

5221.6050 GENERAL TREATMENT PARAMETERS; EXCESSIVE TREATMENT; PRIOR NOTIFICATION.

Subpart 1. General.

A. All treatment must be medically necessary treatment, as defined in part 5221.6040, subpart 10. The health care provider must evaluate the medical necessity of all treatment under item B on an ongoing basis.

Parts 5221.6050 to 5221.6600 do not require or permit any more frequent examinations than would normally be required for the condition being treated, but do require ongoing evaluation of the patient that is medically necessary, consistent with accepted medical practice.

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

(1) the employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;

(2) the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

(3) the employee's functional status, especially vocational activities, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

Except as otherwise provided under parts 5221.6200, subpart 3, item B; 5221.6205, subpart 3, item B; 5221.6210, subpart 3, item B; and 5221.6300, subpart 3, item B, if there is not progressive improvement in at least two of subitems (1) to (3), the modality must be discontinued or significantly modified, or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional directly providing the treatment, but remains the ultimate responsibility of the treating health care provider who ordered the treatment.

C. The health care provider must use the least intensive setting appropriate and must assist the employee in becoming independent in the employee's own care to the extent

possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

Subp. 2. **Documentation.** A health care provider must maintain an appropriate record, as defined in part 5221.0100, subpart 1a, of any treatment provided to a patient.

Subp. 3. **Nonoperative treatment.** Health care providers shall provide a trial of nonoperative treatment before offering or performing surgical treatment unless the treatment for the condition requires immediate surgery, unless an emergency situation exists, or unless the accepted standard of initial treatment for the condition is surgery.

Subp. 4. **Chemical dependency.** The health care provider shall maintain diligence to detect incipient or actual chemical dependency to any medication prescribed for treatment of the employee's condition. In cases of incipient or actual dependency, the health care provider shall refer the employee for appropriate evaluation and treatment of the dependency.

Subp. 5. **Referrals between health care providers.** The primary health care provider directing the course of treatment shall make timely and appropriate referrals for consultation for opinion or for the transfer of care if the primary health care provider does not have any reasonable alternative treatment to offer and there is a reasonable likelihood that the consultant may offer or recommend a reasonable alternative treatment plan. This subpart does not prohibit a referral for consultation in other circumstances based on accepted medical practice and the patient's condition.

A. Referrals from consulting health care provider. If the consultant has reasonable belief that another consultation is appropriate, that consultant must coordinate further referral with the original treating health care provider unless the consultant has been approved as the employee's treating health care provider. The consultant is under no obligation to provide or recommend treatment or further referral, if in the consultant's opinion, all reasonable and necessary treatment has been rendered. The consultant shall in this situation refer the employee back to the original treating health care provider for further follow-up.

B. Information sent to consultant. When a referring health care provider arranges for consultation or transfer of care, except in cases of emergency, the referring health care provider shall, with patient authorization, summarize for the consultant orally or in writing the conditions of injury, the working diagnosis, the treatment to date, the patient's response to treatment, all relevant laboratory and medical imaging studies, return to work considerations, and any other information relevant to the consultation. In addition, the referring health care provider shall make available to the consultant, with patient authorization, a copy of all medical records relevant to the employee's injury.

Subp. 6. Communication between health care providers and consideration of prior care.

A. Information requested by new health care provider. Upon accepting for treatment a patient with a workers' compensation injury, the health care provider shall ask the patient if treatment has been previously given for the injury by another health care provider. If the patient reports that treatment has been previously given for the injury by another health care provider and if the medical records for the injury have not been transferred, the new health care provider shall request authorization from the employee for relevant medical records. Upon receipt of the employee authorization, the new health care provider shall request relevant medical records from the previous health care providers. Upon receipt of the request for medical records and employee authorization, the previous health care providers shall provide the records within seven working days.

B. Treatment by prior health care provider. If the employee has reported that care for an injury has been previously given:

(1) Where a previous health care provider has performed diagnostic imaging, a health care provider may not repeat the imaging or perform alternate diagnostic imaging for the same condition except as permitted in part 5221.6100.

(2) When a therapeutic modality employed by a health care provider was no longer improving the employee's condition under subpart 1, item B, or has been used for the maximum duration allowed under parts 5221.6050 to 5221.6600, another health care provider may not employ the same modality at any time thereafter to treat the same injury except if one of the departures applies under subpart 8, after surgery, or for treatment of reflex sympathetic dystrophy under part 5221.6305.

(3) It is also inappropriate for two health care providers to use the same treatment modality concurrently.

C. Employee refusal. An employee's refusal to provide authorization for release of medical records does not justify repeat treatment or diagnostic testing. An insurer is not liable for repeat diagnostic testing or other duplicative treatment prohibited by this subpart.

Subp. 7. Determinations of excessive treatment; notice of denial to health care providers and employee; expedited processing of medical requests.

A. In addition to services deemed excessive under part 5221.0500 and Minnesota Statutes, section 176.136, subdivision 2, treatment is excessive if:

(1) the treatment is inconsistent with an applicable parameter or other rule in parts 5221.6050 to 5221.6600; or

(2) the treatment is consistent with the parameters in parts 5221.6050 to 5221.6600, but is not medically necessary treatment.

B. If the insurer denies payment for treatment that departs from a parameter under parts 5221.6050 to 5221.6600, the insurer must provide the employee and health care provider with written notice of the reason for the denial and that the treatment rules permit departure from the parameters in specified circumstances. If the insurer denies authorization for proposed treatment after prior notification has been given under subpart 9, the insurer must provide the employee and health care provider in writing with notice of the reason why the information given by the health care provider does not support the proposed treatment and notice of the right to review of the denial under subpart 9, item C. The insurer may not deny payment for a program of chronic management that the insurer has previously authorized for an employee, either in writing or by routine payment for services, without providing the employee and the employee's health care provider with at least 30 days' notice of intent to apply any of the chronic management parameters in part 5221.6600 to future treatment. The notice must include the specific parameters that will be applied in future determinations of compensability by the insurer.

C. If the insurer denies authorization or payment for treatment governed by parts 5221.6050 to 5221.6600, the health care provider or the employee may request a determination from the commissioner or compensation judge by filing a medical request or petition under chapter 5220 and Minnesota Statutes, sections 176.106 and 176.305. The medical request may not be filed before completion of the managed care plan's dispute resolution process, if applicable. If the health care provider has notified the insurer of proposed treatment requiring prior notification under subpart 9, the health care provider or employee must describe or attach a copy of the notification, and any response from the insurer, to the medical request filed with the department. The insurer may, but is not required to, file a medical response where the insurer's response to prior notification under subpart 9 has been attached to the medical request. If the insurer elects to file a medical response in such cases, it must be received within ten working days of the date the medical request was filed with the department. The commissioner or compensation judge may issue a decision based on written submissions no earlier than ten working days after receipt of the medical request, unless a medical response has been filed sooner.

D. A determination of the compensability of medical treatment under Minnesota Statutes, chapter 176, must include consideration of the following factors:

- (1) whether a treatment parameter or other rule in parts 5221.6050 to 5221.6600 applies to the etiology or diagnosis for the condition;
- (2) if a specific or general parameter applies, whether the treatment is consistent with the treatment parameter and whether the treatment was medically necessary as defined in part 5221.6040, subpart 10; and
- (3) whether a departure from the applicable parameter is or was necessary because of any of the factors in subpart 8.

Subp. 8. **Departures from parameters.** A departure from a parameter that limits the duration or type of treatment in parts 5221.6050 to 5221.6600 may be appropriate in any one of the circumstances specified in items A to E. The health care provider must provide prior notification of the departure as required by subpart 9.

A. Where there is a documented medical complication.

B. Where previous treatment did not meet the accepted standard of practice and the requirements of parts 5221.6050 to 5221.6600 for the health care provider who ordered the treatment.

C. Where the treatment is necessary to assist the employee in the initial return to work where the employee's work activities place stress on the part of the body affected by the work injury. The health care provider must document in the medical record the specific work activities that place stress on the affected body part, the details of the treatment plan and treatment delivered on each visit, the employee's response to the treatment, and efforts to promote employee independence in the employee's own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

D. Where the treatment continues to meet two of the following three criteria, as documented in the medical record:

(1) the employee's subjective complaints of pain are progressively improving as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;

(2) the employee's objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

(3) the employee's functional status, especially vocational activity, is objectively improving as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

E. Where there is an incapacitating exacerbation of the employee's condition. However, additional treatment for the incapacitating exacerbation may not exceed, and must comply with, the parameters in parts 5221.6050 to 5221.6600.

Subp. 9. **Prior notification; health care provider and insurer responsibilities.** Prior notification is the responsibility of the health care provider who wants to provide the

treatment in item A. Prior notification need not be given in any case where emergency treatment is required.

A. The health care provider must notify the insurer of proposed treatment in subitems (1) to (4) at least seven working days before the treatment is initiated, except as otherwise provided in subitem (4):

(1) for chronic management modalities where prior notification is required under part 5221.6600;

(2) for durable medical equipment requiring prior notification in parts 5221.6200, subpart 8; 5221.6205, subpart 8; 5221.6210, subpart 8; and 5221.6300, subpart 8;

(3) for any nonemergency inpatient hospitalization or nonemergency inpatient surgery. A surgery or hospitalization is considered inpatient if the patient spends at least one night in the facility; and

(4) for treatment that departs from a parameter limiting the duration or type of treatment in parts 5221.6050 to 5221.6600. The health care provider must notify the insurer within two business days after initiation of treatment if the departure from a parameter is for an incapacitating exacerbation or an emergency.

B. The health care provider's prior notification required by item A may be made orally, or in writing, and shall provide the following information, when relevant:

(1) the diagnosis;

(2) when giving prior notification for chronic management modalities, durable medical equipment, or inpatient hospitalization or surgery required by item A, subitems (1) to (3), whether the proposed treatment is consistent with the applicable treatment parameter; and

(3) when giving prior notification for treatment that departs from a treatment parameter, or notification of treatment for an incapacitating exacerbation or emergency, the basis for departure from any applicable treatment parameter specified in subpart 8; the treatment plan, including the nature and anticipated length of the proposed treatment; and the anticipated effect of treatment on the employee's condition.

C. The insurer must provide a toll-free facsimile and telephone number for health care providers to provide prior notification. The insurer must respond orally or in writing to the requesting health care provider's prior notification of proposed treatment in item A within seven working days of receipt of the request. Within the seven days, the insurer must either approve the request, deny authorization, request additional information, request that the employee obtain a second opinion, or request an examination by the employer's physician. A denial must include notice to the employee and health care provider of the

reason why the information given by the health care provider in item B does not support the treatment proposed, along with notice of the right to review of the denial under subitem (3).

(1) If the health care provider does not receive a response from the insurer within the seven working days, authorization is deemed to have been given.

(2) If the insurer authorizes the treatment, the insurer may not later deny payment for the treatment authorized.

(3) If the insurer denies authorization, the health care provider or employee may orally or in writing request that the insurer review its denial of authorization.

The insurer's review of its denial must be made by a currently licensed registered nurse, medical doctor, doctor of osteopathy, doctor of chiropractic, or a person credentialed by a program approved by the commissioner of Labor and Industry. The insurer may also delegate the review to a certified managed care plan under subpart 10. In lieu of or in addition to the insurer's review under this subitem, the insurer may request an examination of the employee under subitem (4), (5), or (6) and the requirements of those subitems apply to the proposed treatment. Unless an examination of the employee is requested under subitem (4), (5), or (6), the insurer's determination following review must be communicated orally or in writing to the requester within seven working days of receipt of the request for review.

Instead of requesting a review, or if the insurer maintains its denial after the review, the health care provider or the employee may file with the commissioner a medical request or a petition for authorization of the treatment under subpart 7, item C, or except as specified in subitem (4), (5), or (6), may proceed with the proposed treatment subject to a later determination of compensability by the commissioner or compensation judge.

(4) If the insurer requests an examination of the employee by the employer's physician, the health care provider may elect to provide the treatment subject to a determination of compensability by the commissioner or compensation judge under subpart 7, item B. However, the health care provider may not provide nonemergency surgery where the insurer has requested an examination for surgery except as provided in subitems (5) and (6), and may not provide continued passive care modalities where prior approval by the insurer, commissioner, or compensation judge is required under parts 5221.6200, subpart 3, item B, subitem (2); 5221.6205, subpart 3, item B, subitem (2); 5221.6210, subpart 3, item B, subitem (2); and 5221.6300, subpart 3, item B, subitem (2).

(5) If prior notification of surgery is required under item A, subitem (3), the insurer may require that the employee obtain a second opinion from a physician of the employee's choice under Minnesota Statutes, section 176.135, subdivision 1a. If within seven working days of the prior notification the insurer notifies the employee and health care provider that a second opinion is required, the health care provider may not perform

the nonemergency surgery until the employee provides the second opinion to the insurer. Except as otherwise provided in parts 5221.6200, subpart 6, items B and C; 5221.6205, subpart 6, items B and C; 5221.6210, subpart 6, items B and C; 5221.6300, subpart 6, item B; and 5221.6305, subpart 3, item B, if the insurer denies authorization within seven working days of receiving the second opinion, the health care provider may elect to perform the surgery, subject to a determination of compensability by the commissioner or compensation judge under subpart 7.

(6) In any case where prior notification of proposed surgery is required, the insurer may elect to obtain an examination of the employee by the employer's physician under Minnesota Statutes, section 176.155, sometimes referred to as an "independent medical examination." If the insurer notifies the employee and health care provider of the examination within seven working days of the provider's notification, the proposed nonemergency surgery may not be provided pending the examination. However, after 45 days following the insurer's request for an examination, the health care provider may elect to proceed with the surgery, subject to a determination of compensability by the commissioner or compensation judge under subpart 7.

(7) The insurer's request for additional information must be directed to the requesting health care provider and must specify the additional information required that is necessary to respond to the health care provider's notification of proposed treatment. The proposed treatment may not be given until the provider provides reasonable additional information. Once the additional information has been received, the insurer must respond within seven working days according to subitems (1) to (6).

Subp. 10. **Certified managed care plans.** The insurer may delegate responsibility for the notices required in subpart 7, item B, and the response to prior notification under subpart 9, to the certified managed care plan with which the insurer has contracted to manage the employee's medical treatment under Minnesota Statutes, section 176.135, subdivision 1f. Alternatively, the managed care plan may act as an intermediary between the treating health care provider and the insurer. In either case, the notices and time periods in subparts 7, 8, and 9 also apply to the managed care plan. Where the insurer has delegated responsibility to the managed care plan, the insurer may not later deny treatment authorized by the plan.

Subp. 11. **Outcome studies.** The commissioner shall perform outcome studies on the treatment modalities in parts 5221.6200 to 5221.6600. The modalities to be studied shall be selected in consultation with the Workers' Compensation Medical Services Review Board. The commissioner may require health care providers who use these modalities to prospectively gather and report outcome information on patients treated, with necessary consent of the employee. The health care providers shall report the outcome information on

the modalities in parts 5221.6200 to 5221.6600 on a form prescribed by the commissioner, which may include:

- A. the name of the health care provider;
- B. the name of the patient, date of injury, date of birth, gender, and, with patient permission, level of education and social security number;
- C. the name of the workers' compensation insurer and managed care plan, if any;
- D. the pretreatment and posttreatment employment status;
- E. the nature of treatment given before and after the treatment being studied for the same condition;
- F. the diagnosis, symptoms, physical findings, and functional status before and after the treatment being studied for the same condition; and
- G. the presence or absence of preexisting or concurrent conditions.

Statutory Authority: *MS s 176.103; 176.83*

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