) the name, and medical specialty, if any, of the medical director;

(5) the name, address, and telephone number of a communication liaison for the department, the insurer, the employer, and the employee; and

(6) the name of any entity, other than individual health care providers, with whom the managed care plan has a joint venture or other agreement to perform any of the functions of the managed care plan, and a description of the specific functions to be performed by each entity.

C. Each application for certification or application following revocation must be accompanied by a nonrefundable fee of $1,500. If a plan has been provisionally certified under chapter 5218 [Emergency], the application fee shall be $600. Fees for the annual report and changes to the plan as certified are in part 5218.0300.

D. The managed care plan must ensure provision of quality services that meet all uniform treatment standards adopted by the commissioner under Minnesota Statutes, section 176.83, subdivision 5, and all medical and health care services that may be required by Minnesota Statutes, chapter 176.

E. The managed care plan must provide a description of the times, places, and manner of providing services under the plan, including a statement describing how the plan will ensure an adequate number of each category of health care providers is available to give employees convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan, in accordance with this chapter and Minnesota Statutes, section 176.1351, subdivisions 1, clauses (1) and (2), and 10.

(1) The managed care plan must include at a minimum, and provide to an employee when necessary under Minnesota Statutes, section 176.135, subdivision 1, the following types of health care services and providers, unless the managed care plan provides evidence that a particular service or type of provider is not available in the community:

(a) medical doctors, including the following specialties:

i. specialists in at least one of the following fields: family practice, internal medicine, occupational medicine, or emergency medicine;

ii. orthopedic surgeons, including specialists in hand and upper extremity surgery;

iii. neurologists and neurosurgeons; and

iv. general surgeons;

(b) chiropractors;

(c) podiatrists;

(d) osteopaths;

(e) physical and occupational therapists;

(f) psychologists or psychiatrists;

(g) diagnostic pathology and laboratory services;

(h) radiology services; and

(i) hospital, outpatient surgery, and urgent care services.

The managed care plan must submit copies of all types of agreements with providers who will deliver services under the managed care plan, and a description of any other relationships with providers who may deliver services to a covered employee. The managed care plan must attach to each standard document a corresponding list of names, clinics, addresses, and types of license and specialties for the health care providers. The managed care plan must also submit a statement that all licensing requirements for the providers are current and in good standing in Minnesota or the state in which the provider is practicing.

(2) The managed care plan must provide for referral for specialty services that are not specified in subitem (1) and that may be reasonable and necessary to cure or relieve an employee of the effects of the injury under Minnesota Statutes, section 176.135, subdivision 1. The insurer remains liable for any health service required under Minnesota Statutes, section 176.135, that the managed care plan does not provide.

F. The managed care plan must include procedures to ensure that employees will receive services in accordance with subitems (1) to (7):

(1) Employees must receive initial evaluation by a participating licensed health care provider within 24 hours of the employee's request for treatment, following a work injury.

(2) In cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan under part 5218.0500, subpart 1, item A, the employee must receive initial evaluation or treatment by a participating licensed health care provider within five working days of the employee's request for a change of doctor, or referral to the managed care plan.

(3) Following the initial evaluation, upon request, the employee must be allowed to receive ongoing treatment from any participating health care provider as the employee's primary treating health care provider in one of the disciplines in units (a) to (e), if the provider is available within the mileage limitations in subitem (7) and the treatment is required under Minnesota Statutes, section 176.135, subdivision 1, is within the provider's scope of practice, and is appropriate under the standards of treatment adopted by the managed care plan or the standards of treatment adopted by the commissioner under Minnesota Statutes, section 176.83, subdivision 5:

(a) medical doctors;

(b) chiropractors;

(c) podiatrists;

(d) osteopaths; or

(e) dentists.

An evaluating provider may also be offered as a primary treating provider.

(4) Employees must receive any necessary treatment, diagnostic tests, or specialty services in a manner that is timely, effective, and convenient for the employee.

(5) Employees must be allowed to change primary treating providers within the managed care plan at least once without proceeding through the managed care plan's dispute resolution process. In such cases, employees must make a request to the managed care plan for a change in their treating health care provider. A change of providers from the evaluating health care provider in subitems (1) and (2) to a primary treating doctor for ongoing treatment is not considered a change of doctor, unless the employee has received treatment from the evaluating health care provider more than once for the injury.

(6) Employees must be able to receive information on a 24-hour basis regarding the availability of necessary medical services available within the managed care plan. The information may be provided through recorded toll-free telephone messages after normal working hours. The message must include information on how the employee can obtain emergency services or other urgently needed care and how the employee can access an evaluation within 24 hours of the injury as required under unit (a).

(7) Employees must have access to the evaluating and primary treating health care provider within 30 miles of either the employee's place of employment or residence if either the residence or place of employment is within the seven-county metropolitan area. The seven-county metropolitan area includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. If both the employee's residence and place of employment are outside the seven-county metropolitan area, the allowable distance is 50 miles. If the employee requires specialty services that are not available within the stated mileage restriction, the managed care plan may refer the employee to a provider outside of the stated mileage restriction. If the employee is medically unable to travel to a participating provider within the stated mileage restriction, the managed care plan shall refer the employee to an available nonparticipating provider to receive necessary treatment for the injury.

G. The managed care plan must designate the procedures for approval of services from a health care provider outside the managed care plan according to part 5218.0500.

H. The managed care plan must include a procedure for peer review and utilization review as specified in part 5218.0750.

I. The managed care plan must include a procedure for internal dispute resolution according to part 5218.0700 and Minnesota Statutes, section 176.1351, subdivision 2, clause (4), including a method to resolve complaints by injured employees, medical providers, and insurers.

J. The managed care plan must describe how employers and insurers will be provided with information that will inform employees of all choices of medical service providers within the plan and how employees can gain access to those providers. The plan must submit a proposed notice to employees, which may be customized according to the needs of the employer, but which must include the information in part 5218.0250.

K. The managed care plan must describe how aggressive medical case management will be provided according to part 5218.0760 for injured employees, and a program for early return to work and cooperative efforts by the employees, the employer, and the managed care plan to promote workplace health and safety consultative and other services.

L. The managed care plan must describe a procedure or program through which participating health care providers may obtain information on the following topics:

(1) treatment parameters adopted by the commissioner;

(2) maximum medical improvement;

(3) permanent partial disability rating;

(4) return to work and disability management;

(5) health care provider obligations in the workers' compensation system; and

(6) other topics the managed care plan deems necessary to obtain cost-effective medical treatment and appropriate return to work for an injured employee.

The medical director or a designee must document attendance for a minimum of 12 hours of education during the first year, and four hours each year thereafter, covering any of the topics listed in subitems (1) to (6). The documentation shall be submitted to the commissioner upon request. The medical director or designee must be available as a consultant on these topics to any health care provider delivering services under the managed care plan.

M. The managed care plan must specify any medical treatment standards it has developed for medical services that have not already been prescribed by the commissioner and that are reasonably likely to be used in the treatment of workers' compensation injuries. The managed care plan shall make the standards available for review by the commissioner upon request. All managed care plan health care providers and those providing services under part 5218.0500 shall be governed by these treatment standards and by the standards adopted by the commissioner under Minnesota Statutes, section 176.83, subdivision 5. A managed care plan may not prescribe treatment standards that disallow, in all cases, treatment that is permitted by the commissioner's standards. However, this item does not require ongoing treatment in individual cases if the treatment is not medically necessary, even though the maximum amount of treatment permitted under any standard has not been given.

N. The managed care plan must provide other information as the commissioner considers necessary to determine compliance with this chapter.

Subp. 2. **Notification; approval or denial.** Within 30 days of receipt of an application the commissioner must notify an applicant for certification of any additional information required or modification that must be made. The commissioner must notify the applicant in writing of the approval

or denial of certification within 30 days of receipt of the additional information or modification. If the certification is denied, the applicant must be provided, in writing, with the reason for the denial.

Subp. 3. **Review of decision.** Any person aggrieved by a denial of certification by the commissioner may request in writing, within 30 days of the date the denial is served and filed, the initiation of a contested case proceeding under Minnesota Statutes, chapter 14. Following receipt of the administrative law judge's findings and recommendations, the commissioner shall issue a final decision in accordance with Minnesota Statutes, section 14.62. An appeal from the commissioner's final decision and order may be taken to the workers' compensation court of appeals pursuant to Minnesota Statutes, sections 176.421 and 176.442.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379; L 1998 c 294 s 7*

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5218.0200 COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN.

Subpart 1. **Scope.** A managed care plan shall provide comprehensive medical services according to its certification and Minnesota Statutes, chapter 176, and all other applicable statutes and rules.

Subp. 2. **Contracts and coverage.** A managed care plan must contract with the insurer liable for coverage of employees with a personal injury under Minnesota Statutes, chapter 176. Contracts with the insurer must include the provisions required by part 5218.0300, subpart 1, and are subject to the conditions of coverage in subparts 3 to 6.

Subp. 3. **Multiple plans.** Insurers may contract with multiple managed care plans to provide coverage for employers. When an insurer contracts with multiple managed care plans to cover the same employer, each employee shall have the initial choice within a reasonable time designated by the employer and insurer to select the managed care plan that will manage the employee's care. The employee must select a managed care plan from those that have a contract with the insurer liable for the personal injury under Minnesota Statutes, chapter 176, and that provide services within the mileage restrictions under part 5218.0100, subpart 1, item F, subitem (7).

Subp. 4. **Restrictions on employer or insurer formed plans.** Any person or entity, other than a workers' compensation insurer licensed under Minnesota Statutes, chapter 79A, or an employer for its own employees, may apply for certification as a certified managed care plan. A self-insured employer, an entity licensed under Minnesota Statutes, chapter 62C or 62D, or a preferred provider organization that is subject to Minnesota Statutes, chapter 72A, is eligible for certification. An employee of a certified managed care plan shall not be required to obtain services under the plan.

This subpart does not restrict cooperative efforts, whether by contract or otherwise, between a managed care plan, employer, third party administrator, and insurer to accomplish the purposes of Minnesota Statutes, section 176.1351.

Subp. 5. **Coverage.**

A. An employee who gives notice to an employer of a compensable personal injury under Minnesota Statutes, chapter 176, on or after the effective date of the managed care plan contract with the insurer liable for the injury under Minnesota Statutes, chapter 176, shall receive medical services in the manner prescribed by the terms and conditions of the managed care plan contract. An employee may not be

required to receive medical services under the managed care plan until the notice required by part 5218.0250 is given to the employee.

B. If the employer received notice of the injury before the effective date of the managed care plan contract, the employee may continue to treat with a nonparticipating provider who has been treating the injury until the employee requests a change of doctor. At that time, further services shall be provided by the managed care plan according to part 5218.0100, subpart 1, item F, subitems (2) and (3). Services by health care providers who are not participating providers must be delivered according to part 5218.0500.

C. Except as provided in part 5218.0500, an employer may elect to require an employee who has notified the employer of a claimed workers' compensation injury to receive treatment from a certified managed care plan before the employer accepts or denies liability for the injury. In such cases, the employer is liable for the cost of any treatment related to the claimed personal injury that is given by a participating health care provider before notice is given to the employee of a denial of liability, even if the employer is later determined to be not liable for the claimed injury. If liability is denied, the employer cannot pursue reimbursement from the employee. This item does not limit the employer's right to pursue any other applicable subrogation or reimbursement rights it may have against another entity.

D. The employee may receive treatment from any health care provider chosen by the employee after a notice of denial of liability has been given to the employee, or if the employer, after notice of a claimed injury, does not require the employee to receive treatment from a managed care plan prior to accepting liability for a claimed injury. If the employer later accepts liability or is determined by the commissioner, a compensation judge, or an appellate court to be liable for the claimed injury, the employer is responsible for the cost of all reasonable and necessary medical treatment received by the employee from the health care provider. If the employer admits liability for the claimed injury within 14 days after receiving notice of the injury, the employer may require that further medical treatment be received through the managed care plan unless the employee had a documented history of treatment with the health care provider as described in part 5218.0500, before the injury. If liability is admitted or determined later than 14 days after notice of the injury and the employee has been receiving treatment from a nonparticipating provider under this item, the employee is not required to receive further treatment under the managed care plan, if the health care provider agrees to comply with part 5218.0500, subpart 2.

Subp. 6. **Termination of coverage.** To ensure continuity of care, the managed care plan contract shall specify the manner in which an injured employee with a compensable injury will receive medical services when a managed care plan contract or a contract with a health care provider terminates. When a contract with a health care provider terminates, or when managed care plan coverage for an injured employee is being transferred from one managed care plan to another, the employee may continue to treat with the health care provider under the terminated contract until the employee requests a change of doctor. At that time further services shall be provided under the managed care plan in accordance with the procedures in part 5218.0100, subpart 1, item D, subitem (3), units (b) and (c). Services by providers who are not participating providers must be performed according to part 5218.0500.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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5218.0250 NOTICE TO EMPLOYEE BY EMPLOYER.

An employee who is otherwise covered by a certified managed care plan is not required to receive services under a managed care plan until the employer gives the employee notice of items A to E. For employees enrolled after November 30, 1993, this individual notice must be given at the time of enrollment. The notice must also be offered to an employee when the employer receives notice of an injury. In addition, the employer must post a notice of items A to E at a prominent location on the employer's premises. The posted notice shall remain posted as long as the employees are covered by the managed care plan. The posted and individual notices must include the information in items A to E:

A. that the employer has enrolled with the specified managed care plan to provide all necessary medical treatment for workers' compensation injuries. An employee with an injury prior to enrollment may continue to receive treatment from a nonparticipating provider until the employee changes doctors. The notice to employees must specify the effective date of the managed care plan, which must be later than the date the notice is posted;

B. the contact person and telephone number of the employer and the managed care plan who can answer questions about managed care;

C. that the employee may receive treatment from a medical doctor, chiropractor, podiatrist, osteopath, or dentist, if the treatment is available within the community and is appropriate for the injury or illness;

D. how the employee can access care under the managed care plan and the toll-free 24-hour telephone number of the managed care plan that informs employees of available services;

E. that the employee is required to receive services from a health care provider who is a member of the managed care plan, except in the following circumstances:

(1) if the employee has established a documented history of treatment before the injury with a health care provider who maintains the employee's medical records under the requirements in part 5218.0500, subparts 1 and 2, except that if the employee changes doctors it must be to a doctor within the managed care plan;

(2) in an emergency; and

(3) if the employee's place of employment and residence are beyond the mileage parameters set forth in part 5218.0100, subpart 1, item F, subitem (7); and

F. the St. Paul, Duluth, and toll-free telephone numbers of the Department of Labor and Industry for questions.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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5218.0300 REPORTING REQUIREMENTS FOR CERTIFIED MANAGED CARE PLAN.

Subpart 1. **Contracts; modifications.** A managed care plan shall provide the commissioner with a copy of the following contracts.

A. Contracts between the managed care plan and any insurer or self-insured employer, signed by the parties, within 30 days of execution of the contracts. Standard contracts may be submitted instead

of individual contracts if no modifications are made. Standard contracts must include a list of signatories and a listing of all employers covered by each contract including the employer's names, unemployment benefits identification number, and estimated number of employees governed by the managed care plan contract. Amendments and addendums to the contracts must be submitted to the commissioner within 30 days of execution. Contract provisions must be consistent with parts 5218.0010 to 5218.0900 and Minnesota Statutes, section 176.1351. The contract must specify the billing and payment procedures and how the medical case management and return to work functions will be coordinated.

B. New types of agreements between participating health care providers and the managed care plan that are not identical to the agreements previously submitted to the department under part 5218.0100, subpart 1, item E, subitem (1), which shall not be effective until approved by the commissioner.

C. Contracts between the managed care plan and any entity, other than individual participating providers, that performs some of the functions of the managed care plan.

Subp. 2. **Annual reporting.** In order to maintain certification, each managed care plan shall provide on the first working day following each anniversary of certification the following information in items A to D. The annual report must be accompanied by a nonrefundable fee of $400:

A. a current listing of participating health care providers, including provider names, types of license, specialty, business address, telephone number, and a statement that all licenses are current and in good standing;

B. a summary of any sanctions or punitive actions taken by the managed care plan against its participating providers;

C. a report that summarizes peer review, utilization review, reported complaints and dispute resolution proceedings showing cases reviewed, issued involved, and any action taken; and

D. a report of educational opportunities offered to participating providers and a summary of attendance.

Subp. 3. **Plan amendments.** Any of the proposed changes to the certified managed care plan in items A to C, other than changes to the health care provider list, must be reported and may not be implemented under the plan until approved by the commissioner. Submitted changes must be accompanied by a nonrefundable fee of $150:

A. amendments to any contract with participating health care providers;

B. amendments to contracts between the managed care plan and another entity performing functions of the managed care plan; and

C. any other amendments to the managed care plan as certified.

Subp. 4. **Insurers; data.** The managed care plan must report to the insurer any data regarding medical services and supplies related to the workers' compensation claim required by the insurer to determine compensability in accordance with Minnesota Statutes, sections 176.135, subdivision 7, and 176.138, and any other data required by rule.

Subp. 5. **Monitoring.** The commissioner shall require additional information from the managed care plan if the information is relevant to determining the managed care plan's compliance with parts 5218.0100 to 5218.0900 and Minnesota Statutes, section 176.1351.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379; L 1997 c 66 s 80; L 1999 c 107 s 66; L 2000 c 343 s 4*

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5218.0400 COMMENCEMENT AND TERMINATION OF CONTRACT WITH PARTICIPATING PROVIDERS.

Subpart 1. **Commencement.** Prospective new participating health care providers under a managed care plan shall submit an application to the managed care plan. A director, executive director, or administrator may approve the application under the requirements of the managed care plan. The managed care plan shall verify that each new participating health care provider meets all licensing, registration, and certification requirements necessary to practice in Minnesota or other applicable state of practice.

Subp. 2. **Termination.** A participating provider may elect to terminate participation in the managed care plan or be subject to cancellation by the managed care plan under the requirements of the managed care plan. Upon termination of a provider contract, the managed care plan shall make alternate arrangements to provide continuing medical services for an affected injured employee under the plan in accordance with part 5218.0200, subpart 6.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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5218.0500 HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subpart 1. **Authorized services.** A health care provider who is not a participating health care provider may provide medical services to an employee covered by a managed care plan in any of the circumstances in items A to D. The employer or insurer must notify the managed care plan of treatment under items A, B, and D and the managed care plan, employer, or insurer must initiate the contact with the nonparticipating provider. The managed care plan must explain its requirements and procedures to the nonparticipating health care provider, and must provide the plan's toll-free telephone number through which the nonparticipating provider may obtain information about the plan's requirements and procedures and other information specified in part 5218.0100, subpart 1, item L.

A. A nonparticipating provider may deliver services to an employee if the treatment is within the provider's scope of practice, if the health care provider maintains the employee's medical records and has a documented history of treatment with the employee before the date of injury, whether for a work-related condition or not, and so long as the provider complies with subpart 2 and Minnesota Statutes, section 176.1351, subdivision 2, clause (8). A documented history of treatment does not include evaluations for no or minimal compensation or treatment of an injury before notice of the injury is given to the employer. The requirement of a history of treatment will be deemed to be satisfied if the employee documents at least two visits with the provider within the two years before the date of the injury. Employees with a history of treatment that does not meet this standard may request approval from the managed care plan or the insurer. If approval is denied, the employee may contest the denial according to the procedures in subpart 3 and part 5218.0700.

The employee must, within ten calendar days of notice to an employer of an injury, provide the managed care plan or insurer with copies of medical records or a letter from the health care provider documenting the dates of the previous treatment. The managed care plan or insurer must treat the medical records as private data. If the employee requests a change of doctor, further services shall be provided by the managed care plan according to part 5218.0100, subpart 1, item F, subitems (2) and (3).

B. A nonparticipating provider may deliver services to an employee for emergency treatment.

C. A nonparticipating provider may deliver services to an employee when the employee is referred to the provider by the managed care plan.

D. A nonparticipating provider may deliver services to an employee when the employee has received treatment for a claimed injury from a nonparticipating provider under part 5218.0200, subpart 5, items B and D, where liability for the injury is admitted or established later than 14 days after the employer received notice of the injury.

Subp. 2. **Requirements.** To deliver services to an employee under subpart 1, items A and D, a health care provider who is not a participating health care provider must:

A. agree to comply with the managed care plan treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures; and

B. agree to refer the covered employee to the managed care plan for specialized services, including without limitation physical therapy and diagnostic testing, except for minor diagnostic testing that may be done in the nonparticipating provider's office. The nonparticipating provider referring the employee may continue to act as the primary treating provider.

Subp. 3. **Disputes.** Any dispute under subpart 1 or 2 relating to the employee's selection of a health care provider who is not a managed care plan participating health care provider shall be resolved according to part 5218.0700. Any dispute relating to a health care provider's compliance with the managed care plan standards and procedures or treatment standards adopted by the commissioner shall be resolved according to part 5218.0700. A health care provider who has been informed that an injured employee is covered by a managed care plan and who does not comply with the requirements in subpart 2 is subject to denial of payment for the services in accordance with the procedures in part 5218.0700 and sanctions under Minnesota Statutes, section 176.103.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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5218.0600 CHARGES AND FEES.

Billings for medical services under a managed care plan shall be submitted in the form and format as prescribed in part 5221.0700, subpart 2. The payment by the insurer or the managed care plan to participating and nonparticipating health care providers for medical services shall be according to the time frames and procedures in part 5221.0600, subpart 3, and Minnesota Statutes, section 176.135, subdivision 6, and shall be the amount allowed under part 5221.0500 and Minnesota Statutes, section 176.136, subdivisions 1a and 1b. A managed care plan may not require a health care provider to accept a lesser payment or pay a fee as a condition of receiving referrals from or becoming a participating provider in the plan.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

Published Electronically: *June 11, 2008*

5218.0700 DISPUTE RESOLUTION.

Disputes that arise on an issue related to managed care shall first be processed without charge to the employee or health care provider through the dispute resolution process of the managed care plan. The managed care plan dispute resolution process must be completed within 30 days of receipt of a written request. If the dispute cannot be resolved, the parties may proceed under Minnesota Statutes, sections 176.106 and 176.305 or 176.2615.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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5218.0750 UTILIZATION REVIEW AND PEER REVIEW.

Subpart 1. **Peer review.** The managed care plan must implement a system for peer review to improve patient care and cost-effectiveness of treatment. Peer review must include at least one health care provider of the same discipline being reviewed. The peer review must be designed to evaluate the quality of care given by a health care provider to a patient or patients. The plan must describe in its application for certification how the providers will be selected for review, the nature of the review, and how the results will be used.

Subp. 2. **Utilization review.** The managed care organization must implement a program for utilization review. The program must include the collection, review, and analysis of group data to improve overall quality of care and efficient use of resources. In its application for certification, the managed care plan must specify the data that will be collected, how the data will be analyzed, and how the results will be applied to improve patient care and increase cost-effectiveness of treatment.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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5218.0760 MEDICAL CASE MANAGEMENT.

Subpart 1. **Role of case manager.** The medical case manager must monitor, evaluate, and coordinate the delivery of quality, cost-effective medical treatment, and other health services needed by an injured employee, and must promote an appropriate, prompt return to work. Medical case managers must facilitate communication between the employee, employer, insurer, health care provider, managed care plan, and any assigned qualified rehabilitation consultant to achieve these goals. The managed care plan must describe in its application for certification how injured employees will be selected for case management, the services to be provided, and who will provide the services.

Subp. 2. **Qualifications of medical case manager.** Case management for an employee covered by a managed care plan must be provided by a licensed or registered health care professional. Case managers must have at least one year's experience in workers' compensation.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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5218.0800 MONITORING RECORDS.

Subpart 1. **Audits.** The commissioner shall monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements.

Subp. 2. **Records.**

A. All records of the managed care plan and its participating health care providers relevant to determining compliance with parts 5218.0010 to 5218.0900 and Minnesota Statutes, section 176.1351, shall be disclosed within a reasonable time after request by the commissioner. Records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes.

B. The release of records filed with the commissioner is subject to Minnesota Statutes, sections 13.37, 145.61 to 145.67, 176.231, subdivisions 8 and 9, 176.234, and 176.138. If a managed care plan believes that portions of its application are nonpublic trade secret data under Minnesota Statutes, section 13.37, subdivisions 2 and 3, the plan's application must clearly identify the portions of the application it identifies as trade secret in a separate appendix or appendices.

The plan must also submit with the application an analysis of how each section of the appendix it has characterized as trade secret satisfies each of the three parts of the statutory definition of trade secret under Minnesota Statutes, section 13.37, subdivision 2. Absent a clear indication to the contrary, a written opinion submitted by an attorney identifying and analyzing portions of the application as meeting the statutory requirements for a trade secret under Minnesota Statutes, section 13.37, subdivision 2, shall be considered prima facie showing of a trade secret.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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5218.0900 SUSPENSION; REVOCATION.

Subpart 1. **Complaints; investigation.** Complaints pertaining to violations of parts 5218.0010 to 5218.0900 or Minnesota Statutes, section 176.1351, by the managed care plan shall be directed in writing to the commissioner. On receipt of a written complaint, or after monitoring the managed care plan operations, the department shall investigate the alleged violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the investigation reveals reasonable cause to believe that there has been a violation warranting suspension or revocation of certification, the commissioner shall initiate a contested case proceeding under Minnesota Statutes, chapter 14.

Subp. 2. **Criteria.** Under Minnesota Statutes, section 176.1351, subdivision 5, the certification of a managed care plan issued by the commissioner shall be suspended or revoked by the commissioner if:

A. service under the plan is not being provided according to the terms of the certified plan;

B. the plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of parts 5218.0010 to 5218.0900 or Minnesota Statutes, section 176.1351;

C. the managed care plan fails to comply with parts 5218.0010 to 5218.0900 and Minnesota Statutes, section 176.1351, or requirements of utilization and treatment standards adopted under Minnesota Statutes, section 176.83;

D. any false or misleading information is submitted by the managed care plan or participating provider;

E. the managed care plan continues to use the services of a health care provider whose license, registration, or certification has been suspended or revoked, or under Minnesota Statutes, section 176.103, or who is ineligible to provide treatment to an injured employee under Minnesota Statutes, section 256B.0644; or

F. the managed care plan is formed, owned, or operated by an insurer.

Subp. 3. **Effects.** No employee is covered by a contract between a managed care plan and insurer if the managed care plan's certification is revoked. The managed care plan may reapply for certification as specified in the order of revocation. Upon suspension of certification, the managed care plan may continue to provide services under contracts in effect if the commissioner determines injured employees will continue to receive necessary medical services under Minnesota Statutes, section 176.135.

Statutory Authority: *MS s 176.1351*

History: *18 SR 1379*

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