Department of Labor and Industry

Adopted Exempt Permanent Rules Relating to Workers' Compensation; 2016 Adjustments to Independent Medical Examination Fees in Minnesota Rules, chapter 5219; 2016 Adjustments to Relative Value Fee Schedule Conversion Factors and Amendments to Rules Implementing the Workers' Compensation Relative Value Fee Schedule Tables in Minnesota Rules, chapter 5221

5219.0500 INDEPENDENT MEDICAL EXAMINATION FEES.

[For text of subps 1 to 3, see M.R.]

Subp. 4. **Adjustments.** On October 1, 1994, and on October 1 of each succeeding year, the fees in this part must be adjusted by the percentage determined under Minnesota Statutes, section 176.645, in the same manner as the conversion factor of the relative value fee schedule is adjusted under Minnesota Statutes, section 176.136. This provision does not apply to expenses under subpart 3, item E, subitem (1). The fees shall be adjusted as follows:

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

U. on October 1, 2014, the fees adjusted in item T shall be increased by 0.2 percent; ~~and~~

V. on October 1, 2015, the fees adjusted in item U shall be increased by 0.6 percent~~.~~; and

W. on October 1, 2016, there shall be no further adjustment to the fees set forth in item V.

5221.4020 DETERMINING FEE SCHEDULE PAYMENT LIMITS.

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

Subp. 1b. **Conversion factors and maximum fee formulas.**

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

B. The conversion factors for services, articles, and supplies included in parts 5221.4030 to 5221.4061 are as provided in Minnesota Statutes, section 176.136, subdivision 1a, ~~as adjusted by paragraph (g) of that subdivision,~~ as follows:

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

(3) for dates of service from October 1, 2012, to September 30, 2013, the conversion factors are:

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

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $55.58; ~~and~~

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

(5) for dates of service from October 1, 2014, to September 30, 2015, the conversion factors are:

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

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $48.80; ~~and~~

(6) for dates of service from October 1, 2015, to September 30, 2016, the conversion factors are:

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

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $49.09~~.~~; and

(7) for dates of service from October 1, 2016, to September 30, 2017, the conversion factors are:

(a) for medical/surgical services identified by procedure codes described in part 5221.4030, subpart 3: $69.48;

(b) for pathology and laboratory services identified by procedure codes described in part 5221.4040, subpart 3: $56.70;

(c) for physical medicine and rehabilitation services identified by procedure codes described in part 5221.4050, subpart 2d: $55.57; and

(d) for chiropractic services identified by procedure codes described in part 5221.4060, subpart 2d: $49.34.

Subp. 1c. **Sample calculation.** The following is a sample calculation for determining the maximum fee, excluding any applicable adjustments in parts 5221.4030 to 5221.4061, for a new patient office examination (procedure code 99201) in a clinic based on the 2016 National Physician Fee Schedule Relative Value April (RVU16B) Release:

	~~.44640~~ .48	[Work RVU ~~(.45)~~ (.48) * Work Geographic PCI ~~(.992)~~ (1)]
+	~~.53082~~ .714	[Nonfacility PE RVU ~~(.54)~~ (.7) * PE GPCI ~~(.983)~~ (1.02)]
+	~~.00735~~ .01595	[MP RVU ~~(.03)~~ (.05) * MP GPCI ~~(.245)~~ (.319)]
=	~~.98457~~ 1.20995	[Total RVU]
*	$60.00	[Conversion factor for example only]
=	~~$59.0742~~ $72.597	[Maximum fee]
=	~~$59.07~~ $72.60	[Maximum fee, rounded]

Subp. 2. [Repealed, 35 SR 227]

Subp. 2a. **Key to abbreviations and terms and payment instructions.** Columns A to AE are found in the tables in the Medicare National Physician Fee Schedule Relative Value File most recently incorporated by reference by the commissioner by publishing in the State Register pursuant to Minnesota Statutes, section 176.136, subdivision 1a~~,~~ ~~paragraph (h)~~. These columns list indicators necessary to determine the maximum fee for the service. Further payment adjustments may apply as specified in this subpart.

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

S. Column S governs payment for Multiple Procedures. The numerical indicators in column S indicate applicable payment adjustment rules for multiple procedures.

Indicator "0" indicates no payment adjustment rules for multiple procedures apply.

Indicator "2" indicates standard payment adjustment rules for multiple procedures apply as provided in part 5221.4035, subpart 5.

Indicator "3" indicates special rules for multiple endoscopic/arthroscopic procedures apply as provided in part 5221.4035, subpart 5, item E.

Indicator "4" indicates special rules for multiple diagnostic imaging procedures apply as provided in parts 5221.4035, subpart 5, item F; and 5221.4061, subpart 3.

Indicator "5" indicates special rules for multiple therapy services apply as provided in parts 5221.4035, subpart 5, item G; 5221.4051; and 5221.4061.

Indicator "6" indicates special rules for multiple diagnostic cardiovascular services apply as provided in part 5221.4035, subpart 5, item H.

Indicator "7" indicates special rules for multiple diagnostic ophthalmology services apply as provided in part 5221.4035, subpart 5, item I.

Indicator "9" indicates that the concept of multiple procedures does not apply, except as otherwise provided in parts 5221.4051, subpart 2; and 5221.4061, subpart 1a.

[For text of items T to AE, see M.R.]

[For text of subps 3 and 4, see M.R.]

5221.4035 FEE ADJUSTMENTS FOR MEDICAL/SURGICAL SERVICES.

[For text of subps 1 to 4, see M.R.]

Subp. 5. **Coding and payment for multiple surgeries and procedures.** Part 5221.4020, subpart 2a, item S, and column S in the tables incorporated by reference in part 5221.4005, subpart 1, item A, describe codes subject to the multiple procedures payment restrictions. Multiple surgeries are separate surgeries performed by a single

physician on the same patient at the same operative session or on the same day for which separate payment may be allowed.

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

F. For diagnostic imaging procedures with an indicator of 4 in column S, special rules for the technical component (TC) and professional component (PC) of diagnostic imaging procedures apply if the procedure is billed with another diagnostic imaging procedure with indicator 88 in column AB. If the procedure is furnished by the same provider, or different providers in the same group practice, to the same patient in the same session on the same day as another procedure with indicator 88, the procedures must be ranked according to the maximum fee for the technical component and professional component, calculated according to the formula in part 5221.4020, subpart 1b. The technical component with the highest maximum fee is paid at 100 percent, and the technical component of each subsequent procedure is paid at 50 percent. The professional component with the highest maximum fee is paid at 100 percent, and the professional component of each subsequent procedure is paid at 75 percent. For example:

	Unadjusted Maximum Fee, Procedure 1	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
PC	$68	$102	$152	$102 + (.75 x $68)
TC	$476	$340	$646	$476 + (.50 x $340)
Global	$544	$816	$799	$102 + (.75 x $68) + $476 + (.50 x $340)

G. For procedures with an indicator of 5 in column S that are not also listed in part 5221.4050, subpart 2d, or 5221.4060, subpart 2d, the ~~following~~ rules in subitems (1) to (4) apply to establish the maximum fee according to the formula in part 5221.4020, subpart 1b~~:~~.

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

(2) For subsequent units and procedures furnished to the same patient on the same day ~~in office settings and other noninstitutional settings~~, full payment is made for the work and malpractice expense RVUs and ~~80~~ 50 percent payment is made for the practice expense RVU.

~~(3) For subsequent units and procedures furnished to the same patient on the same day in institutional settings, full payment is made for the work and malpractice expense RVUs and 75 percent payment is made for the practice expense RVU.~~

~~(4)~~ (3) For therapy services furnished by a provider, a group practice, or incident to a provider's service, the reduction described under this subitem applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, such as physical therapy, occupational therapy, or speech-language pathology, and regardless of the type of provider or supplier.

~~(5)~~ (4) For example:

	Unadjusted Maximum Fee, Procedure 1 Unit 1	Unadjusted Maximum Fee, Procedure 1 Unit 2	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
Work	$7	$7	$11	$25	No reduction
PE	$10	$10	$8	~~$23.50~~ $19	$10 + (~~.75~~ .50 x $10) + (~~.75~~ .50 x $8)
Mal-practice	$1	$1	$1	$3	No reduction
Total	$18	$18	$20	~~$51.50~~ $47	$18 + ($7 + $1) + (~~.75~~ .50 x $10) + ($11 + $1) + (~~.75~~ .50 x $8)

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

[For text of subps 6 to 10, see M.R.]

5221.4050 PHYSICAL MEDICINE AND REHABILITATION PROCEDURE CODES.

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

Subp. 2d. **List of physical medicine and rehabilitation procedure codes.** The physical medicine and rehabilitation conversion factor in part 5221.4020, subpart 1b, item B, applies to the health care providers listed in part 5221.0700, subpart 3, item C, subitem (4), when they provide, within their scope of practice, the services, articles, or supplies identified by procedure codes 97001 through 97799, 97810 through 97814, and V5336 to V5364 in the Medicare Physician Fee Schedule tables described in part 5221.4005.

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

A. Supervised modalities.

(1) Additional general instructions for supervised modality codes 97010 to 97028, and G0283. All supervised modalities refer to one or more areas. For example, if diathermy is applied to the cervical and low back on the same day, the charge would be one unit. If the diathermy and electrical stimulation are applied to the low back, the charge would be one unit of diathermy and one unit of electrical stimulation.

(2) Additional specific instructions for supervised modalities.

CPT Code	CPT Description	Specific Instructions and Examples

97014	Electrical stimulation	Unattended electrical stimulation includes muscle stimulation, low volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic, and unattended clinical application of TENS. RVU includes the use of disposable or reusable electrodes.
G0283	Electrical stimulation	Unattended electrical stimulation, to one or more areas for indications other than wound care, as part of a therapy plan of care.

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

5221.4051 FEE ADJUSTMENTS FOR PHYSICAL MEDICINE AND REHABILITATION SERVICES.

Subpart 1. **Multiple procedure payment reduction.** For procedures identified in part 5221.4050, subpart 2d, with indicator 5 in column S, the ~~following~~ rules in items A to D apply to establish the maximum fee according to the formula in part 5221.4020, subpart 1b~~:~~.

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

B. For subsequent units and procedures furnished to the same patient on the same day ~~in office settings and other noninstitutional settings~~, full payment is made for the work and malpractice expense RVUs and ~~80~~ 50 percent payment is made for the PE RVU.

~~C. For subsequent units and procedures furnished to the same patient on the same day in institutional settings, full payment is made for the work and malpractice expense RVUs and 75 percent payment is made for the PE RVU.~~

~~D~~ C. For therapy services furnished by a provider, a group practice, or incident to a provider's service, the reduction described in this part applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, such as physical therapy, occupational therapy, or speech-language pathology, and regardless of the type of provider or supplier.

~~E~~ D. For example, for illustrative purposes only; example does not reflect actual maximum fee:

	Unadjusted Maximum Fee, Procedure 1 Unit 1	Unadjusted Maximum Fee, Procedure 1 Unit 2	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
Work	$7	$7	$11	$25	No reduction
PE	$10	$10	$8	~~$23.50~~ $19	$10 + (~~.75~~ .50 x $10) + (~~.75~~ .50 x $8)
Mal-practice	$1	$1	$1	$3	No reduction
Total	$18	$18	$20	~~$51.50~~ $47	$18 + ($7 + $1) + (~~.75~~ .50 x $10) + ($11 + $1) + (~~.75~~ .50 x $8)

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

5221.4060 CHIROPRACTIC PROCEDURE CODES.

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

Subp. 2d. **List of chiropractic procedure codes.** The chiropractic conversion factor in part 5221.4020, subpart 1b, item B, applies to the health care providers listed in part 5221.0700, subpart 3, item C, subitem (5), when they provide, within their scope of practice, services, articles, or supplies identified by any of the following procedure codes in the Medicare Physician Fee Schedule tables described in part 5221.4005:

A. radiologic examination procedure codes from 72010 to ~~73610~~ 73630;

B. pathology and laboratory procedure codes 81000 and 81002;

C. physical medicine and rehabilitation procedure codes from 97010 to 97799;

D. chiropractic manipulative treatment procedure codes 98940, 98941, 98942, and 98943;

E. evaluation and management service procedure codes 99201, 99202, 99203, 99211, 99212, and 99213; ~~and~~

F. procedure code 99199 (special service)~~.~~; and

G. acupuncture codes 97810 to 97814.

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

A. Supervised modalities.

(1) Additional general instructions for supervised modality codes 97010 to 97028, and G0283. All supervised modalities refer to one or more areas. For example, if diathermy is applied to the cervical and low back on the same day, the charge would be one unit. If the diathermy and electrical stimulation are applied to the low back, the charge would be one unit of diathermy and one unit of electrical stimulation.

(2) Additional specific instructions for supervised modalities.

CPT Code	CPT Description	Specific Instructions and Examples
97014	Electrical stimulation	Unattended electrical stimulation includes muscle stimulation, low volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic, and unattended clinical application of TENS. RVU includes the use of disposable or reusable electrodes.
G0283	Electrical stimulation	Unattended electrical stimulation, to one or more areas for indications other than wound care, as part of a therapy plan of care.

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

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

5221.4061 FEE ADJUSTMENTS FOR CHIROPRACTIC SERVICES.

Subpart 1. **Multiple procedure payment reduction.** For procedures identified in part 5221.4060, subpart 2d, with indicator 5 in column S, the ~~following~~ rules in items A to D apply to establish the maximum fee according to the formula in part 5221.4020, subpart 1b~~:~~.

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

B. For subsequent units and procedures furnished to the same patient on the same day ~~in office settings and other noninstitutional settings~~, full payment is made for the work and malpractice expense RVUs and ~~80~~ 50 percent payment is made for the PE RVU.

~~C. For subsequent units and procedures furnished to the same patient on the same day in institutional settings, full payment is made for the work and malpractice expense RVUs and 75 percent payment is made for the PE RVU.~~

~~D~~ C. For therapy services furnished by a provider, a group practice, or incident to a provider's service, the reduction described in this part applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, such as physical therapy, occupational therapy, or speech-language pathology, and regardless of the type of provider or supplier.

~~E~~ D. For example, for illustrative purposes only; example does not reflect actual maximum fee:

	Unadjusted Maximum Fee, Procedure 1 Unit 1	Unadjusted Maximum Fee, Procedure 1 Unit 2	Unadjusted Maximum Fee, Procedure 2	Total Adjusted Maximum Fee	Calculation of Total Adjusted Maximum Fee
Work	$7	$7	$11	$25	No reduction

PE	$10	$10	$8	~~$23.50~~ $19	$10 + (~~.75~~ .50 x $10) + (~~.75~~ .50 x $8)
Mal-practice	$1	$1	$1	$3	No reduction
Total	$18	$18	$20	~~$51.50~~ $47	$18 + ($7 + $1) + (~~.75~~ .50 x $10) + ($11 + $1) + (~~.75~~ .50 x $8)

[For text of subps 1a to 3, see M.R.]

EFFECTIVE DATE. Parts 5219.0500 to 5221.4061 are effective for services, articles, and supplies provided on or after October 1, 2016.