STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE MINNESOTA DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Permanent Rules Relating to Workers' Compensation: Managed Care; Independent Medical Examination Fees; Rules of Practice; Relative Value Medical Fee Schedule and Medical Rules of Practice; and Independent Contractors (Minnesota Rules Chapters 5218, 5219, 5220, 5221, and 5224).

FIRST REPORT OF THE ADMINISTRATIVE LAW JUDGE RELATING TO INDEPENDENT CONTRACTOR, INDEPENDENT MEDICAL EXAMINATION FEES, AND MANAGED CARE RULES

The above-entitled matter came on for hearing before Administrative Law Judge Barbara L. Neilson on July 27, 1993, at 9:00 a.m. in Rooms C-14 and C-15 of the St. Paul Civic Center, 144 West Fourth Street, St. Paul, Minnesota. The hearing continued on July 28, 29, and 30, 1993.

This Report is part of a rulemaking proceeding held pursuant to Minn. Stat. §§ 14.131 to 14.20 (1992) to hear public comment, determine whether the Minnesota Department of Labor and Industry (hereinafter referred to as "the Department") has fulfilled all relevant substantive and procedural requirements of law applicable to the adoption of the rules, assess whether the proposed rules are needed and reasonable, and determine whether or not modifications to the rules proposed by the Department after initial publication are substantially different from those originally proposed.

Six separate sets of rules were consolidated for consideration in this rulemaking proceeding. The rules relate to the following subjects:

1. Independent Contractor Rules (Minn. Rules pt. 5224.0010); 2194
2. Independent Medical Examination Fees (Minn. Rules pt. 5219.0500); 2244
3. Managed Care Plans for Workers' Compensation (Minn. Rules pt. 5218.0010 through 5218.0900); 2239
4. Relative Value Medical Fee Schedule (Minn. Rules pt. 5221.4000 through 5221.4070); 2169
5. Medical Rules of Practice (Minn. Rules pt. 5221.0100 through 5221.0700); and 2169
6. Workers' Compensation Rules of Practice (Minn. Rules pt. 5220.0105 through 5220.2960. 2136

Although, for convenience, the proposed rules were heard in a continuous proceeding, each set of rules is independent of and severable from the others. This First Report of the Administrative Law Judge will encompass the

proposed rules relating to independent contractors, independent medical examination fees, and managed care plans. The remainder of the proposed rules will be discussed in reports to be issued at a later date.

Gilbert S. Buffington, Assistant Attorney General, 520 Lafayette Road, Suite 200, St. Paul, Minnesota 55155, and Penny Johnson, Assistant General Counsel, Department of Labor and Industry, 443 Lafayette Road, St. Paul, Minnesota 55155, appeared on behalf of the Department. The Department's hearing panels for the independent contractor, independent medical examination fees, and managed care rules consisted of Leo Eide, Assistant Commissioner of the Department; Kathryn Berger and Sam Crecelius, Attorneys with the Department's Legal Services Division; Brian Zaidman of the Department's Research and Education Unit; Gloria Gephard, Acting Director of the Department's Rehabilitation and Medical Affairs unit; and William Lohman, M.D., medical consultant for the Department.

Approximately 150 person attended the hearing and 138 signed the hearing register. Many of the attendees gave testimony about these rules. The Administrative Law Judge received 20 agency exhibits and 5 public exhibits as evidence during the hearing. The hearing continued until all interested persons, groups or associations had an opportunity to be heard concerning the adoption of these rules.

The record remained open for the submission of written comments until August 19, 1993, twenty calendar days following the date of the hearing. Pursuant to Minn. Stat. § 14.15, subd. 1 (1992), five working days were allowed for the filing of responsive comments. At the close of business on August 26, 1993, the rulemaking record closed for all purposes. The comment period set in this rulemaking proceeding is the maximum period allowed under Minnesota law.

The Administrative Law Judge received numerous written comments from interested persons during the comment period. The Department submitted written comments responding to matters discussed at the hearing and comments filed during the twenty-day period. In its written comments, the Department proposed further amendments to the rules.

The agency must wait at least five working days before taking any final action on the rules; during that period, this Report must be made available to all interested persons upon request.

Pursuant to the provisions of Minn. Stat. § 14.15, subd. 3 and 4, this Report has been submitted to the Chief Administrative Law Judge for his approval. If the Chief Administrative Law Judge approves the adverse findings of this Report, he will advise the agency of actions which will correct the defects and the agency may not adopt the rule until the Chief Administrative Law Judge determines that the defects have been corrected. However, in those instances where the Chief Administrative Law Judge identifies defects which relate to the issues of need or reasonableness, the agency may either adopt the Chief Administrative Law Judge's suggested actions to cure the defects or, in the alternative, if the agency does not elect to adopt the suggested actions, it must submit the proposed rule to the Legislative Commission to Review Administrative Rules for the Commission's advice and comment.

If the agency elects to adopt the suggested actions of the Chief Administrative Law Judge and makes no other changes and the Chief Administrative Law Judge determines that the defects have been corrected, then the agency may proceed to adopt the rule and submit it to the Revisor of Statutes for a review of the form. If the agency makes changes in the rule other than those suggested by the Administrative Law Judge and the Chief Administrative Law Judge, then it shall submit the rule, with the complete record, to the Chief Administrative Law Judge for a review of the changes before adopting it and submitting it to the Revisor of Statutes.

When the agency files the rule with the Secretary of State, it shall give notice on the day of filing to all persons who requested that they be informed of the filing.

Based upon all the testimony, exhibits and written comments, the Administrative Law Judge makes the following:

FINDINGS OF FACT

Procedural Requirements

1. On June 1, 1993, the Department filed the following documents with the Chief Administrative Law Judge:

(a) a copy of the proposed rules certified by the Revisor of Statutes (Exhibits A-1 through A-6);

(b) an estimate of persons expected to attend the hearing and an estimate of the expected duration of the hearing (Exhibit I);

(c) the Order for Hearing (Exhibit C);

(d) the Notice of Hearing proposed to be issued;

(e) a Statement of Need and Reasonableness (hereinafter referred to as a "SONAR") relating to each of the proposed rules (Exhibits B-1 through B-6); and

(f) the names of agency personnel and witnesses expected to testify on behalf of the Department at the hearing (Exhibit H).

2. On June 21, 1993, a copy of the proposed rules and the Notice of Hearing were published at 17 State Register 3143.

3. On June 18, 1993, the Department mailed the Notice of Hearing to all persons and associations who had registered their names with the Department for the purpose of receiving such notice.

4. On July 1, 1993, the Department filed the following documents with the Administrative Law Judge:

(a) the Notice of Hearing as mailed (Exhibit D);

(b) a copy of the State Register containing the Notice of Hearing and the proposed rules (Exhibit K);

(c) copies of the Notices of Solicitation of Outside Opinion published at 15 State Register 312 (July 30, 1990) (Rules of Practice); 16 State Register 1689 (January 13, 1992) (Compensation and Rehabilitation); 16 State Register 1886 (February 10, 1992) (Medical Fee Schedule); 16 State Register 2993 (June 29, 1992) (General Soliciation); and 17 State Register 2464 (April 12, 1993) (Managed Care); together with all materials received in response to those notices (Exhibits F-1 through F-5 and G-1 through G-5);

(d) the Agency's certification that its mailing list was accurate and complete (Exhibit E); and

(e) a statement that additional discretionary public notice was not given (Exhibit H).

Small Business Considerations in Rulemaking

5. Minn. Stat. § 14.115, subd. 2 (1992), requires state agencies proposing rules that may affect small businesses to consider methods for reducing adverse impact on those businesses. In its Notice of Hearing, the Department asserted that the independent contractor and independent medical examination fee rules would not have an adverse impact on small businesses within the meaning of Minn. Stat. § 14.115. The Department acknowledged that the managed care rules would affect small business health care providers. The Department further contended that the independent medical examination fee and managed care rules are exempt from the small business requirements under Minn. Stat. § 14.115, subd. 7. Subdivision 7(3) exempts from the small business consideration requirements certain "service businesses regulated by government bodies, for standards and costs, such as nursing homes, long-term care facilities, hospitals, providers of medical care, day care centers, group homes, and residential care facilities." Minn. Stat. § 14.115, subd. 7(3) (1992). The Administrative Law Judge agrees that the proposed rules fall within this exemption because the Department regulates providers of workers compensation services for both standards and costs.

Fiscal Note

6. Minn. Stat. § 14.11, subd. 1 (1992), requires agencies proposing rules that will require the expenditure of public funds in excess of $100,000 per year by local public bodies to publish an estimate of the total cost to local public bodies for the two-year period immediately following adoption of the rules. In its Notice of Hearing, the Department stated that the proposed independent contractor, independent medical examination fee, and managed care rules will not require public spending greater than $100,000 in either of the two years following their promulgation. Exhibit D. No one disputed the Department's assessment. The Administrative Law Judge concludes that the Department is not required to publish a fiscal notice under Minn. Stat. § 14.11, subd. 1 (1992).

Impact on Agricultural Land

7. Minn. Stat. § 14.11, subd. 2 (1992), requires that agencies proposing rules that have a "direct and substantial adverse impact on agricultural land in the state" comply with the requirements set forth in Minn. Stat. §§ 17.80 to 17.84 (1992). Because the proposed rules will not have an impact on agricultural land within the meaning of Minn. Stat. § 14.11, subd. 2 (1992), these provisions do not apply to this rulemaking proceeding.

Outside Information Solicited

8. In formulating these proposed rules, the Department published notices soliciting outside information in the State Register. The rule relating to independent medical examination fees received nine comments. Exhibit F-2. Sixty-six comments were submitted on the managed care rules. Exhibit F-1. The Department indicated that it had consulted with the Medical Services Review Board, the Administrative Task Force for Workers' Compensation, and the Legislative Commission to Review Administrative Rules. T. 216-17. Departmental representatives talked to more than 45 groups throughout Minnesota regarding the managed care rules. T. 222. The Department also held open meetings in Richfield, Minnesota, on July 16 and 17, 1992, to obtain input on changes or additions to any aspect of the workers' compensation rules. More than twenty-five members of the public made presentations at the open meetings. Exhibit L.

Thirteen members of the Minnesota House of Representatives submitted a comment during the rulemaking process indicating, inter alia, that none of the proposed rules had been considered by the Advisory Council on Workers' Compensation. At the hearing, however, Departmental representatives stated that it had in fact "kept the Workers' Compensation Advisory Council apprised of what [it was] doing." T. 217. While the duties of the Advisory Council include advising the Department in carrying out the purposes of chapter 176 and the input of Council members could obviously be of assistance in establishing rule requirements, the Commissioner is not required by statute to submit proposed rules to the Advisory Council. See Minn. Stat. § 175.007 (1992).

Analysis of the Proposed Rules

9. The Administrative Law Judge must determine, inter alia, whether the need for and reasonableness of the proposed rules has been established by the Department by an affirmative presentation of fact. The Department prepared a Statement of Need and Reasonableness ("SONAR") in support of the adoption of each of the proposed rules. At the hearing, the Department primarily relied upon the SONAR for that rule as its affirmative presentation of need and reasonableness for each rule. Each SONAR was supplemented by the comments made by the Department at the public hearing and its written post-hearing comments.

The question of whether a rule is reasonable focuses on whether it has a rational basis. The Minnesota Court of Appeals has held a rule to be reasonable if it is rationally related to the end sought to be achieved by the statute. Broen Memorial Home v. Minnesota Department of Human Services, 364 N.W.2d 436, 440 (Minn. Ct. App. 1985); Blocher Outdoor Advertising Co. v.

Minnesota Department of Transportation, 347 N.W.2d 88, 91 (Minn. Ct. App. 1984). The Supreme Court of Minnesota has further defined the burden by requiring that the agency "explain on what evidence it is relying and how the evidence connects rationally with the agency's choice of action to be taken." Manufactured Housing Institute v. Pettersen, 347 N.W.2d 238, 244 (Minn. 1984). An agency is entitled to make choices between possible standards as long as the choice it makes is rational. If commentators suggest approaches other than that selected by the agency, it is not the proper role of the Administrative Law Judge to determine which alternative presents the "best" approach.

This Report is generally limited to the discussion of the portions of the proposed rules that received significant critical comment or otherwise need to be examined. Because some sections of the proposed rules were not opposed and were adequately supported by the SONAR, a detailed discussion of each section of the proposed rules is unnecessary. The Administrative Law Judge specifically finds that the Department has demonstrated the need for and reasonableness of the provisions of the independent contractor, independent medical examination fee, and managed care rules that are not discussed in this Report by an affirmative presentation of facts, that such provisions are specifically authorized by statute, and that there are no other problems that prevent their adoption.

Where changes are made to the rule after publication in the State Register the Administrative Law Judge must determine if the new language is substantially different from that which was originally proposed. Minn. Stat. § 14.15, subd. 4. The standards to determine if the new language is substantially different are found in Minn. Rule 1400.1100. Any language proposed by the Department in the independent contractor, independent medical examination fee, and managed care rules which differs from the rules as published in the State Register and is not discussed in this Report is found not to constitute a substantial change.

The Administrative Law Judge notes that several members of the public submitted comments which appear to relate to the Department's emergency treatment standard rules. Because the treatment standard rules are not at issue in this proceeding, those comments will not be discussed in the reports issued by the Administrative Law Judge. In addition, a few commentators asked the Judge to make determinations regarding coverage or reimbursement questions. It would not be appropriate for the Judge to address these matters.

Format of Rule Report

10. As discussed above, the proposed rules involved in this rulemaking proceeding are actually divisible into six disparate rules within five discrete rule sections. To retain some degree of control over the voluminous comments and myriad issues raised by these rules, both the Department and the Judge have treated each rule separately within this proceeding. This First Report of the Administrative Law Judge will address, in separate sections, only the proposed rules relating to independent contractors, independent medical examination fees, and managed care. Later reports will encompass the other sets of proposed rules.

INDEPENDENT CONTRACTOR RULE

Statutory Authority for the Proposed Independent Contractor Rule

11. In its Notice of Hearing, the Department relies upon Minn. Stat. § 176.83, subds. 1 and 11, as its authority for the independent contractor rule. Those statutory provisions afford the Commissioner authority to "adopt, amend, or repeal rules to implement the provisions" of Chapter 176 and specify that the Commissioner has authority to promulgate rules "establishing criteria to be used by the division, compensation judge, and court of appeals to determine 'independent contractor.'" The Administrative Law Judge concludes that the Department has statutory authority to adopt rules relating to the definition of "independent contractor."

Nature of the Proposed Independent Contractor Rule

12. The proposed rule amends part 5224.0010 of the existing rules, which relates to standards to be used in distinguishing between an employee and an independent contractor for purposes of workers' compensation coverage. The existing rule contains a reference to Minn. Stat. § 176.012(e), which was repealed in 1987. The Department proposes to delete the outdated citation and replace it with a reference to Minn. Stat. §§ 176.021 and 176.041. The amendment was supported by several commentators, including Kent Eggleston of Schanno Transportation, Inc., Donavan J. Olson of Fortune Transportation, Edmund D. Rydeen of Minn-Dak Transport, Inc., and the Minnesota Trucking Association. No one objected to the amendment. The proposed rule has been shown to be needed and reasonable.

INDEPENDENT MEDICAL EXAMINATION FEES

Statutory Authority for the Proposed Independent Medical Examination Fee Rules

13. In 1992, the Minnesota Legislature enacted legislation that required the Commissioner of Labor and Industry to "adopt rules that reasonably limit amounts which may be charged for, or in connection with, independent or adverse medical examinations requested by any party, including the amount that may be charged for depositions, witness fees, or other expenses." Minn. Stat. § 176.136, subd. 1c (1992). In addition, Minn. Stat. § 176.83 (1992) provides the Commissioner with general authority to adopt rules necessary to implement the provisions of Chapter 176. The Administrative Law Judge finds that the Commissioner has statutory authority to promulgate rules limiting the fees that may be charged for independent medical examinations.

Nature of the Proposed Independent Medical Examination Fee Rules

14. Independent medical examinations, or IMEs, are required to be scheduled within 30 days of the filing of a Claim Petition regarding a disputed claim. Minn. Rules pt. 1415.1900, subp. 1 (1991). The examination must be completed and the report must be served on the employee and filed with the Commissioner within 120 days of the service of the Claim Petition. Minn. Stat. § 176.155 (1992). As indicated above, a statute enacted in 1992 directed the Commissioner to adopt rules that "reasonably limit" amounts which may be charged for IMEs. The proposed rules would add a new part 5219.0500 to

the Department's rules that would impose, for the first time, limitations on the amounts that health care providers may charge for various aspects of IMEs. The proposed rules include a citation to relevant statutory authority, a definitional section, limitations on various charges by health care providers in connection with IMEs, and a provision permitting the fee limitations set by the rules to be adjusted on October 1 of each year following promulgation of the rules. The portions of the proposed rules that received substantial critical comment will be discussed below.

Proposed Rule pt. 5219.0500, Subpart 2 - Definitions

15. Subpart 2 of the proposed rules defines the language used in Minn. Stat. § 176.136, subd. 1c (1992), to mean IME charges by a health care provider for the following items: review of medical records; obtaining history from and examination of an employee; reading, interpretation, and analysis of X-rays or other diagnostic imaging or tests; diagnosis, analysis, treatment recommendations, and preparation of the written report; travel expenses and charges; preparation of postexamination supplemental reports; reserve time and cancellation fees; depositions and court appearances; conferences with attorneys; and mental health professionals' hourly charges. No commentator objected to the definitional provision of the proposed rules. The functions listed appear to encompass typical services rendered by health care providers which would be reasonably necessary to perform in evaluating an employee's claim. The definitional section has been shown to be needed and reasonable to identify the types of functions governed by the fee limitations.

Proposed Rule pt. 5219.0500, Subpart 3 - Charges

16. Subpart 3 of the proposed rules sets forth the maximum charges that may be assessed by a health care provider in connection with each of the above-mentioned functions. Pursuant to items A through D and F(1) of the proposed rules, health care providers would be able to charge a maximum amount of approximately $775 for a "basic" IME (reviewing medical records of 50 pages or less, obtaining a history from and examination of the employee, interpreting X-rays or other tests, and issuing a diagnosis, analysis, treatment recommendations, and a written report) and approximately $1,025 for a more complex IME (encompassing the above functions plus the review of an additional 50 pages of medical records and the issuance of a postexamination supplemental report). Item E of the proposed rules permits actual travel expenses to be charged in addition to these amounts and authorizes a travel surcharge of $75 for travel outside the seven-county metropolitan area. An additional $100 could be charged pursuant to item F(2) if additional records of more than 25 pages were required to be reviewed for postsupplemental reports. Should the employee fail to appear for an IME or cancel a scheduled examination less than three business days before the examination date, item G provides that $400 may be charged in lieu of the above charges. Finally, items H, I, and J of the proposed rules set maximum charges for depositions ($400 per hour for a minimum of two hours), court appearances ($400 per hour for a minimum of three hours), attorney conferences ($200 per hour with a one-hour minimum), and hourly rates of psychiatrists or psychologists ($200 per hour for review and analysis of medical data). Subitem H(2) establishes maximum charges for the review of previously-studied records in preparation for depositions or court appearances ($75 if up to 50 pages and $37.50 for each additional 50 pages or part thereof) and subitem H(5) sets limits ranging

from $500 to $800 for cancellations of depositions or court appearances within five business days or less of the scheduled date.

Prior to the publication of the proposed rules, several members of the public opposed the adoption of ceilings on IMEs. See Ex. F-2. Because the Legislature has mandated the adoption of rules setting reasonable limitations on the amounts that may be charged for IMEs, however, the Department must proceed with its efforts to adopt rules in this area. Diversified Medical Resources, Inc., a service organization that arranges for and provides support services relating to IMEs, participated in the drafting of the proposed rule through its attorney, John E. Diehl. Medical Evaluations, Inc. ("MEI"), a firm which provides IMEs and medical reports to employees and employers in workers' compensation cases, also participated through its attorney, Larry Koll. See Ex. F-2; Letter to Joe Wild from Brian Zaidman dated July 20, 1993. Diversified Medical Resources and MEI "provide a significant percentage of the IMEs conducted in the State." Id. Diversified Medical Resources submitted comments expressing its support of the proposed rule on the grounds that the rule "reflects sound policy decisions, . . . is completely consistent with the statutory directives, and . . . is supported by the findings and conclusions in the Statement of Need and Reasonableness . . . ." Leslee Upin of MEI also supported the proposed rules as an effective means to eliminate overcharging for IMEs while allowing a reasonable fee. Several commentators questioned the selection of the maximum charges for particular functions set forth in the proposed rules as well as the aggregate maximum charges set forth in the proposed rules. These comments are discussed in the following paragraphs.

17. Pursuant to item B of subpart 3 of the proposed rules, the maximum charge for obtaining a history from and examination of an employee is $275. Item D sets a maximum charge of $250 for a diagnosis, analysis, treatment recommendations, and a written report. Penny Scherkenbach, Patient Accounts Manager for the Minneapolis Clinic of Neurology, and Andrea J. Linner, Chief Corporate Counsel for State Fund Mutual Insurance Company, suggested that item B be modified. Ms. Scherkenbach asserted that neurological history and examinations can take up to two hours as compared to an orthopedic examination of 15 to 30 minutes, and suggested that the charge be based on a per-hour fee. Ms. Linner recommended that the proposed rules specify a range of charges, perhaps $200-$300, in order to take into account the complexity of the case and the time invested by the examiner. William H. Call, M.D., of Orthopaedic Consultants, suggested that the maximum charge for obtaining a history from and examining the employee in item C be increased from $275 to $350 and that the maximum charge for diagnosis, analysis, treatment recommendations, and a written report in item D be increased to $375 to fairly represent the amount of time spent "on balance" in these cases.

The Department declined to modify items B or D in response to these comments. It emphasized that the proposed rules are structured to reimburse more complex examinations with higher amounts, an approach which it asserts is fairer than overcompensating short examinations to subsidize longer examinations. The Department also stressed that the maximum charge was based upon its review of the actual charges reflected in the State Fund Mutual data, and stated that this data did not show that examination-related fees for orthopedic exams exceeded those for neurologic exams. The Department has shown that the selection of the maximum charges set forth in items B and D is needed and reasonable.

18. Item C provides that the "charge for reading, interpretation, and analysis of X-rays and other diagnostic imaging or tests is $75." Ms. Linner and Ms. Scherkenbach asked that the Department clarify whether the $75 charge is a charge per film or per case. Dr. Call recommended that the maximum charge be increased to $100. Ms. Scherkenbach requested that the Department allow a charge of $75 per film. Ms. Linner suggested that some allowance be made for instances in which three or more films are submitted. In its post-hearing comments, the Department indicated that it decided during the process of drafting the proposed rules that certain provisions relating to taking and reading X-rays and other diagnostic testing were more appropriately included within the relative value fee schedule. It thus determined that the IME rule should impose a single incremental fee of $75 to represent the professional function of interpretation of X-rays or tests during an IME. The Department asserts that the majority of X-ray-related charges would be covered by the relative value fee schedule and that the single fee of $75 "was a consensus amount suggested after consultation with providers in the industry." The Department has shown that item C is needed and reasonable as proposed. The Department may wish to consider adding language to item C stating that the $75 charge is the maxium charge for reading, interpretation, and analysis of "multiple or single" X-rays and tests or adding similar language making it clear that the rule does not authorize the imposition of a $75 charge for each film or test reviewed. Such a modification would serve to clarify the proposed rule and would not constitute a substantial change from the rule as originally proposed.

19. Item F(1) imposes a $150 maximum charge for postexamination supplemental reports issued within six months of the date of examination. Ms. Linner questioned whether the $150 charge was excessive where the additional issues were narrow or few in number, and suggested that a $75 to $150 range of charges be set forth in the rule. The Department emphasized that nothing in the rules prevented the actual charges imposed from ranging below the maximum amount specified. It declined to specify a range of maximum amounts in the rules based on its view that the maximum would in fact tend to be increased to the higher level of the specified range. Item F(1) has been shown to be needed and reasonable as proposed.

20. Item G of the proposed rules permits a maximum charge of $400 to be imposed in lieu of the amounts specified in items A to E if the employee fails to appear for the examination or the examination is canceled less than three business days before the examination date. Dr. Call recommended that the provision be revised to provide for a charge of $700 if the examination is cancelled within ten working days before the examination date, as an incentive to avoid delays and the improper payment of benefits. In its post-hearing responses, the Department indicated that price lists it had reviewed showed cancellation fees with less than three days' notice running from $350 to $600. The Department further asserted that the statute provides adequate incentives for employees to attend IMEs by authorizing the Commissioner or a Compensation Judge to suspend the employee's right to compensation should the employee refuse to comply with a reasonable request for examination. See Minn. Stat. § 176.155, subd. 3 (1992). The Department declined to modify the proposed rule provision based upon its view that the notice period and charges were sufficient and reasonable and will bring about moderation of costs while compensating the provider for lost time. The Department has shown that the $400 charge limitation for cancellations occurring less than three business days before the examination date is needed and reasonable.

21. Item J of the proposed rules sets a maximum hourly charge of $200 per hour for review and analysis of medical data by psychiatrists or psychologists. Ms. Linner and Brian L. Grant, M.D., of Medical Consultants Northwest, Inc., questioned the use of an hourly fee approach for such professionals. Dr. Grant indicated that a time-based approach would reward inefficiency without ensuring that the report eventualy issued would be of higher quality. The commentators recommended that the proposed rules set maximum limitations with respect to total charges submitted by psychiatrists and psychologists rather than creating a different pricing scheme for them. The Department explained in its post-hearing comments that it determined that it would be most practical and reasonable to follow the customary practice of hourly billing for IMEs by psychiatrists and psychologists because mental health examinations typically occur in addition to a physical IME and because such professionals use a wider variety of examination methods with fewer concrete objective indicators. The Department has demonstrated the need for and reasonableness of item J of the proposed rules.

22. Several commentators also questioned the aggregate charges permitted under the proposed rules. Thirteen members of the Minnesota House of Representatives submitted a letter expressing their belief that the proposed rules appear to do little to reduce costs and stated that it would be a better approach to limit the IME fee to that of a comprehensive medical examination. Joe Wild pointed out similarities between the 1991 fee schedule used by Diversified Medical Resources and the maximum charges set in the proposed rules, stated that the fees are outrageous and excessive, and expressed a concern that the Department had in essence allowed Diversified Medical Resources and MEI to promulgate their own fee schedule. Michael J. Foley of Chiron, a provider of IMEs, opposed the proposed rules and urged that, in light of the State Fund Mutual data relied upon by the Department, a $900 total charge would approximate the 50th percentile and would be more reasonable than a $775 charge limitation. Dr. Call expressed concern that an unreasonably low cost schedule would cause quality health care providers to discontinue seeing workers' compensation patients.

In drafting the proposed rules, the Department "undertook to 'reasonably limit' charges for IME's in a way which would moderate costs, regulate providers in the system who might overcharge for their services, inject an ingredient of accountability and predictability into the sytem, and at the same time maintain incentives for the timeliness, availability, and quality of IME services." Department's August 12, 1993, submission at 1. The Department decided to utilize a market-based charge limitation based on its view that such a limitation "is more likely to accomplish all of the objectives stated above but is less likely to produce increased systemic costs by introducing delay which could result from lack of available IME participants in the litigation process." Id. The Department explained in its post-hearing submissions that it decided to freeze charges at current market levels below the 75th percentile and to provide (in subpart 4) for automatic increases on a yearly basis. Hearing Transcript at 36 1/; Department's August 12, 1993, submission at 1. In order to identify current market charges and their distribution, the Department relied in part on the results of an informal

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1/ Citations to the hearing transcript will hereinafter be indicated by a reference to "T. [page number]."

survey conducted in mid-1992 by Diversified Medical Resources. Department's August 12, 1993, submission at 2. The survey results were provided to the Department in response to its June 29, 1992, notice soliciting outside information or opinions. According to this informal survey of 14 unaffiliated providers of IMEs, examination-related fees ranged from approximately $750 to $1300, with an average of $1,004, and deposition-related fees ranged from $875 to $1,400, with an average of $1,124. Id. at 2. Management personnel and physicians then analyzed the aggregate fees within the range and the original draft of the proposed rules was prepared. The Department evaluated the aggregate fee numbers in the proposed rules and their composite parts by comparing the results of the informal survey to data received from State Fund Mutual, a comprehensive insurance company established by the Legislature in 1984, and by reviewing data from a Workers' Compensation Research Institute study, the Minnesota Department of Employee Relations, and the Special Compensation Fund. The Department also checked the price lists of two service companies that arrange IMEs. Id. at 3. The Department concluded that all of the data it had examined "suggests that the aggregate fees for typical IME examinations and depositions tend to fall within current market ranges, clearly below the 75th percentile." Id.

While the Department conceded that State Fund Mutual data compiled from all of the IME billings between March 1992 and February 1993 showed a 75th percentile charge for exam-related IMEs to be $980, it explained that the State Fund Mutual data apparently encompassed more complex examinations as well as basic examinations because the data included additional amounts ranging from $150 to $250 for X-ray interpretation and $100 to $200 for supplemental reports. Based on this data, the Department concluded that "the more complex examinations in the proposed rule as well as basic exams are under the 75th percentile under the proposed rule." Id.

The Legislature directed the Commissioner to adopt rules that reasonably limit amounts which may be charged in connection with IMEs. In drafting the proposed rules, the Department has shown that it engaged in a reasonable analysis of current market rates and attempted to formulate maximum charges for various functions at approximately the 75th percentile level. The Department admittedly allowed two large IME firms to draft initial versions of the rules and provide input during the rulemaking process. The participation of interested parties in the drafting of rules is not improper. Moreover, Departmental staff analyzed the data received from other sources and required various revisions in the draft rules, thereby bringing their own judgment to bear in reaching a final version of the proposed rules. The Administrative Law Judge concludes that the Department has shown by an affirmative presentation of fact that the proposed rules are needed and reasonable.

MANAGED CARE RULES

Statutory Authority for the Proposed Managed Care Rules

23. One method of addressing rising health care costs in the workers' compensation arena is establishing a "managed care" system of delivery, i.e., one which manages the treatment given to patients by health care professionals and other necessary service providers. The Minnesota Legislature enacted legislation in 1992 authorizing employers to require that treatment and

supplies for injuries compensable under the worker's compensation system be provided in whole or in part by a certified managed care plan. Minn. Stat. § 176.135, subd. 1(f) (1992). Minn. Stat. § 176.1351, which was also enacted in 1992, specifically addresses such managed care plans. It requires that certain information be included in the application for certification; provides that the Commissioner must certify a managed care plan if the Commissioner finds that the plan meets certain criteria; requires employees to exhaust the internal dispute resolution procedure of the plan before seeking relief from the Commissioner or a Compensation Judge on an issue related to managed care; and authorizes the Commissioner to refuse to certify or revoke or suspend the certification of a managed care plan that unfairly restricts direct access to any health care provider profession, fails to meet the requirements of § 1351, or is not providing services under the plan in accordance with the plan's terms.

Section 176.1351 authorizes the Commissioner to impose certification requirements deemed "necessary to provide quality medical services and health care to injured workers" and specifically provides that "[t]he commissioner may adopt emergency or permanent rules necessary to implement this section." Minn. Stat. §§ 176.1351, subds. 2(12) and 6 (1992). The statute also permits the Commissioner to prescribe a reasonable application fee, set the period during which a certification will be valid, and specify the information to be included in the application. Minn. Stat. § 176.1351, subd. 1 (1992). The Administrative Law Judge finds that the Department has statutory authority to adopt rules regarding managed care.

Nature of the Proposed Managed Care Rules

24. The Commissioner proposed emergency rules governing managed care plans on July 27, 1992. 17 State Reg. 147 (July 27, 1992). The proposed emergency rules were adopted with modifications following review by the Attorney General and went into effect on October 19, 1992. Notice of the adoption of the emergency rules was published in 17 State Reg. 923 (October 26, 1992). Thereafter, the Commissioner extended the emergency rules for an additional 180 days. 17 State Reg. 2462 (April 12, 1993). The emergency rules will expire on October 14, 1993.

The Department now proposes to implement permanent rules regarding workers' compensation managed care plans. The proposed permanent rules define terms used in the rules, establish application requirements and standards for certification, specify coverage responsibilities, restrict eligible providers, establish requirements for utilization and peer review, provide for periodic audits and the monitoring of records, and set forth criteria for suspension or revocation of plan certification.

Proposed Rule Part 5218.0010 - Definitions

25. Eleven terms are defined in proposed rule part 5218.0010. No critical comments were received with respect to seven of these terms. These definitions have been shown to be needed and reasonable. The four other terms, "emergency care," "health care provider," "insurer," and "primary treating health care provider," will be discussed separately in the paragraphs below.

Subpart 3 - Emergency Care

26. "Emergency care" is defined in subpart 3 as follows:

> "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.

Robin Lackner, Associate Counsel with HealthPartners, suggested that the definition of "emergency care" be expanded to include more specific criteria governing whether an insurer will pay for emergency care rendered by non-participating providers. HealthPartners indicated that it would be helpful if the rule provided some examples of presenting symptoms which would be covered, but did not suggest any specific language. The Department did not discuss these comments in its post-hearing submissions or make any modification to subpart 3 of the proposed rules. In its SONAR, the Department indicates that the definition was derived from Minn. Stat. § 256B.0625, subd. 4. The proposed rule is not rendered unreasonable by its failure to include a specific discussion of situations in which it is deemed necessary to seek emergency care or criteria which will govern the insurer's coverage obligations.

Subpart 5 - Health Care Provider

27. Subpart 5 of the proposed rules provides that "health care provider" will have the meaning given to it by Minn. Stat. § 176.011, subd. 24. This definition was supported by David Kunz and Skip Tillisch of the Minnesota Optometric Association. HealthPartners suggested that the definition be clarified to indicate whether a clinic or group of providers can constitute a "health care provider" within the meaning of the rules. The Department did not respond to this comment. The reference in the rules to the definition of health care provider contained in the workers' compensation statutes ensures that the rule provisions will be construed in a manner which is consistent with the statute. Subpart 5 of the proposed rules has been shown to be needed and reasonable as proposed.

Subpart 6 - Insurer

28. Subpart 6 of the rules as originally proposed defined "insurer" to mean "the insurer providing workers' compensation insurance required by Minnesota Statutes, chapter 176, and includes a self-insured employer and third party administrator for the employer or insurer." Other provisions of the rules as originally proposed prohibited "workers' compensation insurers" from owning, forming, or operating a certified managed care plan and specified that the definition of "insurer" for purposes of subpart 4 includes "any subsidiary, parent, or other related entity affiliated with the insurer or employer, including a third party administrator." Proposed rule pt. 5218.0200, subpart 4.A. and C(2). The interrelation of these rule provisions would have precluded third party administrators ("TPAs") from operating certified managed care plans.

In its SONAR, the Department stated that third party payers who are administering the workers' compensation claim for an employer or insurer had been included in the definition because a third party payer "acts in place of an insurer, has the same interest as an insurer, and performs the same duties as an insurer." SONAR at 4. At the hearing, the Department asserted that the rule as originally proposed was needed and reasonable to eliminate conflicts of interest between the provider of care for injured workers and the entity which ultimately pays for that care. Assistant Commissioner Leo Eide stated:

> [A]nother area of controversy is the area of the issue of whether a third-party administrator should be treated like an insurer in this matter. The third-party administrator is an organization which, as its name implies, does the actual adjustment administration of workers' compensation claims for some entities that is [sic] licensed to provide the actual coverage. . . . Third-party administrators enter into contracts with the same responsibilities to manage the claims efficiently, prudently and frugally that a carrier has. Their business livelihood depends on their ability to control the cost of workers' compensation claims. . . . A third-party administrator who is handling a claim has the same incentives, short-term incentives to save a dollar that an insurer does and the same kind of risk of behavior that may not be good for the system overall. . . . The point I am trying to make is the same pressures apply to a third-party administrator as apply to the carrier who actually writes the policy because they get their business by satisfying the person that they are administering the claim for. That coupled with the fact that in all other aspects of administration of the workers' compensation law we have treated third-party administrators like carriers. We penalize them when they behave inappropriate [sic] on the claim by paying late or not at all or in the wrong amount just like any insurance carrier. We decided that the only sensible way to handle this to avoid even the appearance of a conflict of interest was to treat them like insurance companies and include them in the prohibition of forming their own certified managed care organizations.

T. 252-56.

The Department indicated that it was relying in part upon the Findings of Fact, Conclusions of Law, and Order for Temporary Injunction issued by Judge Campbell in Berkley Administrators v. Minnesota Workers' Compensation Assigned Risk Plan, No. C-4-93-1051 and C2-93-1100 (Ramsey County D. Ct., March 14, 1993). Ex. P-3. In that Order, Judge Campbell determined that "the statutory prohibitions or restrictions that are expressly articulated in the statute with respect to an 'insurer' apply with equal force to the [Assigned Risk] Plan and the Plan's third-party administrators -- neither is eligible to have a managed care plan certified for this purpose under Minn. Stat. § 176.1351." Order at 15. This suit was later settled prior to a trial on the merits,

however, and the Stipulation and Order for Dismissal with Prejudice entered in the matter on June 22, 1993, specifically acknowledged that the preliminary injunction did not constitute a final determination on the merits of the issues before the Court. Public Ex. 4.

Several individuals and organizations testified at the hearing and submitted written comments opposing the definition of "insurer" contained in the proposed rules. Jeannine Churchill, Vice President Workers' Compensation, BlueCross/BlueShield of Minnesota ("BlueCross") suggested that the definition be modified to define "insurer" to mean "the insurer providing workers' compensation insurance required by Minnesota Statutes, Chapter 176, and includes an employer for its own employees and a third-party administrator owned, or controlled by such employer or insurer." Others, including Gloria Gillette, Branch Manager of Crawford & Company Healthcare Management, Robin Lackner, Associate Counsel for HealthPartners, John Diehl, Larkin, Hoffman Daly & Lindgren, on behalf of Adjustco, Inc., and James Volling, Faegre & Benson, on behalf of Occupational Healthcare Management Services, Inc. ("OHMS"), objected to the treatment of TPAs as insurers and urged the Department to delete the reference to TPAs. These commentators asserted that TPAs differ significantly from insurance companies in scope, structure and risk. They emphasized that TPAs are frequently compensated on the basis of predetermined fixed fees or hourly rates plus expenses and argued that, because TPAs do not stand to gain by minimizing health care services, the interests of TPAs are not identical to those of insurers. They further contended that the Department's proposal to define "insurer" to include TPAs exceeds statutory authority, will increase the risk of litigation and delay, is unreasonable, and would prevent entities that have extensive experience in resolving claims and controlling costs from supplying that expertise to managed care.

In its post-hearing reply comment filed on August 26, 1993, the Department modified the definition of "insurer" to delete the reference to third-party administrators. As modified, the definition provides that "insurer" means "the insurer providing workers' compensation insurance required by Minnesota Statutes, chapter 176, and includes a self-insured employer." It also made related changes in the other provisions of the proposed rules which will be discussed below. The Department explains that it modified the proposed rules by deleting the reference to TPAs because the Department decided to adhere strictly to the statutory language. The original version of the proposed rules, in the Department's view, "did not allow for the flexibility permitted in other parts of the rules." Department's August 26, 1993, submission at 19. The Department indicated that "[p]ublic comment has illustrated that any attempt to expand this definition would be extremely difficult to implement and in many cases would likely be inconsistent with the legislative intent." Id. at 17. The Department stressed that the Legislature intended that the rules adopted by the Commissioner "be designed to assist in the formation of managed care organizations while ensuring quality managed care to injured employees." 1992 Laws of Minn., Ch. 510, Art. 4, Sec. 25. The Department further stated that it would be reasonable to expect that "the legislature would have more clearly specified if it had intended to exclude an entire class of entities with experience in workers' compensation managed care, based on a complicated analysis of corporate structure." Id. at 18-19.

Minn. Stat. § 176.1351, subd. 1 (1992), states that "[a]ny person or entity, other than a workers' compensation insurer or an employer for its own

employees, may make written application" for certification as a managed care plan. The statute thus clearly and unambiguously provides that only two types of entities shall be prohibited from applying for certification: workers' compensation insurers and employers for their own employees. Minnesota canons of statutory construction specify that "[e]xceptions expressed in a law shall be construed to exclude all others." Minn. Stat. § 645.19 (1992). Accord Green-Glo Turf Farms, Inc. v. State, 347 N.W.2d 491, 494 (Minn. 1984) ("by specifying one exception, the legislature has excluded all other exceptions"); Stasny v. Minnesota Department of Commerce, 474 N.W.2d 195, 198-99 (Minn. Ct. App. 1991) (where statute set forth exceptions, regulation that attempted to establish an additional exception was "inconsistent with the express language of the statute" and was invalid).

The Administrative Law Judge concludes that it is reasonable for the Department to adhere to the actual language of the governing statute in defining "insurer" and delete the reference to third-party administrators. As the Department properly points out, if the Legislature does wish to preclude TPAs from owning or operating certified managed care plans, it may clarify its intent during the next legislative session. Department Aug. 26, 1993, Post-hearing Comment at 19. The definition of "insurer" received substantial comment at the hearing and in written comments submitted by interested persons. The modification made by the Department is responsive to concerns expressed by several interested parties. The Administrative Law Judge further finds that the modifications do not constitute a substantial change from the rules as originally proposed. Interested members of the public had notice that the emergency managed care rules adopted by the Department did not include TPAs within the definition of "insurer" and that the permanent rules as originally proposed for adoption did include TPAs. Therefore, the regulated public was aware that the Department was considering two possible approaches. The Department has now returned to the approach taken in the emergency rules. There thus "has been no development beyond the scope evident toan informed member of the public at the outset of the hearing." Minnesota Chamber of Commerce v. Minnesota Pollution Control Agency, 469 N.W.2d 100, 106 (Minn. Ct. App. 1991).

29. BlueCross has, however, shown that the language of the definition as modified is defective due to its reference to "self-insured employers." Pursuant to the rule as currently proposed, all self-insured employers would be precluded from establishing certified managed care plans. In enacting the bill that was eventualy codified as Minn. Stat. § 176.1351, the Legislature deleted a reference to "self-insured employer" and substituted the phrase "employer for its own employees." Accordingly, the statute did not prohibit self-insured employers from applying for certification as a managed care plan where the managed care plan is not formed to manage the care of their own employees. The reference in the proposed rule to "self-insured employers" thus conflicts with the governing statute and is defective. To cure the overbreadth, the Administrative Law Judge suggests that subpart 6 be modified to provide that "'[i]nsurer' means the insurer providing workers' compensation insurance required by Minnesota Statutes, chapter 176, and includes an employer for its own employees." Such a modification is responsive to comments made during the rulemaking proceeding and would not result in a rule that is substantially different from the rule as originally proposed.

Subpart 10 - Primary Treating Health Care Provider

30. Subpart 10 defines "primary treating health care provider" to mean a "physician, chiropractor, osteopath, podiatrist, or dentist directing and coordinating the course of medical care to the employee." Later provisions in the proposed rules require that managed care plans provide employees with access to primary treating health care providers within certain mileage restrictions and that employees be allowed to change primary treating providers within the managed care plan at least once. See part 5218.0100, subp. 1.F.(5) and (7). The Minnesota Optometric Association requested that optometrists also be mentioned in the definition of "primary treating health care provider." The Association points out that optometrists are permitted under a recently-enacted law to prescribe topical medications for the treatment of disease and conditions of the anterior portion of the eye and its adnexa and asserts that these eye problems are commonly covered by workers' compensation. The Association further asserts that recent amendments to the workers' compensation statute include optometrists within the definition of "health care provider" and that rules promulgated by the Department of Health specify that optometrists are "primary care providers" who may deliver initial and basic care to enrollees. See Minn. Stat. § 176.011, subd. 24 (1992), and Minn. Rules pt. 4685.0100, subp. 12b.

The Department did not respond directly to the comments made by the Minnesota Optometric Association. In its SONAR in support of the definition, however, the Department indicates that it selected the categories of providers listed in the definition because their statutory scopes of practice permit independent diagnosis of injuries and coordination of treatment. While optometrists are authorized to provide certain medical services and treatment, the scope of their practice is very narrow. Moreover, the proposed rules do not preclude a managed care organization from including optometrists in providing services to injured workers but merely set forth minimum requirements to be met by a managed care plan. The proposed rules do not appear to be inconsistent with the statutory and rule provisions cited by the Optometric Association. The definition of "primary treating health care provider" is not rendered unreasonable by its failure to include optometrists. Subpart 10 has been shown to be needed and reasonable as proposed.

Proposed Rule Part 5218.0030 - Purpose and Scope

31. The American Insurance Association objected to the language in proposed rule part 5218.0030 which prohibited an entity from "suggest[ing] to an employee, or stat[ing] in any name, contract, or literature that an entity constitutes workers' compensation managed care unless the entity is a certified managed care plan under this chapter." In its post-hearing comments, the Department deleted the sentence containing the language quoted above and substituted the following: "No person or entity shall hold itself out to be a workers' compensation managed care organization unless the entity is a certified managed care plan under this chapter." The modification clarifies the intent of the rule and was made in response to the AIA's concern that the prohibition contained in the original language was overbroad and outside the Department's authority. The rule, as modified, has been shown to be needed and reasonable. The modification does not constitute a substantial change.

Proposed Rule Part 5218.0100 - Application for Certification

Subpart 1 - Certification

32. Subpart 1 of proposed rule 5218.0100 sets forth information that must be submitted as part of an application to the Commissioner to provide care under a certified managed care plan. Item B requires the applicant to submit an application form which includes the identification of all directors and officers, the day-to-day administrator of the managed care plan, the financial affairs administrator, the medical director, the communication liaison for the department, and any entity with whom the managed care plan has a joint venture or other agreement to perform any of the functions of the managed care plan.

As originally proposed, item B(6) of subpart 1 would have required that the applicant disclose the nature of any affiliation between the managed care plan, or its parent, subsidiary, or other related organization, and an employer, insurer, or third party administrator. This provision, in conjunction with part 5218.0200, subp. 4A and C of the rules as originally proposed, would have precluded subsidiaries, parents, or other related entities affiliated with a workers' compensation insurer or employer from obtaining certification. As discussed in Finding 46 below, several commentators were critical of the approach taken in the rules that would have precluded affiliates, parents, and subsidiaries of workers' compensation insurers from operating certified managed care plans regardless of whether the workers' compensation insurer exercised actual control. BlueCross specifically requested modification of item B(6). In its post-hearing comments, the Department deleted B(6) from the proposed rules.

Minn. Stat. § 176.1351 provides that an "[a]pplication for certification shall be made in the form and manner and shall set forth information regarding the proposed plan for providing services as the commissioner may prescribe." It is within the Department's discretion to decide that the information encompassed by the original version of the proposed rules need not be submitted as part of the application for certification. The deletion of item B(6) is not a defect and does not result in a rule that is substantially different from the rule as originally proposed.

33. Subpart 1C of the proposed rules imposes fees of $1,500 for new applications for certification and $600 for applications involving plans that were provisionally approved under the emergency managed care rules. The Department set out itemized costs for personnel, supplies, and indirect statewide costs in its post-hearing comments. The totals of these costs very nearly approximate the proposed fees. The Department has met its burden under Minn. Stat. § 16A.128 (or, in the alternative, under Minn. Stat. § 16A.1285) to demonstrate the need for and reasonableness of the fees.

34. Subpart 1E requires that the managed care plan "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 . . . ." Subpart 1E(1) of the proposed rules

specifies types of health care services and providers which must be included at a minimum in the managed care plan unless the particular service or type of provider is not available in the community. The services and providers specified are as follows:

> (a) medical doctors, including specialists in at least one of the following fields: family practice, internal medicine, occupational medicine, or emergency medicine; orthopedic surgeons, including specialists in hand and upper extremity surgery; neurologists and neurosurgeons; and general surgeons;
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> (b) chiropractors;
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> (c) podiatrists;
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> (d) osteopaths;
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> (e) physicial and occupational therapists;
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> (f) psychologists or psychiatrists;
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> (g) diagnostic pathology and laboratory services;
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> (h) radiology services; and
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> (i) hospital, outpatient surgery, and urgent care services.

Subpart 1E(2) of the proposed rules requires that the managed care plan provide for referral to specialty services not specified in the above list where such services "may be reasonable and necessary to cure or relieve an employee of the effects of the injury."

35. Robert Harder of the Minnesota Dental Association suggested that dentists be added to the list of providers set forth in item E and, as discussed in Finding 27 above, the Minnesota Optometric Association recommended that optometrists be included. The Department declined to make the recommended modifications. The Department indicated during the hearing that its aim was to include within item E the most common types of providers and services used in workers' compensation situations. T. 240. It is important to bear in mind that the providers and services specified in item E are merely the minimum required for certification; managed care plans are not precluded from including other providers and services in their plans. Pursuant to item F(3) and (4) of the proposed rules, employees must be allowed to receive ongoing treatment from dentists (and other specified health care providers) following an initial evaluation by a participating licensed health care provider and must receive any necessary specialty services in a timely, effective, and convenient manner. The proposed rule is not rendered unreasonable by its failure to require in all cases that dentists and optometrists be included in the managed care plan.

36. HealthEast Care, Inc., recommended that the reference to pathology, laboratory, and radiology services be deleted from item E(1)(g) of the proposed rule since such services should more appropriately be considered referral services. In response, the Department indicated that radiology and laboratory services are frequently required by injured employees and that it thus is appropriate to require their inclusion in the plan. Given the range of injuries and conditions seen by health care professionals in managed care plans, it is reasonable and necessary to require that such services be immediately available.

37. Item F of subpart 1 requires that the managed care plan formulate procedures to ensure that employees receive services in accordance with various standards set forth in subitems (1) through (7). Comments critical of several aspects of subpart 1F were received. These comments will be discussed below.

38. Item F(1) requires that employees "receive initial evaluation by a participating licensed health care provider within 24 hours of the employee's request for treatment, following a work injury." The proposed rules give the managed care plan the discretion to decide which participating licensed health care provider should conduct the initial evaluation. Scott Mayer, Executive Director of the Minnesota Chiropractic Association, urged the Department to expressly require managed care plans to offer injured workers access to a doctor of chiropractic for the initial evaluation. The Association and several individual chiropractors, including Ann Barkley, Jeffrey Schramm, and Le Ann Shea, indicated that chiropractors have traditionally encountered discrimination and unfair treatment by managed care plans and suggested that safeguards against such discrimination are needed. The Association recommended that the proposed rules be modified to permit initial evaluation "from the discipline of the employee's own choosing" and further require that "the managed care plan must include as participating providers all categories of health care providers licensed to provide care as specified in Minn. Stat. 176.135, subd. 1(a)."

The Association maintains that access to chiropractors is required under Minn. Stat. § 176.135, subd. 1 (1992), and that the proposed rules violate the prohibition contained in Minn. Stat. § 176.1351, subds. 2(10) and (4) (1992). Minn. Stat. § 176.135 provides, in pertinent part:

> The employer shall furnish any medical, psychological, chiropractic, podiatric, surgical and hospital treatment, including nursing, medicines, medical, chiropractic, podiatric, and surgical supplies, crutches and apparatus, including artificial members, or, at the option of the employee, . . . Christian Science treatment . . ., as may reasonably be required <u>at the time of the injury</u> and any time thereafter to cure and relieve from the effects of the injury.

(Emphasis added.) Minn. Stat. § 176.1351, subd. 2(10) (1992), requires as a prerequisite to certification of a managed care plan that the Commissioner find that the plan "does not discriminate against or exclude from

participation in the plan any category of health care provider . . . ." Subdivision 4 of the same statute permits the Commissioner to refuse to certify or to revoke or suspend the certification of a managed care plan that "unfairly restricts direct access within the managed care plan to any health care provider profession" and provides that direct access is deemed to be unfairly restricted "if direct access is denied and the treatment or service sought is within the scope of practice of the profession to which direct access is sought . . . ." The Association provided letters from four legislators in support of its argument that the statute was intended to preclude the approach taken in the proposed rules.

Minn. Stat. § 176.135, subd. 1(a) does require employers to furnish any chiropractic treatment at the time of the injury as may reasonably be required. However, the statute similarly requires employers to furnish surgical supplies and artificial limbs at the time of the injury. Such supplies obviously are only available after or in connection with initial evaluation and treatment by a physician. The statute thus does not clearly mandate that chiropractors provide the initial evaluation of the injured worker. Moreover, Minn. Stat. § 176.1351 does not require that injured workers be given unlimited direct access to all health care provider professions; rather, the statute specifies that direct access is to be deemed to have been denied only if the treatment or service sought is within the scope of practice of the provider sought. See SONAR at 11. While the Association has provided evidence that doctors of chiropractic are trained and licensed to diagnose presenting conditions, they would not properly be able to engage in invasive diagnostic procedures or treat all conditions.

The Legislature has authorized employers to require that treatment and supplies required to be provided to injured workers be received in whole or in part from a managed care plan. Such plans frequently use a "gatekeeper" approach in which health care professionals authorized to assess, diagnose, and treat an injured worker or refer the worker to another provider make initial decisions concerning the propriety of various treatments. The proposed rules do not mandate a "gatekeeper" approach, nor do they preclude the managed care plan from utilizing a chiropractor to conduct the initial evaluation. The rules merely give managed care plans the flexibility to use their discretion to implement a gatekeeper approach and/or select the provider who will conduct an initial evaluation. Other provisions of the proposed rules require that the employee be afforded the opportunity to receive ongoing treatment with any type of provider and prohibit the plan from excluding any type of provider from participation. See Minn. Rules pt. 5218.0100, subp. 1E and F(3). The failure of item F(1) of the proposed rules to require that injured workers be allowed to choose chiropractors to perform the initial evaluation does not conflict with the workers' compensation statutes. The Department has shown that subpart 2F(1) is needed and reasonable as proposed.

39. HealthEast Care, Inc., raised questions regarding the interplay between subpart 1, items E and F. In its post-hearing comments, the Department clarified that item E identifies the types of providers and services which must, at a minimum, be included within the managed care plan for it to be certified and requires that other specialty services be available by referral. Item F identifies the types of health care providers that are allowed to treat the employee as a primary treating health care provider. To clarify the proposed rules, the Department modified item F(3) in its

post-hearing comments to provide that, following the initial evaluation, the employee must upon request be allowed to receive ongoing treatment from any participating health care provider in one of five enumerated groups (medical doctors, chiropractors, podiatrists, osteopaths, or dentists) if the provider, "as the employee's primary treating health care provider," is available within the mileage restrictions set forth in subitem (7) and offers appropriate treatment. The modification serves to clarify the proposed rule and does not constitute a substantial change.

40. HealthPartners recommended that the Department add language to subpart 1F(1) and (3) specifying that the managed care plan may determine, based on its standards of what is medically appropriate, what type of health care provider performs the initial evaluation in each case and which type of provider will be available to provide ongoing treatment. The Department declined to make the suggested changes. The rules are not rendered unreasonable by their failure to include the suggested language.

41. Subpart 1F(5) permits employees to change primary treating providers within the managed care plan at least once without proceeding through the plan's dispute resolution process. BlueCross suggested that the rule be modified to require that the request for a change be made to the plan. The Department agreed that it would be reasonable to require the employee to notify the plan of the change of doctor for case management purposes and to enable the plan to assist in the change. Accordingly, the Department modified the first sentence in subitem (5) following the hearing to provide that employees must be allowed to change primary treating providers within the managed care plan at least once "by making a request to the managed care plan and without proceeding through the managed care plan's dispute resolution process." While the modification has been shown to be needed and reasonable and does not result in a rule that is substantially different from that originally proposed, it appears to the Administrative Law Judge that an understanding of the rule would be facilitated if it were revised slightly to provide that "[e]mployees 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 primary treating provider." The modification suggested by the Administrative Law Judge would clarify the rule and would not constitute a substantial change from the rule as originally proposed or from the rule as modified by the Department.

42. Subpart 1F(6) requires that employees be able to receive information on a 24-hour basis regarding the availability of necessary medical services available within the managed care plan. The proposed rule permits this information to be provided through recorded telephone messages after normal working hours. Several commentators, including the Minnesota Chiropractic Association and the Minnesota Optometric Association, suggested that a toll-free number be provided. The Department agreed with that suggestion and made appropriate changes to item F(6). The availability of a toll-free number will improve the ability of affected persons to obtain necessary information regarding medical services available within the plan. The requirement that such a number be provided will not impose an undue burden on the managed care. The modification proposed by the Department was made in response to comments at and after the hearing. No one objected to the suggested modification. The change has been shown to be needed and reasonable and does not constitute a substantial change from the rules as originally proposed.

43. Subpart 1F(7) establishes geographic limitations for the allowable distances between the employee's residence or workplace and the office of the evaluating and primary treating health care provider. If the employee lives or works in the seven-county metropolitan area, the maximum distance is thirty miles; if the employee's home and workplace are outside the seven-county area, the maximum distance is fifty miles (hereinafter referred to as "the 30/50 restriction"). The proposed rules further provide that the managed care plan may refer an employee to a provider outside of the mileage restriction if the employee requires specialty services that are not available within the 30/50 restriction. The Minnesota Chiropractic Association, the Minnesota Optometric Association, and the Minnesota Dental Association maintained that the 30/50 restriction imposed too great a burden on employees and proposed that a 15/25 restriction be imposed instead. The Minnesota Medical Association recommended that the distance requirements be increased to ensure availability.

The Department asserts that the 30/50 restriction is similar to the distance requirements applicable to Health Maintenance Organizations (HMOs) under applicable Department of Health rules. SONAR at 14. 2/ Following the hearing, the Department modified the rule to add the following final sentence to F(7): "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 non-participating provider to receive treatment for the injury if necessary." The rule as modified is needed and reasonable to ensure that employees who are medically unable to travel within the mileage restrictions obtain necessary treatment. It does not result in a rule that is substantially different from that originally proposed. To clarify the new language, the Department may wish to consider deleting the phrase "if necessary" and referring instead to "necessary treatment for the injury." This suggestion, if accepted by the Department, would not constitute a substantial change from the rules as originally proposed.

44. Subpart 1M of the proposed rules provides in part that "[a] managed care plan may not prescribe treatment standards that disallow, in all cases, treatment that is permitted by the commissioner's [treatment] standards." The Minnesota Chiropractic Association, the Minnesota Optometric Association, the Minnesota Dental Association, and the Minnesota Medical Association recommended that the phrase, "in all cases," be deleted from the proposed rules. They argued that the phrase was ambiguous and that there should be no exceptions to the Commissioner's standards. The Department explained in its post-hearing submission that it included the phrase in the proposed rules in order to "make it clear that case by case determinations of the necessity of treatment are still appropriate. Thus, even though the treatment rules allow up to 12 weeks of passive treatment before referral for a [sic] alternative treatment is necessary, there may be individual cases where a referral is

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2/ The restrictions contained in the HMO rules differ from those proposed in this proceeding. The HMO rules generally require that the maximum travel distrance or time within the HMO's service area to the nearest primary care provider or general hospital provider be the lesser of 30 miles or 30 minutes, and that the distance or time to the nearest provider of all other health services be the lesser of 60 miles or 60 minutes. See Minn. Rules pt. 4685.1010, subd. 3(c).

necessary sooner than 12 weeks, if it is apparent the employee is no benefitting from the treatment." Department's August 26, 1993, Submission at 4. The proposed rules are needed and reasonable to ensure that the plan does not disregard the Commissioner's treatment standards in their entirety but does have the ability to deviate from the treatment standards in appropriate cases.

Proposed Rule Part 5218.0200 - Coverage Responsibility of Managed Care Plan

Subpart 4 - Restrictions on Employer or Insurer Formed Plans

45. Subpart 4 of proposed rule part 5218.0200 sets restrictions on the ability of employers and workers' compensation insurers to form managed care plans. As originally proposed, subpart 4A specified that a workers' compensation insurer may not own, form, or operate a managed care plan. Item A permits self-insured HMOs or preferred provider organizations (PPOs) to apply for certification as a managed care plan, but provides that employees of certified managed care plans may not be required to obtain services under the plan. Thus, an employer that is in the business of providing managed care is not precluded from offering its own services to its own employees, but employee participation in the plan in such situations must be voluntary. Subpart 4B of the rules as originally proposed required managed care plans to disclose certain information in order for the Commissioner to determine on a case-by-case basis whether the managed care plan is owned, operated, or formed by an insurer or employer. SONAR at 21. The information required to be disclosed included whether an insurer or employer had participated in the formation or certification of the plan; whether an insurer or employer was a director or other governing member, officer, agent, or employee of the plan; whether an insurer or employer had any ownership interest or similar financial or investment interest in the plan; or whether an insurer or employer has a contract with the plan that limits the ability of the plan to accept business from others. Subpart 4C included definitions for the purposes of subpart 4. Item C(2) defined "insurer" to include "any subsidiary, parent, or other related entity affiliated with the insurer or employer, including a third party administrator."

46. Subpart 4 of the proposed rules was the subject of numerous comments. State Fund Mutual supported the multi-factor control test set forth in subpart 4B and urged that no one factor should be determinative. Joe Wild argued that the last sentence in subpart 4B was vague and should be deleted, and recommended that the Department permit another state agency to determine whether an applicant was in fact controlled by a workers' compensation insurer or self-insured employer. Several commentators, including the American Insurance Association, Allan R. Syc of Kemper National Insurance Companies, and James Matthews, Lindquist & Vennum, on behalf of Intracorp/Ethix, argued that the blanket exclusion of all parents, subsidiaries, or affiliates of workers' compensation insurers regardless of whether the workers' compensation insurer controlled the entity applying for certification conflicted with the narrow exclusion set forth in Minn. Stat. § 176.1351, subd. 1 (1992). In their view, it would be appropriate to preclude certification only where a workers' compensation insurer in fact controls the applicant.

The American Insurance Association urged the Department to modify the rules to permit workers' compensation insurers to own or form entities to

provide managed care services and merely prohibit such insurers from "being" a managed care plans. HealthPartners argued that the statute should be interpreted to mean that an insurer or an employer may not require its employees to enroll in a manged care plan it forms and should not be interpreted to preclude insurers from forming or operating managed care plans. HealthPartners also urged the Department to clarify the meaning of the references to "employers" in subpart 4. OHMS asserted that the definition of "insurer" set forth in subpart 4C(2) of the rules as originally proposed would impose an undue burden on the Department by requiring the Department to "delve endlessly into the meaning of the most complex corporate structures." OHMS and BlueCross urged that control by a workers' compensation insurer be found only if there was ten percent ownership or voting power. OHMS and BlueCross recommended several modifications to the language of subpart 4. OHMS suggested the insertion of new language in item B which would merely have required applicants to disclose the name and address of each entity directly or indirectly controlling, controlled by, or under common control with, the managed care plan and to identify whether any entity disclosed is an insurer or an employer whose employees could be required to obtain services under the plan.

47. In its post-hearing comments filed on August 26, 1993, the Department accepted the suggestions of many of the commentators and made numerous modifications in the language of subpart 4. Subpart 4, as modified, would provide as follows:

> Subp. 4. Restrictions on employer or workers' compensation insurer formed plans. Any person or entity, other than a workers' compensation insurer licensed under Minn. Stat. Chapter 79A, or an employer for its own employees, may apply for certification as a certified managed care plan. An entity licensed under Chapter 62C or 62D or a preferred provider organization that is subject to 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 item is not intended to limit 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.

The Department revised item A of the rules as originally proposed, deleted most of item B, and eliminated the definitions previously set forth in item C. The Department thus has chosen to strictly apply the statutory language precluding workers' compensation insurers and employers for their own employees from applying for certification and no longer intends to engage in an analysis of corporate relationships between the managed care plan, a corporate affiliate of a workers' compensation insurer, or a third-party administrator. Department's August 26, 1993, submission at 17.

In explaining its post-hearing modification, the Department indicated that "[p]ublic comment has illustrated that any attempt to expand this definition would be extremely difficult to implement and in many case would likely be inconsistent with the legislative intent." Id. The Department stressed that the Legislature had expressed its intent that the Commissioner "proceed with certifying managed care organizations as expeditiously as possible" and had specified that "[a]ny rules or procedures the commissioner

adopts must be designed to assist in the formation of managed care organizations while ensuring quality managed care to injured employees." 1992 Laws of Minnesota, Ch. 510, Art. 4, Sec. 25. The Department points out that TPAs are separately licensed and frequently involved in the workers' compensation system and that insurance companies are commonly part of an overall system of related corporations. The statute, however, does not mention TPAs or corporate affiliates of workers' compensation insurers. The Department reasoned that, if the Legislature had meant to exclude entire groups with experience in workers' compensation managed care, it would have stated its intention more clearly.

The Department now believes that "[i]t is not likely that the legislature intended these intricate relationships to be dissected and analyzed by the Department in determining what entities constitute a workers' compensation insurer." Id. After reviewing the public comments and the suggestions for imposing control tests submitted during the rulemaking process, the Department concluded that any attempt it made to distinguish between complex corporate relationships would in fact frustrate the intent of the law. The Department asserts that the modifications proposed will afford greater flexibility to managed care plans to implement innovative and effective programs and allow experimentation with different forms and organizations. The Department further notes that the provisions authorizing revocation or suspension of certifications and the dispute resolution mechanisms available to employees will encourage TPAs and affiliates of insurers to provide appropriate treatment.

48. The governing statute provides that "[a]ny person or entity, other than a workers' compensation insurer or an employer for its own employees, may make written application" for certification as a managed care organization. Minn. Stat. § 176.1351, subd. 1 (1992). As discussed in Finding 28 above, this is a narrow exception. Because there is no explicit expression of legislative intent to expand the prohibition to encompass TPAs or affiliates of workers' compensation insurers, it is reasonable for the Department to decide that it is not appropriate to impose a more restrictive approach. The Legislature did not mandate that the Department apply a "control" test or analyze the interrelationships between various corporate entities, and it would not be proper for the Administrative Law Judge to require such an approach in light of the language of the statute. With the exception of the language discussed in Finding 49 below, the proposed rules as modified are found to be in accordance with the governing statute and are determined to be needed and reasonable to preclude the entities mentioned in the statute from obtaining certification and more accurately describe the HMOs and preferred provider organizations that are eligible to apply for certification.

The Judge further finds that the rules as modified are not substantially different from the rules that were originally proposed. Minn. Stat. § 14.15, subd. 3 (1992). In deciding whether a proposed final rule is substantially different, the Administrative Law Judge must "consider the extent to which it affects classes of persons who could not have reasonably been expected to comment on the proposed rules at the rulemaking hearing, or goes to a new subject matter of significant substantive effect, or makes a major substantive change that was not raised by the original notice of hearing in such a way as to invite reaction at the hearing, or results in a rule fundamentally different in effect from that contained in the notice of hearing." Minn.

Rules pt. 1400.1100, subp. 2 (1991). The rules as originally proposed would have precluded third-party administrators and parents, subsidiaries, and other affiliates of workers' compensation insurers from obtaining certification and would have required applicants to submit information concerning their relationships with such entities. During the hearing and in post-hearing comments, the Department admitted that there were legitimate questions regarding the meaning of the governing statute and interested persons alleged that the Department's proposed rules were unnecessary, unreasonable, or contrary to the statute. Interested persons were thus placed on notice of the possible outcomes under consideration by the Department. The modifications made to the rules affect the same classes of persons as the original rule (now permitting at least some of them to apply for certification and no longer requiring the submission of "control test" information). The rule as modified involves the same subject matter as the original rules and does not result in a rule that is fundamentally different in effect from the rule as originally proposed. Accordingly, the Judge finds that there has been no substantial change. 3/

49. The language the Department sought to retain from former item B of subpart 4 was modified to read as follows:

> This item is not intended to limit 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.

This sentence is not a rule, but a statement of intention. As such, it cannot be adopted as rule language. Minn. Stat. § 14.02, subd. 4 (1992), defines a

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3/ The Judge is concerned that the Department did not make this extensive modification in its proposed rules until late in the afternoon on August 26, 1993, the date on which the five-day reply period ended and the record closed in this matter. As a consequence, it was not possible for other interested persons to respond to the modifications and provide the Judge with the benefit of their views. The Administrative Procedure Act does not preclude agencies from modifying their proposed rules during the five-day reply period and the Department's modifications were not improper in any sense. The five-day reply period is, however, typically used to respond to new information received during the twenty-day period and accept or reject suggestions for change made during the twenty-day period. The Judge is aware that many of the comments submitted by interested members of the public during the twenty-day period were filed late on the twentieth day and understands that it would not have been possible for the agency to absorb and respond to such comments until the five-day reply period. However, the restrictions on managed care plans formed by workers' compensation insurers, self-insured employers, and TPAs were the subject of extensive debate at the hearing and throughout the twenty-day period. It would have furthered the purposes of the public rulemaking proceeding if the Department had submitted these major modifications during the twenty-day period or, at a minimum, at an earlier point in the five-day reply period.

rule as "every agency statement of general applicability and future effect . . . ." Pursuant to Minn. Stat. § 14.38, subd. 1 (1992), every properly promulgated rule has the force and effect of law. It is not possible to afford a statement of intention the force and effect or law or treat it as a binding statement of general applicability and future effect. Since the language conflicts with the statutory definition of a rule, it is defective and may not be included in the Department's managed care rules. To cure the defect, the Administrative Law Judge suggests that the sentence must be deleted or, in the alternative, revised along the following lines: "This item 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 Statute section 176.1351." The suggested language clearly states what the Department intends, expresses a standard for application in specific cases, and does not constitute a substantial change from the language originally proposed.

Subpart 5 - Coverage

50. Item B of subpart 5 indicates that employees who provide notice of their injury to the employer before the effective date of coverage by the managed care plan may continue to treat with a non-participating provider who has been treating the injury until the employee requests a change of doctor. Mark Olive, Sieben, Grose, Von Holtum, McCoy & Carey, argued that there is no statutory authority for the Department's attempt to treat individuals who request a change of physicians in a manner different than other injured workers with compensable injuries that predate managed care coverage. Mr. Olive further asserts that the Department has not established the need for or reasonableness of such a provision. In response, the Department argued that the Legislature's expression of the urgent nature of the need for managed care is consistent with applying managed care to future treatment of employees regardless of the date of their injury. The Department also asserts that, even in the absence of an express statement of intention, the law may be applied to all dates of injury if the employee's right to compensation is not restricted and the liability of the employer is not enlarged.

The approach taken in the proposed rules is consistent with Minn. Stat. § 176.1251, subd. 2(8) (1992), which permits an employee to continue treating with a doctor with whom the employee has a previous treating relationship. Once the employee requests a change of physician, that statutory provision no longer applies. The employee would remain entitled to all treatment that is reasonably required to cure or relieve the employee of the effects of the injury. See Minn. Stat. § 176.135, subd. 1(f) (1992). The proposed rule would not bring about a substantive change in the employer's liability or in the benefit received by the employee but would merely authorize a change in the manner in which the medical benefit would be delivered to the employee. See Tri-State Insurance Co. v. Bouma, 306 N.W.2d 564 (Minn. 1983); Sherman v. Whirlpool, 386 N.W.2d 221 (Minn. 1986); Nelson v. Mid-Minnesota Women's Center, 40 W.C.D. 580 (WCCA 1988). The Judge concludes that the coverage of previously-injured employees under the managed care plan after they request a change in doctor is not contrary to the governing statute but instead furthers the express intention of the 1992 legislation. The Department has shown that this approach is needed and reasonable.

51. BlueCross suggested that the first sentence of item B as originally proposed be modified to clarify that the non-participating provider must

comply with rule part 5218.0500 and eliminate potential conflict with the last sentence of the item. Following the hearing, the Department modified the language in item B in response to BlueCross' comments. As modified, the proposed rule provides as follows:

> 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 non-participating 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.

The modification reduces ambiguity in the item, is responsive to public comment, and does not result in a rule substantially different from the rule as originally proposed.

Proposed Rule Part 5218.0250 - Notice to Employee by Employer

52. Subpart 5A of proposed rule part 5218.0200 provides, inter alia, that "[a]n employee may not be required to receive medical services under a managed care plan until the notice required by part 5218.0250 is given to the employee." Proposed rule part 5218.0250 prescribes the content of the posted and individual notices that trigger an injured employee's participation in the managed care plan. The notices must contain, among other things, information relating to the effective date of coverage by the managed care plan; the contact person and telephone number of the employer, the managed care plan, and the Department; the scope of available treatment; how the employee may access care under the plan; and circumstances under which the employee is not required to receive services from a health care provider who is a member of the managed care plan.

Commentators suggested that the Department exempt from the notice requirement all employers who were enrolled in managed care plans prior to the effective date of the rules, incorporate the toll-free number requirement, and clarify the reference to "after a specified date" in item A. Following the hearing, the Department made several modifications in the proposed rule. The Department modified the second and third sentences in the opening paragraph of the proposed rule to provide as follows: "For employees enrolled after the effective date of these rules, 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." The Department revised item A to provide that the notice must include the following information:

> 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 non-participating provider until the employee changes doctors. The notice to employees must specify the effective date of the managed care plan, which must be later that [sic] the date the notice is posted . . . .

The Department also modified the rules to refer in item D to the "toll-free 24 hour telephone number of the managed care plan." The modifications clarify the rule and have been shown to be needed and reasonable. 4/ While the requirement of a toll-free number will increase costs slightly, it is reasonable to require the managed care plan to bear the costs of telephone calls regarding access to managed care rather than the injured worker. The revisions were made in response to comments by interested persons and do not result in a rule that is substantially different from the rules as originally proposed.

53. Item E(1) of proposed rule part 5218.0250 indicates that the notice must state that the employee is required to receive services from a health care provider who is a member of the managed care plan except "if the employee has established a relationship with a health care provider who is able to treat the injury and who has treated the employee at least two times within the previous two years before the injury, except that if the employee changes doctors it must be to a doctor within the managed care plan . . . ." The substance of this notice provision stems from proposed rule 5218.0500, subpart 1A. The Administrative Law Judge has found that portion of the proposed rules to be defective because it exceeds the Commissioner's statutory authority (see discussion in Finding 58 below) and must also find the notice provision defective. As explained in Finding 58, the Judge has concluded that the rules must afford an employee the opportunity to demonstrate that a treatment history exists in instances in which the physician has not in fact treated the employee two times within the two years preceding the injury. To correct this defect, the Administrative Law Judge suggests that the Department revise item E(1) to provide: "if the employee has established a relationship with a health care provider who is able to treat the injury, except that if the employee changes health care providers it must be to a provider within the managed care plan . . . ." In the alternative, language paralleling that suggested in Finding 58 below may be used. The suggested modification is necessary to correct a defect in the proposed rule. The modification would not result in a substantial change from the rule as originally proposed.

Proposed Rule Part 5218.0300 - Reporting Requirements for Certified Managed Care Plan

Subpart 1 - Contracts; Modifications

54. Pursuant to subpart 1A of proposed rule part 5218.0300, contracts between the managed care plan and any insurer or self-insured employer must be provided to the Commissioner within thirty days of execution. Items B and C

4/ The Department should correct the typographical error in the modification language by substituting "than" for "that."

of subpart 1 further require the submission to the Commissioner of "[n]ew types of agreements between participating health care providers and the managed care plan, which shall not be effective until approved by the commissioner," and contracts between the managed care plan and any entity that performs some of the functions of the managed care plan. These reporting requirements are intended to offer the Department an opportunity to review the agreements between the entities involved in the delivery of managed care services in order to enable the Department to assess whether the managed care plan will be able to fulfill its responsibilities and whether the arrangements conform with applicable statutes and rules. In addition, the Department intends to computerize the coverage information and make that information available to employees. SONAR at 27. The Department has shown that it is needed and reasonable to require the submission of this information in order to ensure compliance.

HealthEast Care, Inc., commented that it was unclear what was intended by the reference in item B of subpart 1 to "new types of agreements" and suggested that the Department clarify this language. The Department did not address this comment in its post-hearing submissions. It appears clear that the language is intended to refer to any agreement between participating health care providers and the managed care plan that is not identical to the agreement previously submitted to the Department for review as part of the application process. See proposed rule 5218.0100, subpart 1.E.(1). The Administrative Law Judge does not find subpart 1B to be unduly vague in this regard. Should the Department wish, it may clarify the language of item B by revising it to refer to "agreements between participating health providers and the managed care plan that are not identical to the agreements previously submitted to the Department under part 5218.0100, subpart 1.E.(1), which shall not be effective until approved by the commissioner." Such a modification would not constitute a prohibited substantial change.

Subpart 2 - Annual Reporting

55. To maintain its certification, a managed care plan must file current listings of participating providers; a summary of sanctions taken against providers; a summary of peer review, utilization review, complaints, and dispute resolution proceedings; "or" a report of educational opportunities offered to participating providers and a summary of attendance. A $400 fee is required at the time of submission of this annual report. State Fund Mutual commented that the "or" in subpart 2C should be corrected to "and."

Following the hearing, the Department modified subpart 2A to require the submission of "a current listing of particpating health care providers, including provider names, types of license, specailty, business address, telephone number, and a statement that all licenses are current and in good standing." This modification deleted a reference to an outdated citation from the emergency rules and does not constitute a substantial change. The Department has demonstrated that it is needed and reasonable to require the submission of the information identified in items A through D of subpart 2. The Department has further shown that the amount of the fee is needed and reasonable and that the statutory requirements for adopting a fee have been met.

The language of the proposed rule is defective, however, in that it retains the word "or" at the end of item C, thereby rendering the rule

unreasonable. It is likely that this was simply a typographical error in the proposed rules. As currently drafted, however, the rule might be construed to permit managed care plans to pick and choose which of the four categories of information they will file each year. The Department has failed to demonstrate the reasonableness of such an approach. To correct this defect, the Department should change the word "or" to "and." Such a modification will serve to clarify the reporting requirements and will not result in a rule that is substantially different from the rule as originally proposed.

Subpart 3 - Plan Amendments

56. Subpart 3 of the proposed rules requires the managed care plan to report amendments to contracts with participating health care providers, amendments to contracts between the plan and another entity performing functions of the managed care plan, and any other amendments to the managed care plan as certified. As originally proposed, item C would have required that the plan report "changes in the plan's ownership, organizational status or affiliation with an insurer, employer, or third party administration [sic] under part 5218.0200, subpart 3." In its August 26, 1993, submission, the Department proposed to delete item C in keeping with its decision to remove TPAs from the definition of "insurer" and delete the control tests. Consistent with the analysis set forth in Findings 28 and 48 above, the Administrative Law Judge finds that the deletion of item C comports with the governing statute, is needed and reasonable, and does not constitute a substantial change.

HealthEast Care, Inc., objected to the additional fee of $150 required for the filing of plan amendments. Information submitted by the Department shows that the estimated costs involved in the Department's review of plan amendments approximates the $150 fee set forth in the proposed rules. The Department has satisfied the requirements of Minn. Stat. §§ 16A.128 and 16A.1285 with respect to the adoption of fees and has demonstrated that the fee is needed and reasonable.

Proposed Rule Part 5218.0500 - Health Care Providers Who Are Not Participating Health Care Providers

Subpart 1 - Authorized Services

57. Proposed rule part 5218.0500 sets forth the circumstances under which an employee may receive services outside of the managed care plan. As originally proposed, the introductory language of subpart 1 provided, inter alia, that the employer or insurer is required to notify the managed care plan of treatment by nonparticipating health care providers under the rule provisions and indicated that "the managed care plan, employer, or insurer must initiate the contact with the nonparticipating provider." Subpart 2 of the proposed rules requires that the nonparticipating provider must agree to comply with the managed care plan treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures and agree to refer the employee to the managed care plan for specialized services.

The Minnesota Medical Association suggested that language be added to the proposed rules requiring nonparticipating providers to be informed of all of the requirements and obligations. BlueCross similarly suggested that the

managed care plan, employer, or insurer be required to explain the rules for continued treatment of the employee. The Department agreed with these suggestions and added the following additional sentence to the end of the introductory language in subpart 1: "The managed care plan must explain its requirements and procedures to the nonparticipating health care provider, and must provide the plan's toll-free number through which the nonparticipating provider may obtain information about the plan's requirements and procedures and other information specified in part 5221.0100, subp. 1, item L." The introductory language of subpart 1, as modified, is needed and reasonable to ensure that proper information is received by all parties regarding treatment by a nonparticipating provider. The modification made by the Department is responsive to public comment and does not render the final rule substantially different from the rule as originally proposed.

58. As originally proposed, item A of subpart 1 provided as follows:

> A nonparticipating provider may deliver services to an employee if the health care provider maintains the employee's medical records, has a documented history of treatment of that employee at least twice in the two years before the date of injury, whether for a work-related condition or not, and so long as the provider complies with 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 employee must promptly provide the insurer with copies of medical records documenting the previous treatment. The 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).

Several interested persons objected to item A and urged that it be modified. The Minnesota Medical Association, the Minnesota Chiropractic Association, and the Minnesota Dental Association expressed concern about the mandated disclosure of confidential medical records and recommended that the rules simply require the submission of written signed documentation or other evidence of previous treatment. John Engberg, Peterson, Engberg & Peterson, and Mark Olive, Sieben, Grose, Von Holtum, McCoy & Casey, asserted that the standard of two visits in two years is unreasonable and contrary to the provisions of the managed care statute. State Representatives Patrick Beard, Irv Anderson, Jim Farrell, Alice Johnson, Walter Perlt, Tom Rukavina, Kathleen Sekhon, David Batttaglia, Thomas Huntley, Mary Murphy, James Rice, John Sarna, and Stephen Wenzel also argued that the standard is too restrictive and distorts the "family doctor" concept contained in the statute. These members of the Legislature argued that, while the standard of two visits in four years expressed in the emergency managed care rules was also probably too restrictive, that standard at the very least should be retained in the permanent rules. State Fund Mutual expressed support for the standard in the proposed rules of two visits in two years and indicated that it was a more

reasonable time frame than the standard utilized in the emergency managed care rules. State Fund Mutual also recommended that the word "promptly" be replaced with "within two weeks of the initial request for treatment" to avoid delays. BlueCross suggested that additional language be included in item A to eliminate possible confusion between item A of this rule and rule part 5218.0200.

After the hearing, the Department modified the third sentence of item A to reflect its agreement with certain of the above comments. As modified, the third sentence of item A provides as follows: "The employee must within 10 calendar days of notice to the employer of an injury provide the insurer with copies of medical records or a letter from the health care provider documenting the dates of the previous treatment." This modification does not constitute a substantial change and has been shown to be needed and reasonable to clarify the time limitations, conform the rule to the medical reporting standards of proposed rule 5221.0410, guard against unwarranted intrusion into private medical records, and maintain the efficiency of the system. No statutory rights are infringed by those limitations.

The Department declined to make further changes in item A. With respect to the standard of two visits in two years, the Department argued that the Commissioner has the authority to implement and make more specific the workers' compensation law under Minn. Stat. § 176.83, subd. 1 (1992), and that the Commissioner is specifically granted authority under Minn. Stat. § 176.1351, subds. 2(12) and 6 (1992), to adopt rules to implement the managed care law. The Department contends that the proposed rule is reasonable to ensure that there is a current, on-going relationship between the doctor and patient. In its SONAR, the Department justifies its approach as follows:

> [I]f the employee has not seen the provider twice in the past two years, the relationship is remote enough that the provider will not have current knowledge of employee's medical status, and the relationship is not likely of a nature that the employee would benefit from care with that provider more than care with a medical provider who specializes in workers' compensation treatment. This rule attempts to balance competing benefits, but some limitation is necessary. While the statute is not specific as to what constitutes a previous treating provider, it cannot be read to qualify any previous health care provider, because everyone has seen a health care provider at some point in time.

SONAR at 30. At the hearing, the Department indicated that it had decided to make the rule more restrictive than the emergency rule for several reasons, including the importance of getting an employee into a managed care plan, the Department's feeling that there is "somewhat of a relationship" between a doctor and patient if the patient has seen the doctor twice in the previous two years, and the Department's apparent assessment that personal rapport between the doctor and patient is lacking if the patient has not visited the doctor with that level of frequency. T. 267-68.

The managed care statute provides that an injured worker may "receive compensable treatment from a health care provider who is not a member of the managed care plan, if that provider maintains the employee's medical records and has a documented history of treatment with the employee . . . ." Minn. Stat. § 176.1351, subd. 2(8) (1992). While the Department has the authority to promulgate rules that implement the provisions of the managed care statute and other provisions of the workers' compensation laws, the two-visit/two-year standard set forth in the proposed rules places undue restrictions on the statutory right of an employee to continue an established relationship with a health care provider which are not within the language of the statute. Under the proposed rules, employees who cannot meet the two-visit/two-year standard would not have an opportunity to provide evidence that other situations--e.g., eight visits during the previous ten years or a lack of recent visits due to good health or temporary relocation--should be found to constitute a "history of treatment" within the meaning of the statute.

The proposed rules would significantly narrow the scope of the right granted by Minn. Stat. § 176.1351, subd. 2(8) (1992) to receive compensable treatment from a health care provider with whom the employee has a documented history of treatment. Agencies do not have the authority to promulgate rules that narrow the statute. United Hardware Distributing Co. v. Commissioner of Revenue, 284 N.W.2d 820 (Minn. 1979). Agencies also lack statutory authority to adopt rules which significantly limit substantive rights granted by statute. While the Legislature may accord the agency discretion in implementing or administering a law, the Legislature "may not give [the agency head] authority to determine what the law shall be or to supply a substantive provision of the law which he thinks the legislature should have included in the first place." Wallace v. Commissioner of Taxation, 184 N.W.2d 588, 594 (Minn. 1971). See also McGuire v. Viking Tool & Die Co., 104 N.W.2d 519, 528 (Minn. 1960) ("It is axiomatic that an administrative body can neither make nor change substantive law. It may adopt administrative rules, but in doing so cannot change existing, or make new, law"). The proposed rules thus are found to be defective because the Department has exceeded its statutory authority.

This does not mean that the Department must abandon the two-visit/two-year rule entirely, however. The Department may specify in the rule that situations in which the employee has seen the provider two times in two years will be deemed to satisfy the statutory standard, as long as employees who do not meet the two-visit/two-year standard are afforded an opportunity to demonstrate that a history of treatment with the health care provider in fact does exist. The Administrative Law Judge suggests that the following language be used to correct the defect in the proposed rules:

> A nonparticipating provider may deliver services to an employee if the health care provider maintains the employee's medical records, has a documented history of treatment of that employee, whether for a work-related condition or not, and so long as the provider complies with Minnesota Statutes, section 176.1351, subdivision 2, clause (8). The requirement of a history of treatment will be deemed to be satisfied if the employee documents that the employee has had at least two visits with the

provider within the two years before the date of the injury for care other than evaluations for minimal or no compensation or treatment of an injury before notice of the injury is given to the employer. Employees who have a history of treatment with a health care provider that does not meet the standard set in this item may apply for approval with the managed care plan. If that approval is denied, the employee may appeal the denial under the method set out in subpart 3. The employee must, within 10 calendar days of notice to the employer of an injury, provide the insurer with copies of medical records or a letter from the health care provider documenting the dates of the previous treatment. [Remainder of the item unchanged]

The suggested language removes the inappropriate limitation placed on the employee's right to have care provided by a professional with whom the employee has an documented history of treatment while retaining, for administrative convenience, a standard under which employees will be deemed to have made an appropriate showing of a history of treatment. The introductory paragraph in subpart 1 and item A of the proposed rule, with the modifications discussed in this Finding, is needed and reasonable. The modifications made by the Department and suggested by the Administrative Law Judge are needed and reasonable to clarify the intent of the rule, avoid the forced disclosure of irrelevant private medical information, and correct defects in the proposed rule. The modifications do not result in a rule that is substantially different from that originally proposed.

59. Following the hearing, the Department modified item D of subpart 1 to specify that "[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, item B, and item D where liability for the injury is admitted or established later than 14 days after the employer received notice of the injury." The modification was made to clarify that nonparticipating providers who continue to treat an employee for an injury which occurred prior to the managed care contract are subject to the requirements and procedures of the managed care plan. The modification was made in response to recommendations that the intent of the rule be clarified and is consistent with other provisions of the proposed rules. Item D of the proposed rules as modified has been shown to be needed and reasonable, and the modification does not constitute a substantial change.

Proposed Rule Part 5218.0600 - Charges and Fees

60. Proposed rule part 5218.0600 requires that billings for medical services under a managed care plan be submitted in the format specified in applicable rules, that payments be made in accordance with timeframes and procedures established by statute and rule, and that the maximum amounts conform to the fee schedule set in the Department's rules. The last sentence of the proposed rule part prohibits managed care plans from requiring a health care provider to accept a lesser payment or pay a fee as a condition of participating in the plan or receiving referrals from the plan. Several interested parties, including the Minnesota Medical Association, Twin Cities

Managed Care, and HealthEast Care, Inc., supported the proposed rule's prohibition against the discounting of fees beyond the levels specified in the fee schedule, arguing that the proposed relative value fee schedule already reflects reduced levels of reimbursement. Twin Cities Managed Care asserted that permitting discounting of fees would unfairly benefit large provider organizations and have a negative impact on care to injured workers. Other commentators, including the American Insurance Association, HealthPartners, and Kemper National Insurance, objected to the limitation and asserted that managed care plans should be allowed the flexibility to negotiate fee arrangements with providers in order to achieve additional cost savings, consistent with the intent of the Legislature in enacting the 1992 legislation.

The Department declined to modify the proposed rule in response to public comment. In its SONAR, the Department points out that the Legislature required that the relative value fee schedule reflect a 15 percent overall reduction from the 1991 medical fee schedule. Given these already reduced levels of reimbusement, the Department "determined that to permit further reduction of reimbursement to providers could compromise the delivery of medical services and possibly limit the number of quality providers available to participate in managed care." SONAR at 32. The Department also argues that the costs of administering the plan should be negotiated between insurers and managed care plans and that providers should not be required to subsidize administrative costs. Id. The Administrative Law Judge concludes that the Department has shown that proposed rule part 5218.0600 is needed and reasonable to provide appropriate standards for charges and fees without adversely affecting the quality of the care provided.

Proposed Rule Part 5218.0750 - Utilization Review and Peer Review

61. Proposed rule part 5218.0750, subparts 1 and 2, require managed care plans to implement a system for peer review and a program for utilization review. The proposed rules require that the peer review system include at least one health care provider of the same discipline being reviewed. In its application for certification, the managed care plan must describe how the providers will be selected for peer review, the nature of the review, and how the results will be used, and also describe the data that will be collected for utilization review, how the data will be analyzed, and how the results will be applied to improve patient care and increase the cost effectiveness of treatment.

Many commentators, including the Minnesota Chiropractic Association, the Minnesota Optometric Association, the Minnesota Dental Association, the Minnesota Medical Association, and Ann Barkley, a doctor of chiropractic, recommended that the peer review and utilization review requirements be modified. The suggestions for modification of the provisions focused upon the asserted need for the proposed rules to provide at least minimum standards for such reviews. With respect to the peer review provision, commentators suggested that subpart 1 require that the review be conducted by professional associations or by otherwise neutral parties who hold no financial interest in the plan or the provider; provide that a panel of reviewers must include non-participating providers; and specify the qualifications for those participating in the review to ensure that peers are in fact conducting the review. In addition, BlueCross suggested that the second sentence of subpart 1 be modified to provide that the peer review must include at least one health

care provider of the same discipline being reviewed "or similar general specialty as typically manage the medical conditions, procedure or treatment under discussion" to be consistent with standards established by the National Utilization Review Accreditation Commission. With respect to the utilization review provision, commentators suggested that subpart 2 set forth specific minimal standards such as those contained in the Minnesota Utilization Review Act, Minn. Stat. § 62M.01 (1992), and specify how the review will be monitored by the Department.

The Department declined to make any of the suggested changes. The Department pointed out that, while HMOs that are also managed care organizations may be subject to the Utilization Review Act, the Act specifically exempted from coverage workers' compensation health benefit plans. See Minn. Stat. § 62M.02, subd. 12(8) (1992). The Department stressed that the managed care statute does not refer to the Utilization Review Act but merely requires that managed care plans provide "adequate methods of utilization review and peer review and dispute resolution to prevent inappropriate, excessive, or not medically necessary treatment" and that the plan must "exclude participation in the plan by those individuals who violate these treatment standards." Minn. Stat. § 176.1351, subd. 2(4) (1992). The Department asserts that these statutory provisions expressly authorize the managed care plan to perform the peer and utilization review functions. The Department further argues that the approach taken in the proposed rules affords the managed care plan flexibility in implementing the peer and utilization review functions and that a rigid formula would be inappropriate because it would not encourage creativity and positive change. In addition, the Department emphasized that there are several other mechanisms to ensure that quality care is available to employees, including the dispute resolution system.

A rule is not unreasonable simply because another, perhaps more reasonable, choice could have been made. See, e.g., Federal Security Administrator v. Quaker Oats Co., 318 U.S. 218, 233 (1943); Pitts v. Perluss, 27 Cal. Rptr. 19, 377 P.2d 83, 58 Cal. 2d 824 (1962). The Department has shown that it has a rational basis for its selection of the approach taken in the proposed rules and that the proposed rules are logically related to the ends sought to be achieved by the statute. Broen Memorial Home v. Minnesota Department of Human Services, 364 N.W.2d 436, 440 (Minn. Ct. App. 1985); Blocher Outdoor Advertising Co. v. Minnesota Department of Transportation, 347 N.W.2d 88, 91 (Minn. Ct. App. 1984). The approach does not conflict with any statutory directive. The Department will have some oversight over the peer and utilization review methods selected by the managed care plan since the specific procedures to be followed must be set forth in the plan's application for certification and the annual report filed by the plan must provide information regarding sanctions taken against providers and summarize the peer review, utilization review, complaints, and dispute resolution activity. See rule part 5218.0300, subpart 2. There is no indication that peer or utilization reviews are likely to be conducted improperly by managed care plans if performed by their employees. The Department's choice of in-house peer review and utilization review has been shown to be needed and reasonable.

Proposed Rule Part 5218.0760 - Medical Case Management

62. Subpart 1 of proposed rule 5218.0760 provides, inter alia, that a "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." As originally proposed, subpart 1 further required that the managed care plan describe in its application for certification "how employees will be selected for case management, the services to be provided, and who will provide the services." Subpart 2 requires a medical case manager to be a licensed or registered health care professional with at least one year's experience in workers' compensation.

State Fund Mutual commented that the requirement that the plan describe "how employees will be selected for case management" was unclear. Following the hearing, the Department modified the rule to refer to "how injured employees will be selected for case management." The modification clarifies the intent of the rule and does not result in a substantial change.

Mark Olive, Sieben, Grose, Von Holtum, McCoy & Carey, questioned the statutory authority for the creation of a "new player" in workers' compensation. BlueCross, Twin Cities Managed Care, and Kevin McCarthy, Occupational Medicine Coordinator for Sioux Valley Hospital, criticized the experience standard for medical case managers. BlueCross recommended that the rule be modified to require that the case manager have prior experience in managing patient medical care and that at least twenty percent of the case managers used by a managed care plan have at least one year's experience. Mr. McCarthy indicated that it is unnecessary to require one year's experience in workers' compensation and asserted that the Department's rule will exclude experienced case managers who have not been involved in the workers' compensation system. Mr. McCarthy urged that individuals who are Qualified Rehabilitation Consultants or have a masters degree in vocational rehabilitation and are certified as Certified Rehabilitation Consultants or Certified Insurance Rehabilitation Specialists be deemed to be qualified to serve as a medical case manager. Twin Cities Managed Care suggested that the rules require that each plan have at least one RN, COHN, OTR or PT, CIRS/CRC/CCM or eligible person with two years experience in workers' compensation who would be responsible for oversight of cases. It also recommended that the Department require plans to offer a choice of at least three case managers, establish continuing education guidelines, and mandate at least one case manager per 3,000 claims/year.

The Department declined to make any of the suggested modifications to subpart 2. The Department pointed out that Minn. Stat. § 176.1351, subd. 2(6) (1992), requires that the managed care plan provide "aggressive case management" and "provide a program for early return to work." The statute does not require that such functions be performed by a QRC. The Department argued that managed care plans must provide case management and return to work programs from a medical perspective and not from the vocational perspective provided by QRCs. In its SONAR, the Department indicated that the medical case manager will have a critical role in coordinating medical treatment and facilitating the employee's return to work and that this job thus "should be entrusted to someone who is knowledgeable about injuries and medical treatment and has had at least one year's experience in an area of workers' compensation. This may include a variety of experiences, such as treating injured employees or workers' compensation case management." SONAR at 34. Finally, the Department emphasized that subpart 1 of the rule anticipates cooperation with a QRC and that a QRC with a medical background would not be precluded from being a case manager.

The medical case management approach is consistent with the governing statute and is not otherwise improper. The Department has shown that the one-year experience requirement imposed by the proposed rules with respect to medical case managers is needed and reasonable to ensure aggressive case management and the facilitation of an early return to work.

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. The Minnesota Department of Labor and Industry gave proper notice of this rulemaking hearing.

2. The Department has substantially fulfilled the procedural requirements of Minn. Stat. §§ 14.14, subds. 1, 1a, and 2 (1992), and all other procedural requirements of law or rule so as to allow it to adopt the proposed rules.

3. The Department has demonstrated its statutory authority to adopt the proposed rules, and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. §§ 14.05, subd. 1, 14.15, subd. 3, and 14.50 (i) and (ii) (1992), except as noted in Findings 29, 49, 53, and 58 above.

4. The Department has demonstrated the need for and reasonableness of the proposed rules by an affirmative presentation of facts in the record within the meaning of Minn. Stat. §§ 14.14, subd. 2 and 14.50 (iii) (1990), except as noted in Finding 55 above.

5. The additions and amendments to the proposed rules which were suggested by the Department after publication of the proposed rules in the State Register do not result in rules which are substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. § 14.15, subd. 3 (1992), and Minn. Rules pts. 1400.1000, subp. 1 and 1400.1100 (1991).

6. The Administrative Law Judge has suggested action to correct the defects cited at Conclusions 3 and 4 as noted at Findings 29, 49, 53, 55, and 58.

7. Due to Conclusions 3, 4 and 6, this Report has been submitted to the Chief Administrative Law Judge for his approval pursuant to Minn. Stat. § 14.15, subd. 3 (1992).

8. Any Findings which might properly be termed Conclusions and any Conclusions which might properly be termed Findings are hereby adopted as such.

9. A Finding or Conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the Department from further modification of the proposed rules based upon an examination of the public comments, provided that no substantial change is made from the proposed rules as originally published, and provided that the rule finally adopted is based upon facts appearing in this rule hearing record.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS HEREBY RECOMMENDED that the proposed rules be adopted except where specifically otherwise noted above.

Dated this 4th day of October, 1993.

Barbara L. Neilson

BARBARA L. NEILSON
Administrative Law Judge

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