STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE MINNESOTA DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Adoption of Rules of the Minnesota Department of Labor and Industry, Workers' Compensation Division, Governing Workers' Compensation Treatment Parameters.

REPORT OF THE ADMINISTRATIVE LAW JUDGE

The above-entitled matter came on for hearing before Bruce D. Campbell, Administrative Law Judge, at 9:00 a.m. at the State Office Building in St. Paul, Minnesota on August 2, 1994. Additional hearings were held at the same location on August 3 and 4, 1994.

This Report is part of a rulemaking proceeding held pursuant to Minn. Stat. §§ 14.01 - 14.28 (1992), to determine whether the proposed workers' compensation rules regarding treatment parameters should be adopted by the Minnesota Department of Labor and Industry (Department or Agency). The Department must fulfill all relevant substantive and procedural requirements of law applicable to the adoption of rules, demonstrate the need for and reasonableness of the proposed rules and limit any modifications of the rules after initial publication to permissible nonsubstantial changes.

The Department was represented at the hearing by Gilbert S. Buffington, Assistant Attorney General, 900 NCL Tower, 445 Minnesota Street, St. Paul, Minnesota 55101-2127. Mr. Buffington was assisted by Catherine R. Berger, Attorney at Law, Minnesota Department of Labor and Industry, 443 Lafayette Road, St. Paul, Minnesota 55155. Members of the Department panel appearing at the hearing included the following persons: Catherine Berger, Legal Services Division; Assistant Commissioner for Workers Compensation, Leo Eide; William H. Lohman, M.D., Medical Consultant, Minnesota Department of Labor and Industry; Kate Kimpan, Director of Research and Education, Department of Labor and Industry; Joseph Wegner, M.D., Chairman, Medical Services Review Board; Jeffrey Bonsell, D.C., Member, Medical Services Review Board; James House, M.D.; Lawrence Schut, M.D., Member, Medical Services Review Board; David Ketroser, M.D., Member, Medical Services Review Board; and James Hoyme, P.T., Member, Medical Services Review Board.

The hearing register was signed by 111 persons. In addition to the members of the Agency panel previously noted, approximately 15 persons

provided oral testimony at the hearing. All persons desiring to testify orally were given an opportunity to do so. The record remained open through August 24, 1994, for the submission of initial written comments. As authorized by Minn. Stat. § 14.15, subd. 1 (1992), five business days were allowed for the filing of responsive comments. The responsive comment period ended on August 31, 1994. On August 31, 1994, at 4:30 p.m., the record of this rulemaking proceeding finally closed for all purposes.

The Commissioner of the Department of Labor and Industry 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 (1992), 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 Commissioner of actions which will correct the defects and the Commissioner 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 Commissioner may either adopt the Chief Administrative Law Judge's suggested actions to cure the defects or, in the alternative, if the Commissioner does not elect to adopt the suggested actions, he must submit the proposed rule to the Legislative Commission to Review Administrative Rules for the Commission's advice and comment.

If the Commissioner 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 Commissioner may proceed to adopt the rule and submit it to the Revisor of Statutes for a review of the form. If the Commissioner makes changes in the rule other than those suggested by the Administrative Law Judge and the Chief Administrative Law Judge, then he 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 Commissioner files the rule with the Secretary of State, he 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 6, 1994, the Department of Labor and Industry filed the following documents with the Chief Administrative Law Judge:

(a) A copy of the proposed rules certified by the Revisor of Statutes.
(b) The Order for Hearing.

(c) The Notice of Hearing proposed to be issued.
(d) A Statement of the number of persons expected to attend the hearing and estimated length of the Agency's presentation.
(e) A Statement of Additional Notice.

2. The Department's Statement of Need and Reasonableness (SONAR) was received by the Administrative Law Judge on June 23, 1994.

3. On June 22, 1994, the SONAR was provided to the Legislative Commission to Review Administrative Rules.

4. On June 27, 1994, a copy of the proposed rules were published at 18 State Register 2688.

5. On June 23, 1994, 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. The Department also gave discretionary notice on June 8, 1994, and on July 5, 1994, the Department gave discretionary notice to the Certified Managed Care Organizations, the Workers' Compensation Medical Services Review Board and the Workers' Compensation Advisory Task Force. See, Ex. E.

6. On July 7, 1994, the Department filed the following documents with the Administrative Law Judge:

(a) The Notice of Hearing as mailed.
(b) The Agency's certification that its mailing list was accurate and complete.
(c) The Affidavit of Mailing the Notice to all persons on the Agency's list.
(d) An Affidavit of Additional Notice.
(e) The names of Department personnel who would represent the Agency at the hearing, together with the names of any other witnesses solicited by the Agency to appear on its behalf.
(f) A copy of the State Register containing the proposed rules.
(g) All materials received following a Notice of Intent to Solicit Outside Opinion published at 18 State Register, page 311, July 19, 1993, and a copy of the Notice.

The documents were available for inspection at the Office of Administrative Hearings from the date of filing to the date of the hearing.

7. The period for submission of written comment and statements remained open through August 24, 1994, the period having been extended by order of the Administrative Law Judge to 20 calendar days following the hearing. The record closed on August 31, 1994, the fifth business day following the close of the comment period.

8. The time for issuance of this Report has been extended in writing by a representative of the Chief Administrative Law Judge due to the partial physical incapacity of the Administrative Law Judge following the close of the hearing record. This Report was issued within the time extension granted.

Other Rulemaking Requirements

9. The adoption of the proposed rules will not require the expenditure of public money by local public bodies within the meaning of Minn. Stat. § 14.11, subd. 1 (1992). The proposed rules do not adversely impact agricultural land within the meaning of Minn. Stat. § 14.11, subd. 2 (1992). The rules do not affect Spanish speaking people under Minn. Stat. § 3.9223, subd. 4 (1992). The proposed treatment parameters regulate health care providers for standards and costs. Therefore, Minn. Stat. § 14.115 (1992), relating to impact on small businesses, does not apply to this rulemaking proceeding pursuant to Minn. Stat. § 14.115, subd. 7(3) (1992). The Department, however, states that it has attempted to impose on health care providers only those requirements that it deems essential for quality, cost-effective care, irrespective of the size of the service provider. SONAR, p. 6.

Nature of the Proposed Treatment Parameters

10. Between 1979 and 1992, the Department of Labor and Industry has responded to a variety of legislative directives designed to streamline the provision of appropriate care to injured Minnesota workers while containing costs within reasonable bounds. Pages 1 and 2 of the Statement of Need and Reasonableness detail the interaction between the Legislature and the Department in attempts to control the cost of providing appropriate medical services while maintaining the quality of care.

11. In 1983, as a consequence of Laws of 1983 c. 290, the Legislature made a variety of initial amendments to Minnesota Statutes chapter 176. In that session law, the Commissioner was initially given authority to adopt rules regarding treatment parameters to restrict the provision of excessive care. Those provisions of the session law were amended by the Legislature in 1992 to require additional oversight by the Commissioner. Minn. Stat. § 176.83, subd. 5 (1992), was amended to state more explicitly the subjects that proposed rules must encompass to be in accordance with the statutory mandate.

12. In June of 1992, the Department of Labor and Industry solicited outside information from the public on the subject of treatment parameters. The Medical Services Review Board (MSRB), an advisory group of health care providers and others who advise the Commissioner, worked on developing treatment parameters. A list of the MSRB members is attached as Appendix 1 to the SONAR. The MSRB divided into committees, working on low back care, upper extremity care, and chronic pain management. The committees included representatives of physicians, surgeons and chiropractors. In addition, a physical therapist participated in the low back committee. Health care providers, including physicians in the chronic pain management area, participated in the chronic pain management meetings. Drafts of emergency rules were developed by the MSRB during the summer of 1992 and circulated to members of the Minnesota Medical Association, Minnesota Chiropractic Association, Minnesota Physical Therapy Association, Minnesota Occupational Therapy Association, Minnesota Orthopedic Society, radiologists, surgeons, chiropractors and other individuals.

13. The MSRB drafts, the written comments received in response to the solicitation of outside opinion and the comments from health care providers received both by the Department and the MSRB were reviewed by the Department's medical consultant, William Lohman, M.D. The rules, which represented a consensus position, with the possible exception of the doctors of chiropractic, were issued as emergency rules, pursuant to statutory authority, on February 1, 1993. Based on additional comments received on the rules, changes were made up to and through February 26, 1993. The emergency rules were approved by the Attorney General and became effective on May 18, 1993. The emergency rules were extended for an additional 180-day period pursuant to Minn. Stat. § 14.35 (1992). The temporary emergency rules expired for all purposes on May 13, 1994.

14. Between February 26, 1993, and the date of the hearing herein, the Department monitored the application and effect of the emergency rules and received additional comment. On July 19, 1993, the Department solicited outside opinion for the permanent rules through a publication in the State Register. In September of 1993, as a result of the Department's experience under the emergency rules and the comments received, the staff of the Department prepared a draft of permanent rules, based largely on the emergency rules. That draft was sent to the Medical Services Review Board for comment. In addition to review by the MSRB, the Department solicited comments from the interested public, including professional associations of health care providers, as detailed at page 3 of the SONAR. The Department believes that, with the exception of the chiropractic community of health care providers, the proposed permanent rules represent a consensus opinion. The rules have been formulated, as required by statute, with the assistance of the MSRB, reflecting comment received from health care providers.

15. The emergency rules, in conjunction with the Managed Care Plans and provider fee schedule, which were all authorized by the 1992 Legislature and implemented by the Department, have produced substantial cost savings in Workers' Compensation. Tr. 31-32. The savings in care costs have not been offset by increases in indemnity for lost time and permanent benefit payments. Tr. 32. The State of Minnesota, a self-insurer, has experienced a 25% decrease in medical expenditures for FY 94, as compared to FY 93. Tr. 40. In previous years, costs had risen dramatically each year. Tr. 36. During FY 94, the state, as a self-insurer for its employees, saved $1.7 million, without evidence of a decrease in the quality of care. Similar savings were being realized by insurers and other self-insurers generally. Tr. 40-41.

16. In the permanent rules, some minimum levels of care and maximum levels of treatment are prescribed. The Department decided that the parameters mandated by Minn. Stat. § 176.83, subd. 5 (1992), should be targeted to the injured worker. The Department also considered that Minn. Stat. § 176.83, subd. 5 (1992) required the proposed parameters to address diagnostic services, conservative or nonsurgical care, surgery, hospitalization, medical equipment and chronic pain for the most common work-related injuries, including back and upper extremity injuries. The Department, therefore, developed parameters for the entire episode of care for each of the diagnoses required by the statute. Rather than rigidly prescribing care, the Department determined that a middle ground framework should be used in which the health care provider assigns a clinical category

to each patient and proceeds, if necessary, through three stages of care: initial non-surgical care; surgical evaluation; and chronic management. For each of these three possible treatment scenarios, a wide variety of treatment modalities may be selected by the health care provider.

Statutory Authority

17. In its Statement of Need and Reasonableness, the Department outlines its statutory authority for adopting the proposed rules. SONAR, pp. 9-11. The authority for the proposed rules is also stated in Part 5221.6010 of the proposed rules. The Administrative Law Judge finds that the statutes relied upon by the Department give the Commissioner not only the authority to adopt the proposed rules, but a specific requirement that he do so. The necessary content of the rules, at least as regards the subject matters to be addressed, is also specifically stated in Minn. Stat. § 176.83, subd. 3 (1992). See, Tr. 52; Tr. 56-57; Tr. 58; Tr. 63; Tr. 70; Tr. 71-72; Tr. 82; Tr. 158; Comments of Blue Cross, Blue Shield of Minnesota; August 24, 1994, pp. 2-5.

18. Although no participant in the rulemaking hearing directly challenged the constitutionality of Minn. Stat. § 176.83, subd. 5 (1992), a number of legal arguments on the emergency rules have been considered by individual compensation judges, and the Workers' Compensation Court of Appeals. One case, Hirsch v. Bartley-Lindsay Co., is currently pending in the Minnesota State Supreme Court.

19. The Minnesota Trial Lawyers Association, the Department and several public witnesses have brought to the attention of the Administrative Law Judge the following proceedings involving the emergency rules in addition to Hirsch v. Bartley-Lindsay Co., previously noted. Pike v. Sullivan Services; Osweskey v. Wholesale Club (WCCA); Boileau v. A-Plus Industries; Rubin v. Greenstein & Sons; Larson v. Bertelson Bros.; Parnow v. Villa St. Vincent; and Jordan v. Howard Lumber Co.. In these proceedings, the compensation judge or special reviewing court declined to apply the emergency rules for a variety of reasons. These proceedings are considered here because it is appropriate to consider the same issues raised concerning the emergency rules as are also applicable to the permanent rules.

20. For the reasons hereinafter discussed, the Administrative Law Judge concludes that the cases previously noted do not limit the authority of the Commissioner to adopt rules regarding treatment parameters. SONAR, pp. 11-21; Submission of Minnesota Trial Lawyers Association, August 10, 1994; Submission of John Ward, Deputy Chief Administrative Law Judge, Workers' Compensation Division, July 13, 1994; Ex. P; Department submission, August 16, 1994.

It is initially argued that the treatment parameters do not bind workers' compensation judges who are free to apply compensation precedent developed in that special system over the past 75 years. Specifically, it is asserted that a workers' compensation judge, acting under Minn. Stat. § 176.135 (1992), is still free to proceed on a case-by-case basis to define the standard of reasonable or excessive care according to his or her own opinion. This argument is developed in Hirsch, Osweskey, Boileau, Rubin, Parnow, and Jordan. The reasoning appears to be as follows: Minn. Stat. § 176.135 (1992), is concerned with the provision of reasonable medical and chiropractic

care to injured workers. Because an individual compensation judge in his or her opinion believes that a certain fact situation is within a personal or precedential category of reasonable care, the opinion-writer concludes that the emergency rules conflict with Minn. Stat. § 176.135 (1992). None of the cited opinions attempts to harmonize Minn. Stat. § 176.83, subd. 5 (1992) or the emergency rules with Minn. Stat. § 176.135 (1992).

It is hornbook law that a rule, when properly promulgated, has the force and effect of law, the same as a governing statute. State v. Hopf, 323 N.W.2d 746, 752 (Minn. 1982); Cable Communications Board v. Nor-West Cable Communications Partnership, 356 N.W.2d 658, 667 (Minn. 1984); Minnesota-Dakotas Retail Hardware Association v. State, 279 N.W.2d 360, 365 (Minn. 1979); Minn. Stat. § 14.38, subd. 1 (1992). A rule is defined by statute as an agency statement of general applicability and future effect adopted to implement or make specific the law enforced or administered by the agency or to govern its organization or procedure. Minn. Stat. § 14.02, subd. 4 (1992).

21. A properly promulgated rule may not be disregarded any more than an applicable statute may be disregarded under some guise. In re Orr, 396 N.W.2d 657 (Minn. App. 1986). In Minn. Stat. § 176.371 (1992), which relates to an award or disallowance of compensation, it is specifically provided that the compensation judge's decision shall "include a determination of all contested issues of fact and law and an award or disallowance of compensation or other order as the pleadings, evidence, this chapter and rule require". The rules of practice of the Workers' Compensation Division of the Office of Administrative Hearings also require that a workers' compensation judge apply applicable rules which have the force and effect of law.

22. It is argued in the workers' compensation decisions submitted to the Administrative Law Judge that the emergency rules and, presumably, the permanent rules, should not be followed because they conflict with the duty of the compensation judge to determine reasonable treatment under Minn. Stat. § 176.135 (1992). None of the decisions noted consider the legislative mandate contained in Minn. Stat. § 176.83, subd. 5 (1992). It is also hornbook law, however, that before disregarding a rule or statute as being irreconcilably in conflict with another provision of law, one must try to harmonize statutes and rules in pari materia. Minn. Stat. § 645.26 (1992), places upon the interpreter the duty to reconcile apparent conflicts between provisions if possible. Moreover, one must read together and harmonize, if possible, provisions on the same subject matter. Minn. Stat. § 645.16 (1992); State v. Babcock, 175 Minn. 583, 222 N.W. 285 (1928); State ex rel. Interstate Air-Parts v. Minneapolis-St. Paul Metropolitan Airports Commission, 25 N.W.2d 718 (Minn. 1947); Foley v. Whelan, 219 Minn. 209, 17 N.W.2d 367 (1945); Lenz v. Coon Creek Watershed District, 278 Minn. 1, 153 N.W.2d 209 (1967); Hahn v. City of Ortonville, 238 Minn. 428, 57 N.W.2d 254 (1953). The same canons of construction apply to rules, as well as statutes. Minn. Stat. § 645.001 (1992).

The Administrative Law Judge believes that the Department has correctly identified the relationship between Minn. Stat. § 176.135 (1992), Minn. Stat. § 176.83, subd. 5 (1992), the temporary, expired treatment parameter rules and the permanent rules on the same subject matter considered in this proceeding. Minn. Stat. § 176.83, subd. 5 (1992), allows the Commissioner to adopt rules defining for purposes of Minn. Stat. § 176.135 (1992), reasonable treatment.

This definition, with appropriate safeguards, developed in conjunction with the medical advisory resources available to the Commissioner, is meant to substitute for the individual decision of the compensation judge in a particular proceeding. See, SONAR, pp. 15, 16. It is not open to the workers' compensation judge to determine independently under Minn. Stat. § 176.135 (1992), even if done with respect to previous caselaw, the definition of reasonable treatment. That determination, which the workers' compensation judge must apply, is contained within the rules. This reading of Minn. Stat. § 176.83, subd. 5 (1992), harmonizes that statute with Minn. Stat. § 176.135 (1992).

It is also suggested in some of the decisions previously noted that a fact-finding judge may disregard rules due to the lack of formality of the proceedings. The law is clear, in the absence of irreconcilable conflict, the fact-finder must apply all agency rules. Springborg v. Wilson & Co., 245 Minn. 489, 493, 73 N.W.2d 433; 435 (1955); State ex rel. Independent School District No. 6 v. Johnson, 242 Minn. 539, 548, 65 N.W.2d 668, 673 (1954); In re Orr, 396 N.W.2d 657 (Minn. App. 1986).

It might be possible to attempt to interpret Minn. Stat. § 176.83, subd. 5 (1992), to include a legislative intent that the rules promulgated by the Commissioner should not be binding on workers' compensation judges in their determinations. That would, however, introduce a type of Alice-in-Wonderland logic to workers' compensation law where the governing parameter would differ depending on whether a health care provider contested a matter before a compensation judge. As previously noted, the very definition of a rule is that it has the force and effect of law and is to make specific the statute being considered. Finally, there is no evidence in Minn. Stat. § 176.83, subd. 5 (1992), that workers' compensation judges would not be required to interpret and apply both temporary and permanent treatment parameters just as they apply fee schedules contained in rules, disability schedules contained in rules and a variety of other departmental rules.

The Administrative Law Judge also accepts the reasoning of the Department, contained in the SONAR, that Minn. Stat. § 176.83, subd. 5 (1992), was not intended by the Legislature to require the Commissioner to merely codify existing workers' compensation caselaw. SONAR, pp. 11-13.

It has also been suggested that the mere length of the rules and their technicality do not promote "quick and efficient" delivery of medical benefits as required by Minn. Stat. § 176.001 (1992). SONAR, pp. 16-18. In response to legislative direction, the Department, through the Commissioner, has prescribed a number of extremely detailed sets of rules. The approach of the Department appears, currently, to favor specificity. It is not the function of the Administrative Law Judge to fashion the most reasonable set of rules that might be adopted, as long as the Department has statutory authority to adopt the proposed rules, demonstrates the need for and reasonableness of the proposed rules and does not propose a substantial change after the publication of the rules. Differences in approach, specificity or comprehensiveness should be addressed to the Commissioner or the chief executive who is responsible for his appointment. See, Finding 25, infra.

23. Some of the caselaw decided by workers' compensation judges and the Workers' Compensation Court of Appeals either relies upon or obliquely

references vested rights that injured workers may possess in particular treatments. The argument advanced is that retroactive treatment parameters are illegal. See, Hirsch, Pike, and Larson. The Administrative Law Judge will consider those cases and record comments regarding retroactivity in conjunction with Minn. Rules, pt. 5221.6020, subp. 2, infra.

General Findings

24. Some of the proposed rule provisions received no negative public comment and were adequately supported by the extensive Statement of Need and Reasonableness filed by the Department. This Report will not specifically address those provisions in the discussion following. It is found that the need for and reasonableness of the proposed rules which are not hereinafter discussed have been demonstrated and that the Commissioner has statutory authority to adopt them. Also, in response to public comment at the hearing and based on further review of the proposed rules, the Department proposed changes to the proposed rules. Changes to the proposed rules are attached hereto as Exhibit A. With respect to those amendments to the rules that did not receive public comment, the changes involve primarily corrections and clarifications and do not change the intent of the rules as originally proposed. Therefore, they are not hereinafter discussed. The Administrative Law Judge finds that the amendments to the proposed rules suggested by the Department which did not receive public comment do not constitute prohibited substantial changes within the meaning of Minn. Stat. § 14.15, subd. 3 (1992), and Minn. Rules, pt. 1400.1000, subp. 1 and 1400.1100 (1990). The Agency has also demonstrated the need for and reasonableness of these amendments to the rules that did not receive adverse public comment. Proposed modifications which did receive public comment will be discussed individually under the appropriate section of the proposed rules.

The balance of this Report will address the degree to which the Department has documented its statutory authority, and demonstrated the need for and reasonableness of the remaining rule provisions.

25. An agency may demonstrate the reasonableness of its proposed rules by showing that the rule is rationally related to the end sought to be achieved. Blocher Outdoor Advertising Co. v. Minnesota Department of Transportation, 347 N.W.2d 88 (Minn. App. 1984). An agency is entitled to choose among possible alternative standards, so long as the choice is rational. It is not the role of the Administrative Law Judge to determine the "best" rule or to determine whether commentators' suggested alternatives, which may also be reasonable, are preferable.

General Public Comments

26. A number of individuals at the public hearing testified about general support for the proposed rules. Tr. 297-98; Tr. 300; Tr. 351; Tr. 447. The Administrative Law Judge also received a variety of public comments which generally placed organizations on record as supporting the proposed rules in their entirety. See, Comments of State Fund Mutual Insurance Company, August 19, 1994; Comments of Smead Hastings Manufacturing Company, August 18, 1994; Comments of the Minnesota Chamber of Commerce, August 19,

1994; Comments of Dr. Jeffrey Bonsell, August 2, 1994; Comments of Scott A. McPherson, M.D., July 25, 1994, p. 1; Comments of the Minnesota Self-Insurers Association, August 17, 1994; Comments of the Workers' Compensation Administrative Task Force, August 18, 1994; Comments of Blue Cross Blue Shield of Minnesota, August 23, 1994, cover letter. The Administrative Law Judge also received some comments in general opposition to the treatment parameters. Tr. 132; Tr. 532; Comments of Timothy G. Vestal, August 24, 1994; Comments of the Minnesota Medical Association, August 24, 1994, p. 1, par. 1a; comments of Dr. John Stark, August 24, 1994; Testimony of John Stark, Tr. 305-36, 319, 330, 333, 338-39, 462, 477-78, 484-85. General comments without reason stated either in support or opposition to the proposed rules are given little weight by the Administrative Law Judge in determining whether the Department has demonstrated the need for and reasonableness of the proposed rules. To the extent that general comments also include specific statements about portions of the proposed rules, such comments will be considered as each discussed portion of the proposed rules is considered.

Part 5221.6020 -- Purpose and Application

27. Subpart 1 of this Part states that the rules are not intended to affect any determination of liability or to expand or restrict a health care provider's scope of practice. This subpart did not receive public comment. The Agency has demonstrated the need for and reasonableness of subpart 1 of Part 5221.6020. SONAR, pp. 21-22.

28. Subpart 2 of Part 5221.6020 describes the application of the proposed rules. A requirement for all treatment rendered under the practice parameters is that treatment be medically necessary. The subpart also states that in the absence of a specific parameter, applicable to a particular case, all applicable general parameters govern. This subpart does not, however, make it clear that Part 5221.6050, subp. 8 governs and authorizes permissible departures from the parameters under five particularly stated circumstances. It is clear that both the general and specific parameters are meant to apply to most situations where they would otherwise be applicable. When, however, the requisite conditions specified in Part 5221.6050, subp. 8 exist, reasonable departures from the parameters are available. As stated by the Agency in its Statement of Need and Reasonableness, for a treatment which is not in accordance with an applicable specific parameter or, in the absence of a specific parameter, the general parameter contained in Part 5221.6050, a deviation from the standards is available. That relationship should be stated in Part 5221.6020, subp. 2, "Application". In the absence of such a statement, it is not apparent to the reader that exceptions or deviations may be appropriate under identified circumstances. Subpart 2 of Part 5221.6020, therefore, is impermissibly vague and confusing to the reader. See, Thompson v. City of Minneapolis, 300 N.W.2d 763, 768 (Minn. 1980); In re Charges of Unprofessional Conduct Against N.P., 361 N.W.2d 386, 394 (Minn. 1985).

29. To correct the defect, the Agency must insert in Part 5221.6020, subp. 2, at line 24, a statement to the effect that the rules are guidelines generally applicable but that deviations from the parameters, both general and specific, are provided for in Part 5521.6050, subp. 8 under the circumstances identified in that subpart. If the Agency does not intend all of Parts 521.6010-522.6600 to be subject to the availability of a departure under Part

5221.6050, subp. 8, they must so state and specify in the appropriate place in the rules the parts for which a variance would be available under the conditions specified in Part 5221.6050, subp. 8.

30. Subpart 2 of Part 5221.6020 also applies the treatment parameters to all injuries irrespective of the date of injury. All future treatment provided to injured workers would be governed by the rules, irrespective of the date of injury. Consideration of this "retroactive" application of the rules involves two concepts which have been somewhat confused in decisions involving the emergency rules. The first consideration is statutory authority to adopt rules that are or may be considered "retroactive". The second consideration is whether applying the treatment parameters to past dates of injury would illegally withdraw from employees some vested right or benefit, as would be involved with an impairment of contract or a right that has otherwise legally matured.

Before analyzing whether the Department has authority under the governing statutes to make the proposed rules "retroactive" to dates of injury occurring before the effective date of the rules, it must be determined whether such an application to future treatment is a "retroactive" application of the rules. Minn. Stat. § 645.21 (1992), provides that no law shall be construed to be retroactive unless clearly and manifestly so intended by the Legislature. That statute makes retroactivity a function of the authority granted to the Agency by the Legislature. Article 1, section 11 of the Minnesota Constitution provides that no bill of attainder, ex post facto law, nor any law impairing the obligations of contract should ever be passed. This parallels Article 1, section 10 of the United States Constitution.

31. The Administrative Law Judge concludes that applying the treatment standards to future care under the circumstances herein discussed is not a retroactive application of the rules within the meaning of the law. Troy v. City of St. Paul, 155 Minn. 391, 193 N.W. 726 (1923); Bailey v. Mason, 4 Minn. 546 (Gil. 430) (1860). The treatment parameters do not attempt to go back in time and affect or change a past event. They apply only to future medical treatment. As recognized by the Department in the SONAR, pp. 20-21, what the injured worker is entitled to receive has not changed. The worker is entitled to appropriate or reasonable and necessary care. All medical and treatment standards change over time. At one time, it was thought that passive care should be emphasized. The more modern approach is to empower the worker and encourage active participation by the worker in improving his or her own condition. It is recognized that excessive passive therapy can reinforce the dependence of the patient and, ultimately, prove counter-productive. The argument that somehow application of the treatment standards involves a retroactive application of the rules to a past transaction is like arguing that someone injured before the invention of MRI scanning equipment in approximately 1986 would not be entitled to an MRI test in the future, if necessary, because that test was unknown as of the date of his or her injury. It would also be like arguing that a person would have a right to continue treatments that have been determined to be ineffective because such treatments were available on the date of his or her injury. It strains credulity to suggest that a health care provider should provide specific care on the basis of the patient's workers' compensation date of injury. In this regard, application of the rules to past dates of injury is similar to the situation in which a right is defined or vests after the effective date of the rule,

when the treatment is actually provided. See, Midwest Mutual Insurance Co. v. Bleick, 46 N.W.2d 435, 438 (Minn. App. 1992); Calder v. City of Crystal, 318 N.W.2d 838 (Minn. 1982).

Even assuming that considerations similar to Minn. Stat. § 645.21 (1992), apply, it is clearly the intent of the Commissioner that the rule be applied to past dates of injury. Minn. Rules, pt. 5221.6020, subp. 2. The law generally provides that an administrative agency may make a rule retroactive as long as it is reasonable to do so and no vested rights are disturbed, no contract impaired and due process is provided. Ashbourne School v. Commonwealth Department of Education, 403 A.2d 161, 165 (Pa. 1979). The Minnesota court has recognized that an administrative agency may adopt an otherwise retroactive rule if it is reasonable to do so and no vested rights are disturbed. Mason v. Farmers Insurance Companies, 281 N.W.2d 344, 348 (Minn. 1979). See, Summit Nursing Home v. United States, 572 F.2d 737 (Ct. Cl. 1978). The court in Mason appears to adopt a test of reasonableness. It only requires that the rule itself state the intended retroactivity and not disturb vested rights. As previously discussed with respect to the issue of whether a retroactive application is involved at all, treatment decisions should be based on the most recent, medically supportable treatment parameters, not on some standard of practice applicable in the past. Hence, under Mason, supra, if applying these rules to dates of injury prior to the effective date of the rules involves a retroactivity, the statement in the rule that retroactivity is intended satisfies Minn. Stat. § 645.21 (1992).

Apart from the holding of the court in Mason, supra, if specific legislative intent for retroactive rules were required, the Department has detailed in the SONAR, legislative history and contemporaneous additional legislation from which an intent to make the treatment standards retroactive can be attributed to the Legislature. SONAR, pp. 19-20.

Apart from the issue of the application of Minn. Stat. § 645.21 (1992), is the issue of the impairment of a vested right or an abrogation of contract, if the parameters are applied to dates of injury prior to the effective date of the rules.

32. The Administrative Law Judge concludes that there is no substantive change in the rights of either employees or employers by adoption of permanent rules which merely interpret the statutory mandate contained in Minn. Stat. § 176.135, subd. 1 (1992), that the injured workers is entitled to receive health care "reasonably required . . . to cure and relieve" the employee. The rules merely define what is to be considered reasonable according to the most current standards of medical practice. As previously discussed, it would not make sense to hold that an employee who was injured has a "vested" right in any particular treatment or course of treatments as long as reasonable care is provided to the employee.

Nor does the Administrative Law Judge believe that adoption of the rules would impermissibly compromise existing contracts of settlement or compensation orders entered in cases with a date of injury prior to the effective date of the rules. Under the analysis of the court in Midwest Family Mutual Insurance Co. v. Bleick, 486 N.W.2d 435, 438-40 (Minn. App. 1992), the argument of an impairment of vested right to particular treatment is appropriately rejected. Initially, the rules do not substantially impair a

contractual obligation. What the injured worker is entitled to receive by virtue of a previous settlement or compensation order is appropriate treatment. As discussed at several points previously, the rule does not change that entitlement. It merely defines the treatments to be provided in accordance with the most recent thinking of the medical, chiropractic and physical therapy communities. See, Findings 117-120, infra. The second part of the analysis adopted by the court in Midwest Family Mutual Insurance Co., supra, that the enactment must be for a public purpose as opposed to a private purpose is also clearly met. The purpose of adopting the treatment parameters is to provide the most effective treatment at the most reasonable cost. The most efficient operation of the workers' compensation system is clearly to advance a public purpose. As to the third element of the test, reasonable means, the Legislature has determined that treatment parameters are reasonable and appropriate and, in the amendments to Minn. Stat. § 176.83, subd. 5 (1992), mandated the promulgation of rules governing particular subject matters. The 1992 legislative amendment authorizing the rules is reasonably and appropriately tailored to meet the Legislature's stated goals.

The general rules in workers' compensation cases is that the rights and liabilities of the parties are fixed at the time of the injury. Halverson v. Rolvaag, 274 Minn. 273, 143 N.W.2d 239 (Minn. 1966). The Minnesota Supreme Court has held that a retroactive change in a vested obligation of an employer to pay monetary benefits is unconstitutional. Yeager v. Delano Granite Works, 250 Minn. 303, 308, 84 N.W.2d 363, 366 (1957). This is based upon the contractual nature of the workers' compensation system. A substantive or vested right is defined as one which arises upon a contract and which has been so far determined that "nothing remains to be done by the party asserting it." Yeager, 250 Minn. at 307, 84 N.W.2d at 366.

In contrast, the Minnesota Court has held that non-monetary benefits do not vest until liability has been established. Non-monetary benefit changes may be applied retroactively. Gutz v. Honeywell, Inc., 399 N.W.2d 557 (Minn. 1987); Solberg v. FMC Corp., 325 N.W.2d 807, 35 W.C.D. 314 (Minn. 1982); Sherman v. Whirlpool Corporation, 386 N.W.2d 221 (Minn. 1986). Medical benefits are such benefits. With medical benefits, the employee does not have a vested right to any particular medical treatment until the employee proves the medical treatment is reasonable and necessary. See, Wright v. Kimro, Inc., 34 W.C.D. 702 (W.C.C.A. 1982); Wylie v. Dan's Plumbing & Heating, 47 W.C.D. 235 (W.C.C.A. 1992). The employee must meet this burden with respect to each and every treatment obtained or desired. Id. An employee's right to specific medical treatment "vests" when proven reasonable and necessary, when it is rendered, or proposed to be rendered, not on the date of injury.

The Administrative Law Judge, therefore, finds that the rules are not inappropriately retroactive as applied to dates of injury prior to the effective date of the rules. Further, the rules do not impair the vested rights of any person.

Part 5221.6040. Definitions

33. All of the definitions contained in part 5221.6040 are based upon current medical usage. The only suggested modification to the definitional sections is contained in the August 24, 1994, submission of Dr. John G. Stark,

M.D., in the divider which annotates the proposed rules. Dr. Stark suggests amending subpart 10 dealing with medically necessary treatment to include "or the predisposing factors or effects which lead to the condition". The Administrative Law Judge rejects this suggested amendment to subpart 10 of this Part. It is not clear what predisposing factors or effects which lead to the condition Dr. Stark is referring to in his comments. Moreover, the term "condition" in the same sentence is defined as findings "relating to a current claim for compensation". Part 5221.6040, subd. 4. This subpart only applies to a "compensable injury". These rules do not propose to affect liability determinations. Part 5221.6020, subp. 1. Hence, the suggestion of Dr. Stark for the initial amendment to subpart 10 of this Part is inappropriate.

34. Dr. Stark also proposes to amend subpart 10 by including language at the end of the subpart recognizing the services of nurses and social workers to be within the scope of medically necessary treatment. The Administrative Law Judge agrees with the Department in its August 31, 1994, response to this proposed change that it would be inappropriate to single out some health care providers authorized to provide treatment to the exclusion of other health care providers, which are defined in Minn. Stat. § 176.011, subd. 24 (1992).

35. Dr. Stark also proposes to add to the 13 subparts proposed by the Department additional definitions of the following terms: Insurer; Credentials; Administrative Credentials; Advocacy; Provider Credentials; Injury; Disease; and NASS. For the reasons stated in the submission of the Department dated August 31, 1994, relating to the proposed definitions of Dr. Stark, the Administrative Law Judge rejects the amendments to this Part he proposes. See also, Comment of Roby C. Thompson, Jr., M.D., August 30, 1994.

36. The Administrative Law Judge finds that subparts 1-3 of this Part are needed and reasonable. SONAR, pp. 25-26.

Part 5221.6050. General Treatment Parameters; Excessive Treatment; Prior Notification

37. The only adverse public comment received on subpart 1 of this Part is contained in the August 24, 1994, submission of Dr. Stark in the divider suggesting amendments to the proposed treatment parameters. Dr. Stark suggests three amendments to this subpart. For the reasons stated in the August 31, 1994, submission of the Department with respect to the three proposed amendments, the Administrative Law Judge rejects the amendments to this subpart suggested by Dr. Stark.

38. Subpart 3 of this Part relates to non-operative treatment. Dr. Stark proposes to amend this subpart by adding the following language at the end of the subpart: "Relative treatment will be assessed based upon appropriate credentials, knowledge and experience." As noted by the Department in its August 31, 1994, submission, the language proposed by Dr. Stark is confusing. The rule does not require the provider to assign a relative value to non-operative treatment. It is also not clear whether Dr. Stark is suggesting a hierarchy of credentials and that only certain individuals be allowed to make treatment decisions. If that is Dr. Stark's intention, he suggests no way to identify such individuals. The Administrative Law Judge, therefore, rejects the amendment to subpart 3 of this Part proposed by Dr. Stark.

39. The Administrative Law Judge finds that subparts 1-3 of this Part are needed and reasonable. SONAR, pp. 25-26.

40. Subpart 5 of this Part deals with referrals between health care providers. One commentator noted in item B of this subpart that an exchange of information on referrals is also necessary in the event that care is transferred. The Department, in response to the public comment, proposes to amend subpart 5, item B, as indicated in Exhibit A hereto, after the word "consultation" in line 22 of the Revisor's draft by adding the phrase "or transfer of care". The Department has demonstrated the need for and reasonableness of this subpart, as amended. Since the amendment is merely a clarifying amendment adopted in response to public comment, it does not constitute a prohibited substantial change within the meaning of Minn. Stat. § 14.15, subd. 3 (1992) and Minn. Rules, pt. 1400.1000, subp. 1 and 1400.1100. Minn. Rules, pt. 1400.1100 defines substantial change in terms of factors therein stated. Rather than repeat the criteria each time hereinafter that an amendment is proposed, the Administrative Law Judge will state whether the amendment was clarifying only, was in response to public comment, or materially expands the scope of the proposed rule.

41. Dr. Stark, in his submission of August 24, 1994, proposes to amend item A of subpart 5 of this Part by adding at the end of the subpart the following: "The injured employee may decide consistent with 'patients bill of rights' to pursue higher level care." Dr. Stark does not define a "higher level care". The rules do not limit an employee's right to change doctors if the employee chooses to do so. This right is granted by a previously adopted rule, Minn. Rules, pt. 5221.0430 (1992). If the employee is dissatisfied with the application of the treatment parameters to his or her injury, the dispute resolution process described in Part 5221.6050, subp. 7(C) of the proposed rules would apply. The Administrative Law Judge, therefore, rejects the proposed amendment to subpart 5 suggested by Dr. Stark.

42. Subpart 6 of this Part relates to communication between health care providers and consideration of prior care. The Department proposes to amend item B of the subpart, as indicated in Exhibit A attached hereto. This clarifying restructuring of the subpart was made in response to providers commenting that the rules should state that if the provider has asked the patient about prior care and receives erroneous information, the provider should not be denied payment. The clarifying amendment allows the decision-maker to determine whether an employee is liable for the cost in such cases. The amendment to item B clarifies that a provider is prohibited from repeating treatment "if the employee has reported that care for an injury has been previously given". See, Comment of the Minnesota Medical Association, August 24, 1994, p. 3.

43. Dr. Stark, in his submission of August 24, 1994, proposes to amend subpart 6 in items B and C. The amendment proposed by Dr. Stark to item B is merely stylistic and is not necessary or reasonable. The proposed amendment to item C has been clarified in the amendment proposed by the Department and discussed in the previous Finding.

44. Subpart 6 of this Part, as amended, is found to be both needed and reasonable. The Department amendment previously discussed is not a prohibited

substantial change within the meaning of Minn. Stat. § 14.15, subd. 3 (1992) and Minn. Rules, pt. 1400.1000, subp. 1 and 1400.1100 (1992), since the amendment is only one of clarification made in response to public comments at the hearing.

45. Subpart 7 of Part 5221.6050 relates to determinations of excessive treatment, notice of denial to health care providers and the employee and the expedited processing of medical requests. Item A of subpart 7 received no public comment and is found to be needed and reasonable as proposed.

46. The Minnesota Medical Association commented that item B of subpart 7 of this Part was helpful and necessary in that it required an insurer to provide the employee and health care provider with written notice of the reason for denial and the allowance of deviations from the treatment parameters under stated circumstances. Comments of Minnesota Medical Association, August 24, 1994, p. 4. Another commentator described a situation in which the insurer denied payment for a health club membership when documentation of attendance was not provided, even though payment had previously been made without such documentation. Letter of Joseph Smisek, July 25, 1994.

47. In response to that public comment, the Agency proposes to amend item B of this subpart by adding the following new language at the end of the subpart:

> The insurer may not deny payment for a program of chronic management, for an individual employee, that the insurer has previously authorized, either in writing or by routine payment for services, without providing the employee and the employee's health care provider with at least 30 days notice of intent to apply any of the chronic management parameters in Part 5221.6600 to future treatment. The notice must include the specific parameters that will be applied in future determinations of compensability by the insurer.

See, Exhibit A. The change was proposed by the Agency in response to public comment requiring specific notice where prior payment has been made in a chronic management situation of the intent of the insurer to apply specific parameters. This will allow the employee and the health care provider to comply with documentation requirements. It would solve the problem discussed by Mr. Smisek. Since the proposed amendment to this item B was made in response to public comment at the hearing and does not expand the application of the rules, it is not an impermissible substantial change within the meaning of Minn. Stat. § 14.15, subd. 3 and Minn. Rules, pt. 1400.1000, subp. 1 and 1400.1100 (1992).

48. Dr. Stark, in his submission of August 24, 1994, proposes to amend subpart 7 of this Part, in item B by requiring that a denial of payment must be made by a clinician of similar credentials and experience as the treating clinician. Dr. Stark also would include the following language: "literature based support and academic debate will surround each decision". As will be discussed, the Administrative Law Judge believes that it is appropriate to have decisions regarding the application of the rules made by individuals with at least a minimum level of qualification. The Administrative Law Judge does

not believe, however, it is feasible to require a person applying the rules to a claim to have both education and experience similar to the treating clinician in every case. Dr. Stark does not indicate how the requirement of "literature based support and academic debate" could or would ever be enforced. The Administrative Law Judge, therefore, rejects the initial amendment to item B of subpart 7 of this Part suggested by Dr. Stark. The second amendment to item B of subpart 7 suggested by Dr. Stark is rejected for the reasons stated in the August 31, 1994, submission of the Department.

49. Items C and D of subpart 7 did not receive public comment and are found to be both needed and reasonable.

50. As a consequence of Findings 45-49, supra, the Department has established the need for and reasonableness of subpart 7, as amended, by an affirmative presentation of fact.

51. Subpart 8 relates to departures from treatment parameters. The five items list the five situations in which there is reason for departure from the treatment standards. One commentator asked whether all items must be present before a departure from a general or specific parameter is allowed. Comment of Liberty Mutual Insurance Company, August 22, 1994, p. 1. In response to the public comment, the Department proposes to amend subpart 8 of this Part at line 22, page 10 of the Revisor's draft, by adding the word "one" after the word "any" in that line. See, Exhibit A. Since the change is merely a clarifying amendment making specific the original intent, it is not a prohibited substantial change.

52. Item D of the subpart requires treatment to meet two of three stated criteria before it can be continued. If the treatment is, therefore, both reasonable and necessary, it may be continued past the time parameters authorized by the criteria as long as it improves the employee's subjective complaints of pain and either improves the employee's objective clinical findings or the employee's functional status.

53. Limitations on care, particularly passive care, are discussed at a later juncture in this Report. See, Finding 117-120, infra. The Administrative Law Judge, however, desires to note that item E of this subpart has been relied upon by a number of commentators to allow an exception for treatment necessary to regain an individual's functional status. Hence, if an occasional chiropractic treatment is necessary to regain functional ability, it would be authorized under item E upon appropriate documentation. Tr. 259; Tr. 260; Tr. 90; Tr. 288. The Department also so states that intention in its response to the letter of Mr. Joseph Smisek dated July 25, 1994, contained in the Department's August 24, 1994, written comments. It is with that understanding and in reliance upon the assertions by the Department of the intent of this item that the Administrative Law Judge finds that necessary and reasonable treatment is not denied but only reasonably defined by these parameters.

54. The Administrative Law Judge interprets subpart 8 to allow a departure from a general and/or specific treatment parameter in individual cases. If it is the intention of the Department to exclude any treatment parameter contained in parts 5221.6050 through 5221.6600 from subpart 8 it should so state that intention specifically in the introduction to subpart 8. Such a change, if based on the record, would not be a prohibited substantial

change. In the absence of any limitation adopted by the Department, the subpart applies to every treatment parameter contained within Parts 5221.6050 - 5221.6600.

55. As a consequence of Finding 51-54, supra, the Administrative Law Judge finds that subpart 8, as amended, is both needed and reasonable.

56. Subpart 9 of this Part relates to prior notification and the relative responsibility of health care providers and insurers. The purpose of subpart 9 is to promote communication among all parties where the treatment is likely to involve an invasive in-patient procedure, where the treatment is costly, or where the treatment as proposed is beyond the parameters contained in the rules. Having procedures for communication between the parties is likely to reduce litigation on the appropriateness of treatment because the rules require discussion before treatment is provided. The prior notification and insurer response rules provide a structured system for documenting the necessity of treatment or for treatment outside the parameters. SONAR, p. 31.

57. In response to public comments, the Department proposed to amend item C in line 27 of page 12 of the Revisor's draft, item C(4), line 30 at page 13 of the Revisor's draft and at line 2, page 14 of the Revisor's draft, as shown in Exhibit A attached hereto. The changes to subitem (6) and the introductory paragraph in item C were discussed by Mr. Hoyme in his testimony and proposed in Exhibit X. Tr. 289-290. The same change was recommended by the Medical Services Review Board on August 18, 1994. The change to subitem (4) corrects an erroneous citation. The change to subitem (5) was suggested by the Minnesota Medical Association in its submission of August 24, 1994. Since the changes merely clarify subpart 9, do not expand the scope of the rule and were made in response to public comments, the amendments proposed by the Department to this subpart do not constitute prohibited substantial changes.

58. Therapy Werks, in its comment of August 3, 1994, stated that the requirement of prior authorization results in tremendous paperwork for providers who see their primary responsibility as patient treatment. The Administrative Law Judge is cognizant of the documentation requirements placed on providers by this subpart. However, such documentation is necessary for the orderly review of service requests and to document the necessity for treatment.

59. St. Cloud Orthopedic Associates Ltd., in its comment of July 5, 1994, commented that the 45-day period authorized at line 6, page 14 of the Revisor's draft is too long a period of time to wait for surgery for a variety of conditions. As noted by the Department, however, the MSRB and insurers have agreed that the time frame of 45 days for scheduling an independent medical exam, updating the report, and authorizing or denying payment was reasonable. It should also be noted that this subpart does not apply in cases of emergency surgery.

60. The Administrative Law Judge finds that subpart 9 of this Part, as amended, is needed and reasonable.

61. Subpart 10 of this Part did not receive adverse public comment. It is discussed in the SONAR beginning at page 34. The Department has

established the need for and reasonableness of subpart 10 by an affirmative presentation of fact. It is found to be needed and reasonable.

62. Subpart 11 deals with outcome studies. As originally drafted, the Commissioner had discretion as to whether outcome studies would be conducted. A number of commentators stated that such studies should be mandatory. The rationale for making such studies mandatory is that the effectiveness of the treatments authorized by the parameters cannot be evaluated without outcome studies. See, e.g., Comments of the Minnesota Medical Association, August 24, 1994; Statement of Dr. Jeffrey Bonsell, August 2, 1994, p. 3.

63. The Commission proposed an amendment to this subpart making outcome studies mandatory. See, Exhibit A hereto. The Department agreed with the public comments for the reasons previously discussed.

64. In addition to the comments previously noted, Dr. Stark, in his submission of August 24, 1994, recommended amendments to items D and G and additional items H and I. The amendments to items F and G proposed by the Department satisfy the request of Dr. Stark for amendments to items D and the addition of an item G. For the reasons discussed in the August 31, 1994, submission of the Department, the Administrative Law Judge rejects the added items H and I suggested by Dr. Stark.

65. The Department has demonstrated the need for and reasonableness of subpart 11, as amended, by an affirmative presentation of fact in the record. Because the amendments to subpart 11 do not materially expand the scope of the rules, are made in response to public comments, and do not go to a different subject matter, they are not prohibited substantial changes.

66. A variety of commentators, principally health care providers, argued that there should be some minimum credentialing of persons who make decisions for the insurers on the payment of claims involving the application of the proposed rules. A number of insurance companies stated that they currently use some medical personnel including chiropractors, doctors and registered nurses to review some or selected claims. The Department also responded that it is undertaking educational efforts regarding the application of the proposed rules and stated that any perceived problem will largely resolve itself when current managed care programs become virtually universal.

67. A sampling of the comment received by the Administrative Law Judge on the subject matter of minimum credentials is as follows: Tr. 491; Tr. 464; Tr. 443; Tr. 432; Tr. 430; Tr. 426; Tr. 383; Tr. 307; Comments of the Minnesota Medical Association, August 24, 1994; Comments of Health Werks, August 5, 1994; Comments of Honeywell, Inc., August 29, 1994; Comments of the Minnesota Nurses Association, August 30, 1994; Comments of Neurosurgical Associates Ltd., August 31, 1994; Comments of Western National Mutual Insurance Co., August 30, 1994; Comments of Metropolitan Spine Group, submitted on behalf of Dr. John G. Stark, M.D., August 26, 1994; Supplemental Information Related to the State of Minnesota Hearings, John G. Stark, M.D., August 24, 1994; Letter of Mr. Leo Eide, Assistant Commissioner, August 31, 1994, included in the Department's August 31, 1994, submission.

68. The Administrative Law Judge realizes that the Department hopes for evolutionary change through education and the use of medically credentialed

person as reviewers. The Administrative Law Judge is also aware that requiring oversight of the claims process by medically credentialed individuals may increase the cost of claims administration to workers' compensation insurance companies. However, the record here compels the conclusion that there must be some avenue for obtaining review by a minimally credentialed person. The Administrative Law Judge finds that in the absence of a rule stating minimum credentials for at least the review of payment decisions involving the application of the rules on a requested basis the treatment parameters would not be reasonable as applied.

69. To correct the defect the agency must include in this general parameter or in another section of the rules a provision based on the record related to minimum credentials for claims personnel. The Administrative Law Judge, as a condition of need and reasonableness requires that claims at least be reviewed upon request either by an individual with some stated credential in medical or chiropractic treatment or by an individual who has participated in the "intensive education courses" that the Department refers to in its letter from Leo M. Eide, Assistant Commissioner, contained in the Department's August 31, 1994 submission to the Administrative Law Judge.

70. So long as the curative rule is based on the record of this proceeding, the amendment would not constitute a prohibited substantial change. It is required in response to a number of public comments, does not significantly expand the rules to a different subject matter and was fairly raised to invite comment by the Notice of and Order for Hearing. When such an amendment is developed by the Department, appropriate changes should also be made to those subparts of this Part that deal with notice. That is, the availability of review by a person with the required credential should be stated in any notice of denial of payment by the insurer.

Part 5221.6100, Parameters for Medical Imaging

71. Subpart 1 of this Part relates to general principles applicable to all medical imaging performed. Subpart 1 includes items A, B, C, D, and E. Items under subpart 1 represent the consensus of the Medical Services Review Board and the majority opinion of the medical community. They are also similar to workers' compensation treatment parameters written in Massachusetts, Rhode Island and Colorado. SONAR, p. 34.

72. Item A of this subpart requires the health care provider to perform initially the single most useful imaging technique. The results of that study must be obtained before ordering any other imaging studies. It is the position of the Department that this requirement will prevent unnecessary studies, that is, those not required for an appropriate treatment plan. A number of commentators discussed the requirement of the "most effective imaging study" for diagnosing the patient's condition. Dr. John Stark, in his comments of August 24, 1994, states that there are at least 12 factors that should be examined in making a decision regarding an imaging study. These factors include: safety; expense; efficacy; sensitivity; information type; patient tolerance; position dependence; availability of equipment and specialized personnel; time dependence; surgical definition and planning; idiosyncratic or individual presentation; and proof, confirmation and completeness. It is Dr. Stark's position that, particularly, a surgeon should

not proceed on the basis of a single test. Tr. 496-504, Tr. 541, Tr. 554. It is Dr. Stark's position that the "single best imaging" requirement places an unwise limitation on treating clinicians. Dr. Stark also believes that the single best study requirement may harm the most seriously ill individuals like those potentially suffering from cauda equina syndrome which has a variable presentation which is not always reflected by any single imaging technique. Dr. Scott A. McPherson, in his comments of July 25, 1994, states that he believes that it may be occasionally necessary to order two imaging modalities that provide mutually exclusive information. Dr. McPherson suggests that the rule be altered to allow "those imaging studies that are indicated". Dr. Joseph Perra testified that, under his interpretation of item A, an MRI would be required for any injury involving the low back because "in no circumstances is any other test or in very few circumstances is any other test more effective than the MRI", Tr. 394.

73. The Administrative Law Judge agrees with the Department in its response of August 31, 1994 to Dr. Stark's criticism of the "single best test" approach of item A. In all circumstances there is a best test to begin the evaluation of a patient's complaint. This is the test which provides the most information with respect to the most likely etiology of the patient's condition. The results of that test will determine whether further testing is appropriate, or necessary. In selecting the most appropriate initial test, of course, the clinician must make a reasoned judgment involving the 12 factors suggested by Dr. Stark in his August 24, 1994 submission. The results of the first most appropriate test should determine whether further testing occurs. The approach taken by the rules is supported by the Medical Services Review Board and by attachment 13 to the Department's August 24, 1994 submission. That article from the Spine Medical Journal states that the "single best test" should be used and the use of duplicative tests should be avoided.

74. The Department has proposed, in its submission of August 31, 1994, to amend item A as indicated in Exhibit A hereto. The amendments to item A and subsequent amendments to items D and E of this subpart are clarifying amendments offered by the Department in response to Dr. Stark's testimony at the hearing and his submission of August 24, 1994. The amendments are merely clarifying in nature and are made in response to public comment; they do not constitute prohibited substantial changes.

75. The Department has established the need for and reasonableness of item A of subpart 1, as amended, by an affirmative presentation of fact.

76. Items B and C of this subpart did not receive any adverse public comment. Items, B and C of this subpart are found to be both needed and reasonable.

77. Item D of this subpart relates to repeat imaging. It discusses circumstances under which a clinician may have taken the same views of the same body part with the same imaging modality. The item would prohibit repeat imagining except under circumstances described in subitem (1) through subitem (6). The purpose of item D is to eliminate unnecessary, repetitive imaging.

78. Dr. Stark, in his submission of August 24, 1994, suggests that item D be amended by the addition of an additional circumstance under which repeat imaging would be appropriate as follows:

Change in technique (i.e. bone and soft tissue methods) in passage of time, tissue change.

Dr. Stark also suggests a significant change to subitem 6 regarding inadequate studies. Dr. Robert J. Scheuerell, in his comments of July 5, 1994, states that words "orthopedist and neurosurgeon" should be inserted following the word "radiologist" at lines 22 and 23 of page 16 of the Revisor's draft of the rules. He requests that these two groups of physicians be added because, in his opinion, such individuals are more experienced regarding spine films than are radiologists. Dr. James House, in his hearing testimony suggested a similar amendment. Tr. 203-04. Dr. Joseph Perra, in his hearing testimony, also argued that subitem 6 of this item should be amended to include tests other than MRI or CT scans. Tr. 395. He also argued that the requirement that the original radiologist repudiate his or her previous test is too "harsh" and may not allow for adequate testing to be performed. Tr. 395-96.

79. In response to public comments, the Department proposed to amend subitem 6 of item D as follows:

When the treating health care provider and a radiologist from a different practice have reviewed a previous imaging study and agree that it is a technically inadequate study.

See, Exhibit A. The proposed amendment was made in response to the comments of Dr. Stark, Dr. House, Dr. Perra and Dr. Scheuerell. Since the amendment is a clarifying amendment made in response to public comment it is not a prohibited substantial change. The need for and reasonableness of item D of this subpart, as amended, has been demonstrated by an affirmative presentation of fact; it is found to be needed and reasonable.

80. Item E of this subpart relates to alternative imaging. This item lists the circumstances under which alternative imaging will be allowed. Again, the purpose of this item is to restrict unnecessary, excessive alternative imaging. The only discussion of this item is Dr. Stark's comments in his August 24, 1994, submission that additional studies should be authorized if findings are inconclusive or necessary to demonstrate a changing or less obvious problem or in response to a "high index of suspicion". The Department proposes to amend item E(3) by adding a definition of "inconclusive finding". This definition is added to respond to Dr. Stark's concerns.

81. The amendment to subitem (3) of item E is added for purposes of clarity and does not expand the application of the proposed rule. It is therefore, not a prohibited substantial change. The Department has demonstrated the need for and reasonableness of item E, as amended, with an affirmative presentation of fact. This item, as amended, is found to be both needed and reasonable.

82. Dr. Stark also suggested additions to item E in his submission of August 24, 1994. The initial change suggested is that persistence of a patient's subjective complaint alone may be a legitimate indication for a repeat imaging study. The Administrative Law Judge agrees with the Department in their August 31, 1994 submission that the change suggested by Dr. Stark does not represent current practice in general medicine. There must be a

change in condition or proposed diagnosis before ongoing and unlimited testing should result.

83. Dr. Stark also states that a decision should be based on the 12 factors previously discussed and "the need, in certain circumstances, for proof, confirmation, and completeness". The restatement of the 12 factors really adds nothing to the rule. Decisions regarding imaging should always be based on those 12 factors. With respect to the quoted portion of the amendment suggested by Dr. Stark it would, in effect, negate the rule itself which seeks to limit alternative imaging except in defined circumstances. The Administrative Law Judge therefore does not accept the alternative imaging item amendments suggested by Dr. Stark.

84. As a consequence of Findings 71-83, supra, subpart 1 of this Part, as amended, is needed and reasonable.

85. Subpart 2 of this Part relates to specific imaging procedures for the lower back. The introduction to subpart 2 requires that, in the absence of emergency evaluation or significant trauma, a health care provider must document the history in the medical record, do a physical examination, and review all existing records before ordering an imaging study of the low back. Items A through M then discuss the types of imaging that may be indicated under particular conditions. The Administrative Law Judge finds that it is both needed and reasonable to require a health care provider to take an appropriate history, perform a physical examination and review existing records before ordering imaging. The introduction to subpart 2 is, therefore, both needed and reasonable.

86. Item A of subpart 2 relates to computed tomography (CT) scanning and states the circumstances under which a CT scan is indicated and not indicated. Dr. Scheuerell, in his comment of July 5, 1994, states that the word "progressive" should be eliminated from line 13 of page 17 of the Revisor's draft and line 18 of page 17 of the Revisor's draft should be changed to some period of time shorter than eight weeks. Consulting Radiologists, Ltd., in their comments of July 25, 1994, also state that it is not in the best interest of the patient to have an eight-week time constraint for specific imaging procedures. They would, however, retain the preauthorization requirement. Most patient's back injuries, however, resolve themselves within eight weeks. Ordering an expensive imaging study before that period of time is not cost effective. The criteria contained in this item has been approved by the MSRB, the medical advisors to the Department. SONAR, pp. 34-35. The Administrative Law Judge believes, in accordance with expert medical opinion, that generally a CT scan should not be performed for a back injury prior to the first eight weeks. There are exceptions contained in the rule for emergency and other situations, such as cauda equina syndrome, progressive neurologic deficit or bony lesion. These circumstances are the specific situations under which a departure from the eight-week parameter is appropriate. The Department has demonstrated the need for and reasonableness of item A of subpart 2 with an affirmative presentation of fact. It is found to be needed and reasonable.

87. Item B of this subpart relates to the situations in which magnetic resonance imaging, MRI scanning, is indicated. Except as specified in subitems (1) through (4), for largely emergency situations, the rule provides

that an MRI scan is not indicated in the first eight weeks after an injury. The item goes on to provide the situations after eight weeks in which MRI scanning is indicated. The only public comment on this provision is contained in the August 24, 1994 submission of Dr. Stark. Dr. Stark wishes to add a number of specified situations when a MRI may be indicated. He suggests adding subitems (5)-(7) as stated in his submission. He also suggests expanding subitem (4) of item B. The amendment suggested by Dr. Stark to subitem (4) of item B is inappropriate because it is already covered in item F in Gadolinium Enhanced MRI scanning which is a more sensitive and specific test for these conditions. The Administrative Law Judge does not adopt subitem (5) suggested by Dr. Stark because it is unclear what kind of lesion he is referring to in that subitem. The Administrative Law Judge agrees with the Department that early scanning for degenerative changes is not appropriate. Other sagittal lesions off the midline are otherwise covered by item B. The change suggested by Dr. Stark in subitem 6 is not adopted by the Administrative Law Judge for the same reasons he rejected proposed subitem (5). Subitem (7) suggested by Dr. Stark is not adopted by the Administrative Law Judge because he agrees with the Department that an MRI scan is not indicated simply because another imaging study had failed to demonstrate the existence of a lesion. If an imaging study has failed to demonstrate an abnormal finding then another study is only indicated if it is a better or more appropriate test to look at alternative etiology which would not have been adequately investigated by the first imaging study.

88. Dr. Stark also suggests changes to the second and the final paragraph of this item by substituting the phrase "may be" for the word "is" and inserting the word "generally" before the phrase "is not". The Administrative Law Judge determines that these changes are not appropriate because the Department does not intend that an MRI must be performed after eight weeks. The test would only be performed if it is the "single best effective imaging study" under Part 5221.6100, subp. 1.A. The Department intends to permit an MRI after eight weeks, it does not mandate one.

89. Item B is found to be needed and reasonable. SONAR, p. 36.

90. Item C relates to myelography. This item states the circumstances under which myelography is indicated. The only comment on this section was made by Dr. Stark in his August 24, 1994 submission. He would amend subitems (1) and (3) as indicated in his submission. For the reasons stated in the August 31, 1994 comments of the Department, the Administrative Law Judge does not adopt the suggested amendments of Dr. Stark.

91. The need for and reasonableness of subitem C is discussed in the SONAR at page 36. The Department has demonstrated the need for and reasonableness of item C of subpart 2 by an affirmative presentation of fact. It is found to be needed and reasonable.

92. Item D relates to computed tomography myelography. It states the conditions under which the imagery is indicated. Item E relates to intravenous enhanced CT scanning and states the circumstances under which it is indicated and item F relates to the Gandolineum Enhanced MRI scanning, indicating the situations under which it is indicated. The Statement of Need and Reasonableness at page 36, provides support for items D, E and F. No adverse public comment was received at the public hearing or in written

comments about these items. The Department has, therefore, demonstrated the need for and reasonableness of items D, E and F by an affirmative presentation of fact in the record. They are found to be needed and reasonable.

93. Item G indicates the circumstances under which discography is indicated. At the hearing, Dr. Joseph Perra stated that the limitations contained in subitems (1) and (2) of this item are too narrow. Tr. 396-97. Dr. Perra stated that discography appears to be the best diagnostic test to determine whether an otherwise unidentified lesion is the cause of pain. Tr. 397. Dr. Stark, in his submission of August 24, 1994, purposes to amend item G by adding additional situations under which discography ought to be allowed. The Department has discussed the need for and reasonableness of item G at page 36 of the SONAR. For the reasons advanced by the Department at page 36 of the SONAR and contained in their submission of August 31, 1994, the Administrative Law Judge rejects the changes suggested by the witnesses and finds that item G of this subpart is needed and reasonable.

94. Item H, I and J received no public comment which requires consideration by the Administrative Law Judge. The need for and reasonableness of these items are discussed at pages 36 and 37 of the SONAR. The Department has demonstrated the need for and reasonableness of items H, I and J by an affirmative presentation of fact in the record. They are found to be needed and reasonable.

95. Item K relates to anterior-posterior (AP) and lateral x-rays of the lumbosacral spine. It states the situations in which such x-rays are indicated and those in which they are not indicated. Most of the comment centered around the limitation of x-rays to persons over the age of 50. The commentators argue that the routine nature and fundamental diagnostic benefit of the x-ray make it appropriate for individuals under the age of 50 generally. The Department also proposed to amend this item as stated in Exhibit A attached hereto. The Department's amendments are clarifying amendments made in response to public testimony. They are needed and reasonable. Because they do not significantly expand the application of the proposed rules, they do not constitute prohibited substantial changes.

The Administrative Law Judge notes that the word "later" which appears in the first line of the suggested amendment several words after "(AP)" should read "lateral" by comparison to the Revisor's draft of the rules.

A modification is suggested by the Department by adding a subitem (f) in subitem (1), item K in response to comments by Dr. Perra and Dr. Stark. This makes the use of these x-rays consistent with the use of CT scan and MRI scans. They are still not indicated in the first eight weeks after an injury accept as allowed by subitems (a) - (e) of subitem (1) of item K because the majority of all patients will recover from their condition within an eight-week period of time based on medical experience. The amendment to subitem (b) of subitem (1) of this item was made in response to a comment by Dr. Stark that any one of these items may indicate, infection or inflammatory lesion; they need not all be present.

96. A number of commentators argued that a general x-ray of the lumbosacral spine should be available in patients less than 50 years of age, if the requesting clinician believes that it is appropriate. Tr. 460-66; Tr. 471; Tr. 474; Tr. 343; Tr. 398; Tr. 481-82; Tr. 489. As the Department

states, however, the probability of occult tumor infection or inflammatory lesion rises dramatically after the age of 50. That is the reason the Department would allow an x-ray for patients older than 50 years at the discretion of the treating health care provider. For persons under the age of 50, absent a factor stated in subitem (1), the Medical Services Review Board determined that AP and lateral x-rays were over-utilized in the initial evaluation of low back pain and that they offer very little useful information, generally. Such x-rays are not benign and expose the patient to unnecessary radiation, especially to the reproductive organs. SONAR, p. 37. For the reasons stated by the Department at page 37 of the SONAR, it is appropriate to limit the AP and lateral x-rays of the lumbosacral spine in persons under 50 generally, unless one of the additional lettered items contained in (a)-(f) is present.

97. The Department has demonstrated the need for and reasonableness of item k, as amended, with an affirmative presentation of fact. It is found to be needed and reasonable, as amended.

98. Item L limits oblique x-rays of the lumbosacral spine. It states conditions under which they are indicated and those situations in which they are not generally indicated. Dr. Perra, in his hearing testimony, stated that an oblique x-ray is one of the better, more sensitive ways to determine whether or not spondylolisthesis has occurred or a stress fracture in the pars interarticularis exists. In his comments of July 5, 1994, Dr. Robert J. Scheuerell stated that the x-rays should be indicated if "no abnormality is seen on routine x-rays and the diagnosis of spondylolysis is being considered". Dr. Stark, in his submission of August 24, 1994, believes that the oblique x-ray of the lumbosacral spine should be authorized for "evaluation of sacral, sacroiliac or iliac problems". As stated by the Department, however, x-rays of the lumbar spine are not the same as x-rays of the sacroiliac joints. Proposed rules only limit the use of x-rays of the lumbar spine and not specific views of the sacroiliac joint. Submission of the Department, August 31, 1994. Also as recognized by the Department in its submission of August 24, 1994, oblique x-rays are indicated for spondylolisthesis. See, page 20 of proposed rules, line 34. The same comment adequately responds to the comment of Dr. Perra made at page 399 of the transcript.

99. For the reasons stated at page 37 of the SONAR, the Department has demonstrated the need for and reasonableness of item L of this subpart by an affirmative presentation of fact. It is found to be needed and reasonable.

100. Item M relates to electronic x-ray analysis of plain radiographs and diagnostic ultrasound testing as usable for diagnosis for any of the low back conditions stated in Part 5221.6200, subp. 1, item A, Lower Back Injury. After the hearing, the Department, in response to comments by Dr. Stark, proposed to amend Item M, as indicated in Exhibit A hereto. The purpose of the amendment is a clarifying amendment to eliminate only diagnostic ultrasound of the lumbar spine. The amendment, proposed by the Department, is a clarifying amendment which does not expand the application of the proposed rule. It is, therefore, not a prohibited substantial change.

101. The consensus of medical opinion and the MSRB is that electric x-ray analysis adds no additional clinically important information not available

from traditional radiographic interpretation. In the opinion of the MSRB, it adds substantial cost and is, therefore, not a cost-effective approach to low back pain.

102. John Reid, D.C., and Dallas F. Weisz of Vivo, Inc., submitted comments to the Administrative Law Judge that diagnostic ultrasound of the spine should be permitted. The consensus of expert medical opinion, however, indicates no utility for ultrasound of the spine for the diagnosis of low back conditions. Moreover, no board-certified radiologist has objected to the exclusion of diagnostic ultrasound of the spine. The articles submitted by Dr. Reid do not support the use of ultrasound technology for diagnosis of spine conditions. The Administrative Law Judge notes, as stated by the Department in its submission of August 24, 1994, that therapeutic use of ultrasound is permitted by the parameters.

103. For the reasons stated at page 37 of the SONAR and the response of the Department to the submissions of Dr. Reid and Mr. Weisz, item M has been demonstrated to be needed and reasonable, as amended.

Part 5221.6200. Low Back Pain

104. This Part discusses the appropriate approach to the entire episode of care for a patient with a new low back injury. The rule initially deals with parameters outlining the appropriate diagnostic procedures for treatment. It then sets out the initial non-surgical approach with subsequent follow-up. Surgery, if required, is provided for in this rule, as is rehabilitation and/or pain management, if needed.

105. Subpart 1 of this Part deals with diagnostic procedures for treatment of low back injury. After the hearing, the Department proposed to amend item A of subpart 1, as indicated in Exhibit A attached hereto. The modification was made in response to several comments by Dr. Stark. Item A is limited to the specific back diagnosis in subitems A (1)-(4). The word "visceral" was proposed to be added by the Department to item A at line 21 of page 21 of the Revisor's draft to clarify an erroneous interpretation suggested by Dr. Stark. Since the amendment is a clarifying amendment which does not expand the application of the rule, it is not a prohibited substantial change. The need for and reasonableness of item A was discussed by the Department at pages 37-38 of the SONAR. The Administrative Law Judge finds that item A of subpart 1, as amended, is needed and reasonable. The clinical categories presented represent a distillation of recommendations in the medical literature for grouping lower back conditions. The categories were reviewed by the medical community and approved by the Medical Services Review Board.

106. Item B of this subpart relates to the situations in which a laboratory test may be indicated for the evaluation of a patient with regional low back pain, radicular pain or cauda equina syndrome. Item C requires that medical imaging evaluation of the lumbosacral spine be based on the findings of the history and physical examination. Item D states the conditions under which EMG and nerve conduction studies are appropriate for regional low back pain as defined in item A, subitem (1) and radicular pain and cauda equina syndrome as defined in item A, subitems (2)-(4). Items B, C and D received no

public comment at the hearing or in written submissions. They are both needed and reasonable. SONAR, p. 38.

107. Item E relates to procedures and tests that are not indicated for the diagnosis of any of the clinical categories in item A. The reasoning behind these exclusions is stated at page 38-39 of the SONAR. After the hearing, the Department proposed to amend subitem (5) of item E by adding the phrase "of the lumbar spine" after the word "ultrasound". See, Exhibit A, infra. The qualification was added to demonstrate that the use of ultrasound of the abdomen or internal body parts was not meant to be limited by the rule. Since this is merely a clarifying amendment, it is not a prohibited substantial change.

108. Several commentators suggested that diagnostic ultrasound should not be included in the list of proscribed testing procedures. See, Submission of Dallas E. Weisz, August 9, 1994; Submission of John D. Reid, D.C., received on August 3, 1994; and Submission of John D. Reid, D.C., received on August 19, 1994. For the reasons previously discussed, the Administrative Law Judge accepts the consensus of expert medical opinion and the recommendation of the MSRB that diagnostic ultrasound of the spine not be included in compensable testing for purposes of workers' compensation. The Administrative Law Judge finds that item E of subpart 1 of this rule, as amended, is needed and reasonable.

109. Item G of this subpart relates to personality or psychological evaluations for persons who continue to have symptomology despite appropriate care; it provides for psychological testing and treatment. The justification for this provision is stated at page 39 of the SONAR. In the view of the Department, psychological factors should be considered when an employee does not improve with the usual natural history of low back pain.

110. Liberty Mutual Insurance Company, in their submission of August 22, 1994, expressed concern about the psychological and psychosocial evaluations that may be indicated for evaluating patients who continue to have problems despite appropriate care. Liberty Mutual is concerned about the unspecified outcome when these evaluations are made. For example, who is responsible for necessary psychological or psychiatric treatment if personality factors or disorders unrelated to the injury are discovered? Is there any limitation to such treatment? Liberty Mutual also seeks to impose a requirement that the doctor doing the evaluation be neutral and not in any way related to the doctor or facility providing the treatment. Dr. Stark, in his August 24, 1994, submission, seeks to amend item G(1) by adding the following language at the end of that subitem: "and their relative importance to the organic lesions (if any) diagnosed". In response to the comments of Liberty Mutual Insurance Co., it should be noted that Part 5221.6600, subp. 2F specifically allows psychological treatment if one of the indications in subpart 1, item A interferes with recovery from the physical injury. Minn. Stat. § 176.135, subd. 1 (1992), requires the employer and the insurer to provide psychological treatment that is reasonably required to cure and relieve from the effects of the injury. With respect to the neutrality of the doctor providing the assessment in psychological circumstances, typically, the employee's primary health care provider will coordinate and make referrals for psychological treatment. Department submission of August 31, 1994. With respect to Dr. Stark's comment regarding subitem (1) of item G, the Administrative Law Judge

agrees with the Department that the addition suggested by Dr. Stark is not appropriate. It is always necessary for the physician to judge the relative importance of any information obtained. The Administrative Law Judge finds that item G of this subpart is needed and reasonable. SONAR, p. 39.

111. Item H of this subpart did not receive adverse public comment. Its rationale is stated in the SONAR at page 39. The Administrative Law Judge finds that item H of this subpart is needed and reasonable.

112. Item I relates to a functional capacity assessment or evaluation. The only comment received on this item was provided by the Key Method Chiropractic Group in its letter of August 17, 1994. This comment also relates to other provisions concerned with a functional capacity assessment or evaluation. The Key Method Group suggests that a functional capacity assessment or evaluation should be allowed to establish a baseline. It is also the suggestion of the commentator that periodic functional capacity assessments may be needed during the course of treatment to assess improvement. The need for and reasonableness of this item is discussed at page 39 of the SONAR. Such tests are expensive. It was the consensus recommendation that they are not appropriate in the initial stages of treatment because 80-90% of patients will recover within eight to 12 weeks. The Minnesota Physical Therapy Association endorses the rules regarding functional capacity assessments as written. It should also be noted that the goal of a functional capacity evaluation is to determine the final capabilities of a patient after he or she has been treated, not to formulate a treatment plan. The Administrative Law Judge finds that item I of this subpart is needed and reasonable.

113. The Administrative Law Judge did not receive any adverse comments on item J of this subpart. It is found to be both needed and reasonable. SONAR, pp. 39-40.

114. Subpart 2 of this Part relates to general treatment parameters for low back pain. It contains items A through C. Subpart 2 states that all medical care for low back pain, appropriately assigned to a clinical category in subpart 1, item A of this Part, is determined by the clinical category to which the patient has been assigned. Item A is needed and reasonable to provide an overview and instruction for use of the subpart and to direct the health care provider to the appropriate specific rules for each clinical category. It also reminds the provider to reassess the appropriateness of the clinical category at each visit. Item A of subpart 2 did not receive adverse public comment.

115. Item B of this subpart outlines the general approach to be taken for low back pain patients. The course of treatment may be divided into three possible phases. The first phase is non-surgical management. The second phase is surgical evaluation, and the third phase is chronic management. Item B of this subpart is discussed at page 40 of the SONAR. Dr. Stark, in his submission of August 24, 1994, proposed to amend item B(2)(d) of this subpart by adding language as follows:

> Consideration for major surgery will be made based on functional level, risk, and benefits at a time consistent with good practice.

The Administrative Law Judge rejects the suggested amendment of Dr. Stark for the reasons stated in the Department's comments of August 31, 1994. Item B is found to be needed and reasonable.

116. Item C of this subpart provides that a treating health care provider may refer the employee for a consultation at any time during the course of treatment, consistent with accepted medical practice. It is not the intent of this item to limit the circumstances in which a consultation may be obtained. See, SONAR, pp. 40-41. Item C did not receive adverse public comment. It is found to be needed and reasonable.

117. Subpart 3 relates to passive treatment modalities, as defined in subpart 12 of proposed rule 5221.6040. Passive care includes chiropractic care and physical therapy. With several exceptions, including principally Part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting is stated to be not indicated after 12 calendar weeks from its initiation. The employee is allowed, however, to use passive treatment modalities as may be necessary at his or her home without temporal limitation. Item B of this part represents a compromise which was discussed by the MSRB and then was the subject of a meeting and agreement which included the president of the Minnesota Chiropractic Association. That item allows an additional 12 clinical visits for passive care treatment modalities over a further 12 months if all of the items stated in subitems (a)-(f) apply. After the additional 12-month period, additional passive care visits are only possible under the exception subsection contained in Part 5221.6050, subpart 8, or only after prior approval by the insurer, commissioner or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining employability. If the employee is permanently totally disabled or if, upon retirement, the employee is eligible for ongoing medical benefits for the work injury, treatment may continue beyond the additional 12 visits after prior approval by the insurer, commissioner or compensation judge if it is documented in the medical record that further passive treatment is effective or necessary in maintaining functional status.

118. Except as stated in the general exception provision, item B of Part 5221.6050, subp. 8, items A and B of this subpart represent a limitation on the availability of passive treatment modalities. The medical literature and the consensus of health care providers within the treatment community supports the timeframes established in items A and B to avoid habituation or unnecessary reliance on passive treatment modalities after the period of time in which they are most likely to be beneficial. There are no scientifically valid studies which show that long-term passive care results in eventual recovery of function or cure of symptoms. There is support in the medical literature for the use of passive treatment modalities in the early stages of recovery in acute cases. The 12-week calendar limitation contained in item A, when supplemented by item B, accommodates the schedule of care proven useful in the literature. The proposed limitations also follow the recommendations of many professional organizations.

119. It is also appropriate to limit the duration of passive care because patients with musculoskeletal injuries who have not improved within the expected timeframes, generally are suffering from the consequences of their acute injuries, physical impairment or chronic pain syndrome, or both. Appropriate treatment for these consequences is chronic management, not additional passive care.

120. Finally, epidemiologic data shows that prolonged inactivity makes it more unlikely that an injured worker will ever return to work. If a worker has not returned to work within two years of an injury, the chances of that worker ever returning to work in any job are almost zero. Any treatment that countenances prolonged inactivity or disability is counterproductive to restoring function.

121. It should be noted that subpart 3 has been endorsed by the medical advisors to the department, the SMRB, which includes providers of passive care, including a chiropractor and a physical therapist.

122. Item B of this subpart allows additional passive care after twelve weeks under specified circumstances. This represents a compromise position involving the MSRB, a representative of the Minnesota Chiropractic Association, an employee, a self-insured employer, the Department's medical consultant Dr. Lohman, and three members of the Medical Services Review Board. The discussion was facilitated by the Department of Administration, Dispute Resolution Service. The names of the participants in that conference are attached to the SONAR as Appendix 4. The group that developed the compromise reflected in item B included Dr. Bolles, the head of the Minnesota Chiropractic Association. Dr. Bolles approved the compromise provision reflected in Item B. At the hearing, on behalf of the Minnesota Chiropractic Association which represents 1,800 licensed doctors of chiropractic in the state, Dr. Bolles testified that the rules should not be adopted and he particularly disagreed with the limitation on passive treatment modalities, as it impacts chiropractic, found in subp. 3. The testimony of Dr. Bolles is reflected in Exhibit 7. On behalf of the MCA, Dr. Bolles urged the Administrative Law Judge not to approve the proposed treatment rules because: (1) they are arbitrary; (2) they contradict existing statutory law; (3) they are not based on guidelines that are a measure of reasonable chiropractic care; and (4) they are currently being reviewed within the Minnesota judicial system. When questioned about his apparent change of position at the hearing, Dr. Bolles testified that the addition of Item B was better than not having such a provision. He claimed, however, that it was never his intention to endorse a time limitation on the provision of passive care, particularly chiropractic, as a treatment modality for musculoskeletal injuries.

123. At the hearing, a number of individuals commented on this subpart and other portions of the proposed rules involving limits on the use of passive care modalities: testimony of Dr. Jeffrey Bonsell, Tr. 187-96; testimony of Dr. Joseph Wegner, Tr. 174-78; testimony of Dr. Steven Bolles, Tr. 148-50; testimony of Dr. Ketroser, Tr. 258-61; testimony of Mr. James Hoyme, P.T., Tr. 282-86; testimony of Dr. Brian Nelson, Tr. 340-41; and testimony of Dr. Robert Fitzgerald, Tr. 533-34. Limitations on the use of passive treatment modalities in back care was also addressed in a number of written submissions: Material provided by Robert Fitzgerald, D.C.; comments of Liebl Family Chiropractic, July 22, 1994; comments of Honeywell, Inc., August 29, 1994; comments of the Minnesota Chiropractic Association, August 29, 1994; comments of Douglas A. Franks, D.C., August 17, 1994, p. 2; comments of Blue Cross Blue Shield of Minnesota, August 23, 1994, pp. 5-6.

124. The Administrative Law Judge finds that the Department, relying on the greater consensus of the provider community, has established the need for

and reasonableness of subpart 3, items A and B by an affirmative presentation of fact. It is necessary to limit the use of passive treatment modalities to those periods of time in which both the literature and practical experience demonstrate they are most likely to be effective. The compromise reflected in item B, in fact, if it errs, is on the side of additional passive treatment. The Administrative Law Judge also agrees with Dr. Bonsell, D.C., that the cases that actually require passive treatment for the restoration of function after the time periods allowed by items A and B would be considered under the exception to the treatment parameters contained in item B, subp. 8 of Part 5221.6050. Tr. 192-94. Dr. Stark proposes to amend subp. 3, item A of this Part by adding the following:

> Passive modalities should certainly be discontinued before the 12-week period if deemed ineffective.

The Administrative Law Judge finds that addition of the admonition is unnecessary. Part 5221.6050, subp. 1A; Part 5221.6050, subp. 10.

125. Items C through K of this subpart set forth particular items of passive care. For each a period of time for effectiveness is also established. The timeframes for effective use are taken from both practical experience and the applicable scientific literature. The specific periods stated in those items and the identification of passive care modalities did not receive any adverse public comment. The Administrative Law Judge finds that items C through K are needed and reasonable. This finding is made by the Administrative Law Judge on the understanding that items C through K are also subject to items A and B of this Part and item B, subp. 8 of Part 5221.6050, the general exception provision.

126. The Administrative Law Judge finds that subpart 3 of this Part is needed and reasonable.

127. Subpart 4 of this part relates to active treatment modalities. The need for and reasonableness of this subpart are discussed at page 45 of the SONAR.

128. Liberty Mutual Insurance Company stated, in its comments of August 22, 1994, that the language regarding active treatment modalities requires clarification. The company asks whether the maximum number of treatments encompasses the initial period of treatment as well as any additional extended period of treatment. In response, the Department states that there is no time limit on the active treatment modalities specified in the introductory paragraph of subp. 4, as long as they do not exceed the specified duration. The maximum duration for supervised exercise is twelve weeks, which may extend past the 12-week limit on passive care as stated in subp. 4.

129. Dr. Timothy A. Garvey, in his letter of July 25, 1994, questions item D of subp. 4, by stating that the current literature does not support exercise specifically aimed at the musculature of the lumbosacral spine. Dr. Garvey believes that this subpart and other similar subparts should be changed to emphasize aerobic conditioning, extremity strengthening, and trunk strengthening, rather than focusing on the musculature and stressing flexibility. In response, the Department states that it believes that the

rule is consistent with Dr. Garvey's comments, since the rule states that the exercise must include flexibility, strength, endurance or muscle relaxation.

130. For the reasons stated at page 45 of the SONAR, the Administrative Law Judge finds that subp. 4 of Part 5221.6200 is both needed and reasonable.

131. Subpart 5 of this Part deals with therapeutic injections. The need for and reasonableness of subp. 5 is discussed at page 45 of the SONAR. The only comment received on subp. 5 is contained in the letter of Dr. Garvey of July 25, 1994, which relates to item C. Dr. Garvey states that there is some literature support for the use of Prolotherapy. Part 5221.6200, subp. 5C provides that Prolotherapy is not indicated in the treatment of low back problems and is not reimbursable. In response to Dr. Garvey, the Department states that it and the MSRB will continue to monitor the appropriateness of this treatment. Submission of the Department, August 24, 1994. If additional medical literature demonstrates the efficacy of this treatment, the Department in later amendments to the rules will consider the subject again.

132. The Administrative Law Judge finds that the need for and reasonableness of subp. 5 of this Part has been demonstrated by an affirmative presentation of fact.

133. Subpart 6 of this Part relates to surgery, including decompression procedures and arthrodesis. The Administrative Law Judge received no comment on this subpart. It is discussed at page 46 of the SONAR. Subpart 6 is found to be needed and reasonable.

134. Subpart 8 of this part deals with durable medical equipment. The use of durable medical equipment is discussed at page 47 of the SONAR. Dr. Garvey, in his letter of July 25, 1994, commented that it may be cost-effective for some patients to have the availability of bicycles and treadmills at home before a chronic management program starts. The Department responded that purchase of such equipment is not cost-effective prior to chronic management because most employees recover fully from back injuries in eight to 12 weeks. If it is determined that a home-based exercise program is needed on a long-term basis, it may be begun as early as 12 weeks after an injury. Dr. Stark, in his submission of August 24, 1994, proposed to amend subp. 8, items B and C by adding language giving the health care provider the power to determine comparability. Under the statutory law and these rules, after dialogue between the provider and insurer, disputes would be resolved by the Commissioner or a compensation judge, not the provider.

Dr. Stark also sought to amend item D of this subpart by specifically allowing the prescription of hospital beds for a postoperative period not to exceed 12 weeks. The Administrative Law Judge rejects the amendment advanced by Dr. Stark for the reason stated in the Department's comments of August 31, 1994.

135. The Department has demonstrated the need for and reasonableness of subp. 8 of this Part by an affirmative presentation of fact. It is found to be both needed and reasonable.

136. Subpart 10 of this Part relates to the use of scheduled and nonscheduled medications. This subpart provides that the use of scheduled and

nonscheduled controlled substances is not indicated for regional low back pain after the first two weeks. Dr. Garvey, in his letter of July 25, 1994, states that the use of mild, low-dose narcotic medication may be indicated over a longer period of time than two weeks. The Department and the Medical Services Review Board discussed the proposed rule both before and after receiving Dr. Garvey's letter. At the meeting of the MSRB after the issuance of Dr. Garvey's letter, the Medical Services Review Board was made aware that there may be limited circumstances in which the use of low-dose scheduled medications are to be permitted within strict guidelines established by the Board of Medical Practices. The Department, however, believes that since an extended period of scheduled drug use is allowed for radicular pain and a general exception provision is available in item B, subp. 8 of Part 5221.6050, the rule, as originally proposed, is appropriate. The Department states that it will make further analysis of applicable dosages and medications and the restrictions on extended use developed by the Board of Medical Practices. Submission of the Department, August 24, 1994.

137. Dr. Stark, in his August 24, 1994, submission, suggests adding language to subp. 10 of this Part allowing the extended use of scheduled medications when a patient has "a chronic condition with acute exacerbation". This addition is unnecessary in light of Part 5221.6050, subp. 8B.

138. Given the availability of the exception provision and the extension of use for radicular pain, the Administrative Law Judge finds this subpart to be both needed and reasonable, with the understanding that the Department will study and monitor the restrictions on extended use of scheduled drugs developed by the Board of Medical Practices and consider including them in the rule at a later date.

139. Subparts 11 through 13 of this Part are discussed at pages 48-51 of the SONAR. The only comments on these subparts were made by Dr. Stark in his August 24, 1994, submission. He proposes to amend subp. 11, item A by adding language dealing with diagnostic injections. That subject is specifically governed by another provision of the proposed rules. Dr. Stark also proposes to amend subp. 11B(1) and (2). The Administrative Law Judge rejects these two amendments proposed by Dr. Stark for the reasons stated by the Department in its submission of August 31, 1994. For the reasons stated in the SONAR, these subparts are found to be needed and reasonable.

Part 5221.6205 - Neck Pain

140. Subpart 1 of this Part deals with diagnostic procedures for the treatment of neck injury. It is discussed at page 51 of the SONAR. This subpart parallels Part 5221.6200, subp. 1, supra. The Department proposes to amend item A of this subpart in line 12 of page 44 of the Revisor's draft of the rules, as stated in Exhibit A attached hereto. This amendment adds the word "visceral" after the word "neurologic" and before the word "or" in that line. The Department also proposes an amendment to item E at lines 11 and 12 of page 46 of the Revisor's draft and at subitem (5) at line 19 of page 46 of the Revisor's draft of the rules. These modifications are proposed in response to Dr. Stark's interpretation of the rules which the Department had not intended. Also, item E for neck injuries as drafted is inconsistent with the low back rule, therefore, a clarification is added. Subitem (5) is

amended to demonstrate that ultrasound of the abdomen or other internal body parts is not limited by the rules. These amendments only clarify the rule in response to public comment and are not prohibited substantial changes. Other comments on subsections F and G of this subpart were made. However, they have already been responded to under the identical items contained in Part 5221.6200, subp. 1, supra. For the reasons previously discussed with respect to that subpart and based on the SONAR, at p. 51, subp. 1 of this Part, as amended, is found to be both needed and reasonable.

141. Subpart 2 of this Part deals with general treatment parameters for neck pain. This portion parallels a similar portion contained in Part 5221.6200, subp. 2, with appropriate modifications for the subject matter of the neck. Subpart 2 is found to be both needed and reasonable.

142. Subparts 3 through 14 parallel similar sections in Part 5221.6200, subp. 3-13, except as modified for the specific subject matter of the neck. These sections are discussed at pages 53 and 54 of the SONAR. The only comments that were made on these sections have already been dealt with by the Administrative Law Judge in considering the equivalent portions of Part 5221.6200. For the reasons previously discussed, the Administrative Law Judge finds these remaining subparts of this Part to be needed and reasonable.

Part 5221.6210 - Thoracic Back Pain

143. This Part states in 13 subparts the possible courses of treatment for the entire episode of thoracic pain injury beginning with diagnosis and ending with specific treatment parameters for described conditions of the thoracic spine.

144. The Department has proposed to amend subpart 1, item A, at line 17 of page 67 of the Revisor's draft of the rules and item E at page 68, line 33 and page 69, line 5, as stated in Exhibit A attached hereto. The amendments to subpart 1, item A, and item E, are the same as were discussed with respect to the equivalent section in the previous rule. For the reasons therein stated, the amendments are not substantial changes. Subpart 1 of Part 5221.6210, as amended, is found to be needed and reasonable.

145. Subpart 2 of this Part relates to general treatment parameters for thoracic back pain. Subp. 3 relates to passive treatment modalities. Subpart 4 relates to active treatment modalities. Subpart 5 relates to therapeutic injections. Subpart 6 relates to surgery, including decompression procedures. Subpart 7 relates to chronic management. Subpart 8 relates to durable medical equipment. Subpart 9 relates to evaluation of treatment by health care provider. Subpart 10 relates to scheduled and nonscheduled medications. These provisions, except for changes making the rule specific to the thoracic back, are identical to provisions in Part 5521.6200 and part 5521.6205. They are discussed at pages 55-56 of the SONAR. The only comments in the record that would affect this portion of the proposed rule have already been discussed with respect to either lower back pain or neck pain. The Administrative Law Judge therefore finds that these subparts are needed and reasonable.

146. Subpart 11 relates to specific treatment parameters for regional thoracic back pain. This subpart is discussed at page 56 of the SONAR. The only comment the Administrative Law Judge received on this subpart was by Dr. Robert J. Scheuerell in his letter of July 5, 1994. He states that item B and item B(1) of this subpart should be modified to allow a decision regarding surgery to be made at some time later than 12 weeks. Dr. Scheuerell believes that active therapy is indicated for more than twelve weeks in many instances before making a decision to proceed with arthrodesis. As long as a patient is continuing to improve, however, Part 5221.6050, subp. 8, allows ongoing treatment. If the employee is no longer improving and surgery is not yet indicated, another type of treatment is indicated. Furthermore, Part 5221.6310, subp. 11 specifies that passive, active, injection, equipment and medication modalities may be used in sequence or simultaneously. This could result in initial non-surgical treatment extending well beyond twelve weeks. The Administrative Law Judge finds that subpart 11 of this Part is needed and reasonable.

147. Subparts 12 and 13 of this Part are discussed at page 56 of the SONAR. These subparts did not receive public comment during the hearing. They are, therefore, found to be needed and reasonable.

Part 5221.6300 - Upper Extremity Disorders

148. This Part largely parallels Parts 5221.6200, 5221.6205 and 5221.6210. In 16 subparts, it deals with the entire episode of possible appropriate treatment for an upper extremity disorder.

150. The Department proposes to amend subp. 1 of Part 5221.6300 at line 30 of item A, page 88 of the Revisor's draft of the rules by adding the word "visceral", before the word "vascular" in that same line. See, Exhibit A. This amendment does not constitute a prohibited substantial change. The clarification is made that visceral conditions are excluded in response to an interpretation of the rule made by Dr. Stark.

151. The Department also proposes to amend item A of this subpart at line 32 of page 88 of the Revisor's draft by adding the word "lacerations," after the word "fractures," in the same line. See, Exhibit A. The exclusion of lacerations is made by the Department in response to a letter from Rebecca Foley dated August 3, 1994, which discusses the treatment of wounds. Because lacerations are not included in the clinical categories in subitems (1) through (6), it is appropriate to state specifically that the treatment of lacerations is excluded from the parameters. This amendment is made in response to public comment, does not expand the application of the rule and was made for purposes of clarification. It is not, therefore, a prohibited substantial change.

152. Subpart 1 did not receive public comment other than that made by Dr. Stark and Rebecca Foley previously discussed. The need for and reasonableness of subp. 1 is discussed at pages 56-58 of the SONAR. It is, therefore, found to be both needed and reasonable as amended.

153. Subpart 2 of this Part deals with general treatment parameters for upper extremity disorder. It did not receive any comment at the hearing or in public submissions. The need for and reasonableness of subp. 2 is discussed

at page 59 of the SONAR. Subpart 2 of this Part is, therefore, found to be both needed and reasonable.

154. Subpart 3 of this Part relates to passive treatment modalities. It parallels the passive treatment modality provisions in Part 5221.6200, 5221.6205 and 5221.6210. It is discussed at pages 59-61 of the SONAR. The only significant argument particular to this subpart relates to whether manipulation should be used on the upper extremities as a passive treatment modality. The rule allows such manipulation under limitations applicable to the other passive treatment rules previously discussed. Several medical practitioners stated that there is no evidence that manipulation of the upper extremities is useful as a passive treatment modality. Chiropractors, however, tend to support the use of manipulation as a passive treatment modality for the upper extremities. The disagreement is discussed in the following submissions: comment of Dr. Jeffrey Bonsell, August 2, 1994, p. 4; comment of Dr. Robert J. Scheuerell, July 5, 1994, p. 2; comment of Dr. Scott A. McPherson, July 25, 1994, p. 1; letter of Joseph T. Smisek, July 25, 1994; comment of Dr. Douglas A. Franks, August 17, 1994, p. 1; comments of Dr. James H. House, July 29, and August 4, 1994. Several commentators also discussed the subject matter at the hearing. Tr. 195; Tr. 211.

155. The Administrative Law Judge agrees with the Department that there is some disagreement about the propriety of using manipulation of the upper extremities as a passive treatment modality. Given the disagreement it is appropriate to err, if at all, on the side of inclusion rather on exclusion. It should also be noted that no one is required by these rules to undergo passive treatment by manipulation of the upper extremities. It is only compensable if it is chosen as a treatment modality.

156. The Department proposed to amend item H of this Part as shown in Exhibit A, attached hereto, in response to a comment by Dr. Scheuerell dated July 5, 1994, p. 2. This amendment is made to make item H of this subpart consistent with the other rules, and it does not expand the operation of the rules. It is not, therefore, a prohibited substantial change. The Department also seeks to amend items I and Item J of this subpart as a shown in Exhibit A, attached hereto. These amendments are also in response to comments by Dr. Robert Scheuerell dated July 5, 1994, p. 3. Since these amendments are made in response to public comment and do not expand the application of the rules, they are not prohibited substantial changes.

157. With the exception of the comments related to the use of manipulation of the upper extremities as a passive treatment modality, previously discussed, and the clarifying amendments suggested by Dr. Sheuerell, subpart 3 did not receive comments which have not been considered by the Administrative Law Judge with respect to an earlier portion of the rules. Subpart 3 is discussed in the SONAR at page 59-62. Subpart 3 of this part, as amended, is found to be needed and reasonable.

158. Subpart 4 of this part relates to active treatment modalities. It is discussed at page 62 of the SONAR. Subpart 4 did not receive adverse public comment during the rulemaking proceeding. For the reasons stated in the SONAR, subpart 4 is found be needed and reasonable.

159. Subpart 5 of this part relates to therapeutic injections. Item A relates to trigger point injections. Item B relates to soft tissue injections and Item C relates to injections for peripheral nerve entrapment. Subpart 5 is discussed at page 63 of the SONAR. The only comment made during the rulemaking proceeding on subpart 5 is contained in the comments of Dr. Scott A. McPherson, July 25, 1994. Dr. McPherson states that cortisone injections should be limited to the carpal tunnel region only and that injections with Xylocaine to other peripheral nerves for diagnostic purposes would be reasonable. In response to the comment of Dr. McPherson, the Department proposed to amend item C of subpart 5 as indicated in Exhibit A, attached hereto. Because the amendment is made in response to public comment and does not expand the application of the rules it is not a prohibited substantial change.

160. For the reasons stated in the SONAR, the Administrative Law Judge finds that subpart 5 of this Part, as amended, is needed and reasonable.

161. Subpart 6 relates to surgery. The Department proposes to amend subpart 6 as shown in Exhibit A, attached hereto. The change was made by the Department to correct an erroneous citation. Also, a new subitem B was inadvertently omitted from this section. The requirement that repeat surgery must be confirmed by a second opinion is consistent with all the back parameters. The Department has also included a reference to this item B in Part 5221.6050, subp. 9(C)(4). The only other comment made on this section was made by Dr. Scott A. McPherson. In his opinion, subitem (2) of item A should be increased to 12 weeks. Dr. McPherson believes that oftentimes in surgical procedures three months is a more realistic time frame for when the patient has realized the maximum benefits from post operative therapy. This, the doctor states, would be consistent with the 12 weeks given for passive modalities in other conditions. The Department did not respond to this comment by Dr. McPherson. However, the rules represent the position of the MSRB which contains practitioners of similar credentials to Dr. McPherson. The Administrative Law Judge therefore finds that subpart 6, as amended, is needed and reasonable.

162. Subpart 7 of this Part deals with chronic management. Subpart 8 of this Part deals with durable medical equipment. Subpart 9 deals with evaluation of treatment by health care providers. Subpart 10 relates to scheduled and nonscheduled medication. The only comment received on these subparts which have not been previously discussed is the comment of Dr. Scheuerell, dated July 5, 1994, with respect to subpart 9, evaluation of treatment by health care provider. Dr. Scheuerell states that repetitive use injuries often times remain symptomatic for long periods of time and do not necessarily show significant improvement from one office visit to the next. The doctor is concerned that using the classifications contained in items A through C of this subpart would require the treating professional to discontinue effective treatment, remove the injured worker from his workplace, or greatly modify his employment in order to be reasonably sure that the treatment would fall into the guidelines. Dr. Scheuerell does not believe that this should necessarily be the approach taken to an injured worker. The Department responded that if a clinical modality is being used, the treatment should result in progressive improvement within the applicable response time. If the treatment is home-based, the rules allow home-based treatment indefinitely, since there is no specific "response time" given for home-based treatment.

163. The Administrative Law Judge finds that subparts 7, 8, 9 and 10 as proposed are needed and reasonable.

164. Subpart 11 deals with specific treatment parameters for epicondylitis. The need for and reasonableness of this subpart is discussed at page 65 of the SONAR. Dr. Scheuerell, in his letter of July 5, 1994, p. 3, states that although he agrees with the statement contained in lines 21 through 24, page 101 of the Revisor's draft of subitem A (3) of this subpart, epicondylitis frequently recurs or has changing intensity associated with repetitive movement occupations. Repeating a short course of ultrasound, for example, may allow an employee to continue his job. Part 5221.6050, subp. 8, however, allows continuation of treatment, if the employee has an incapacitating exacerbation. Part 5221.6300, subp. 3 allows ongoing care for up to 12 times in an additional year, if needed for vocational functioning, and additional treatment thereafter with authorization by the insurer, compensation judge or commissioner under stated conditions. The Administrative Law Judge finds that item A of subpart 11 of this Part is needed and reasonable.

165. Item B of subpart 11 of this Part deals with surgical evaluation. The need for and reasonableness of item B of this subpart is discussed at page 65 of the SONAR. The only comments received during the rulemaking proceeding on item B relate to subitem (6) of item B of this subpart. Several commentators stated that it would be inappropriate in some cases to wait a full 12 months after initial surgical management was begun to actually perform surgery. While this may be an appropriate general rule, it might not, in some cases, be appropriate to keep a worker from surgery for a full 12 months if it is clear that he or she will require surgery. Tr. 206; Ex. T; Comments of Dr. Scheuerell, July 5, 1994; Comments of Dr. Scott A. McPherson, July 25, 1994, p. 2.

In response to these comments, the Department proposes to modify subitem (6) of item B as indicated in Exhibit A, attached hereto. This change, as has been indicated, was recommended by a variety of practitioners and the Medical Services Review Board concurred. The amendment requires a second surgical opinion to ensure that unnecessary surgery is not performed too early, since, in most cases, the 12-month parameter is appropriate. Since this amendment was made in response to public comment and does not expand the application of the proposed rule, it does not constitute a prohibited substantial change.

166. The Administrative Law Judge finds that item B of this subpart, as amended, is needed and reasonable.

167. Subpart 12 of this Part deals with specific treatment parameters for tendonitis of the forearm, wrist and hand. The need for and reasonableness of this subpart is discussed at page 65 of the SONAR. In his comments of July 5, 1994, Dr. Scheuerell commented that, with respect to lines 22 through 32 of page 107 of the Revisor's draft, there should be an amendment to allow surgery before the stated periods of time for patients with deQuervains syndrome and for patients with trigger finger or trigger thumb. Demanding that patients wait until a stated period of time for a procedure they feel is necessary when the symptoms prevent them from doing their jobs "insults the employee's intelligence and is not productive for the patient or the employee". Comments

of Dr. Scheuerell, July 5, 1994, p. 3. At the hearing, Dr. House expressed similar sentiments. Tr. 206-07.

168. The Department, in its response of August 24, 1994, states that not all patients will have recurrent symptoms if appropriate conservative care incorporating both passive treatment and active interventions are used. The Department and the MSRB believe that it is in the best interests of the patient to correct an underlying problem with the job activity rather than to treat the result with surgery which permanently alters the anatomy and carries with it a slight but real risk of morbidity. Some patients who have been treated with surgery will also experience a recurrence of symptoms because no activity modifications have been made. It should also be noted in response to Dr. Scheuerell and Dr. House that the exception provision contained in Part 5221.6050, subp. 8, item B could allow a deviation in an appropriate case if there is a significant incapacitating exacerbation present. The Administrative Law Judge finds that subpart 12, item B is needed and reasonable.

169. Subpart 14 of this Part deals with specific treatment parameters for muscle pain syndromes. The need for and reasonableness of this subpart is discussed at page 65 of the SONAR. At the hearing, James Hoyme, P.T., argued with respect to subitem C of subpart 14 that a patient should not have to wait at least 12 months for any chronic management under some circumstances. Tr. 290-91. Mr. Hoyme, on behalf of the Physical Therapy Association, offered Exhibit X into the record. Tr. 291. In response to Mr. Hoyme's comment, the Department proposed to amend item C, line 21, page 109 of the Revisor's draft, by dropping from the text the requirement of 12 months of initial non-surgical management. This change is necessary to correct an inconsistency in the rules. Item A of subpart 14 cross-references subpart 11, item A, which provides in subitem (4) that at any time during the 12-month period, chronic management may be utilized. Since the amendment to item C is necessary for the internal consistency of the rules and was made in response to public comment, it is not a prohibited substantial change. The Administrative Law Judge finds that subpart 14 of this Part, as amended, is needed and reasonable.

170. Although not discussed at the hearing, subpart 15 relates to specific treatment parameters for shoulder impingement syndromes. The Administrative Law Judge calls to the attention of the Department the inclusion in subpart 15 of a variety of statements that limit chronic management to beginning only after a stated period of time. The Administrative Law Judge questions whether subpart 15 of this Part raises the same considerations as were discussed by Mr. Hoyme in regard to item C of subpart 14 of Part 5221.6300, appearing at line 21 of the Revisor's draft of the rules at page 109. If, in the judgment of the Department, subpart 15 raises the same concerns as were discussed by Mr. Hoyme with respect to subpart 14, the Department may change the appropriate portions of subpart 15 for the same reasons stated by Mr. Hoyme. Tr. 289; Ex. X. Such a change would not constitute a prohibited substantial change. If different considerations are involved in subpart 15 of this Part, and, in the judgment of the Department, amendments to subpart 15 to reflect Mr. Hoyme's testimony would be inappropriate, the Department is not required to make such changes.

Part 5221.6305. Reflex Sympathetic Dystrophy of the Upper and Lower Extremities

171. This part deals with any condition of the upper or lower extremity characterized by the concurrent presence in the extremity of the conditions stated in subpart 1, Scope. This part discusses in subparts 1 through 4 the scope of the rule, initial non-surgical management, surgery and chronic management. The need for and reasonableness of Part 5221.6305 is discussed at pages 66-68 of the SONAR. It is also discussed by Dr. House at pages 214-19 of the hearing transcript.

172. Subpart 1 of this Part deals with the scope of the rule. The only portion of this subpart receiving comment was item C dealing with thermography. The rule provides that thermography may be used, but it is not to be reimbursed separately from the office visit. Dr. Jack E. Hubbard, in his comments of July 21, 1994, argues that thermography should be reimbursed separately from the office visit. Dr. Hubbard believes that a thermographic examination is similar to an x-ray procedure. Dr. Hubbard states that thermography is a medical imaging test and should be reimbursed separately.

The Department, in its response of August 24, 1994, states that a symptom of reflex sympathetic dystophy is dysfunction of skin temperature. Such a dysfunction can be identified by the provider's touch of the affected area. This would be part of the office examination. If a more expensive test is substituted for that part of the physical examination, no separate reimbursement is appropriate. Dr. Hubbard does not take the position that thermography provides any more accurate information than obtained from physical examination by the provider. Moreover, in Reference 18 to the SONAR, the American Medical Association has adopted a resolution that thermography has not been proven to be efficacious. SONAR, p. 67. The Administrative Law Judge finds that subpart 1 of this Part is needed and reasonable as proposed.

173. Subpart 2 of this Part relates to initial non-surgical management. The initial non-surgical management is limited to the modalities specified in items A-D of this subpart. Dr. McPherson, in his comments of July 25, 1994, discusses changes in item A related to therapeutic injection modalities. Dr. McPherson states that he believes that regional IV blocks should also be considered a useful modality. Specifically, a cortisone bier block is sometimes used for reflex sympathetic dystrophy and is well documented in the literature as being efficacious. Dr. House also discussed intravenous infusion as being appropriate. Dr. Lowell Peterson, in his letter of July 26, 1994, suggests the additional of epidural blocks in item A.

In response to the comments received by the Administrative Law Judge, the Department and the Medical Services Review Board proposed to amend item A of subpart 2 of this Part as indicated in Exhibit A hereto. Since the changes are made for purposes of completeness, do not specifically expand the application of the rule and are made in response to public comment, they do not constitute prohibited substantial changes. The Department has demonstrated that subpart 2 of this Part, as amended, is needed and reasonable.

174. Subpart 3 relates to surgery for upper and lower extremity reflex sympathetic dystrophy. The only discussion of this subpart is contained in

the letter of Dr. Lowell Peterson, dated July 26, 1994. Dr. Peterson pointed out that a morphine pump may also be appropriate, as might a dorsal column stimulator for patients with neuropathic pain unresponsive to all other treatment modalities under described circumstances. The Department, in its letter of October 4, 1994, made a part of Exhibit A, agrees with Dr. Peterson and proposes the amendments shown in Exhibit A attached hereto, to include a morphine pump in item B of this subpart 3 and to make an additional change required to accommodate the first insertion in the item. Since the amendments are made in response to public testimony, are necessary for purposes of completeness and do not significantly expand the application of the proposed rule, the amendments to this item do not constitute a prohibited substantial change. For the reasons stated at page 68 of the SONAR, the Administrative Law Judge finds that subpart 3, item B, as amended, is needed and reasonable.

Part 5221.6400. Inpatient Hospitalization Parameters

175. Part 5221.6400 relates to parameters for non-emergency hospital care. This Part is discussed at pages 68 and 69 of the SONAR. It was not the subject of any comment at the hearings. It is, therefore, found to be both needed and reasonable.

Part 5221.6500. Parameters for Surgical Procedures

176. Part 5221.6500 relates to parameters for surgical procedures. The Part includes a subpart dealing with each of the following subjects: general parameter; spinal surgery; upper extremity surgery; and lower extremity surgery. The need for and reasonableness of this rule is discussed at pages 69-70 of the SONAR.

177. With respect to subpart 2, Spinal Surgery, Dr. Joseph Perra stated at the hearing that items A and B should be amended to change the singular "lumbar nerve root" and "cervical nerve root" to the plural to include cauda aquina, which is the portion of the plural nerve roots. As Dr. Perra points out, the rule should include not only those lesions peripherally of the nerve root, but centrally in the canal.

In response to the comments of Dr. Perra, the Department proposed to amend items A and B, as shown in Exhibit A, attached hereto. The Department proposes to add the words "or roots" after the word "nerve" in item A and B, as proposed by Dr. Perra. Also, as proposed by Dr. Perra, the word "spondylolisthesis" is added as an "iv" to item C of subitem (l)(d). It was inadvertently omitted, as demonstrated by Dr. Perra. Also, as recommended by Dr. House at the hearing, the Department has proposed to include a cross-reference to the general low back, neck and thoracic treatment parameters for ease of application of the rules. This does not constitute a prohibited substantial change because it is added only for purposes of ease of use of the rules and does not add any obligation.

178. The Administrative Law Judge finds, for the reasons stated at page 69 of the SONAR, that subpart 2 of this part, as amended, is needed and reasonable.

179. Subpart 3 of this Part deals with the various types of upper extremity surgery. The department proposed to amend subpart 3 after line 36 on page 121 of the Revisor's draft by inserting the language stated in Exhibit A, attached hereto. It is merely a cross-reference to initial non-surgical, surgical and chronic management parameters for upper extremity disorders. This is in response to a recommendation by Dr. House that the surgical section of the upper extremity rules should include cross-references to Part 5221.6300 for ease in application. No substantive change is made by adding the cross-reference noted. The Administrative Law Judge finds that the amendment to subpart 3 is not a prohibited substantial change since it does not expand the application of the rule and was made in response to a public comment received at the hearing. It is also needed and reasonable for ease of application of the rules.

180. With respect to item C of subpart 3, Dr. Scheuerell, in his letter of July 5, 1994, states that lines 17 and 18 of page 123 of the Revisor's draft should be deleted, since all patients will improve over the first week if they receive ice analgesics and a sling. That does not, however, bear on the question of what is the appropriate treatment. At lines 19 and 20 of page 123 of the Revisor's draft, Dr. Scheuerell, in the same comment, states that the use of a brace is not usually an effective form of treatment. Finally, he states that lines 21 and 22, page 123 of the Revisor's draft, which deal with grade III separation, usually call for surgery. There are, however, some few patients that are greatly bothered by the cosmesis of an acromioclavicular joint separation. Dr. Scheuerell believes these patients should not be barred from having reduction and fixation. The Department responds that surgery can proceed if non-surgical treatment is not permanently effective. It does not believe that initial non-surgical treatment should never be tried simply because some patients may eventually need surgery or may be non-compliant. Finally, the Department states that surgery for cosmetic purposes is not indicated unless function is also involved.

181. Dr. Scheuerell also commented regarding item D of this subpart, subitem (2)(a), that lines 2 through 4 should be deleted. Dr. Scheuerell believes that all patients given initial care of sling, ice and analgesics will improve, but some of those patients will later develop symptoms associated with activity. The Department, in its response of August 24, 1994, points out that initial improvement does not preclude later surgery if symptoms recur.

182. Dr. Scheuerell, in his comments of July 5, 1994, also states that lines 33 and 34 of subpart 3E(2)(b), page 124 of the Revisor's draft, should be deleted. Dr. James House made a similar comment during the hearing. Tr. 207. In response to these comments, the Department proposed to delete at line 33 of page 124 of the Revisor's draft the following: ", CT scan, or MRI scan". The Medical Services Review Board agreed that CT and MRI scans are not used to diagnose a history of multiple dislocation or subluxations. There also was concern that the rule could be read to create a new standard of care which would require all of the studies, even if they are not indicated. Tr. 207. The amendment at Exhibit A to line 33 of page 124 of the Revisor's draft is not a prohibited substantial change because it does not expand the application of the rule, is only made for purposes of clarity, and was made in response to appropriate public comment. The amendment to item E is needed and

reasonable so that unnecessary imaging need not be performed prior to or as a condition of surgery.

183. Dr. House also suggested that the surgical section of the upper extremity rule include cross-references to Part 5221.6300 for ease in application. As previously noted, an amendment was made to the initial portion of subpart 3. In accordance with that same amendment and for purposes of clarity, it is proposed to add new subitems G, relating to epicondylitis surgery; H, relating to tendonitis; I, relating to nerve entrapment syndromes; J, relating to muscle pain syndromes; and K, relating to traumatic sprains and strains. The additional items G through K do not make a prohibited substantial change in the rule since they do not add any substantive requirements and are only cross-references included for purposes of clarity. New items G-K, inclusive, are needed and reasonable to assist the user in applying the rules by the inclusion of appropriate cross-references.

184. The Administrative Law Judge finds, for the reasons previously discussed and for the reasons stated at pages 69-70 of the SONAR, that subpart 3 of this Part, as amended, is needed and reasonable.

185. Subpart 4 of this Part relates to lower extremity surgery. Dr. Scheuerell, in his comments of July 5, 1994, comments on line 2 of page 126 of the Revisor's draft of the rules, item B. He states that a Maquet procedure may also be done for patellofemoral degenerative and patellofemoral malalignment, not solely for patellar dislocation, as stated in the rule. The Department, in its submission of August 24, 1994, states that the position of Dr. Scheuerell with respect to the use of the Maquet procedure does not have universal acceptance in the medical community and requires further study by the Department and the MSRB. The Administrative Law Judge finds that item B of subpart 4 is needed and reasonable as proposed.

186. Dr. Scheuerell also comments on item C, subitem (2)(a) at line 24 of page 126 of the Revisor's draft. He states that the phrase "night pain in the joint" should be removed, since he believes it is too restrictive. In Dr. Scheuerell's experience, there are a number of stoic patients with severe degenerative changes and functional loss that deny having night pain. In response to the comment of Dr. Scheuerell and further consideration by the Medical Services Review Board, and at the suggestion of Dr. Wynn Kearney, a member of the Medical Services Review Board, item C(2)(a) was modified by including after the word "joint" in line 24 of page 126 of the Revisor's draft, the phrase "or pain with weight bearing". See, Exhibit A. Pain with weight bearing is another indication for this surgery. The Administrative Law Judge finds that the amendment is not a prohibited substantial change. It was made in response to additional study and public comment and does not materially expand the scope of the rule. This indication is merely added for purposes of completeness. Item C(2)(a), as amended, is found to be needed and reasonable.

187. Dr. Scheuerell also commented on item D(1)(b). Comments of Dr. Scheuerell, July 5, 1994, p. 4. Dr. Scheuerell believes that the word "traumatic" should be deleted. In his opinion, total knee replacement is indicated for a variety of arthritities, not solely traumatic arthritis. The Department responded that Dr. Scheuerell misread the rule. Traumatic

arthritis is required for fusions in item D, not for knee joint replacement, for which "advanced arthritis" is an indication in item C(2)(b).

188. Dr. Scheuerell also commented on item D(2)(b)(i) and (ii). He believes that, in lines 13 and 14 of page 127 of the Revisor's draft, the reference to xylocaine injection should be deleted and that in line 17 of the same page, the reference to decreased range of motion should be deleted. The Department responded that xylocaine injection and decreased range of motion offer objective information for diagnosis. The Administrative Law Judge finds that item D(2)(b)(i) and (ii) are needed and reasonable as proposed.

189. Dr. Scheuerell also commented on item E(2)(b)(iii) as it refers to a a 15-degree lateral opening at the ankle joint. In the opinion of the Department and the MSRB, the rule as written represents the majority opinion. The Administrative Law Judge finds that item E(2)(b)(iii) is needed and reasonable as proposed.

Part 5221.6600. Chronic Management

190. Subpart 1 of this Part defines the purposes of chronic management, describes patients that may be candidates for chronic management and states that chronic management applies to all types of physical injuries, even if the injury is not specifically governed by Parts 5221.6200 - 5221.6500. At the hearing herein, Dr. Lawrence Schut described the need for and reasonableness of chronic management. Tr. 236-45. It is the position of Dr. Schut and the Board that patient independence is to be maximized through the use of active management practices by both health care providers and the injured worker. Dr. Schut cautions against reliance on drug therapy and the tendency of the provider to become co-dependent in the relationship with the patient. Dr. Schut believes that with chronic pain, there is a tremendous excess in employment of diagnostic testing and utilization of services. Tr. 238. In Dr. Schut's opinion, active treatment techniques, including therapeutic exercise, relaxation therapy and stress management techniques avoid practitioner/patient co-dependence and result in many patients being able to function with their condition.

191. Liberty Mutual Insurance Company, in its submission of August 22, 1994, stated that it was the opinion of the company that the doctor or facility performing the assessment for chronic management should be neutral and should not be or be in any way related to the doctor or facility who will provide management. The Department, in its response of August 31, 1994, states that typically the employee's primary health care provider will coordinate and make referrals for most chronic management modalities. If Liberty Mutual is referring to chronic pain programs its suggestion would mandate second opinions for every pain clinic evaluation. It is not necessary to mandate a second opinion in every case because under Part 5221.6050, subp. 9, the insurer may obtain an evaluation by a doctor of its choosing for assessment of the appropriateness of the chronic management modalities. Hence, in suspected cases of abuse, a second opinion already may be obtained.

192. Subpart 1 of this Part is found to be needed and reasonable.

193. Subpart 2 of this Part relates to chronic management modalities. The Department, in its response of August 24, 1994, proposed to amend subpart 2, as indicated in Exhibit A, attached hereto. The amendment is proposed in response to a comment describing a situation in which the insurer denied payment for a health club membership in part because of a lack of attendance records, even though such documentation had not been required in the past. This proposed change would require notice to be given of a future application of the rules to ongoing chronic management programs. This will give the employee and the health care provider an opportunity to comply with documentation requirements. Subpart 2, lines 6 through 11 of the Revisor's draft of the proposed rules are found to be needed and reasonable, as amended. The amendment proposed by the Department in response to public comment is not a prohibited substantial change.

194. Item B of subpart 2 relates to health clubs. Subitem (3) of item B limits a health club membership to 13 weeks unless there is a demonstrated attendance and progression in activity during the preceding period of treatment. Dr. Timothy A. Garvey, in his letter of July 25, 1994, states that membership ought not to be limited to 13 weeks if a patient has had successful resolution of their symptomatology and has returned to work. Dr. Garvey suggests that there continue to be active exercise to minimize the likelihood that such a worker would return to medical treatment. The Department, in its submission of August 24, 1994, states that the rule does allow extensions of the 13-week period to accomplish successful resolution of symptomatology with documentation of attendance. At some point, if there is resolution of the symptoms, the health club membership is no longer necessary to cure and relieve the work injury. The Administrative Law Judge finds that item B(3) is both needed and reasonable.

195. Item C of this subpart relates to computerized exercise programs. Dr. Scheuerell does not believe that the language contained on page 131, lines 24 through 28 of the Revisor's draft, is inclusive enough. Not all use of computerized exercise equipment for rehabilitation is in a deconditioned patient, in Dr. Scheuerell's opinion. The Department, in its response of August 24, 1994, states that computerized exercises are only appropriate for people who cannot be rehabilitated successfully with standard physical therapy techniques, since the majority of patients will recover with these techniques. If a patient does not recover, chronic management is appropriate and computerized exercise would be allowed. The Administrative Law Judge finds that the Department has established the need for and reasonableness of item C of this subpart. It is found to be needed and reasonable.

196. Dr. Stark, in his submission of August 24, 1994, suggests amendments to item E of this subpart. Dr. Stark would add, as a descriptive function of chronic management pain programs the function of providing ongoing referral. Dr. Stark also suggests that patients with apparent organic problems should be returned to medical management for further evaluation. The Department, in its response of August 31, 1994, states that chronic pain programs only apply to people who have been diagnosed with chronic pain syndrome. As defined in Part 5221.6040, subp. 3D and E, chronic pain syndrome includes behaviors that ". . . have not responded to previous appropriate treatment and are not consistent with a known organic syndrome which has remained untreated". Further, Part 5221.6200, subp. 11C requires a referral for chronic management only if the patient continues with symptoms and objective physical findings

after initial non-surgical care and surgery, or if the patient was not a candidate for surgery. There is no prohibition against a chronic management program referring a patient back to the "medical arena" if there is a change in the employee's condition. The rules require completed evaluation and initial non-surgical or surgical treatment prior to referral for chronic management and allow reevaluation if there is a change in condition for which additional studies and consultations are indicated. Appropriate referrals are allowed as needed. The Administrative Law Judge finds that item E is needed and reasonable as proposed.

Part 5221.8900. Disciplinary Actions; Penalties

197. Subpart 1 of this Part is a general provision describing discipline that a health care provider might be subject to. It is discussed at page 73 of the SONAR. It is found to be needed and reasonable.

198. Subpart 2 of this Part relates to complaints. Dr. Stark, in his submission of August 24, 1994, proposes to amend the complaint section by making it apply not only to health care providers but to "administrators or advocates". Apparently, Dr. Stark intends the language to include "claims representatives, attorneys and others". The Department responds that this change suggested by Dr. Stark and changes to subpart 3, subpart 6 and subpart 7, which also insert "administrator or advocate" into the rules are governed by different provisions of the statutes and rules, particularly Minn. Stat. §§ 176.221, 176.225 (1992), Minn. Rules, pt. 5220.2740 and pt. 5220.2760 (1992).

With respect to the suggestion that attorneys should be sanctioned under the process described in this rule, the canons of professional responsibility govern the conduct of lawyers. Complaints against lawyers are investigated by the Lawyers Professional Responsibility Board and, if necessary, acted upon by the Supreme Court. The ability of the Commissioner to sanction attorneys for particular acts would violate the separation of powers doctrine as allowing the executive to exercise a function of the judiciary. The Administrative Law Judge, therefore, rejects Dr. Stark's amendments to this Part.

199. The Minnesota Medical Association, in its submission of August 26, 1994, comments on subpart 2, subpart 3 and 4 of this Part. The Minnesota Medical Association initially states that with respect to subpart 2 of Part 5221.8900, it is absolutely critical that the rules identify the classification of data collected by the Commissioner. In particular, the rules need to address the classification of complaint data, investigation data and final determination data. The Minnesota Medical Association states that unsubstantiated complaints against a provider can be damaging and should not be made public. It concludes that such data should be private. The Department, in its response of August 24, 1994, states that the Commissioner of the Department has no authority by rule to declare data private. The protection of the data is as governed by Minnesota Statutes chapter 13, the Government Data Practices Act. Minn. Stat. §§ 13.41 and 13.49 (1992), govern. The method for applying chapter 13 is stated in that chapter and, in the event of doubt, determinations may be made by the Commissioner of Administration, subject to judicial review. The Administrative Law Judge finds that subpart 2, as proposed, is needed and reasonable.

200. The Minnesota Medical Association, with respect to subpart 3 of this Part, requests that an affirmative statement be included that deviation from the parameters will often be necessary and appropriate. The Administrative Law Judge does not believe this is an appropriate condition. It is clear, since the rules contain a general exception provision as subpart 8 of Part 5221.6050, that deviations from the rules made in good faith will be required.

201. With respect to subpart 4 of this Part, the Minnesota Medical Association, in its comments of August 24, 1994, states that a health care provider is not allowed to charge for the cost of copying records in any discipline investigation. The Association believes that the provider should not be required to pay for services or medical records used in a discipline process. Particularly if the provider has not violated a rule, the provider should not have to pay for the provider's services or for the cost of copying records. In response to the comment of the Minnesota Medical Association and the comment of Dr. Scheuerell, dated July 5, 1994, the Department proposes an amendment as indicated in Exhibit A attached hereto, at page 136, lines 2 and 3 of the Revisor's draft. The Department agrees that it is inappropriate for the provider to pay for the cost of copies of medical records. Therefore, the rule is modified to be consistent with Minn. Stat. § 147.131 (1992), in which the Board of Medical Practice is required to pay for medical records. The two proceedings, the Department believes, should be treated comparably. Since the amendment was made in response to public comment and does not substantially enlarge the scope of the rules, it is not a prohibited substantial change. The Administrative Law Judge finds that Minn. Rules, pt. 5521.8900, as amended, is needed and reasonable.

202. Dr. Stark, at the hearing and in his submissions outlined diagramatically a set of treatment parameters wholely different than that of the Department. Dr. Stark stated that he showed his diagram to a number of treatment professionals who expressed interest in his ideas. Dr. Stark did not share his approach with the MSRB or the Department prior to the rulemaking proceeding. As previously noted, the presentation of the Department need not establish that its set of rules is the most reasonable that could be developed or that alternative proposals could not be advanced. See, Finding 25, supra. The Department must only show that its proposal is authorized and needed and reasonable. It has done so.

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

CONCLUSIONS

1. The Department of Labor and Industry gave proper notice of the hearing in this matter.

2. The Department has fulfilled the procedural requirements of Minn. Stat. §§ 14.14, subds. 1, 1a and 14.14, subd. 2, and all other procedural requirements of law or rule.

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)(ii), except as noted at Finding 28, supra.

4. The Department has documented the need for and reasonableness of its proposed rules with an affirmative presentation of facts in the record within the meaning of Minn. Stat. §§ 14.14, subd. 2 and 14.50 (iii), except as noted at Finding 68, supra.

5. The amendments and additions 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, and Minn. Rule 1400.1000, subp. 1 and 1400.1100.

6. The Administrative Law Judge has suggested action to correct the defects cited in Conclusions 3 and 4 as noted at Findings 29 and 69, supra.

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

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

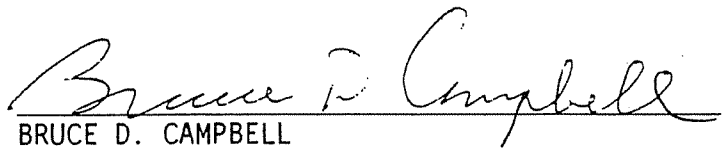
9. A finding or conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the Department from further modification of the proposed rules based upon an examination of the public comments, provided that no substantial change is made from 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 2nd day of November, 1994.



BRUCE D. CAMPBELL
Administrative Law Judge

Reported: Kirby A. Kennedy & Associates, (612) 922-1955.

Proposed Department Changes: Workers' Compensation Treatment Rules
(Page References to the Revisor's Draft)

Part 5221.6050, Subp. 5. Referrals Between Health Care Providers

Page 7:

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

Rationale: A commentor noted that this communication is necessary whether the patient's care is being transferred to another provider, or simply being temporarily referred for a consultation.

Part 5221.6050, Subp. 6. Communication Between Health Care Providers and Consideration of Prior Care

Page 8:

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

(1) A health care provider may not repeat or perform alternate diagnostic testing previously performed by another health care provider except as permitted in part 5221.6100.

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

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

Rationale: Several providers have commented that the rules could be clarified to state that if the provider has asked the patient about prior care and receives erroneous information, the provider should not be denied payment. Many of these cases will be very fact specific and the workers' compensation law on employee liability in this area is unclear. For example, an employee may not recall treatment, which is different than withholding information. The rule is intended to leave room for the decision-maker (in most cases the compensation judge) to determine whether an employee is liable for the cost in such cases. Therefore, Item B is modified to clarify that a provider is prohibited from repeating treatment "if the employee has reported that care for an injury has been previously given."

Part 5221.6050, subp. 7. Determinations of Excessive Treatment : Notice of Denial to Health Care Providers and Employee; Expedited Processing of Medical Requests

Page 9:

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

Rationale: A commentor described a situation in which the insurer denied payment for a health club membership, in part based on lack of attendance records, even though payment had previously been made without this documentation. Accordingly, a change is proposed to the rule to require that notice be given of future application of rules to ongoing chronic management programs. This will provide the employee and health care provider with the opportunity to comply with the documentation requirements.

Part 5221.6050, Subp. 8. Departures from Parameters

Page 10:

A departure from a treatment parameter in parts 5221.6050 to 5221.6600 may be appropriate in any one of the circumstances specified in items A to E.

. . . .

Rationale: A commentor queried whether all the items needed to apply before a departure would be appropriate. Although the rule as proposed states a departure is allowed for "any" of the items, which should be clear, the rule is changed to state that a departure is allowed in any "one" of the circumstances in items A to E, to ensure there is absolutely no question.

Part 5221.6050, subp. 9. Prior Notification

Pages 12 - 14:

C. The insurer must provide a toll-free facsimile and telephone number for health care providers to provide prior notification. The insurer must respond orally or in writing to the requesting health care provider's prior notification of proposed treatment in item A within seven working days of receipt of the request. Within the seven days, the insurer must either approve the request, deny authorization, request additional information, request that the employee obtain a second opinion, or request an examination by the employer's physician. A denial must include notice to the employee and health care provider of the reason why the information given by the health care provider in item B does not support the treatment proposed.

. . . .

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

(5) In any case where prior notification of proposed surgery is required, the insurer may elect to obtain an examination of the employee by the employer's physician under Minnesota Statutes, Section 176.155, sometimes referred to as an "independent medical examination" ....

(6) The insurer's request for additional information must be directed to the requesting health care provider and must specify the additional information required that is necessary to respond to the health care provider's notification of proposed treatment ....

Rationale: The changes to item 6 and the introductory paragraph in item C were discussed by Mr. Hoyme in his testimony and proposed in Exhibit X. (T-289-290). It was also recommended by the Medical Services Review Board on August 18, 1994. The rule clarifies that the provider who requests authorization is the provider that the insurer should communicate with. The change to item 4 corrects an erroneous citation; there is no item C for part 5221.6300, subp. 6. Ms. Sigel of the MMA commented that the rule is confusing to providers and suggested the addition of the commonly used phrase "independent medical examination" to distinguish item 5 from item 4, which governs second opinions from a doctor elected by the employee.

Part 5221.6100, Subpart 1. General Principles

A. Effective imaging. A health care provider should order the single most effective imaging study for diagnosing the suspected etiology of a patient's condition. No concurrent or additional imaging studies should be ordered until the results of the first study are known and reviewed by the treating health care provider. ~~Additional studies may be obtained if the first imaging study was inconclusive with suggestive findings.~~ If the first imaging study is negative, no additional imaging is indicated ~~unless:~~ except for repeat and alternative imaging allowed under items D and E.

~~(1) there is a change in the suspected etiology based on the results of the first imaging study; or~~

~~(2) there is a change in the patient's condition which would in itself warrant imaging.~~

. . . .

D. Repeat imaging. Repeat imaging, of the same views of the same body part with the same imaging modality is not indicated except as follows:

(1) to diagnose a suspected fracture or suspected dislocation;

(2) to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment; repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment;

(3) to follow up a surgical procedure;

(4) to diagnose a change in the patient's condition marked by new or altered physical findings;

(5) to evaluate a new episode of injury or exacerbation which in itself would warrant an imaging study; or

(6) when the treating health care provider and a ~~original radiologist and another~~ radiologist from a different practice have reviewed a previous imaging study ~~MRI or CT scan~~ and agree that it is a technically inadequate study.

E. Alternative imaging.

(1) Persistence of a patient's subjective complaint or failure of the condition to respond to treatment are not legitimate indications for repeat imaging. In this instance an alternative imaging study may be indicated if another etiology of the patient's condition is suspected because of the failure of the condition to improve.

(2) Alternative imaging is not allowed to follow up negative findings unless there has been a change in the suspected etiology and the first imaging study is not an appropriate evaluation for the suspected etiology.

(3) Alternative imaging is allowed to follow up abnormal ~~or~~ but inconclusive findings in another imaging study. An inconclusive finding is one that does not provide an adequate basis for accurate diagnosis.

Rationale: Subitems 1 and 2 of item A are deleted because these requirements are included in items D(4) and (5) and E(2). A close review in response to Dr. Stark's concerns about this rule indicated that application of these subitems could be confusing because the language is not identical to the corresponding and more clearly stated provisions in items D and E. Dr. Stark further questioned the sentence in item A that allowed additional studies "if the first imaging study was inconclusive with suggestive findings." This sentence corresponds to item E(3), and therefore a more precise definition of "inconclusive finding" is added to subitem 3. These changes are consistent with Dr. Stark's notes 22 and 24, in which he agrees that additional studies may be required in order to demonstrate changing (items D(2) and (4) and E(2)) or less obvious (item E(3)) problems, or in response to a "high index of suspicion" (items E(2) and (3)).

For example, in a patient with symptoms and physical findings of S-1 radiculopathy, a CT scan may show a disc bulge, but not demonstrate conclusively whether the disc bulge is compressing the S-1 nerve root. Another imaging study needs to be done to demonstrate whether the bulge is the cause of the radicular symptoms.

The change to item D(6) was proposed in the Department's August 24, 1994 submission and is repeated here for completeness.

Part 5221.6050, Subp. 11. Outcome Studies

Page 14:

The Commissioner shall perform outcome studies on the treatment modalities in parts 5221.6200 to 5221.6600. The modalities to be studied shall be selected in consultation with the Workers' Compensation Medical Services Review Board. The commissioner may require health care providers who use ~~the~~ these modalities ~~in parts 5221.6200 to 5221.6600~~ to prospectively gather and report outcome information on patients treated, with necessary consent of the employee. The health care providers shall report the outcome information on the modalities in parts 5221.6200 to 5221.6600 on a form prescribed by the commissioner, which may include:

. . . .

F. The diagnosis, symptoms, physical findings and functional status before and after the treatment being studied for the same condition.

G. The presence or absence of preexisting or concurrent conditions.

Rationale: Dr Stark recommended adding the diagnosis to item F, and item G. Diagnosis is added without requiring a specific coding system. The presence or absence of other conditions is added because these may affect treatment and patient outcomes.

The added first sentence of subpart 11 was proposed in the Department's August 24, 1994 submission.

Part 5221.6100, Subp. 2. Specific Imaging Procedures for Low Back

Page 20-21:

K. Anterior - posterior (AP) and ~~later~~ Lateral x-rays of the lumbosacral spine are limited by subitems (1) and (2).

(1) They are indicated in the following circumstances:

. . . .

(b) when the history, signs, symptoms, ~~and~~ or laboratory studies indicate possible tumor, infection, or inflammatory lesion;

(f) eight weeks after an injury if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

Rationale: Unit (b) is modified in response to a comment by Dr. Stark that any one of these items may indicate the specified conditions. This was the intent of the rule so a modification is made accordingly. The change to unit (f) was proposed in the Department's August 24, 1994 submission.

Part 5221.6200, Subp. 1. Diagnostic Procedures for Treatment of Low Back Injury

Page 21:

A health care provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular pain" means pain radiating distal to the knee, or pain conforming to a dermatomal distribution and accompanied by anatomically congruent motor weakness or reflex changes. This part does not apply to fractures of the lumbar spine, or back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral or neoplastic disease process.

. . . .

E. The use of the following procedures or tests is not indicated for the diagnosis of any of the clinical categories in item A:

. . . .

(5) diagnostic ultrasound of the lumbar spine;

Rationale: The above modifications are proposed in response to Dr. Stark's interpretation of the rules. Items A and E have always been limited to the specific back diagnosis in subitems (A)(1) to (4). However, since Dr. Stark interpreted the rules to preclude diagnostic testing for conditions not listed in items (1) to (4), a clarification is added. Ultrasound of the abdomen or other internal body parts is not limited by the rules.

Part 5221.6205, Subp. 1. Diagnostic Procedures for Treatment of Neck Injury

Page 44:

A health care provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular pain" means pain radiating distal to the shoulder. This part does not apply to fractures of the cervical spine, or cervical pain due to an infectious, immunologic, metabolic, endocrine, neurologic, <u>visceral</u> or neoplastic disease process.

. . . .

E. The use of the following procedures or tests ~~shall not be reimbursed~~ <u>is not indicated for the diagnosis of any of the clinical categories in item A:</u>

. . . .

(5) diagnostic ultrasound <u>of the spine</u>;

Rationale: The above modifications are proposed in response to Dr. Stark's interpretation of the rules. Items A and E have always been limited to the specific back diagnosis in subitems (A)(1) to (4). However, since Dr. Stark interpreted the rules to preclude diagnostic testing for conditions not listed in items (1) to (4), and since the language in item E for neck injuries is inconsistent with that of the low back rule, a clarification is added. Ultrasound of the abdomen or other internal body parts is not limited by the rules.

Part 5221.6210, Subp. 1. Diagnostic Procedures for Treatment of Thoracic Back Injury

Page 67:

A health care provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular pain" means pain radiating in a dermatomal distribution around the chest or abdomen. This part does not apply to fractures of the thoracic spine, or thoracic back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral or neoplastic disease process.

. . . .

E. The use of the following procedures or tests ~~shall not be reimbursed~~ is not indicated for the diagnosis of any of the clinical categories in item A:

. . . .

(5) diagnostic ultrasound of the spine;

Rationale: The above modifications are proposed in response to Dr. Stark's interpretation of the rules. Items A and E have always been limited to the specific back diagnosis in subitems (A)(1) to (4). However, since Dr. Stark interpreted the rules to preclude diagnostic testing for conditions not listed in items (1) to (4), and since the language in item E for thoracic injuries is inconsistent with that of the low back rule, a clarification is added. Ultrasound of the abdomen or other internal body parts is not limited by the rules.

Part 5221.6300, Subp. 1. Diagnostic Procedures for Treatment of Upper Extremity Disorders

Page 88:

A health care provider shall determine the nature of an upper extremity disorder before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must at each visit assign the patient to the appropriate clinical category according to subitems (1) to (6). The diagnosis must be documented in the medical record. Patients may have multiple disorders requiring assignment to more than one clinical category. This part does not apply to upper extremity conditions due to a visceral, vascular, infectious, immunological, metabolic, endocrine, systemic neurologic, or neoplastic disease process, fractures, lacerations, amputations, or sprains or strains with complete tissue disruption.

Rationale: The exclusion of lacerations is proposed in response to the letter from Becky Foley dated August 3, 1994 in which she addressed treatment of wounds. Accordingly, the rule clarifies that, treatment of lacerations are also excluded from the parameters, because these injuries are not included in the clinical categories in subitems 1 to 6. A clarification is made that visceral conditions are also excluded, in response to the interpretation of the rule made by Dr. Stark.

Part 5221.6300, Subp. 3. Passive Treatment Modalities

Page 98, line 35:

H. Manual therapy incudes soft tissue and joint mobilization~~,~~ and therapeutic massage~~, and manual traction~~:

(1) time for treatment response, three to five treatments;

(2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(3) maximum treatment duration, 12 weeks.

I. Splints, braces, ~~casts,~~ and other movement-restraining appliances. Bracing required for longer than two weeks must be accompanied by active ~~range of~~ motion exercises to avoid stiffness and prolonged disability:

(1) time for treatment response, ten days;

(2) maximum treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and

(3) maximum continuous duration, eight weeks. Prophylactic use is allowed indefinitely.

J. Rest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Total restriction of use of an affected body part should not be prescribed for more than two weeks, unless rigid immobilization is required. In cases of rigid immobilization, active motion exercises at adjacent joints should begin no later than two weeks after application of the immobilization.

Rationale: These recommendations by Dr. House were accepted by the Medical Services Review Board on August 18, 1994. "Manual traction" is deleted from item 14 because manual traction is not done for upper extremity disorders. The changes to items I and J are made to reflect that sometimes casting or other immobilization of an upper extremity extends beyond 2 weeks and the rule as proposed could be read to preclude this. In item J, the Medical Services Review Board recommended that when casting is done, appropriate motion exercises must be done to the adjacent body part, for consistency with item I.

Part 5221.6300, Subp. 5. Therapeutic injections.

Page 101, line 35:

C. Injections for ~~peripheral~~ median nerve entrapment ~~include injections of~~ at the carpal tunnel~~, the pronator area of the forearm, the radial tunnel, Guyon's canal, and the cubital tunnel at the elbow~~: . . .

Rationale: This change is recommended by Dr. House, and also by Dr. McPherson in his July 25, 1994 letter. The Medical Services Review Board concurred on August 18, 1994, that therapeutic injections should be limited to carpal tunnel syndrome, and are not indicated for the deleted conditions for anatomical reasons.

Part 5221.6300, Subp. 6. Surgery

Page 102:

Surgery may only be performed if it meets applicable parameters in subparts 11 to ~~14~~ 16 and part 5221.6500.

A. In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) for rotator cuff repair, acromioclavicular ligament repair, or any surgery for a clinical category in this part which requires joint reconstruction, 16 weeks; or

(2) for all other surgery for clinical categories in this part, eight weeks.

The health care provider must provide the insurer with prior notification of nonemergency inpatient surgery according to part 5221.6050, subpart 9.

B. Repeat surgery must also meet the parameters of subp. 11 to 16 and parts 5221.6500 and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if requested by the insurer.

Rationale: This corrects an erroneous citation - the applicable subparts are 11 to 16. Also, paragraph B was inadvertently omitted from this section. The requirement that repeat surgery must be confirmed by a second opinion is consistent with all the back parameters and a reference to item B was included in part 5221.6050, subp. 9(C)(4).

Part 5221.6300, Subp. 11. Epicondylitis.

Page 106, lines 28-30:

(B) . . . (6) If surgery is indicated, it may not be performed until 12 months after initial non-surgical management was begun except in a patient who has had resolution of symptoms with appropriate treatment followed by a recurrence with intractable pain. In this instance, a second surgical opinion must confirm the need for surgery sooner than 12 months after initial non-surgical management was begun.

Rationale: This change was recommended by Dr. House and the Medical Services Review Board concurred, with modifications, on August 18, 1994. The concern is that there may be unique circumstances in which surgery may be appropriate earlier than 12 months, if the specified indication is met. A second opinion is necessary to ensure that unnecessary surgery is not performed too early, since in most cases the 12 month parameter is appropriate.

Part 5221.6300, Subp. 14. Muscle Pain Syndromes.

Page 109, line 22:

C. If the patient continues with symptoms and objective physical findings after ~~12 months of~~ initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with muscle pain syndrome must meet all of the parameters of part 5221.6600.

Rationale: As noted by Mr. Hoyme in his testimony (T-289) and proposed in Exhibit X, this change is necessary to correct an inconsistency in the rules. Item A of subp. 14 cross references subp. 11, item A which provides in sub-item 4 that at any time during the 12 month period chronic management may be utilized.

Part 5221.6305, Subp. 2. Reflex Sympathetic Dystrophy: Initial Non-Surgical Management

Page 112 - 113:

A. Therapeutic injection modalities. The only injections allowed for reflex sympathetic dystrophy ~~is~~ are sympathetic block, intravenous infusion of steroids or sympatholytics, or epidural block.

(1) Unless medically contraindicated, sympathetic blocks or the intravenous infusion of steroids or sympatholytics must be used if reflex sympathetic dystrophy has continued for four weeks and the employee remains disabled as a result of the reflex sympathetic dystrophy.

~~(1)~~ (a) time for treatment response: within 30 minutes.

~~(2)~~ (b) maximum treatment frequency: can repeat an injection at a site if there was a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections must be discontinued. No more than three injections to different sites are reimbursable per patient visit.

~~(3)~~ (c) maximum treatment duration: may be continued as long as injections control symptoms and facilitate objective functional gains, if the period of improvement is progressively longer with each injection.

(2) Epidural block may only be performed in patients who had an incomplete improvement with sympathetic block or intravenous infusion of steroids or sympatholytics.

Subp. 3. Surgery (page 115)

. . . .

B. Dorsal column stimulator or morphine pump may be indicated for a patient with neuropathic pain unresponsive to all other treatment modalities who is not a candidate for any other therapy and has had a favorable response to a trial screening period. Use of these devices ~~a dorsal column stimulator~~ is indicated, only if a second opinion confirms that this treatment is indicated, and a personality or psychosocial evaluation indicates that the patient is likely to benefit from this treatment.

Rationale: The change regarding intravenous infusions was recommended by Dr. McPherson and Dr. House, and the Medical Services Review Board concurred as modified on August 18, 1994. The change adds a type of infusion that may be used in the treatment of reflex sympathetic dystrophy.

The addition of epidural blocks in item A and the morphine pump in item B are made in response to the letter from Lowell Peterson, M.D., in his letter of July 26, 1994.

Part 5221.6500, Subp. 2. Spinal Surgery

Page 118:

Initial non-surgical, surgical and chronic management parameters are also included in part 5221.6200, Low Back Pain; Part 5221.6205, Neck Pain; and part 5221.6210, Thoracic Back Pain.

. . . .

Rationale: As recommended by Dr. House, cross references to the general low back, neck and thoracic treatment parameters are included here for ease in application of the rules.

Part 5221.6500, Subp. 2. Spinal Surgery

Page 118 - 120:

A. Surgical decompression of a lumbar nerve root or roots includes, but is not limited to, the following lumbar procedures: (. . . .)

B. Surgical decompression of a cervical nerve root or roots includes, but is not limited to, the following cervical procedures: (. . . .)

C. Lumbar arthrodesis with or without instrumentation:

(1) Indications: one of the following conditions must be satisfied to indicate that the surgery is reasonably required:

. . . .

(d) incapacitating low back pain, ICD-9-CM code 724.2, for longer than three months, and one of the following conditions involving lumbar segments L-3 and below is present:

. . . .

iv. Spondylolisthesis

Rationale: The rule was never intended to require separate operations when two nerve roots met the criteria. Since Dr. Perra interpreted the rule in such a manner, the rule is so clarified. Spondylolisthesis was inadvertently omitted, as pointed out by Dr. Perra.

Part 5221.6500, Subp. 3. Upper Extremity Surgery

Page 121-125:

Initial Non-Surgical, surgical and chronic management parameters for upper extremity disorders are found in part 5221.6300, subparts 1 - 16.

. . . .

G. Epicondylitis. Specific requirements for surgery for epicondylitis are included in part 5221.6300, subp. 11.

H. Tendinitis. Surgery for tendinitis is governed by part 5221.6300, subp. 12.

I. Nerve Entrapment Syndromes. Specific requirements for nerve entrapment syndromes are included in Part 5221.6300, subp. 13.

J. Muscle Pain Syndromes. Surgery is not indicated for muscle pain syndromes.

K. Traumatic sprains and strains. Surgery is not indicated for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

Rationale: Dr. House recommended that the surgical section of the upper extremity rules include cross references to Part 5221.6300, for ease in application. No substantial modification to the parameters are made; relevant surgical parameters from Parts 5221.6300, subps. 11 - 16 are merely repeated here.

Part 5221.6500, Subp. 3. Upper Extremity Surgery

Page 124, lines 33-34:

E. Repair of shoulder dislocation or subluxation (any procedure):

. . . .

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following clinical findings must exist for repair of a shoulder dislocation:

(a) the employee exhibits a history of multiple dislocations or subluxations that inhibit activities of daily living; and

(b) x-ray~~, CT scan, or MRI scan~~ findings are consistent with multiple dislocations or subluxations.

Rationale: Dr. House and the Medical Services Review Board agreed that CT and MRI scans are not used to diagnose a history of multiple dislocation or subluxations. There was a concern that the rule could be read to create a new standard of care to require these studies, which are not indicated.

Part 5221.6500, Subp. 4. Lower Extremity Surgery

Page 126, line 23-26:

C. Knee joint replacement:

. . . .

(2) Criteria and indications: . . .

(a) clinical findings: the employee exhibits limited range of motion, night pain in the joint or pain with weightbearing, and no significant relief of pain with an adequate course of initial nonsurgical care; . . . .

Rationale: This change was recommended by Dr. Wynn Kearney, a member of the Medical Services Review Board, and was approved by the Medical Services Review Board at the July, 1994 meeting. Pain with weight-bearing is another indication for this surgery.

Part 5221.6600, subp. 2. Chronic Management Modalities

Page 130:

The health care provider must provide prior notification of the chronic management modalities in items B to F according to part 5221.6050, subpart 9. Prior notification is not required for home-based exercises in item A, unless durable medical equipment is prescribed for home use. The insurer may not deny payment for a program of chronic management, for an individual employee, that the insurer has previously authorized, either in writing or by routine payment for services, without providing the employee and the employee's health care provider with at least 30 days notice of intent to apply any of the chronic management parameters in part 5221.6600 to future treatment. The notice must include the specific parameters that will be applied in future determinations of compensability by the insurer.

Rationale: A commentor described a situation in which the insurer denied payment for a health club membership, in part based on lack of attendance records, even though payment had previously been made without this documentation. Accordingly, a change is proposed to the rule to require that notice be given of future application of rules to ongoing chronic management programs. This will provide the employee and health care provider with the opportunity to comply with the documentation requirements.

Part 5221.8900, Subp. 4. Cooperation with Disciplinary Proceedings.

Page 136, lines 2 - 3:

A health care provider who is the subject of a complaint investigated by the commissioner under Minnesota Statutes, Section 176.103, shall cooperate fully with the investigation. Cooperation includes, but is not limited to, responding fully and promptly to any questions raised by the commissioner relating to the subject of the investigation and providing copies of records, reports, logs, data and cost information as requested by the commissioner to assist in the investigation. The health care provider shall not charge for services ~~or~~ but may charge for the cost of copies of medical records, at the rate set in Minn. Rules, Part 5219.0300, subp. 2, for this investigation. Cooperation includes attending, in person, a meeting scheduled by the commissioner for the purpose of subpart 5. This subpart does not limit the health care providers right to be represented by an attorney.

Rationale: Ms. Sigel of the Minnesota Medical Association noted that under Minn. Stat. §147.131, the Board of Medical Practice is required to pay for medical records. Although there is no compensable statute for workers' compensation disciplinary proceedings, the rule is modified for consistency to allow payment for the cost of copies of medical records pursuant to the rule setting the rate for these copies.