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The Minnesota

State Register

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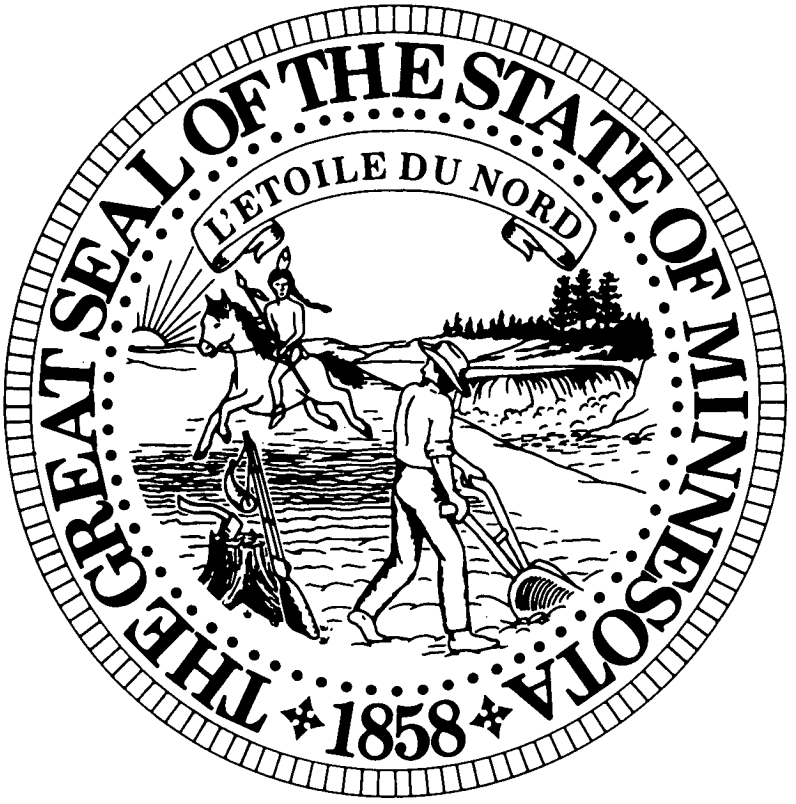

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Judicial Notice Shall Be Taken of Material Published in the *State Register*

The *State Register* is the official publication of the State of Minnesota, containing executive and commissioners' orders, proposed and adopted rules, official and revenue notices, professional-technical-consulting contracts, non-state bids and public contracts and grants.

A *Contracts Supplement* is published Tuesday, Wednesday and Friday and contains bids and proposals for commodities, including printing bids.

Printing Schedule and Submission Deadlines

Deadline extensions may be possible at the editor's discretion. Requests for deadline extensions should only be made in valid emergency situations. Please call 297-7963 and leave your fax number—you will be faxed a one-page information sheet regarding submissions and a submission calendar.

Vol. 18 Issue Number	PUBLISH DATE	Deadline for both Adopted and Proposed RULES	Deadline for: Emergency Rules, Executive and Commissioner's Orders, Revenue and Official Notices, State Grants, Professional-Technical-Consulting Contracts, Non-State Bids and Public Contracts
52	Monday 27 June	Monday 13 June	Monday 20 June
Vol 19 # 1	Tuesday 5 July	Monday 20 June	Monday 27 June
# 2	Monday 11 July	Monday 27 June	Friday 1 July
# 3	Monday 18 July	Friday 1 July	Monday 11 July

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FOR LEGISLATIVE NEWS

Publications containing news and information from the Minnesota Senate and House of Representatives are available free to concerned citizens and the news media. To be placed on the mailing list, write or call the offices listed below:

SENATE

Briefly-Preview—Senate news and committee calendar; published weekly during legislative sessions.

Perspectives—Publication about the Senate.

Session Review—Summarizes actions of the Minnesota Senate.

Contact: Senate Public Information Office
Room 231 State Capitol, St. Paul, MN 55155
(612) 296-0504

HOUSE

Session Weekly—House committees, committee assignments of individual representatives; news on committee meetings and action. House action and bill introductions

This Week—weekly interim bulletin of the House.

Session Summary—Summarizes all bills that both the Minnesota House of Representatives and Minnesota Senate passed during their regular and special sessions.

Contact: House Information Office
Room 175 State Office Building, St. Paul, MN 55155
(612)) 296-2146

Contents

Minnesota Rules: Amendments and Additions

NOTICE: How to Follow State Agency Rulemaking in the *State Register*

The ***State Register*** is the official source, and only complete listing, for all state agency rulemaking in its various stages. State agencies are required to publish notice of their rulemaking action in the ***State Register***. Published every Monday, the ***State Register*** makes it easy to follow and participate in the important rulemaking process. Approximately 75 state agencies have the authority to issue rules. Each agency is assigned specific ***Minnesota Rule*** chapter numbers. Every odd-numbered year the ***Minnesota Rules*** are published. This is a ten-volume bound collection of all adopted rules in effect at the time. Supplements are published to update this set of rules. Proposed and adopted emergency rules do not appear in this set because of their short-term nature, but are published in the ***State Register***.

If an agency seeks outside opinion before issuing new rules or rule amendments, it must publish a NOTICE OF INTENT TO SOLICIT OUTSIDE OPINION in the ***Official Notices*** section of the ***State Register***. When rules are first drafted, state agencies publish them as **Proposed Rules**, along with a notice of hearing, or notice of intent to adopt rules without a hearing in the case of noncontroversial rules. This notice asks for comment on the rules as proposed. Proposed emergency rules and withdrawn proposed rules are also published in the ***State Register***. After proposed rules have gone through the comment period, and have been rewritten into their final form, they again appear in the ***State Register*** as **Adopted Rules**. These final adopted rules are not printed in their entirety in the ***State Register***, only the changes made since their publication as Proposed Rules. To see the full rule, as adopted and in effect, a person simply needs two issues of the ***State Register***, the issue the rule appeared in as proposed, and later as adopted. For a more detailed description of the rulemaking process, see the ***Minnesota Guidebook to State Agency Services***.

The ***State Register*** features partial and cumulative listings of rules in this section on the following schedule: issues 1-13 inclusive; issues 14-25 inclusive; issue 26, cumulative for issues 1-26; issues 27-38 inclusive; issue 39, cumulative for 1-39; issues 40-51 inclusive; and issue 52, cumulative for 1-52. An annual subject matter index for rules appears in August. For copies of the ***State Register***, a subscription, the annual index, the ***Minnesota Rules*** or the ***Minnesota Guidebook to State Agency Services***, contact the Print Communications Division, 117 University Avenue, St. Paul, MN 55155 (612) 297-3000 or toll-free in Minnesota 1-800-657-3757.

Issues #1-52 Inclusive

Proposed Rules

Pursuant to Minn. Stat. §14.22, an agency may propose to adopt, amend, suspend or repeal rules without first holding a pubic hearing, as long as the agency determines that the rules will be noncontroversial in nature. The agency must first publish a notice of intent to adopt rules without a public hearing, together with the proposed rules, in the *State Register*. The notice must advise the public:

1. that they have 30 days in which to submit comment on the proposed rules;
2. that no public hearing will be held unless 25 or more persons make a written request for a hearing within the 30-day comment period;
3. of the manner in which persons shall request a hearing on the proposed rules; and
4. that the rule may be modified if the modifications are supported by the data and views submitted

If, during the 30-day comment period, 25 or more persons submit to the agency a written request for a hearing of the proposed rules, the agency must proceed under the provisions of §§14.14-14.20, which state that if an agency decides to hold a public hearing, it must publish a notice of intent in the *State Register*.

Pursuant to Minn. Stat. §§14.29 and 14.30, agencies may propose emergency rules under certain circumstances. Proposed emergency rules are published in the *State Register* and, for at least 25 days thereafter, interested persons may submit data and views in writing to the proposing agency.

Department of Labor and Industry

Proposed Permanent Rules Relating to Workers' Compensation; Treatment Parameters

Notice of Hearing

NOTICE IS HEREBY GIVEN that a public hearing will be held pursuant to *Minnesota Statutes* § 14.14, subdivision 1 in the above-captioned matter. The hearing will be held at the State Office Building, Room 200, 100 Constitution Avenue, St. Paul, Minnesota, beginning at 9:00 A.M. on August 2, 1994 and continuing if needed on August 3 and 4, 1994 until all interested persons and groups have had an opportunity to be heard concerning the proposed rules. The proposed rules may be modified as a result of the hearing process. You are encouraged to participate if you are in any way affected by these rules.

The statutory authority to promulgate these proposed rules can be found in *Minnesota Statutes*, section 176.83, subds. 1, 3, 4, and 5 and section 176.103, subd. 2. The proposed rules set forth parameters for reasonable treatment of workers' compensation injuries, including low back, thoracic back, cervical back, upper extremity and reflex sympathetic dystrophy conditions. Types of treatment parameters include diagnostic and medical imaging studies; passive treatment, such as physical therapy and chiropractic; active treatment such as exercise; therapeutic injections and nerve blocks; medication; spinal, and upper and lower extremity surgery; durable medical equipment; chronic management such as health clubs, work conditioning, work hardening, pain management programs and psychological treatment; and hospitalization. General treatment parameters include evaluation of treatment; referrals and communication between health care providers; and bases for departure from the specific parameters. The proposed rules also include procedures for health care providers to give prior notification of non-emergency surgery, certain medical equipment, chronic management programs and departures from the parameters; procedures for workers' compensation insurers to respond to prior notification, including requests for other medical opinions or additional medical information; and the role of certified managed care plans in giving and receiving the required notices. Other rules govern filing Medical Requests and determinations of excessive treatment under the rules; health care provider reporting requirements for outcome studies by the agency; and procedures and standards for sanctioning health care providers for failure to comply with the treatment parameters or other workers' compensation rules.

The rules affect small business health care providers. However, the requirements of *Minnesota Statutes* § 14.115 concerning impact on small business do not apply because the rules regulate health care providers for standards and costs under subd. 7(c) of that statute.

The rules are not expected to require any local public body to spend more than $100,000 in either of the two years following adoption. Therefore, a fiscal note is not required under *Minnesota Statutes* § 14.11, subd. 1.

How to Obtain a Copy of the Rules: The proposed rules follow this notice in the *State Register*. One free copy of the proposed rules may be obtained in any of the following ways:

Send in a Request: You may mail or fax a request to Darlene Wells, Department of Labor and Industry, 443 Lafayette Road, St. Paul, Minnesota 55155. The fax number is (612) 297-7098. Please specify how you would like the Workers' Compensation Treatment Parameter rules:

☐ 3.5" computer disc (ASCII format)

☐ 3.5" computer disc (WordPerfect format)

☐ Paper Copy

Name and address you would like the rules mailed to:

_____

_____

Personal Contact: You may obtain a paper or computer disc (3.5") copy of the rules in person from Darlene Wells at the above address or by phoning her at (612) 297-3970 from 8:00 a.m. - 4:30 p.m., Monday-Friday.

Statement of Need and Reasonableness: NOTICE IS HEREBY GIVEN that a Statement of Need and Reasonableness for the proposed rules is now available for review at the agency and at the Office of Administrative Hearings. This Statement of Need and Reasonableness includes a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and the reasonableness of the proposed rules. Copies of the Statement of Need and Reasonableness may be reviewed at the Department of Labor and Industry or the Office of Administrative Hearings and copies may be obtained from the Office of Administrative Hearings at the cost of reproduction.

Public Comment and Hearing Procedures: Any person may present views on the proposed rules in one or more of the following ways: by submitting written data to the administrative law judge at any time before the close of the hearing; by submitting oral or written data at the hearing; and by submitting written material to the administrative law judge during the comment period following the hearing. Statements may be submitted without appearing at the hearing.

Written material may be submitted and recorded in the hearing record for five working days after the public hearing ends. This comment period may be extended for a longer period not to exceed twenty calendar days if so ordered by the administrative law judge at the hearing. The written comments received during this period shall be available for review at the Office of Administrative Hearings. The Department of Labor and Industry and any interested persons may respond in writing within five working days after the comment period ends to any new information submitted. Any written material or responses submitted must be received at the Office of Administrative Hearings no later that 4:30 p.m. on the final day. No additional evidence may be submitted during this five-day period.

The rule hearings procedure is governed by *Minnesota Statutes*, section 14.14 to 14.20 and by parts 1400.0200 to 1400.1200 of *Minnesota Rules*. Questions regarding procedure may be directed to the administrative law judge. The administrative law judge assigned to preside over the hearing is:

Bruce D. Campbell
Administrative Law Judge
Office of Administrative Hearings
100 Washington Square, Suite 1700
Minneapolis, MN 55401-2138
Phone: (612) 341-7602

NOTICE: Any person may request notification of the date on which the administrative law judge's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the administrative law judge. Any person may request notification of the date on which the rules were adopted and filed with the secretary of state. The notice must be mailed on the same day that the rules are filed. If you want to be so notified you may so indicate at the hearing or send a request in writing to the agency at any time prior to the filing of the rules with the secretary of state.

Lobbyist Registration: *Minnesota Statutes*, Chapter 10A requires each lobbyist to register with the State Ethical Practices Board.

Questions should be directed to the Ethical Practices Board, First Floor South, Centennial Building, 658 Cedar Street, St. Paul, Minnesota 55155, telephone (612) 296-5248.

Dated: 9 June 1994

State of Minnesota
John B. Lennes, Jr., Commissioner
Department of Labor and Industry

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Rules as Proposed (all new material)

5221.6010 AUTHORITY.

Parts 5221.6010 to 5221.8900 are adopted under the authority of *Minnesota Statutes*, sections 176.83, subdivisions 1, 3, 4, and 5, and 176.103, subdivision 2.

5221.6020 PURPOSE AND APPLICATION.

Subpart 1. **Purpose.** Parts 5221.6010 to 5221.6600 establish parameters for reasonably required treatment of employees with compensable workers' compensation injuries to prevent excessive services under *Minnesota Statutes*, sections 176.135 and 176.136, subdivision 2. Parts 5221.6010 to 5221.6600 do not affect any determination of liability for an injury under *Minnesota Statutes*, chapter 176, and are not intended to expand or restrict a health care provider's scope of practice under any other statute.

Subp. 2. **Application.** All treatment must be medically necessary as defined in part 5221.6040, subpart 10. In the absence of a specific parameter, any applicable general parameters govern. Parts 5221.6010 to 5221.6600 apply to all treatment provided after the effective date of parts 5221.6010 to 5221.6600, regardless of the date of injury. All limitations on the duration of a specific treatment modality or type of modality begin with the first time the modality is initiated after the effective date of parts 5221.6050 to 5221.6600. However, consideration may be given to treatment initiated under the emergency rules (parts 5221.6050 to 5221.6500 [Emergency]). Parts 5221.6010 to 5221.6600 do not apply to treatment of an injury after an insurer has denied liability for the injury. However, in such cases the rules do apply to treatment initiated after liability has been established. References to days and weeks in parts 5221.6050 to 5221.6600 mean calendar days and weeks unless specified otherwise.

5221.6030 INCORPORATION BY REFERENCE.

The ICD-9-CM diagnostic codes referenced in parts 5221.6010 to 5221.6600 are contained in the fourth edition of the International Classification of Diseases, Clinical Modification, 9th Revision, 1994, and corresponding annual updates. This document is subject to annual revisions and is incorporated by reference. It is published by the United States Department of Health and Human Services, Health Care Financing Administration, and may be purchased through the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. It is available through the Minitex interlibrary loan system.

5221.6040 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 5221.6010 to 5221.6600 have the meanings given them in this part.

Subp. 2. **Active treatment.** "Active treatment" means treatment specified in parts 5221.6200, subpart 4; 5221.6205, subpart 4; 5221.6210, subpart 4; 5221.6300, subpart 4; and 5221.6305, subpart 2, item C, which requires active patient participation in a therapeutic program to increase flexibility, strength, endurance, or awareness of proper body mechanics.

Subp. 3. **Chronic pain syndrome.** "Chronic pain syndrome" means any set of verbal or nonverbal behaviors that:

A. involve the complaint of enduring pain;

B. differ significantly from the patient's preinjury behavior;

C. have not responded to previous appropriate treatment;

D. are not consistent with a known organic syndrome which has remained untreated; and

E. interfere with physical, psychological, social, or vocational functioning.

Subp. 4. **Condition.** A patient's "condition" means the symptoms, physical signs, clinical findings, and functional status that characterize the complaint, illness, or injury related to a current claim for compensation.

Subp. 5. **Emergency treatment.** "Emergency treatment" means treatment that is:

A. required for the immediate diagnosis and treatment of a medical condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death; or

B. immediately necessary to alleviate severe pain.

Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency but that is necessary to determine whether an emergency exists.

Subp. 6. **Etiology.** "Etiology" means the anatomic alteration, physiologic dysfunction, or other biological or psychological abnormality which is considered a cause of the patient's condition.

Subp. 7. **Functional status.** "Functional status" means the ability of an individual to engage in activities of daily living and other social, recreational, and vocational activities.

Subp. 8. **Initial nonsurgical management or treatment.** "Initial nonsurgical management or treatment" is initial treatment provided after an injury that includes passive treatment, active treatment, injections, and durable medical equipment under parts

5221.6200, subparts 3, 4, 5, and 8; 5221.6205, subparts 3, 4, 5, and 8; 5221.6210, subparts 3, 4, 5, and 8; 5221.6300, subparts 3, 4, 5, and 8; and 5221.6305, subpart 2. Scheduled and nonscheduled medication may be a part of initial nonsurgical treatment. Initial nonsurgical management does not include surgery or chronic management modalities under part 5221.6600.

Subp. 9. **Medical imaging procedures.** A "medical imaging procedure" is a technique, process, or technology used to create a visual image of the body or its function. Medical imaging includes, but is not limited to: X-rays, tomography, angiography, venography, myelography, computed tomography (CT) scanning, magnetic resonance imaging (MRI) scanning, ultrasound imaging, nuclear isotope imaging, PET scanning, and thermography.

Subp. 10. **Medically necessary treatment.** "Medically necessary treatment" means those health services for a compensable injury that are reasonable and necessary for the diagnosis and cure or significant relief of a condition consistent with any applicable treatment parameter in parts 5221.6050 to 5221.6600. Where parts 5221.6050 to 5221.6600 do not govern, the treatment must be reasonable and necessary for the diagnosis or cure and significant relief of a condition consistent with the current accepted standards of practice within the scope of the provider's license or certification.

Subp. 11. **Neurologic deficit.** "Neurologic deficit" means a loss of function secondary to involvement of the central or peripheral nervous system. This may include, but is not limited to, motor loss; spasticity; loss of reflex; radicular or anatomic sensory loss; loss of bowel, bladder, or erectile function; impairment of special senses, including vision, hearing, taste, or smell; or deficits in cognitive or memory function.

A. "Static neurologic deficit" means any neurologic deficit that has remained the same by history or noted by repeated examination since onset.

B. "Progressive neurologic deficit" means any neurologic deficit that has become worse by history or noted by repeated examination since onset.

Subp. 12. **Passive treatment.** "Passive treatment" is any treatment modality specified in parts 5221.6200, subpart 3; 5221.6205, subpart 3; 5221.6210, subpart 3; 5221.6300, subpart 3; and 5221.6305, subpart 2, item B. Passive treatment modalities include bedrest; thermal treatment; traction; acupuncture; electrical muscle stimulation; braces; manual and mechanical therapy; massage; and adjustments.

Subp. 13. **Therapeutic injection.** "Therapeutic injection" is any injection modality specified in parts 5221.6200, subpart 5; 5221.6205, subpart 5; 5221.6210, subpart 5; 5221.6300, subpart 5; and 5221.6305, subpart 2, item A. Therapeutic injections include trigger point injections, sacroiliac injections, facet joint injections, facet nerve blocks, nerve root blocks, epidural injections, soft tissue injections, peripheral nerve blocks, injections for peripheral nerve entrapment, and sympathetic blocks.

5221.6050 GENERAL TREATMENT PARAMETERS; EXCESSIVE TREATMENT; PRIOR NOTIFICATION.

Subpart 1. **General.**

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

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

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

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

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

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

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

C. The health care provider must use the least intensive setting appropriate and must assist the employee in becoming independent in the employee's own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

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

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

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

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

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

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

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

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

B. Treatment by prior health care provider. If the employee has reported that care for an injury has been previously given, 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. When a therapeutic modality employed by a health care provider was no longer improving the employee's condition under subpart 1, item B, or has been used for the maximum duration allowed under parts 5221.6050 to 5221.6600, another health care provider may not employ the same modality at any time thereafter to treat the same injury except if one of the departures applies under subpart 8, after surgery, or for treatment of reflex sympathetic dystrophy under part 5221.6305. It is also inappropriate for two health care providers to use the same treatment modality concurrently.

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

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

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

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

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

B. If the insurer denies payment for treatment that departs from a parameter under parts 5221.6050 to 5221.6600, the insurer must provide the employee and health care provider with written notice of the reason for the denial and that the treatment rules permit departure from the parameters in specified circumstances. If the insurer denies authorization for proposed treatment after prior notification has been given under subpart 9, the insurer must provide the employee and health care provider in writing with notice of the reason why the information given by the health care provider does not support the proposed treatment.

C. If the insurer denies authorization or payment for treatment governed by parts 5221.6050 to 5221.6600, the health care provider or the employee may request a determination from the commissioner or compensation judge by filing a medical request or petition under chapter 5220 and *Minnesota Statutes*, sections 176.106, 176.2615, and 176.305. The medical request may not be filed before completion of the managed care plan's dispute resolution process, if applicable. If the health care provider has notified the insurer of proposed treatment requiring prior notification under subpart 9, the health care provider or employee must describe or attach a copy of the notification, and any response from the insurer, to the medical request filed with the department. The insurer may, but is not required to, file a medical response where the insurer's response to prior notification under subpart 9 has been attached to the medical request. If the insurer elects to file a medical response in such cases, it must be received within ten working days of the date the medical request was filed with the department. The commissioner or compensation judge may issue a decision based on written submissions no earlier than ten working days after receipt of the medical request, unless a medical response has been filed sooner.

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

(1) whether a treatment parameter or other rule in parts 5221.6050 to 5221.6600 applies to the etiology or diagnosis for the condition;

(2) if a specific or general parameter applies, whether the treatment is consistent with the treatment parameter and whether the treatment was medically necessary as defined in part 5221.6040, subpart 10; and

(3) whether a departure from the applicable parameter is or was necessary because of any of the factors in subpart 8.

Subp. 8. **Departures from parameters.** A departure from a treatment parameter in parts 5221.6050 to 5221.6600 may be appropriate in any of the circumstances specified in items A to E.

A. Where there is a documented medical complication.

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

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

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

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

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

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

E. Where there is an incapacitating exacerbation of the employee's condition. However, additional treatment for the incapacitating exacerbation may not exceed, and must comply with, the parameters in parts 5221.6100 to 5221.6600.

Subp. 9. **Prior notification; health care provider and insurer responsibilities.** Prior notification is the responsibility of the health care provider who wants to provide the treatment in item A. Prior notification need not be given in any case where emergency treatment is required.

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

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

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

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

(4) for treatment that departs from a specific parameter in parts 5221.6100 to 5221.6600. The health care provider must notify the insurer within two business days after initiation of treatment if the departure from a parameter is for an incapacitating exacerbation or an emergency.

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

(1) the diagnosis;

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

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

C. The insurer must provide a toll-free facsimile and telephone number for health care providers to provide prior notification. The insurer must respond orally or in writing to 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.

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

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

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

(4) If prior notification of surgery is required under item A, subitem (3), the insurer may require that the employee obtain a second opinion from a physician of the employee's choice under *Minnesota Statutes*, section 176.135, subdivision 1a. If within seven working days of the prior notification the insurer notifies the employee and health care provider that a second opinion is required, the health care provider may not perform the nonemergency surgery until the employee provides the second opinion to the insurer. Except as otherwise provided in parts 5221.6200, subpart 6, items B and C; 5221.6205, subpart 6, items B and C; 5221.6300, 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. If the insurer notifies the employee and health care provider of the examination within seven working days of the provider's notification, the proposed nonemergency surgery may not be provided pending the examination. However, after 45 days following the insurer's request for an examination, the health care provider may elect to proceed with the surgery, subject to a determination of compensability by the commissioner or compensation judge under subpart 7.

(6) The insurer's request for additional information must specify the additional information required that is necessary to respond to the health care provider's notification of proposed treatment. The proposed treatment may not be given until the provider provides reasonable additional information. Once the additional information has been received, the insurer must respond within seven working days according to subitems (1) to (5).

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

Subp. 11. **Outcome studies.** The commissioner may require health care providers who use the 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:

A. the name of the health care provider;

B. the name of the patient, date of injury, date of birth, gender, and, with patient permission, level of education and social security number;

C. the name of the workers' compensation insurer and managed care plan, if any;

D. the pretreatment and posttreatment employment status;

E. the nature of treatment given before and after the treatment being studied for the same condition; and

F. the symptoms and functional status before and after the treatment being studied for the same condition.

5221.6100 PARAMETERS FOR MEDICAL IMAGING.

Subpart 1. **General principles.** All medical imaging must comply with items A to E. Except for emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition, before ordering any imaging study.

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:

(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.

B. Appropriate imaging. Imaging solely to rule out a diagnosis not seriously being considered as the etiology of the patient's condition is not indicated.

C. Routine imaging. Imaging on a routine basis is not indicated unless the information from the study is necessary to develop a treatment plan.

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 original radiologist and another radiologist from a different practice have reviewed a previous 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 inconclusive findings in another imaging study.

Subp. 2. **Specific imaging procedures for low back pain.** Except for the emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition, before ordering any imaging study of the low back.

A. Computed tomography (CT) scanning is indicated any time that one of the following conditions is met:

(1) when cauda equina syndrome is suspected;

(2) for evaluation of progressive neurologic deficit; or

(3) when bony lesion is suspected on the basis of other tests or imaging procedures.

Except as specified in subitems (1) to (3), CT scanning is not indicated in the first eight weeks after an injury.

Computed tomography scanning is indicated after eight weeks 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.

B. Magnetic resonance imaging (MRI) scanning is indicated any time that one of the following conditions is met:

(1) when cauda equina syndrome is suspected;

(2) for evaluation of progressive neurologic deficit;

(3) when previous spinal surgery has been performed and there is a need to differentiate scar due to previous surgery from disc herniation, tumor, or hemorrhage; or

(4) suspected discitis.

Except as specified in subitems (1) to (4), MRI scanning is not indicated in the first eight weeks after an injury.

Magnetic resonance imaging scanning is indicated after eight weeks 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.

C. Myelography is indicated in the following circumstances:

(1) may be substituted for otherwise indicated CT scanning or MRI scanning in accordance with items A and B, if those imaging modalities are not locally available;

(2) in addition to CT scanning or MRI scanning, if there are progressive neurologic deficits or changes and CT scanning or MRI scanning has been negative; or

(3) for preoperative evaluation in cases of surgical intervention, but only if CT scanning or MRI scanning have failed to provide a definite preoperative diagnosis.

D. Computed tomography myelography is indicated in the following circumstances:

(1) the patient's condition is predominantly sciatica, and there has been previous spinal surgery, and tumor is suspected;

(2) the patient's condition is predominantly sciatica and there has been previous spinal surgery and MRI scanning is equivocal;

(3) when spinal stenosis is suspected and the CT or MRI scanning is equivocal;

(4) in addition to CT scanning or MRI scanning, if there are progressive neurologic symptoms or changes and CT scanning or MRI scanning has been negative; or

(5) for preoperative evaluation in cases of surgical intervention, but only if CT scanning or MRI scanning have failed to provide a definite preoperative diagnosis.

E. Intravenous enhanced CT scanning is indicated only if there has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor, but only if intrathecal contrast for CT-myelography is contraindicated and MRI scanning is not available or is also contraindicated.

F. Gadolinium enhanced MRI scanning is indicated when:

(1) there has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor;

(2) hemorrhage is suspected;

(3) tumor or vascular malformation is suspected;

(4) infection or inflammatory disease is suspected; or

(5) unenhanced MRI scanning was equivocal.

G. Discography is indicated when:

(1) all of the following are present:

(a) back pain is the predominant complaint;

(b) the patient has failed to improve with initial nonsurgical management;

(c) other imaging has not established a diagnosis; and

(d) lumbar fusion surgery is being considered as a therapy; or

(2) there has been previous spinal surgery, and pseudoarthrosis, recurrent disc herniation, annular tear, or internal disc disruption is suspected.

H. Computed tomography discography is indicated when:

(1) sciatica is the predominant complaint and lateral disc herniation is suspected; or

(2) if appropriately performed discography is equivocal or paradoxical, with a normal X-ray pattern but a positive pain response, and an annular tear or intra-annular injection is suspected.

I. Nuclear isotope imaging (including technicium, indium, and gallium scans) are not indicated unless tumor, stress fracture, infection, avascular necrosis, or inflammatory lesion is suspected on the basis of history, physical examination findings, laboratory studies, or the results of other imaging studies.

J. Thermography is not indicated for the diagnosis of any of the clinical categories of low back conditions in part 5221.6200, subpart 1, item A.

K. Anterior-posterior (AP) and lateral X-rays of the lumbosacral spine are limited by subitems (1) and (2).

(1) They are indicated in the following circumstances:

(a) when there is a history of significant acute trauma as the precipitating event of the patient's condition, and fracture, dislocation, or fracture dislocation is suspected;

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

(c) for postoperative follow-up of lumbar fusion surgery;

(d) when the patient is more than 50 years of age; or

(e) before beginning a course of treatment with spinal adjustment or manipulation.

(2) They are not indicated in the following circumstances:

(a) to verify progress during initial nonsurgical treatment; or

(b) to evaluate a successful initial nonsurgical treatment program.

L. Oblique X-rays of the lumbosacral spine are limited by subitems (1) and (2).

(1) They are indicated in the following circumstances:

(a) to follow up abnormalities detected on anterior-posterior or lateral X-ray;

(b) for postoperative follow-up of lumbar fusion surgery; or

(c) to follow up spondylolysis or spondylolisthesis not adequately diagnosed by other indicated imaging procedures.

(2) They are not indicated as part of a package of X-rays including anterior-posterior and lateral X-rays of the lumbosacral spine.

M. Electronic X-ray analysis of plain radiographs and diagnostic ultrasound are not indicated for diagnosis of any of the low back conditions in part 5221.6200, subpart 1, item A.

5221.6200 LOW BACK PAIN.

Subpart 1. **Diagnostic procedures for treatment of low back injury.** 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, or neoplastic disease process.

(1) Regional low back pain, includes referred pain to the leg above the knee unless it conforms to an L2, L3, or L4 dermatomal distribution and is accompanied by anatomically congruent motor weakness or reflex changes. Regional low back pain includes the diagnoses of lumbar, lumbosacral, or sacroiliac: strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, spondylosis, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the lumbar spine or sacroiliac joints and which effects the lumbosacral region, with or without referral to the buttocks and/or leg above the knee, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721, 721.3, 721.5 to 721.90, 722, 722.3, 722.32, 722.5, 722.51, 722.52, 722.6, 722.9, 722.90, 722.93, 724.2, 724.5, 724.6, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.2 to 739.4, 756.1 to 756.19, 847.2 to 847.9, 922.3, 926.1, 926.11, and 926.12.

(2) Radicular pain, with or without regional low back pain, with static or no neurologic deficit. This includes the diagnoses of sciatica; lumbar or lumbosacral radiculopathy, radiculitis or neuritis; displacement or herniation of intervertebral disc with myelopathy, radiculopathy, radiculitis or neuritis; spinal stenosis with myelopathy, radiculopathy, radiculitis or neuritis; and any other diagnoses for pain in the leg below the knee believed to originate with irritation of a nerve root in the lumbar spine, including, but not limited to, the ICD-9-CM codes 721.4, 721.42, 721.91, 722.1, 722.10, 722.2, 722.7, 722.73, 724.0, 724.00, 724.02, 724.09, 724.3, 724.4, and 724.9. In these cases, neurologic findings on history and physical examination are either absent or do not show progressive deterioration.

(3) Radicular pain, with or without regional low back pain, with progressive neurologic deficit. This includes the same diagnoses as subitem (2), however, this category applies when there is a history of progressive deterioration in the neurologic symptoms and physical findings which include worsening sensory loss, increasing muscle weakness, or progressive reflex changes.

(4) Cauda equina syndrome, which is a syndrome characterized by anesthesia in the buttocks, genitalia, or thigh and accompanied by disturbed bowel and bladder function, ICD-9-CM codes 344.6, 344.60, and 344.61.

B. Laboratory tests are not indicated in the evaluation of a patient with regional low back pain, radicular pain, or cauda equina syndrome, except in any of the following circumstances:

(1) when a patient's history, age, or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis;

(2) to evaluate potential adverse side effects of medications; or

(3) as part of a preoperative evaluation.

Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

C. Medical imaging evaluation of the lumbosacral spine must be based on the findings of the history and physical examination and cannot be ordered before the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with all of the standards in part 5221.6100, subparts 1 and 2. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are always inappropriate for regional low back pain as defined in item A, subitem (1). EMG and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and cauda equina syndrome as defined in item A, subitems (2) to (4), after the first three weeks of radicular symptoms. Repeat EMG and nerve conduction studies for radicular pain and cauda equina syndrome are not indicated unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

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

(1) surface electromyography or surface paraspinal electromyography;

(2) thermography;

(3) plethysmography;

(4) electronic X-ray analysis of plain radiographs;

(5) diagnostic ultrasound; or

(6) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing may be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit with a physician, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

G. Personality or psychosocial evaluations may be indicated for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

(1) Is symptom magnification occurring?

(2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?

(3) Are there other personality factors or disorders which are interfering with recovery?

(4) Is the patient chemically dependent?

(5) Are there any interpersonal conflicts interfering with recovery?

(6) Does the patient have a chronic pain syndrome or psychogenic pain?

(7) In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

H. Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve injection, epidural differential spinal block, nerve block, and nerve root block.

(1) These procedures are used to localize the source of pain before surgery and to diagnose conditions which fail to respond to initial nonsurgical management.

(2) These injections are invasive and when done as diagnostic procedures only, are not indicated unless noninvasive procedures have failed to establish the diagnosis.

(3) Selection of patients, choice of procedure, and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

(4) These blocks and injections can also be used as therapeutic modalities and as such are subject to the parameters of subpart 5.

I. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

(1) Functional capacity assessment or evaluation is not indicated during the period of initial nonsurgical management.

(2) After the period of initial nonsurgical management functional capacity assessment or evaluation is indicated in either of the following circumstances:

(a) activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to do a specific job.

(3) A functional capacity evaluation is not appropriate to establish baseline performance before treatment, or for subsequent assessments, to evaluate change during or after treatment.

(4) Only one completed functional capacity evaluation is indicated per injury.

J. Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with accepted medical practice.

Subp. 2. **General treatment parameters for low back pain.**

A. All medical care for low back pain, appropriately assigned to a clinical category in subpart 1, item A, is determined by the clinical category to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 13, as follows:

(1) subpart 11 governs regional low back pain;

(2) subpart 12 governs radicular pain with no or static neurologic deficits; and

(3) subpart 13 governs cauda equina syndrome and radicular pain with progressive neurologic deficits.

The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed, the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subparts 3 to 10, or to repeat a therapy or treatment previously provided for the same injury.

B. In general, a course of treatment is divided into three phases.

(1) First, all patients with low back problems, except patients with progressive neurologic deficit or cauda equina syndrome under subpart 1, item A, subitems (3) and (4), must be given initial nonsurgical management which may include active treatment modalities, passive treatment modalities, injections, durable medical equipment, and medications. These modalities and parameters are described in subparts 3, 4, 5, 8, and 10. The period of initial nonsurgical treatment begins with the first active, passive, medication, durable medical equipment, or injection modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subparts 6 and 11 to 13, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Patients with radicular pain with progressive neurological deficit, or cauda equina syndrome may require immediate surgical therapy.

(b) Any patient who has had surgery may require postoperative therapy in a clinical setting with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical care.

(c) Surgery must follow the parameters in subparts 6 and 11 to 13, and part 5221.6500.

(d) A decision against surgery at this time does not preclude a decision for surgery made at a later date.

(3) Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may include durable medical equipment as described in subpart 8.

C. 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.

Subp. 3. **Passive treatment modalities.**

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to I is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to I are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits 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 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 functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

(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.

D. Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

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

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

E. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

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

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

(a) time for patient education and training, one to three sessions; and

(b) patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

F. Mechanical traction:

(1) Treatment given in a clinical setting:

(a) time for treatment response, three treatments;

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

(c) maximum treatment duration, 12 weeks in a clinical setting but only if used in conjunction with other therapies.

(2) Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education:

(a) time for patient education and training, one session; and

(b) patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

G. Acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure:

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

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

(3) maximum treatment duration, 12 weeks.

H. Manual therapy includes soft tissue and joint mobilization, 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. Phoresis includes iontophoresis and phonophoresis:

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

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

(3) maximum treatment is nine sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

J. Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

K. Spinal braces and other movement-restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability:

(1) time for treatment response, three days;

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

(3) maximum continuous duration, three weeks unless patient is status postfusion.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities can extend past the 12-week limitation on passive treatment modalities so long as the maximum duration for the active modality is not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow-up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the lumbosacral spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment, this shall not be the primary focus of the exercise program.

Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation and monthly thereafter.

Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, three times per week for three weeks, and should decrease in frequency thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program, and may supplement or follow the period of supervised exercise:

(a) maximum treatment frequency, up to three visits for instruction and monitoring; and

(b) there is no limit on the duration or frequency of exercise at home.

Subp. 5. **Therapeutic injections.** Injection modalities are indicated as set forth in items A to C. Use of injections can extend past the 12-week limit on passive treatment modalities so long as the maximum treatment for injections is not exceeded.

A. Therapeutic injections, including injections of trigger points, facet joints, facet nerves, sacroiliac joints, sympathetic nerves, epidurals, nerve roots, and peripheral nerves. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

(1) Trigger point injections:

(a) time for treatment response, within 30 minutes;

(b) maximum treatment frequency, once per week to any one site if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. No more than three injections to different sites are reimbursable per patient visit; and

(c) maximum treatment, four injections to any one site.

(2) Sacroiliac joint injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first injection. Only two injections are reimbursable per patient visit; and

(c) maximum treatment, two injections to any one site.

(3) Facet joint or nerve injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks to any one site if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. No more than three injections to different sites are reimbursable per patient visit; and

(c) maximum treatment, three injections to any one site.

(4) Nerve root blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first injection. Only three injections to different sites are reimbursable per patient visit; and

(c) maximum treatment, two injections to any one site.

(5) Epidural injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection is reimbursable per patient visit; and

(c) maximum treatment, three injections.

B. Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site:

(1) time for treatment response, within one week;

(2) maximum treatment frequency, may repeat once for any site; and

(3) maximum duration, two injections to any one site.

C. Prolotherapy and botulinum toxin injections are not indicated in the treatment of low back problems and are not reimbursable.

Subp. 6. **Surgery, including decompression procedures and arthrodesis.** Surgery may only be performed if it also meets the specific parameters specified in subparts 11 to 13 and part 5221.6500. The health care provider must provide prior notification of nonemergency inpatient surgery according to part 5221.6050, subpart 9.

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 the initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) eight weeks following lumbar decompression or implantation of a dorsal column stimulator or morphine pump; or

(2) 12 weeks following arthrodesis.

B. Repeat surgery must also meet the parameters of subparts 11 to 13 and part 5221.6500, and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if a second opinion is requested by the insurer.

C. The following surgical therapies have very limited application and require a second opinion that confirms that the treatment is indicated and within the parameters listed, and a personality or psychosocial evaluation that indicates that the patient is likely to benefit from the treatment.

(1) Dorsal column stimulator is indicated for a patient who has neuropathic pain, and is not a candidate for any other surgical therapy, and has had a favorable response to a trial screening period.

(2) Morphine pump is indicated for a patient who has somatic pain, and is not a candidate for any other surgical therapy, and has had a favorable response to a trial screening period.

Subp. 7. **Chronic management.** Chronic management of low back pain must be provided according to the parameters of part 5221.6600.

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only in the situations specified in items A to D. The health care provider must provide prior notification as required in items B and C according to part 5221.6050, subpart 9.

A. Lumbar braces, corsets, or supports are indicated as specified in subpart 3, item K.

B. For patients using electrical stimulation or mechanical traction devices at home, the device and any required supplies are indicated within the parameters of subpart 3, items E and F. Prior notification must be provided to the insurer for purchase of the device or for use longer than one month. The insurer may provide equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonsurgical care or during reevaluation and surgical therapy. Prior notification must be provided to the insurer for the purchase of home exercise equipment. The insurer may decide which brand of a prescribed type of exercise equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate use of that facility instead of authorizing purchase of the equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

D. The following durable medical equipment is not indicated for home use for low back conditions:

(1) whirlpools, Jacuzzi, hot tubs, and special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, and loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial nonsurgical treatment is effective according to items A to C. No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in items A to C:

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

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

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

If there is not progressive improvement in at least two items of items A to C, the modality must be discontinued or significantly modified, or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional directly providing the treatment, but remains the ultimate responsibility of the treating health care provider.

Subp. 10. **Scheduled and nonscheduled medication.** Prescription of controlled substance medications scheduled under *Minnesota Statutes*, section 152.02, including without limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated in the treatment of patients with regional low back pain after the first two weeks.

Patients with radicular pain may require longer periods of treatment.

The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonscheduled medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and that the most cost-effective regimen is used.

Subp. 11. **Specific treatment parameters for regional low back pain.**

A. Initial nonsurgical treatment must be the first phase of treatment for all patients with regional low back pain under subpart 1, item A, subitem (1).

(1) The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

(2) The only therapeutic injections indicated for patients with regional back pain are trigger point injections, facet joint injections, facet nerve injections, sacroiliac joint injections, and epidural blocks, and their use must meet the parameters of subpart 5.

(3) After the first week of treatment, initial nonsurgical treatment must at all times contain active treatment modalities according to the parameters of subpart 4.

(4) Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

(5) Except as otherwise specified in subpart 3, passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

B. Surgical evaluation or chronic management is indicated 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.The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

(1) Surgical evaluation, if indicated, may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

(2) Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the parameters of part 5221.6100. Medical imaging studies which do not meet these parameters are not indicated.

(3) Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the parameters of subpart 1, item H.

(4) Surgical evaluation may also include personality or psychosocial evaluation, consistent with the parameters of subpart 1, item G.

(5) Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

(6) The only surgical procedures indicated for patients with regional low back pain only are decompression of a lumbar nerve root or lumbar arthrodesis, with or without instrumentation, which must meet the parameters of subpart 6 and part 5221.6500, subpart 2, items A and C. For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated; their use must meet the parameters of subpart 6, item C.

(a) If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the pro-

posed surgery, it should be performed as expeditiously as possible consistent with sound medical practice, and consistent with any requirements of part 5221.6050, subpart 9, for prior notification of the insurer or second opinions.

(b) If surgery is not indicated, or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management according to the parameters of part 5221.6600.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, 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 which must be provided according to the parameters of part 5221.6600.

Subp. 12. **Specific treatment parameters for radicular pain, with or without regional low back pain, with no or static neurologic deficits.**

A. Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional low back pain, with no or static neurologic deficits under subpart 1, item A, subitem (2), and must be the first phase of treatment. It must be provided within the parameters of subpart 11, item A, with the following modifications: epidural blocks, and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional low back pain, therapeutic facet joint injections, facet nerve injections, trigger point injections, and sacroiliac injections may also be indicated.

B. Surgical evaluation or chronic management is indicated 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.It must be provided within the parameters of subpart 11, item B.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered, the patient refused surgical therapy, or the patient was not a candidate for surgical therapy, 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 radicular pain, with or without regional back pain, with static neurologic deficits must meet all of the parameters of part 5221.6600.

Subp. 13. **Specific treatment parameters for cauda equina syndrome and for radicular pain, with or without regional low back pain, with progressive neurologic deficits.**

A. Patients with cauda equina syndrome or with radicular pain, with or without regional low back pain, with progressive neurologic deficits may require immediate or emergency surgical evaluation at any time during the course of the overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any initial nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, except that surgical evaluation and surgical therapy may begin at any time.

B. If the health care provider decides to proceed with a course of initial nonsurgical care for a patient with radicular pain with progressive neurologic changes, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, 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 radicular pain, with or without regional back pain, with foot drop or progressive neurologic changes at first presentation must meet the parameters of part 5221.6600.

5221.6205 NECK PAIN.

Subpart 1. **Diagnostic procedures for treatment of neck injury.** 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, or neoplastic disease process.

(1) Regional neck pain includes referred pain to the shoulder and upper back. Regional neck pain includes the diagnoses of cervical strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the cervical spine and which affects the cervical region, with or without referral to the upper back or shoulder, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12.

(2) Radicular pain, with or without regional neck pain, with no or static neurologic deficit. This includes the diagnoses of brachialgia; cervical radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and other diagnoses for pain in the arm distal to the shoulder believed to originate with irritation of a nerve root in the cervical spine, including, but not limited to, the ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00. In these cases neurologic findings on history and examination are either absent or do not show progressive deterioration.

(3) Radicular pain, with or without regional neck pain, with progressive neurologic deficit, which includes the same diagnoses as subitem (2); however, in these cases there is a history of progressive deterioration in the neurologic symptoms and physical findings, including worsening sensory loss, increasing muscle weakness, and progressive reflex changes.

(4) Cervical compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.

B. Laboratory tests are not indicated in the evaluation of a patient with regional neck pain, or radicular pain, except:

(1) when a patient's history, age, or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis;

(2) to evaluate potential adverse side effects of medications; or

(3) as part of a preoperative evaluation.

Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

C. Medical imaging evaluation of the cervical spine must be based on the findings of the history and physical examination and cannot be ordered prior to the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with the standards in part 5221.6100, subpart 1. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are always inappropriate for the regional neck pain diagnoses in item A, subitem (1). EMG and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and myelopathy diagnoses in item A, subitems (2) to (4), after the first three weeks of radicular or myelopathy symptoms. Repeat EMG and nerve conduction studies for radicular pain and myelopathy are not indicated unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

E. The use of the following procedures or tests shall not be reimbursed:

(1) surface electromyography or surface paraspinal electromyography;

(2) thermography;

(3) plethysmography;

(4) electronic X-ray analysis of plain radiographs;

(5) diagnostic ultrasound; or

(6) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing can be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

G. Personality or psychological evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation

with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

(1) Is symptom magnification occurring?

(2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?

(3) Are there other personality factors or disorders which are interfering with recovery?

(4) Is the patient chemically dependent?

(5) Are there any interpersonal conflicts interfering with recovery?

(6) Does the patient have a chronic pain syndrome or psychogenic pain?

(7) In cases in which surgery is a possible treatment, are psychological factors, such as those in subitems (1) to (6), likely to interfere with the potential benefit of the surgery?

H. Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve block, epidural differential spinal block, nerve block, and nerve root block.

(1) These procedures are used to localize the source of pain prior to surgery and to diagnose conditions which fail to respond to initial nonsurgical management.

(2) These blocks and injections are invasive and when done as diagnostic procedures only, are not indicated unless noninvasive procedures have failed to establish the diagnosis.

(3) Selection of patients, choice of procedure, and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

(4) These blocks and injections can also be used as therapeutic modalities and as such are subject to the parameters of subpart 5.

I. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not necessarily limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine a patient's physical capacities in general or to determine and report work tolerance for a specific job, task, or work activity.

(1) Functional capacity assessment or evaluation is not reimbursable during the period of initial nonoperative care.

(2) Functional capacity assessment or evaluation is reimbursable in either of the following circumstances:

(a) permanent activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to do a specific job.

J. Consultations with other health care providers may be initiated at any time by the treating health care provider, consistent with accepted medical practice.

Subp. 2. **General treatment parameters for neck pain.**

A. All medical care for neck pain appropriately assigned to a clinical category in subpart 1, item A, is determined by the diagnosis and clinical category in subpart 1, item A, to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 14, as follows:

(1) subpart 11 governs regional neck pain;

(2) subpart 12 governs radicular pain with static neurologic deficits;

(3) subpart 13 governs radicular pain with progressive neurologic deficits; and

(4) subpart 14 governs myelopathy.

The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subparts 3 to 10, or to repeat a therapy or treatment previously provided for the same injury.

B. In general, a course of treatment is divided into three phases.

(1) First, all patients with neck problems, except patients with radicular pain with progressive neurological deficit, or myelopathy under subpart 1, item A, subitems (3) and (4), must be given initial nonsurgical care which may include both active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and parameters are described in subparts 3, 4, 5, 8, and 10. The period of initial nonsurgical management begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonoperative care is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice, and subparts 6 and 11 to 14, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Patients with radicular pain with progressive neurological deficit, or myelopathy may require immediate surgical therapy.

(b) Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical management.

(c) Surgery must follow the parameters in subparts 6 and 11 to 14, and part 5221.6500.

(d) A decision against surgery at this time does not preclude a decision for surgery made at a later date.

(3) Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may include durable medical equipment as described in subpart 8.

C. 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.

Subp. 3. **Passive treatment modalities.**

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to I is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to I are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits 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 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 functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

(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.

D. Thermal treatment includes all superficial and deep heating modalities and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

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

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

E. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

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

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

(3) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

(a) time for patient education and training, one to three sessions; and

(b) patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

F. Mechanical traction:

(1) Treatment given in a clinical setting:

(a) time for treatment response, three treatments;

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

(c) maximum treatment duration, 12 weeks in a clinical setting, but only if used in conjunction with other therapies.

(2) Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education:

(a) time for patient education and training, one session; and

(b) a patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

G. Acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure:

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

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

(3) maximum treatment duration, 12 weeks.

H. Manual therapy includes soft tissue and joint mobilization, 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. Phoresis includes iontophoresis and phonophoresis:

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

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

(3) maximum treatment duration, 12 weeks.

J. Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

K. Cervical collars, spinal braces, and other movement-restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability:

(1) time for treatment response, three days;

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

(3) maximum continuous duration, up to three weeks unless patient is status postfusion.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities, so long as the maximum duration for the active modality is not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow-up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the cervical spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment, it must not be the primary focus of the exercise program.

Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation and monthly thereafter. Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, three times per week for three weeks, decreasing in frequency thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program, and may supplement or follow the period of supervised exercise:

(a) maximum treatment frequency, up to three visits for instruction and monitoring; and

(b) there is no limit on the duration or frequency of exercise at home.

Subp. 5. **Therapeutic injections.** Injection modalities are indicated as set forth in items A to C. Use of injections may extend past the 12-week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

A. Therapeutic injections include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

(1) Trigger point injections:

(a) time for treatment response, within 30 minutes;

(b) maximum treatment frequency, once per week if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. Only three injections are reimbursable per patient visit; and

(c) maximum treatment, four injections to any one site.

(2) Facet joint injections or facet nerve blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections or blocks should be discontinued. Only three injections or blocks are reimbursable per patient visit; and

(c) maximum treatment, three injections or blocks to any one site.

(3) Nerve root blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection no sooner than two weeks after the previous injection if a positive response to the first injection. No more than three blocks are reimbursable per patient visit; and

(c) maximum treatment, two blocks to any one site.

(4) Epidural injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection is reimbursable per patient visit; and

(c) maximum treatment, three injections.

B. Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site:

(1) time for treatment response, within one week;

(2) maximum treatment frequency, may repeat once for any site; and

(3) maximum duration, two injections to any one site.

C. Prolotherapy and botulinum toxin injections are not indicated in the treatment of neck problems and are not reimbursable.

Subp. 6. **Surgery, including decompression procedures and arthrodesis.** Surgery may only be performed if it meets the specific parameters of subparts 11 to 14 and part 5221.6500. The health care provider must provide prior notification for nonemergency inpatient surgery according to part 5221.6050, subpart 9.

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 the initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) eight weeks following decompression or implantation of a dorsal column stimulator or morphine pump; or

(2) 12 weeks following arthrodesis.

B. Repeat surgery must also meet the parameters of subparts 11 to 14 and part 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.

C. The following surgical therapies have very limited application and require a second opinion which confirms that the treatment is indicated and within the parameters listed, and a personality or psychosocial evaluation indicates that the patient is likely to benefit from the treatment.

(1) Dorsal column stimulator is indicated for a patient who has neuropathic pain, is not a candidate for any other invasive therapy, and has had a favorable response to a trial screening period.

(2) Morphine pump is indicated for a patient who has somatic pain, is not a candidate for any other invasive therapy, and has had a favorable response to a trial screening period.

Subp. 7. **Chronic management.** Chronic management of neck disorders must be provided according to the parameters of part 5221.6600.

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only as specified in items A to D. The health care provider must provide prior notification as required in items B and C according to part 5221.6050, subpart 9.

A. Cervical collars, braces, or supports and home cervical traction devices may be indicated within the parameters of subpart 3, items F and K.

B. For patients using electrical stimulation at home, the device and any required supplies are indicated within the parameters of subpart 3, item E. Prior notification must be given for purchase of the device or for use longer than one month. The insurer may provide equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonoperative care or during reevaluation and surgical therapy. Prior notification must be given to the insurer before purchase of the home exercise equipment. The insurer may decide which brand of a prescribed type of exercise equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate the use of that facility instead of authorizing purchase of equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

D. The following durable medical equipment is not indicated for home use for neck pain conditions:

(1) whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, and loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary, and shall evaluate whether initial nonsurgical management is effective according to items A to C.

No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality has resulted in progressive improvement as specified in items A to C:

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

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

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

If there is not progressive improvement in at least two items of items A to C, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional working under the direction of the treating health care provider but remains the ultimate responsibility of the treating health care provider.

Subp. 10. **Scheduled and nonscheduled medication.** Prescription of controlled substance medications scheduled under *Minnesota Statutes*, section 152.02, including, without limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated in the treatment of patients with regional neck pain after the first two weeks.

Patients with radicular pain may require longer periods of treatment.

The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonnarcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and the most cost-effective regimen is used.

Subp. 11. **Specific treatment parameters for regional neck pain.**

A. Initial nonsurgical treatment must be the first phase of treatment for all patients with regional neck pain under subpart 1, item A, subitem (1).

(1) The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition.

(2) The only therapeutic injections indicated for patients with regional neck pain are trigger point injections, facet joint injections, facet nerve blocks, and epidural blocks, and their use must meet the parameters of subpart 5.

(3) After the first week of treatment, initial nonsurgical treatment must at all times contain active treatment modalities according to the parameters of subpart 4.

(4) Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

(5) Except as otherwise provided in subpart 3, passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

B. Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

(1) Surgical evaluation if indicated may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

(2) Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the parameters of part 5221.6100, subpart 1.

(3) Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the parameters of subpart 1, item H.

(4) Surgical evaluation may also include personality or psychosocial evaluation, consistent with the parameters of subpart 1, item G.

(5) Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

(6) The only surgical procedure indicated for patients with regional neck pain only is cervical arthrodesis, with or without instrumentation, which must meet the parameters of subpart 6. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

(a) If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it should be performed as expeditiously as possible consistent with sound medical practice, and consistent with any requirements of part 5221.6050, subpart 9, for prior notification of the insurer or second opinions.

(b) If surgery is not indicated or if the patient does not wish to proceed with surgical therapy, then the patient is a candidate for chronic management.

C. If the patient continues with symptoms and objective physical findings after surgery has been rendered or the patient refuses surgery or the patient was not a candidate for surgery, 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 according to part 5221.6600.

Subp. 12. **Specific treatment parameters for radicular pain, with or without regional neck pain, with no or static neurologic deficits.**

A. Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional neck pain, with no or static neurologic deficits under subpart 1, item A, subitem (2), and must be the first phase of treatment. It must be provided within the parameters of subpart 11, item A, with the following modifications: epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional neck pain, therapeutic facet joint injections, facet nerve blocks, and trigger point injections may also be indicated.

B. Surgical evaluation or chronic management is indicated 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. It must be provided within the parameters of subpart 11, item B, with the following modifications: the only surgical procedures indicated for patients with radicular pain are decompression of a cervical nerve root which must meet the parameters of subpart 6 and part 5221.6500, subpart 2, item B, and cervical arthrodesis, with or without instrumentation. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered, the patient refused surgical therapy, or the patient was not a candidate for surgical therapy, 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 radicular pain, with or without regional neck pain, with static neurologic changes must meet all of the parameters of part 5221.6600.

Subp. 13. **Specific treatment parameters for radicular pain, with or without regional neck pain, with progressive neurologic changes.**

A. Patients with radicular pain, with or without regional neck pain, with progressive neurologic deficits may require immediate or emergency evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, with the following modifications:

(1) surgical evaluation and surgical therapy may begin at any time; and

(2) the only surgical procedures indicated for patients with radicular pain are decompression of a cervical nerve root which must meet the parameters of subpart 6 and part 5221.6500, subpart 2, item B, or cervical arthrodesis, with or without instrumentation. For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

B. If the health care provider decides to proceed with a course of nonsurgical care for a patient with radicular pain with progressive neurologic changes, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, 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 radicular pain, with or without regional neck pain, with progressive neurologic changes at first presentation must meet all of the parameters of part 5221.6600.

Subp. 14. **Specific treatment parameters for myelopathy.**

A. Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, with the following modifications:

(1) surgical evaluation and surgical therapy may begin at any time; and

(2) the only surgical procedures indicated for patients with myelopathy are anterior or posterior decompression of the spinal cord, or cervical arthrodesis with or without instrumentation. For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

B. If the health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, 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 myelopathy must meet all of the parameters of part 5221.6600.

5221.6210 THORACIC BACK PAIN.

Subpart 1. **Diagnostic procedures for treatment of thoracic back injury.** 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 consistency 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, or neoplastic disease process.

(1) Regional thoracic back pain includes the diagnoses of thoracic strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and any other diagnosis for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the thoracic spine and which effects the thoracic region, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12.

(2) Radicular pain, with or without regional thoracic back pain, includes the diagnoses of thoracic radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and any other diagnoses for pain believed to originate with irritation of a nerve root in the thoracic spine, including, but not limited to, the ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00.

(3) Thoracic compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.

B. Laboratory tests are not indicated in the evaluation of a patient with regional thoracic back pain, or radicular pain, except when a patient's history, age, or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis, or side effects of medications. Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the

need for the tests ordered with clear documentation of the indications. Laboratory tests may also be ordered as part of a preoperative evaluation.

C. Medical imaging evaluation of the thoracic spine must be based on the findings of the history and physical examination and cannot be ordered prior to the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with all of the standards in part 5221.6100, subpart 1. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are always inappropriate for regional thoracic back pain and radicular pain under item A, subitems (1) to (3).

E. The use of the following procedures or tests shall not be reimbursed:

(1) surface electromyography or surface paraspinal EMG;

(2) thermography;

(3) plethysmography;

(4) electronic X-ray analysis of plain radiographs;

(5) diagnostic ultrasound; or

(6) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. Computerized range of motion or strength measuring tests are not reimbursable during the period of initial nonsurgical care, but may be reimbursable during a period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonoperative care computerized range of motion or strength testing can be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

G. Personality or psychological evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

(1) Is symptom magnification occurring?

(2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?

(3) Are there other personality factors or disorders which are interfering with recovery?

(4) Is the patient chemically dependent?

(5) Are there any interpersonal conflicts interfering with recovery?

(6) Does the patient have a chronic pain syndrome or psychogenic pain?

(7) In cases in which surgery is a possible treatment, are psychological factors, such as those listed in subitems (1) to (6), likely to interfere with the potential benefit of the surgery?

H. Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve block, epidural differential spinal block, nerve block, and nerve root block.

(1) These procedures are used to localize the source of pain prior to surgery and to diagnose conditions which fail to respond to initial nonoperative care.

(2) These blocks and injections are invasive and when done as diagnostic procedures only are not indicated unless noninvasive procedures have failed to establish the diagnosis.

(3) Selection of patients, choice of procedure, and localization of the level of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

(4) These blocks and injections can also be used as therapeutic modalities and as such are subject to the guidelines of subpart 5.

I. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A func-

tional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

(1) Functional capacity assessment or evaluation is not reimbursable during the period of initial nonoperative care.

(2) Functional capacity assessment or evaluation is reimbursable in either of the following circumstances:

(a) permanent activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to do a specific job.

J. Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with standard medical practice.

Subp. 2. **General treatment parameters for thoracic back pain.**

A. All medical care for thoracic back pain, appropriately assigned to a category of subpart 1, item A, is determined by the diagnosis and clinical category in subpart 1, item A, to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 13, as follows:

(1) subpart 11 governs regional thoracic back pain;

(2) subpart 12 governs radicular pain; and

(3) subpart 13 governs myelopathy.

The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in items C to F, or to repeat a therapy or treatment previously provided for the same injury.

B. In general, a course of treatment is divided into three phases.

(1) First, all patients with thoracic back problems, except patients with myelopathy under subpart 1, item A, subitem (3), must be given initial nonoperative care which may include active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and parameters are described in subparts 3, 4, 5, 8, and 10. The period of initial nonsurgical treatment begins with the first clinical passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subparts 6 and 11 to 13, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Patients with myelopathy may require immediate surgical therapy.

(b) Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical care.

(c) Surgery must follow the parameters in subparts 6 and 11 to 13, and part 5221.6500.

(d) A decision against surgery at this time does not preclude a decision for surgery made at a later date in light of new clinical information.

(3) Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may also include durable medical equipment as described in subpart 8.

C. 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.

Subp. 3. **Passive treatment modalities.**

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to I is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to I are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits 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 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 functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

(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.

D. Thermal treatment includes all superficial and deep heating modalities and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

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

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

E. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

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

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

(a) maximum time for patient education and training, up to three sessions; and

(b) patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

F. Mechanical traction:

(1) Treatment given in a clinical setting:

(a) time for treatment response, three treatments;

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

(c) maximum treatment duration, 12 weeks in a clinical setting but only if used in conjunction with other therapies.

(2) Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education:

(a) maximum time for patient education and training, one session; and

(b) a patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

G. Acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure:

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

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

(3) maximum treatment duration, 12 weeks.

H. Manual therapy includes soft tissue and joint mobilization, 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. Phoresis includes iontophoresis and phonophoresis:

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

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

(3) maximum treatment duration, 12 weeks.

J. Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

K. Spinal braces and other movement-restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability:

(1) time for treatment response, three 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, three weeks unless patient is status postfusion.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities may extend past the 12-week limit on passive treatment modalities, so long as the maximum durations for the active treatment modalities are not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which includes an initial education and training session, and two follow-up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, back, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the thoracic spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment this shall not be the primary focus of the exercise program.

Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance shall be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation and monthly thereafter. Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, three times per week for three weeks and should decrease with time thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program and may supplement or follow the period of supervised exercise:

(a) maximum treatment frequency, one to three visits for instruction and monitoring; and

(b) there is no limit on the duration and frequency of exercise at home.

Subp. 5. **Therapeutic injections.** Injection modalities are indicated as set forth in items A to C. Use of injections may extend past the 12-week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

A. Therapeutic injections include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site.

(1) Trigger point injections:

(a) time for treatment response, within 30 minutes;

(b) maximum treatment frequency, once per week if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections should be redirected to other areas or discontinued. No more than three injections are reimbursable per patient visit; and

(c) maximum treatment, four injections to any one site.

(2) Facet joint injections or facet nerve blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections or blocks should be discontinued. Only three injections or blocks are reimbursable per patient visit; and

(c) maximum treatment, three injections or blocks to any one site.

(3) Nerve root blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection two weeks after the previous injection if a positive response to the first block. Only three injections are reimbursable per patient visit; and

(c) maximum treatment, two blocks to any one site.

(4) Epidural injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection is reimbursable per patient visit; and

(c) maximum treatment, three injections.

B. Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site:

(1) time for treatment response, within one week;

(2) optimum treatment frequency, may repeat once for any site; and

(3) maximum duration, two injections to any one site.

C. Prolotherapy and botulinum toxin injections are not indicated in the treatment of thoracic back problems and are not reimbursable.

Subp. 6. **Surgery, including decompression procedures.** Surgery may only be performed if it meets the specific parameters of subparts 11 to 13 and part 5221.6500. The health care provider must provide prior notification of nonemergency inpatient surgery according to part 5221.6050, subpart 9.

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 the initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) eight weeks following decompression or implantation of a dorsal column stimulator or morphine pump; or

(2) 12 weeks following arthrodesis.

B. Repeat surgery must also meet the parameters of subparts 11 to 13 and part 5221.6500 and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if a second opinion is requested by the insurer.

C. The surgical therapies in subitems (1) and (2) have very limited application and require a second opinion which confirms that the treatment is indicated and within the parameters listed, and a personality or psychosocial evaluation which indicates that the patient is likely to benefit from the treatment.

(1) Dorsal column stimulator is indicated for a patient who has neuropathic pain, and is not a candidate for any other invasive therapy, and has had a favorable response to a trial screening period.

(2) Morphine pump is indicated for a patient who has somatic pain, and is not a candidate for any other invasive therapy, and has had a favorable response to a trial screening period.

Subp. 7. **Chronic management.** Chronic management of thoracic back pain must be provided according to the parameters of part 5221.6600.

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only in certain specific situations, as specified in items A to D. The health care provider must provide the insurer with prior notification as required by items B and C, according to part 5221.6050, subpart 9.

A. Braces or supports may be indicated within the parameters of subpart 3, item K.

B. For patients using electrical stimulation or mechanical traction devices at home, the device and any required supplies are indicated within the parameters of subpart 3, items E and F. Prior notification of the insurer is required for purchase of the device or for use longer than one month. The insurer may provide equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonoperative care or during reevaluation and surgical therapy. Prior notification of the insurer is required for the purchase of home exercise equipment. The insurer may decide which brand of a prescribed type of exercise equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate the use of that facility instead of authorizing purchase of equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

D. The following durable medical equipment is not indicated for home use for thoracic back pain conditions:

(1) whirlpools, Jacuzzis, hot tubs, special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, or loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial nonsurgical management is effective according to items A to C. No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in items A to C:

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

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

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

If there is not progressive improvement in at least two items of items A to C, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional working under the direction of the treating health care provider but remains the ultimate responsibility of the treating health care provider.

Subp. 10. **Scheduled and nonscheduled medication.** Prescription of controlled substance medications scheduled under *Minnesota Statutes*, section 152.02, including, without limitation, narcotics, is indicated only for the treatment of severe acute pain. These medications are not indicated in the treatment of patients with regional thoracic back pain after the first two weeks.

Patients with radicular pain may require longer periods of treatment.

The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonnarcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and the most cost-effective regimen is used.

Subp. 11. **Specific treatment parameters for regional thoracic back pain.**

A. Initial nonsurgical treatment must be the first phase of treatment for all patients with regional thoracic back pain under subpart 1, item A, subitem (1).

(1) The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

(2) The only therapeutic injections indicated for patients with regional thoracic back pain are trigger point injections, facet joint injections, facet nerve blocks, and epidural blocks, and their use must meet the parameters of subpart 5.

(3) After the first week of treatment, initial nonsurgical management must at all times contain active treatment modalities according to the parameters of subpart 4.

(4) Initial nonsurgical treatment must be provided in the least intensive setting consistent with quality health care practices.

(5) Except as provided in subpart 3, passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not indicated beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

B. Surgical evaluation or chronic management is indicated if the patient continues with symptoms and objective 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. The purpose of surgical evaluation is to determine whether surgery is indicated in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is indicated.

(1) Surgical evaluation may begin as soon as eight weeks after, but must begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgical therapy does not preclude surgery at a later date.

(2) Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the parameters of part 5221.6100. Medical imaging studies which do not meet these parameters are not indicated.

(3) Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the parameters of subpart 1, item H.

(4) Surgical evaluation may also include personality or psychosocial evaluation, consistent with the parameters of subpart 1, item G.

(5) Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks and injections, if performed, and the patient's ongoing subjective complaints and objective physical findings.

(6) The only surgical procedure indicated for patients with regional thoracic back pain only is thoracic arthrodesis with or without instrumentation, which must meet the parameters of subpart 6, and part 5221.6500, subpart 2, item C. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

(a) If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery it should be performed as expeditiously as possible consistent with sound medical practice, and consistent with any requirements of parts 5221.6010 to 5221.6500 for prior notification of the insurer or second opinions.

(b) If surgery is not indicated or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management.

C. If the patient continues with symptoms and objective physical findings after surgery has been rendered or the patient refuses surgery or the patient was not a candidate for surgery, 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 according to the parameters of part 5221.6600.

Subp. 12. **Specific treatment parameters for radicular pain.**

A. Initial nonsurgical treatment is appropriate for all patients with radicular pain under subpart 1, item A, subitem (2), and must be the first phase of treatment. It must be provided within the parameters of subpart 11, item A, with the following modifications: epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections indicated for patients with radicular pain only. If there is a component of regional thoracic back pain, therapeutic facet joint injections, facet nerve blocks, and trigger point injections may also be indicated.

B. Surgical evaluation or chronic management is indicated 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. It shall be provided within the parameters of subpart 11, item B, with the following modifications: the only surgical procedures indicated for patients with radicular pain are decompression or arthrodesis. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refused surgical therapy or the patient was not a candidate for surgical therapy, 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 radicular pain, with or without regional thoracic back pain, must meet all of the parameters of part 5221.6600.

Subp. 13. **Specific treatment parameters for myelopathy.**

A. Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, with the following modifications:

(1) surgical evaluation and surgical therapy may begin at any time; and

(2) the only surgical procedures indicated for patients with myelopathy are decompression and arthrodesis. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

B. If the health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it must follow the parameters of subpart 12, item A.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, 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 myelopathy must meet all of the parameters of part 5221.6600.

5221.6300 UPPER EXTREMITY DISORDERS.

Subpart 1. **Diagnostic procedures for treatment of upper extremity disorders (UED).** 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 vascular, infectious, immunological, metabolic, endocrine, systemic neurologic, or neoplastic disease process, fractures, amputations, or sprains or strains with complete tissue disruption.

(1) Epicondylitis. This clinical category includes medial epicondylitis and lateral epicondylitis, ICD-9-CM codes 726.31 and 726.32.

(2) Tendonitis of the forearm, wrist, and hand. This clinical category encompasses any inflammation, pain, tenderness, or dysfunction or irritation of a tendon, tendon sheath, tendon insertion, or musculotendinous junction in the upper extremity at or distal to the elbow due to mechanical injury or irritation, including, but not limited to, the diagnoses of tendonitis, tenosynovitis, tendovaginitis, peritendinitis, extensor tendinitis, de Quervain's syndrome, intersection syndrome, flexor tendinitis, and trigger digit, including, but not limited to, ICD-9-CM codes 726.4, 726.5, 726.8, 726.9, 726.90, 727, 727.0, 727.00, 727.03, 727.04, 727.05, and 727.2.

(3) Nerve entrapment syndromes. This clinical category encompasses any compression or entrapment of the radial, ulnar, or median nerves, or any of their branches, including, but not limited to, carpal tunnel syndrome, pronator syndrome, anterior interosseous syndrome, cubital tunnel syndrome, Guyon's canal syndrome, radial tunnel syndrome, posterior interosseous syndrome, and Wartenburg's syndrome, including, but not limited to, ICD-9-CM codes 354, 354.0, 354.1, 354.2, 354.3, 354.8, and 354.9.

(4) Muscle pain syndromes. This clinical category encompasses any painful condition of any of the muscles of the upper extremity, including the muscles responsible for movement of the shoulder and scapula, characterized by pain and stiffness, including, but not limited to, the diagnoses of chronic nontraumatic muscle strain, repetitive strain injury, cervicobrachial syndrome, tension neck syndrome, overuse syndrome, myofascial pain syndrome, myofasciitis, nonspecific myalgia, fibrositis, fibromyalgia, and fibromyositis, including, but not limited to, ICD-9-CM codes 723.3, 729.0, 729.1, 729.5, 840, 840.3, 840.5, 840.6, 840.8, 840.9, 841, 841.8, 841.9, and 842.

(5) Shoulder impingement syndromes, including tendonitis, bursitis, and related conditions. This clinical category encompasses any inflammation, pain, tenderness, dysfunction, or irritation of a tendon, tendon insertion, tendon sheath, musculotendinous junction, or bursa in the shoulder due to mechanical injury or irritation, including, but not limited to, the diagnoses of

impingement syndrome, supraspinatus tendonitis, infraspinatus tendonitis, calcific tendonitis, bicipital tendonitis, subacromial bursitis, subcoracoid bursitis, subdeltoid bursitis, and rotator cuff tendinitis, including, but not limited to, ICD-9-CM codes 726.1 to 726.2, 726.9, 726.90, 727 to 727.01, 727.2, 727.3, 840, 840.4, 840.6, 840.8, and 840.9.

(6) Traumatic sprains or strains of the upper extremity. This clinical category encompasses an instantaneous or acute injury, as a result of a single precipitating event to the ligaments or the muscles of the upper extremity including, without limitation, ICD-9-CM codes 840 to 842.19. Injuries to muscles as a result of repetitive use, or occurring gradually over time without a single precipitating trauma, are considered muscle pain syndromes under subitem (4). Injuries with complete tissue disruption are not subject to this parameter.

B. Certain laboratory tests may be indicated in the evaluation of a patient with upper extremity disorder to rule out infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders such as rheumatoid arthritis, or side effects of medications. Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

C. Medical imaging evaluation of upper extremity disorders must be based on the findings of the history and physical examination and cannot be ordered before the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with the standards in part 5221.6100, subpart 1. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are only appropriate for nerve entrapment disorders and recurrent nerve entrapment after surgery.

E. The following diagnostic procedures or tests are not indicated for diagnosis of upper extremity disorders:

(1) surface electromyography;

(2) thermography; or

(3) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. The following diagnostic procedures or tests are considered adjuncts to the physical examination and are not reimbursed separately from the office visit:

(1) vibrometry;

(2) neurometry;

(3) Semmes-Weinstein monofilament testing; or

(4) algometry.

G. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing can be performed but must be done in conjunction with and are not reimbursed separately from an office visit with a physician, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

H. Personality or psychosocial evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate initial nonsurgical care. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

(1) Is symptom magnification occurring?

(2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?

(3) Are there other personality factors or disorders which are interfering with recovery?

(4) Is the patient chemically dependent?

(5) Are there any interpersonal conflicts interfering with recovery?

(6) Does the patient have a chronic pain syndrome or psychogenic pain?

(7) In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

I. Diagnostic analgesic blocks or injection studies.

(1) These procedures are used to localize the source of pain and to diagnose conditions which fail to respond to appropriate initial nonsurgical management.

(2) Selection of patients, choice of procedure, and localization of the site of injection should be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

(3) These blocks and injections can also be used as therapeutic modalities and as such are subject to the parameters of subpart 5.

J. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the required information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

(1) Functional capacity assessment or evaluation is not indicated during the first 12 weeks of initial nonsurgical treatment.

(2) Functional capacity assessment or evaluation is indicated after the first 12 weeks of care in either of the following circumstances:

(a) activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to return to do a specific job.

(3) A functional capacity evaluation is not appropriate to establish baseline performance before treatment, or for subsequent assessments, to evaluate change during or after treatment.

(4) Only one completed functional capacity evaluation is indicated per injury.

K. Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with accepted medical practice.

Subp. 2. **General treatment parameters for upper extremity disorders.**

A. All medical care for upper extremity disorders, appropriately assigned to a category of subpart 1, item A, is determined by the diagnosis and clinical category in subpart 1, item A, to which the patient has been assigned. General parameters for treatment modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 16 as follows:

(1) subpart 11 governs epicondylitis;

(2) subpart 12 governs tendonitis of the forearm, wrist, and hand;

(3) subpart 13 governs upper extremity nerve entrapment syndromes;

(4) subpart 14 governs upper extremity muscle pain syndromes;

(5) subpart 15 governs shoulder impingement syndromes; and

(6) subpart 16 governs traumatic sprains and strains of the upper extremity.

The health care provider must at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category and these changes must be recorded in the medical record. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subparts 3 to 10, or to repeat a therapy or treatment previously provided for the same injury, unless the treatment or therapy is subsequently delivered to a different part of the body.

When treating more than one clinical category or body part for which the same treatment modality is appropriate, then the treatment modality should be applied simultaneously, if possible, to all indicated areas.

B. In general, a course of treatment must be divided into three phases:

(1) First, all patients with an upper extremity disorder must be given initial nonsurgical management, unless otherwise specified. Initial nonsurgical management may include any combination of the passive, active, injection, durable medical equipment, and medication treatment modalities listed in subparts 3, 4, 5, 8, and 10, appropriate to the clinical category. The period of initial nonsurgical treatment begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice and subparts 6 and 11 to 16, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(a) Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy can be in addition to any received during the period of initial nonsurgical management.

(b) Surgery must follow the parameters in subparts 6 and 11 to 16, and part 5221.6500.

(c) A decision against surgery at this time does not preclude a decision for surgery made at a later date.

(3) Third, for those patients who are not candidates for surgery or refuse surgery, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. Chronic management modalities are described in part 5221.6600, and may include durable medical equipment is described in subpart 8.

C. 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.

Subp. 3. **Passive treatment modalities.**

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to H is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to H are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits 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 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 functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

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

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

(3) maximum treatment duration, 12 weeks.

D. Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

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

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

E. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(1) Treatment given in a clinical setting:

(a) time for treatment response, two to four treatments;

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

(c) maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

(a) time for patient education and training, one to three sessions; and

(b) patient may use the electrical stimulation device unsupervised for one month, at which time effectiveness of the treatment must be reevaluated by the provider before continuing home use of the device.

F. Acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure:

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

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

(3) maximum treatment duration, 12 weeks.

G. Phoresis includes phonopheresis and iontophoresis:

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

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

(3) maximum treatment duration is nine sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

H. Manual therapy includes soft tissue and joint mobilization, 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-restricting appliances. Bracing required for longer than two weeks must be accompanied by 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.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities so long as the maximum treatment for the active treatment modality is not exceeded.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to upper extremity function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is three visits, which include an initial education and training session, and two follow-up visits.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is three visits.

D. Exercise, which is important to the success of a nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the upper extremity. While aerobic exercise may be performed as adjunctive treatment this must not be the primary focus of the exercise program.

Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the testing sooner than two weeks after the initial evaluation and monthly thereafter.

Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, up to three times per week for three weeks. Should decrease with time thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting and may supplement or follow the period of supervised exercise.

Subp. 5. **Therapeutic injections.** Therapeutic injections include injections of trigger points, sympathetic nerves, peripheral nerves, and soft tissues. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site. Use of injections may extend past the 12-week limitation on passive modalities, so long as the maximum treatment for injections in items A to C is not exceeded.

A. Trigger point injections:

(1) time for treatment response, within 30 minutes;

(2) maximum treatment frequency, once per week to any one site if a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then

trigger point injections should be redirected to other areas or discontinued. No more than three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, four injections to any one site over the course of treatment.

B. Soft tissue injections include injections of a bursa, tendon, tendon sheath, ganglion, tendon insertion, ligament, or ligament insertion:

(1) time for treatment response, within one week;

(2) maximum treatment frequency, once per month to any one site if a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, three injections to any one site over the course of treatment.

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

(1) time for treatment response, within one week;

(2) maximum treatment frequency, can repeat injection in one month if a positive response to the first injection. Only three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, two injections to any one site over the course of treatment.

Subp. 6. **Surgery.** Surgery may only be performed if it meets applicable parameters in subparts 11 to 14 and part 5221.6500. 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.

Subp. 7. **Chronic management.** Chronic management of upper extremity disorders must be provided according to the parameters of part 5221.6600.

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only in the situations specified in items A to D. The health care provider must provide the insurer with prior notification as required in items B and C and part 5221.6050, subpart 9.

A. Splints, braces, straps, or supports may be indicated as specified in subpart 3, item I.

B. For patients using an electrical stimulation device at home, the device and any required supplies are indicated within the parameters of subpart 3, item E. Prior notification of the insurer is required for purchase of the device or for use longer than one month. The insurer may provide the equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonsurgical care or during reevaluation and surgical therapy. Prior notification of the insurer is required for the purchase of home exercise equipment. The insurer may decide which brand of a prescribed type of equipment is provided to the patient. If the employer has an appropriate exercise facility on its premises with the prescribed equipment the insurer may mandate use of that facility instead of authorizing purchase of the equipment for home use.

(1) Indications: the patient is deconditioned and requires reconditioning which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

D. The following durable medical equipment is not indicated for home use for the upper extremity disorders specified in subparts 11 to 16:

(1) whirlpools, Jacuzzi, hot tubs, and special bath or shower attachments; or

(2) beds, waterbeds, mattresses, chairs, recliners, and loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary and whether initial nonsurgical treatment is effective according to items A to C.

No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in items A to C:

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

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

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

If there is not progressive improvement in at least two items in items A to C, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional directly providing the treatment, but remains the ultimate responsibility of the treating health care provider.

Subp. 10. **Scheduled and nonscheduled medication.** Prescription of controlled substance medications scheduled under *Minnesota Statutes*, section 152.02, including, without limitation, narcotics, is indicated only for the treatment of severe acute pain. Therefore, these medications are not routinely indicated in the treatment of patients with upper extremity disorders. The health care provider must document the rationale for the use of any scheduled medication. Treatment with nonscheduled medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and the most cost-effective regimen is used.

Subp. 11. **Specific treatment parameters for epicondylitis.**

A. Initial nonsurgical management is appropriate for all patients with epicondylitis and must be the first phase of treatment.

(1) The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures specified in subparts 3, 4, 5, 8, and 10, may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition. After the first week of treatment, initial nonsurgical care must at all times include active treatment modalities according to subpart 4.

(2) Initial nonsurgical management must be provided in the least intensive setting consistent with quality health care practices.

(3) Except as provided in subpart 3, use of passive treatment modalities in a clinic setting or requiring attendance by a health care provider for a period in excess of 12 weeks is not indicated.

(4) Use of home-based treatment modalities with monitoring by the treating health care provider may continue for up to 12 months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

B. If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. The purpose and goal of surgical evaluation is to determine whether surgery is indicated for the patient who has failed to recover with appropriate nonsurgical care or chronic management.

(1) Surgical evaluation, if indicated, must begin no later than 12 months after beginning initial nonsurgical management.

(2) Surgical evaluation may include the use of appropriate laboratory and electrodiagnostic testing within the parameters of subpart 1, if not already obtained during the initial evaluation. Repeat testing is not indicated unless there has been an objective change in the patient's condition which in itself would warrant further testing. Failure to improve with therapy does not, by itself, warrant further testing.

(3) Plain films may be appropriate if there is a history of trauma, infection, or inflammatory disorder and are subject to the general parameters in part 5221.6100, subpart 1. Other medical imaging studies are not indicated.

(4) Surgical evaluation may also include personality or psychological evaluation consistent with the parameters of subpart 1, item H.

(5) Consultation with other health care providers is an important part of surgical evaluation of a patient who fails to recover with appropriate initial nonsurgical management. The need for consultation and the choice of consultant will be determined by the diagnostic findings and the patient's condition. Consultation is governed by part 5221.6050, subpart 6.

(6) If surgery is indicated, it may not be performed until 12 months after initial surgical management was begun.

(7) If surgery is not indicated, or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

C. If the patient continues with symptoms and objective physical findings after surgery or the patient refused surgery or the patient was not a candidate for surgery, 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 according to part 5221.6600.

Subp. 12. **Specific treatment parameters for tendonitis of forearm, wrist, and hand.**

A. Except as provided in item B, subitem (3), initial nonsurgical management is appropriate for all patients with tendonitis and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A.

B. If the patient continues with symptoms and objective physical findings after initial nonsurgical management, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

(1) For patients with a specific diagnosis of de Quervain's syndrome, surgical evaluation and surgical therapy, if indicated, may begin after only two months of initial nonsurgical management.

(2) For patients with a specific diagnosis of trigger finger or trigger thumb, surgical evaluation and potential surgical therapy may begin after only one month of initial nonsurgical management.

(3) For patients with a locked finger or thumb, surgery may be indicated immediately without any preceding nonsurgical management.

C. If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery or the patient was not a candidate for surgery, 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 tendonitis must meet all of the parameters of part 5221.6600.

Subp. 13. **Specific treatment parameters for nerve entrapment syndromes.**

A. Initial nonsurgical management is appropriate for all patients with nerve entrapment syndromes, except as specified in subitem (2), and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A, with the following modifications: nonsurgical management may be inappropriate for patients with advanced symptoms and signs of nerve compression, such as abnormal two-point discrimination, motor weakness, or muscle atrophy, or for patients with symptoms of nerve entrapment due to acute trauma. In these cases, immediate surgical evaluation may be indicated.

B. If the patient continues with symptoms and objective physical findings after 12 weeks 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 surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

(1) Surgical evaluation may begin, and surgical therapy may be provided, if indicated, after 12 weeks of initial nonsurgical management, except where immediate surgical evaluation is indicated under item A.

(2) Surgery is indicated if an EMG confirms the diagnosis, or if there has been temporary resolution of symptoms lasting at least seven days with local injection.

(3) If there is neither a confirming EMG or appropriate response to local injection, or if surgery has been previously performed at the same site, surgery is not indicated unless a second opinion confirms the need for surgery.

C. If the patient continues with symptoms and objective physical findings after all surgery, or the patient refused surgery therapy or the patient was not a candidate for surgery therapy, 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 nerve entrapment syndromes must meet all of the parameters of part 5221.6600.

Subp. 14. **Specific treatment parameters for muscle pain syndromes.**

A. Initial nonsurgical management is appropriate for all patients with muscle pain syndromes and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A.

B. Surgery is not indicated for the treatment of muscle pain syndrome.

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.

Subp. 15. **Specific treatment parameters for shoulder impingement syndromes.**

A. Initial nonsurgical management is appropriate for all patients with shoulder impingement syndromes without clinical evidence of rotator cuff tear and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A, except as follows:

(1) continued nonsurgical management may be inappropriate, and early surgical evaluation may be indicated, for patients with:

(a) clinical findings of rotator cuff tear; or

(b) acute rupture of the proximal biceps tendon;

(2) use of home-based treatment modalities with monitoring by the health care provider may continue for up to six months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

B. If the patient continues with symptoms and objective physical findings after six 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 surgical evaluation or chronic management is indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

(1) Surgical evaluation must begin no later than six months after beginning initial nonsurgical management.

(2) Diagnostic injection, arthrography, CT-arthrography, or MRI scanning may be indicated as part of the surgical evaluation.

(3) The only surgical procedures indicated for patients with shoulder impingement syndrome and related conditions are rotator cuff repair, acromioplasty, excision of distal clavicle, excision of bursa, removal of adhesion, or repair of proximal biceps tendon, all of which must meet the parameters of part 5221.6500, subpart 3.

C. If the patient continues with symptoms and objective physical findings after 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 shoulder impingement syndrome must meet the parameters of part 5221.6600.

Subp. 16. **Specific treatment parameters for traumatic sprains and strains of the upper extremity.**

A. Initial nonsurgical management must be the first phase of treatment for all patients with traumatic sprains and strains of the upper extremity without evidence of complete tissue disruption. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11.

B. 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.

C. If the patient continues with symptoms and objective physical findings after 12 weeks 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 must meet all of the parameters of part 5221.6600.

5221.6305 REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER AND LOWER EXTREMITIES.

Subpart 1. **Scope.**

A. This clinical category encompasses any condition of the upper or lower extremity characterized by concurrent presence in the involved extremity of five of the following conditions: edema; local skin color change of red or purple; osteoporosis in underlying bony structures demonstrated by radiograph; local dyshidrosis; local abnormality of skin temperature regulation; reduced passive range of motion in contiguous joints; local alteration of skin texture of smooth or shiny; or typical findings of reflex sympathetic dystrophy on bone scan. This clinical category includes, but is not limited to, the diagnoses of reflex sympathetic dystrophy, causalgia, Sudek's atrophy, algoneurodystrophy, and shoulder-hand syndrome, and including, but not limited to, ICD-9-CM codes 337.9, 354.4, and 733.7.

B. Reflex sympathetic dystrophy occurs as a complication of another preceding injury. The treatment parameters of this part refer to the treatment of the body part affected by the reflex sympathetic dystrophy. The treatment for any condition not affected by reflex sympathetic dystrophy continues to be subject to whatever treatment parameters otherwise apply. Any treatment under this part for the reflex sympathetic dystrophy may be in addition to treatment received for the original condition.

C. Thermography may be used in the diagnosis of reflex sympathetic dystrophy, but is considered an adjunct to physical examination and is not reimbursed separately from the office visit.

Subp. 2. **Initial nonsurgical management.** Initial nonsurgical management is appropriate for all patients with reflex sympathetic dystrophy and must be the first phase of treatment. Any course or program of initial nonsurgical management is limited to the modalities specified in items A to D.

A. Therapeutic injection modalities. The only injection allowed for reflex sympathetic dystrophy is sympathetic block. Unless medically contraindicated, sympathetic blocks 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) Time for treatment response: within 30 minutes.

(2) 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) 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.

B. Only the passive treatment modalities set forth in subitems (1) to (4) are indicated. These passive treatment modalities in a clinical setting or requiring attendance by a health care provider are not indicated beyond 12 weeks from the first modality initiated for treatment of the reflex sympathetic dystrophy.

(1) Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(a) Treatment given in a clinical setting:

i. time for treatment response, two to four treatments;

ii. maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and

iii. maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies specified in this subpart.

(b) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without professional assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

(2) Desensitizing procedures, such as stroking or friction massage, stress loading, and contrast baths:

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

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

(c) maximum treatment duration in a clinical setting, 12 weeks. Home use of desensitizing procedures may be prescribed at any time during the course of treatment.

(3) Electrical stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(a) Treatment given in a clinical setting:

i. time for treatment response, two to four treatments;

ii. maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and

iii. maximum treatment duration, 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

(b) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

i. time for patient education and training, one to three sessions; and

ii. patient may use the electrical stimulation device unsupervised for one month, at which time effectiveness of the treatment must be reevaluated by the provider before continuing home use of the device.

(4) Acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure:

(a) time for treatment response, three to five sessions;

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

(c) maximum treatment duration, 12 weeks.

C. Active treatment includes supervised and unsupervised exercise. After the first week of treatment, initial nonsurgical management must include exercise. Exercise is essential for a return to normal activity and must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must be specifically aimed at the involved musculature. Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation, and monthly thereafter.

(1) Supervised exercise. One goal of a supervised exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, up to five times per week for three weeks. Should decrease in frequency thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting and may supplement or follow the period of supervised exercise. Maximum duration is unlimited.

D. Oral medications may be indicated in accordance with accepted medical practice.

Subp. 3. **Surgery.**

A. Surgical sympathectomy may only be performed in patients who had a sustained but incomplete improvement with sympathetic blocks by injection.

B. Dorsal column stimulator 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 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.

Subp. 4. **Chronic management.** If the patient continues with symptoms and objective physical findings after surgery, or the

patient refuses surgery, or the patient was not a candidate for surgery, 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 must satisfy all of the treatment parameters of part 5221.6600.

5221.6400 INPATIENT HOSPITALIZATION PARAMETERS.

Subpart 1. **General principles.**

A. The health care provider must provide prior notification of inpatient hospital admission for nonemergency care according to part 5221.6050, subpart 9. Hospitalization is characterized as inpatient if the patient spends at least one night in the hospital.

B. Treatment for emergency conditions, including incapacitating pain, should not be delayed to provide the insurer with prior notification. The admitting health care provider should notify the insurer within two business days following an emergency admission, or within two business days after the health care provider learns that it is a workers' compensation injury. The medical necessity for the emergency hospitalization is subject to retrospective review, based on the information available at the time of the emergency hospitalization.

C. Unless the patient's condition requires special care, only ward or semiprivate accommodations are indicated. The admitting health care provider must document the special care needs.

D. Admissions before the day of surgery are indicated only if they are medically necessary to stabilize the patient before surgery. Admission before the day of surgery to perform any or all of a preoperative work-up which could have been completed as an outpatient is not indicated.

E. Inpatient hospitalization solely for physical therapy, bedrest, or administration of injectable drugs is indicated only if the treatment is otherwise indicated and the patient's condition makes the patient unable to perform the activities of daily life and participate in the patient's own treatment and self-care.

F. Discharge from the hospital must be at the earliest possible date consistent with proper health care.

G. If transfer to a convalescent center or nursing home is indicated, prior notification is required as provided for inpatient hospitalization.

Subp. 2. **Specific requirements for hospital admission of patients with low back pain.** Hospitalization for low back pain is indicated in the circumstances in items A to D.

A. When the patient experiences incapacitating pain as evidenced by inability to mobilize for activities of daily living, for example unable to ambulate to the bathroom, and in addition, the intensity of service during admission meets the criteria in subitems (1) and (2).

(1) Physical therapy is necessary at least twice daily for assistance with mobility. Heat, cold, ultrasound, and massage therapy alone do not meet this criterion.

(2) Muscle relaxants or narcotic analgesics are necessary intramuscularly or intravenously for a minimum of three injections in 24 hours. Need for parenteral analgesics is determined by:

(a) an inability to take oral medications or diet (N.P.O.); or

(b) an inability to achieve relief with aggressive oral analgesics.

B. For surgery which is otherwise indicated according to part 5221.6500 and is appropriately scheduled as an inpatient procedure.

C. For evaluation and treatment of cauda equina syndrome, according to part 5221.6200, subpart 13.

D. For evaluation and treatment of foot drop or progressive neurologic deficit, according to part 5221.6200, subpart 13.

5221.6500 PARAMETERS FOR SURGICAL PROCEDURES.

Subpart 1. **General.**

A. The health care provider must provide prior notification according to part 5221.6050, subpart 9, before proceeding with any elective inpatient surgery.

B. Emergency surgery may proceed without prior notification. The reasonableness and necessity for the emergency surgery is subject to retrospective review based on the information available at the time of the emergency surgery.

Subp. 2. **Spinal surgery.**

A. Surgical decompression of a lumbar nerve root includes, but is not limited to, the following lumbar procedures:laminectomy, laminotomy, discectomy, microdiscectomy, percutaneous discectomy, or foraminotomy. When providing prior notification

for decompression of multiple nerve roots, the procedure at each nerve root is subject independently to the requirements of subitems (1) to (3).

(1) Diagnoses: surgical decompression of a lumbar nerve root may be performed for the following diagnoses:

(a) intractable and incapacitating regional low back pain with positive nerve root tension signs and an imaging study showing displacement of lumbar intervertebral disc which impinges significantly on a nerve root or the thecal sac, ICD-9-CM code 722.10;

(b) sciatica, ICD-9-CM code 724.3; or

(c) lumbosacral radiculopathy or radiculitis, ICD-9-CM code 724.4.

(2) Indications: both of the following conditions in units (a) and (b) must be satisfied to indicate that the surgery is reasonably required.

(a) Response to nonsurgical care: the employee's condition includes one of the following:

i. failure to improve with a minimum of eight weeks of initial nonsurgical care; or

ii. cauda equina syndrome, ICD-9-CM code 344.6, 344.60, or 344.61; or

iii. progressive neurological deficits.

(b) Clinical findings: the employee exhibits one of the findings of subunit i in combination with the test results of subunit ii or, in the case of diagnosis in subitem (1), unit (a), a second opinion confirms that decompression of the lumbar nerve root is the appropriate treatment for the patient's condition:

i. subjective sensory symptoms in a dermatomal distribution which may include radiating pain, burning, numbness, tingling, or paresthesia, or objective clinical findings of nerve root specific motor deficit, including, but not limited to, foot drop or quadriceps weakness, reflex changes, or positive EMG; and

ii. medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(3) Repeat surgical decompression of a lumbar nerve root is not indicated at the same nerve root unless a second opinion, if requested by the insurer, confirms that surgery is indicated.

B. Surgical decompression of a cervical nerve root. Surgical decompression of a cervical nerve root includes, but is not limited to, the following cervical procedures: laminectomy, laminotomy, discectomy, foraminotomy with or without fusion. When providing prior notification for decompression of multiple nerve roots, the procedure at each nerve root is subject independently to the requirements of subitems (1) to (3).

(1) Diagnoses: surgical decompression of a cervical nerve root may be performed for the following diagnoses:

(a) displacement of cervical intervertebral disc, ICD-9-CM code 722.0, excluding fracture; or

(b) cervical radiculopathy or radiculitis, ICD-9-CM code 723.4, excluding fracture.

(2) Indications: the requirements in units (a) and (b) must be satisfied to indicate that surgery is reasonably required:

(a) response to nonsurgical care, the employee's condition includes one of the following:

i. failure to improve with a minimum of eight weeks of initial nonsurgical care;

ii. cervical compressive myelopathy; or

iii. progressive neurologic deficits;

(b) clinical findings: the employee exhibits one of the findings of subunit i, in combination with the test results of subunit ii:

i. subjective sensory symptoms in a dermatomal distribution which may include radiating pain, burning, numbness, tingling, or paresthesia, or objective clinical findings of nerve root specific motor deficit, reflex changes, or positive EMG; and

ii. medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(3) Second opinions: surgical decompression of a cervical nerve root is not indicated for the following conditions, unless a second opinion, if requested by the insurer, confirms that the surgery is indicated:

(a) repeat surgery at same level; or

(b) request for surgery at the C3-4 level.

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:

(a) unstable lumbar vertebral fracture, ICD-9-CM codes 805.4, 805.5, 806.4, and 806.5; or

(b) for a second or third surgery only, documented reextrusion or redisplacement of lumbar intervertebral disc, ICD-9-CM code 722.10, after previous successful disc surgery at the same level and new lumbar radiculopathy with or without incapacitating back pain, ICD-9-CM code 724.4. Documentation under this item must include an MRI or CT scan or a myelogram; or

(c) traumatic spinal deformity including a history of compression (wedge) fracture or fractures, ICD-9-CM code 733.1, and demonstrated acquired kyphosis or scoliosis, ICD-9-CM codes 737.1, 737.10, 737.30, 737.41, and 737.43; or

(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:

i. for the first surgery only, degenerative disc disease, ICD-9-CM code 722.4, 722.5, 722.6, or 722.7, with postoperative documentation of instability created or found at the time of surgery, or positive discogram at one or two levels; or

ii. pseudoarthrosis, ICD-9-CM code 733.82; or

iii. for the second or third surgery only, previously operated disc.

(2) Contraindications: lumbar arthrodesis is not indicated as the first primary surgical procedure for a new, acute lumbosacral disc herniation with unilateral radiating leg pain in a radicular pattern with or without neurological deficit.

(3) Retrospective review: when lumbar arthrodesis is performed to correct instability created during a decompression, laminectomy, or discectomy, approval for the arthrodesis will be based on a retrospective review of the operative report.

Subp. 3. **Upper extremity surgery.**

A. Rotator cuff repair:

(1) Diagnoses: rotator cuff surgery may be performed for the following diagnoses:

(a) rotator cuff syndrome of the shoulder, ICD-9-CM code 726.1, and allied disorders: unspecified disorders of shoulder bursae and tendons, ICD-9-CM code 726.10, calcifying tendinitis of shoulder, ICD-9-CM code 726.11, bicipital tenosynovitis, ICD-9-CM code 726.12, and other specified disorders, ICD-9-CM code 726.19; or

(b) tear of rotator cuff, ICD-9-CM code 727.61.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), both of the following conditions must be satisfied to indicate that surgery is reasonably required:

(a) response to nonsurgical care: the employee's condition has failed to improve with adequate initial nonsurgical treatment; and

(b) clinical findings: the employee exhibits:

i. severe shoulder pain and inability to elevate the shoulder; or

ii. weak or absent abduction and tenderness over rotator cuff, or pain relief obtained with an injection of anesthetic for diagnostic or therapeutic trial; and

iii. positive findings in arthrogram, MRI, or ultrasound, or positive findings on previous arthroscopy, if performed.

B. Acromioplasty:

(1) Diagnosis: acromioplasty may be performed for acromial impingement syndrome, ICD-9-CM codes 726.0 to 726.2.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), both of the following conditions must be satisfied for acromioplasty:

(a) response to nonsurgical care: the employee's condition has failed to improve after adequate initial nonsurgical care; and

(b) clinical findings: the employee exhibits pain with active elevation from 90 to 130 degrees and pain at night, and a positive impingement test.

C. Repair of acromioclavicular or costoclavicular ligaments:

(1) Diagnosis: surgical repair of acromioclavicular or costoclavicular ligaments may be performed for acromioclavicular separation, ICD-9-CM codes 831.04 to 831.14.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), the requirements of units (a) and (b) must be satisfied for repair of acromioclavicular or costoclavicular ligaments:

(a) response to nonsurgical care: the employee's condition includes:

i. failure to improve after at least a one-week trial period in a support brace; or

ii. separation cannot be reduced and held in a brace; or

iii. grade III separation has occurred; and

(b) clinical findings: the employee exhibits localized pain at the acromioclavicular joint and prominent distal clavicle and radiographic evidence of separation at the acromioclavicular joint.

D. Excision of distal clavicle:

(1) Diagnosis: excision of the distal clavicle may be performed for the following conditions:

(a) acromioclavicular separation, ICD-9-CM codes 831.01 to 831.14;

(b) osteoarthrosis of the acromioclavicular joint, ICD-9-CM codes 715.11, 715.21, and 715.31; or

(c) shoulder impingement syndrome.

(2) Criteria and indications: in addition to one of the diagnosis in subitem (1), the following conditions must be satisfied for excision of distal clavicle:

(a) response to nonsurgical care: the employee's condition fails to improve with adequate initial nonsurgical care; and

(b) clinical findings: the employee exhibits:

i. pain at the acromioclavicular joint, with aggravation of pain with motion of shoulder or carrying weight;

ii. confirmation that separation of AC joint is unresolved and prominent distal clavicle, or pain relief obtained with an injection of anesthetic for diagnostic/therapeutic trial; and

iii. separation at the acromioclavicular joint with weight-bearing films, or severe degenerative joint disease at the acromioclavicular joint noted on X-rays.

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

(1) Diagnosis: surgical repair of a shoulder dislocation may be performed for the following diagnoses:

(a) recurrent dislocations, ICD-9-CM code 718.31;

(b) recurrent subluxations; or

(c) persistent instability following traumatic dislocation.

(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.

F. Repair of proximal biceps tendon:

(1) Diagnosis: surgical repair of a proximal biceps tendon may be performed for proximal rupture of the biceps, ICD-9-CM code 727.62 or 840.8.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), both of the following conditions must be satisfied for repair of proximal biceps tendon:

(a) the procedure may be done alone or in conjunction with another indicated repair of the rotator cuff; and

(b) clinical findings: the employee exhibits:

i. complaint of pain that does not resolve with attempt to use arm; and

ii. palpation of "bulge" in upper aspect of arm.

Subp. 4. **Lower extremity surgery.**

A. Anterior cruciate ligament (ACL) reconstruction:

(1) Diagnoses: surgical repair of the anterior cruciate ligament, including arthroscopic repair, may be performed for the following diagnoses:

(a) old disruption of anterior cruciate ligament, ICD-9-CM code 717.83; or

(b) sprain of cruciate ligament of knee, ICD-9-CM code 844.2.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1) the conditions in units (a) to (c) must be satisfied for anterior cruciate ligament reconstruction. Pain alone is not an indication:

(a) the employee gives a history of instability of the knee described as "buckling or giving way" with significant effusion at time of injury, or description of injury indicates a rotary twisting or hyperextension occurred;

(b) there are objective clinical findings of positive Lachman's sign, positive pivot shift, and/or positive anterior drawer; and

(c) there are positive diagnostic findings with arthrogram, MRI, or arthroscopy and there is no evidence of severe compartmental arthritis.

B. Patella tendon realignment or Maquet procedure:

(1) Diagnosis: patella tendon realignment may be performed for dislocation of patella, open, ICD-9-CM code 836.3, or closed, ICD-9-CM code 836.4, or chronic residuals of dislocation.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), all of the following conditions must be satisfied for a patella tendon realignment:

(a) the employee gives a history of rest pain as well as pain with patellofemoral movement, and recurrent effusion, or recurrent dislocation; and

(b) there are objective clinical findings of patellar apprehension, synovitis, lateral tracking, or Q angle greater than 15 degrees.

C. Knee joint replacement:

(1) Diagnoses: knee joint replacement may be performed for degeneration of articular cartilage or meniscus of knee, ICD-9-CM codes 717.1 to 717.4.

(2) Criteria and indications: in addition to the diagnosis in subitem (1), the following conditions must be satisfied for a knee joint replacement:

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

(b) diagnostic findings: there is significant loss or erosion of cartilage to the bone, and positive findings of advanced arthritis and joint destruction with standing films, MRI, or arthroscopy.

D. Fusion; ankle, tarsal, metatarsal:

(1) Diagnoses: fusion may be performed for the following conditions:

(a) malunion or nonunion of fracture of ankle, tarsal, or metatarsal, ICD-9-CM code 733.81 or 733.82; or

(b) traumatic arthritis (arthropathy), ICD-9-CM code 716.17.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following conditions must be satisfied for an ankle, tarsal, or metatarsal fusion:

(a) initial nonsurgical care: the employee must have failed to improve with an adequate course of initial nonsurgical care which included:

i. immobilization which may include casting, bracing, shoe modification, or other orthotics; and

ii. anti-inflammatory medications;

(b) clinical findings:

i. the employee gives a history of pain which is aggravated by activity and weight-bearing, and relieved by xylocaine injection; and

ii. there are objective findings on physical examination of malalignment or specific joint line tenderness, and decreased range of motion; and

(c) diagnostic findings: there are medical imaging studies confirming the presence of:

i. loss of articular cartilage and joint space narrowing;

ii. bone deformity with hypertrophic spurring and sclerosis; or

iii. nonunion or malunion of a fracture.

E. Lateral ligament ankle reconstruction:

(1) Diagnoses: ankle reconstruction surgery involving the lateral ligaments may be performed for the following conditions:

(a) chronic ankle instability, ICD-9-CM code 718.87; or

(b) grade III sprain, ICD-9-CM codes 845.0 to 845.09.

(2) Criteria and indications: in addition to one of the diagnoses in subitem (1), the following conditions must be satisfied for a lateral ligament ankle reconstruction:

(a) initial nonsurgical care: the employee must have received an adequate course of initial nonsurgical care including, at least:

i. immobilization with support, cast, or ankle brace, followed by

ii. a physical rehabilitation program; and

(b) clinical findings:

i. the employee gives a history of ankle instability and swelling; and

ii. there is a positive anterior drawer sign on examination; or

iii. there are positive stress X-rays identifying motion at ankle or subtalar joint with at least a 15 degree lateral opening at the ankle joint, or demonstrable subtalar movement, and negative to minimal arthritic joint changes on X-ray, or ligamentous injury is shown on MRI scan.

(3) Prosthetic ligaments: prosthetic ligaments are not indicated.

(4) Implants: requests for any plastic implant must be confirmed by a second opinion.

(5) Calcaneus osteotomy: requests for calcaneus osteotomies must be confirmed by a second opinion.

5221.6600 CHRONIC MANAGEMENT.

Subpart 1. **Scope.** This part applies to chronic management of all types of physical injuries, even if the injury is not specifically governed by parts 5221.6200 to 5221.6500. If a patient continues with symptoms and physical findings after all appropriate initial nonsurgical and surgical treatment has been rendered, 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. The purpose of

chronic management is twofold: the patient should be made independent of health care providers in the ongoing care of a chronic condition; and the patient should be returned to the highest functional status reasonably possible.

A. Personality or psychological evaluation may be indicated for patients who are candidates for chronic management. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

(1) Is symptom magnification occurring?

(2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?

(3) Are there other personality factors or disorders which are interfering with recovery?

(4) Is the patient chemically dependent?

(5) Are there any interpersonal conflicts interfering with recovery?

(6) Does the patient have a chronic pain syndrome or psychogenic pain?

(7) In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

B. Any of the chronic management modalities of subpart 2 may be used singly or in combination as part of a program of chronic management.

C. No further passive treatment modalities or therapeutic injections are indicated, except as otherwise provided in parts 5221.6200, subpart 3, item B; 5221.6205, subpart 3, item B; 5221.6210, subpart 3, item B; and 5221.6300, subpart 3, item B.

D. No further diagnostic evaluation is indicated unless there is the development of symptoms or physical findings which would in themselves warrant diagnostic evaluation.

E. A program of chronic management must include appropriate means by which use of scheduled medications can be discontinued or severely limited.

Subp. 2. **Chronic management modalities.** 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.

A. Home-based exercise programs consist of aerobic conditioning, stretching and flexibility exercises, and strengthening exercises done by the patient on a regular basis at home without the need for supervision or attendance by a health care provider. Maximum effectiveness may require the use of certain durable medical equipment that may be prescribed and reimbursed within any applicable treatment parameters in parts 5221.6200 to 5221.6305.

(1) Indications: exercise is necessary on a long-term basis to maintain function.

(2) Requirements: the patient should receive specific instruction and training in the exercise program. Repetitions, durations, and frequencies of exercises must be specified. Any durable medical equipment needed must be prescribed in advance and the insurer must be given prior notification of proposed purchase.

(3) Treatment period, one to three visits for instruction and monitoring.

B. Health clubs:

(1) Indications: the patient is deconditioned and requires a structured environment to perform prescribed exercises. The health care provider must document the reasons why reconditioning cannot be accomplished with a home-based program of exercise.

(2) Requirements: the program must have specific prescribed exercises stated in objective terms, for example "30 minutes riding stationary bicycle three times per week." There must be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a prescribed frequency of attendance and the patient must maintain adequate documentation of attendance. There must be a prescribed duration of attendance.

(3) Treatment period, 13 weeks. Additional periods of treatment require additional prior notification of the insurer. Additional periods of treatment at a health club are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment. If the employer has an appropriate exercise facility on its premises the insurer may mandate use of that facility instead of providing a health club membership.

C. Computerized exercise programs utilize computer controlled exercise equipment that allows for the isolation of specific muscle groups and the performance of graded exercise designed to increase strength, tone, flexibility, and range of motion. In combination with computerized range of motion or strength measuring tests, these programs allow for quantitative measurement of effort and progress.

(1) Indications: the patient is deconditioned and requires a structured environment to accomplish rehabilitation goals. The health care provider must document the reasons why reconditioning cannot be accomplished with a home-based program of exercise.

(2) Requirements: the program must have specific goals stated in objective terms, for example "improve strength of back extensors 50 percent." There must be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a prescribed frequency and duration of attendance.

(3) Treatment period, six weeks. Additional periods of treatment require additional prior notification of the insurer. Additional periods of treatment are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment.

D. Work conditioning and work hardening programs are intensive, highly structured, job oriented, individualized treatment plans based on an assessment of the patient's work setting or job demands, and designed to maximize the patient's return to work. These programs must include real or simulated work activities. Work conditioning is designed to restore an individual's neuromusculoskeletal strength, endurance, movement, flexibility, and motor control, and cardiopulmonary function. Work conditioning uses physical conditioning and functional activities related to the individual's work. Services may be provided by one discipline of health care provider. Work hardening is designed to restore an individual's physical, behavioral, and vocational functions within an interdisciplinary model. Work hardening addresses the issues of productivity, safety, physical tolerances, and work behaviors. An interdisciplinary team includes professionals qualified to evaluate and treat behavioral, vocational, physical, and functional needs of the individual.

(1) Indications: the patient is disabled from usual work and requires reconditioning for specific job tasks or activities and the reconditioning cannot be done on the job. The health care provider must document the reasons why work hardening cannot be accomplished through a structured return to work program. Work conditioning is indicated where only physical and functional needs are identified. Work hardening is indicated where, in addition to physical and functional needs, behavioral and vocational needs are also identified that are not otherwise being addressed.

(2) Requirements: the program must have specific goals stated in terms of work activities, for example "able to type for 30 minutes." There must be an individualized program of activities and the activities must be chosen to simulate required work activities or to enable the patient to participate in simulated work activities. There must be a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There must be a set frequency and hours of attendance and the program must maintain adequate documentation of attendance. There must be a set duration of attendance. Activity restrictions must be identified at completion of the program.

(3) Treatment period, six weeks. Additional periods of treatment require prior notification of the insurer. Additional periods of treatment at a work hardening program or work conditioning program are not indicated unless there is documentation of attendance and progression in activities during the preceding period of treatment or unless there has been a change in the patient's targeted return to work job which necessitates a redesign of the program.

E. Chronic pain management programs consist of multidisciplinary teams who provide coordinated, goal-oriented services to reduce pain disability, improve functional status, promote return to work, and decrease dependence on the health system of persons with chronic pain syndrome. Pain management programs must provide physical rehabilitation, education on pain, relaxation training, psychosocial counseling, medical evaluation, and, if indicated, chemical dependency evaluation. The program of treatment must be individualized and based on an organized evaluative process for screening and selecting patients. Treatment may be provided in an inpatient setting, outpatient setting, or both as appropriate.

(1) Indications: the patient is diagnosed as having a chronic pain syndrome.

(2) Requirements: an admission evaluation must be performed by a doctor, and a licensed mental health professional, each with at least two years experience in evaluation of chronic pain patients and chronic pain treatment, or one year of formal train-

ing in a pain fellowship program. The evaluation must confirm the diagnosis of chronic pain syndrome and a willingness and ability of the patient to benefit from a pain management program. There must be a specific set of prescribed activities and treatments, and a specific timetable of progression in those activities. There must be a set frequency and hours of attendance and the program must maintain adequate documentation of attendance. There must be a set duration of attendance.

(3) Treatment period: for initial treatment, a maximum of 20 eight-hour days, though fewer or shorter days can be used, and a maximum duration of four weeks no matter how many or how long the days prescribed. For aftercare, a maximum of 12 sessions is allowed. Only one completed pain management program is indicated for an injury.

F. Individual or group psychological or psychiatric counseling.

(1) Indications: a personality or psychosocial evaluation has revealed one or more of the problems listed in subpart 1, item A, which interfere with recovery from the physical injury, but the patient does not need or is not a candidate for a pain management program.

(2) Requirements: there must be a specific set of goals based on the initial personality or psychosocial evaluation and a timetable for achieving those goals within the prescribed number of treatment or therapy sessions. There must be a prescribed frequency of attendance and the treating health care provider must maintain adequate documentation of attendance. There must be a prescribed duration of treatment.

(3) Treatment period: a maximum of 12 sessions. Only one completed program of individual or group psychological or psychiatric counseling is indicated for an injury.

5221.8900 DISCIPLINARY ACTION; PENALTIES.

Subpart 1. **Discipline.** A health care provider is subject to disciplinary action under *Minnesota Statutes*, section 176.103, for failure to comply with the requirements in parts 5221.6010 to 5221.6600 or the violation of any of the provisions of *Minnesota Statutes*, chapter 176, or other rules or orders issued pursuant thereto.

Subp. 2. **Complaints.** Complaints about professional behavior or services of health care providers relating to noncompliance with established workers' compensation laws, rules, or orders shall be made in writing to the commissioner. The commissioner or a designee shall assist a person in filing a complaint, if necessary. A complaint may be submitted by any person who becomes aware of a violation, including designees of the commissioner, administrative law judges, and presiding officials at judicial proceedings.

Subp. 3. **Review and investigation.** The commissioner shall investigate all complaints to determine whether there has been a violation of established workers' compensation laws, rules, or orders. The commissioner may refer a matter to another agency that has jurisdiction over the provider's license or conduct, or to an agency that has prosecuting authority in the event of suspected theft or fraud or to a peer review organization for an opinion. Absent suspected theft or fraud, providing treatment outside a parameter set forth in parts 5221.6020 to 5221.6500 shall not in itself result in a referral to a prosecuting authority.

If an investigation indicates that discipline may be warranted, the commissioner shall determine whether the violation involves inappropriate, unnecessary, or excessive treatment, or whether the violation involves other statutes or rules. The commissioner shall take appropriate action according to subpart 6, 7, or 8.

Subp. 4. **Cooperation with disciplinary proceedings.** 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 for cost of copies of medical records for this investigation. Cooperation includes attending, in person, a meeting scheduled by the commissioner for the purposes of subpart 5. This subpart does not limit the health care provider's right to be represented by an attorney.

Subp. 5. **In-person meeting.** When conferring with the parties to a complaint is deemed appropriate, the commissioner shall schedule a meeting for the purpose of clarification of issues, obtaining information, instructing parties to the complaint, or for the purpose of resolving disciplinary issues.

Subp. 6. **Resolution by instruction or written agreement.** The commissioner may resolve a complaint through instruction of a provider, or may enter into stipulated consent agreements regarding discipline with a provider in lieu of initiating a contested case or medical services review board proceeding.

Subp. 7. **Inappropriate, unnecessary, or excessive treatment.**

A. Except as otherwise provided in subparts 3 and 6, if the suspected violation involves a treatment standard set forth in parts 5221.6020 to 5221.6500 the commissioner must refer the health care provider to the medical services review board for review under *Minnesota Statutes*, section 176.103, subdivision 2, if:

(1) the situation requires medical expertise in matters beyond the department's general scope;

(2) wherever possible under *Minnesota Statutes*, chapter 176, a final determination has been made by a workers' compensation presiding official, or provider licensing or registration body that the medical treatment in issue was inappropriate, unnecessary, or excessive; and

(3) a pattern of consistently providing inappropriate, unnecessary, or excessive services exists for three or more employees.

B. Where the medical service review board's report to the commissioner indicates a violation of treatment standards or other inappropriate, unnecessary, or excessive treatment the commissioner shall order a sanction. Sanctions may include, but are not limited to, a warning; a fine of up to $200 per violation; a restriction on providing treatment; requiring preauthorization by the board, the payor, or the commissioner for a plan of treatment; and suspension from receiving compensation for the provision of treatment.

C. Within 30 days of receipt of the order of sanction, the health care provider may request in writing a review by the commissioner of the sanction in accordance with the procedure set forth in *Minnesota Statutes*, section 176.103, subdivision 2a. Within 30 days following receipt of the compensation judge's decision reviewing the sanction, a provider may petition the workers' compensation court of appeals for review according to the procedures in *Minnesota Statutes*, section 176.103, subdivision 2a.

Subp. 8. **Violations of statutes and rules other than those involving inappropriate, unnecessary, or excessive treatment.** If the suspected violation warranting discipline involves a statute or rule other than treatment standards, the commissioner shall initiate a contested case hearing for disciplinary action under *Minnesota Statutes*, section 176.103, subdivision 3, paragraph (b), and the administrative procedure act in *Minnesota Statutes*, chapter 14.

A. Upon petition of the commissioner and following receipt of the recommendation of the administrative law judge, the medical services review board may issue a fine of up to $200 for each violation, or disqualify or suspend the health care provider from receiving payment for services, according to *Minnesota Statutes*, section 176.103, subdivision 3, paragraph (b).

B. Within 30 days after service of the board's decision, a provider may petition the workers' compensation court of appeals for review according to *Minnesota Statutes*, section 176.421.

Subp. 9. **Penalties.** In addition to disciplinary action under subparts 1 to 8, the commissioner may assess a penalty under part 5220.2810 if a health care provider fails to release existing written medical data according to *Minnesota Statutes*, section 176.138. A penalty may also be assessed under part 5220.2830 and *Minnesota Statutes*, section 176.231, subdivision 10, if a health care provider fails to provide reports required by part 5221.0410.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Adopted Rules

The adoption of a rule becomes effective after the requirements of Minn. Stat. §§14.14-14.28 have been met and five working days after the rule is published in *State Register,* unless a later date is required by statutes or specified in the rule.

If an adopted rule is identical to its proposed form as previously published, a notice of adoption and citation to its previous *State Register* publication will be printed.

If an adopted rule differs from its proposed form, language which has been deleted will be printed with strikeouts and new language will be underlined. The rule's previous *State Register* publication will be cited.

An emergency rule becomes effective five working days after the approval of the Attorney General as specified in Minn. Stat. §14.33 and upon the approval of the Revisor of Statutes as specified in §14.36. Notice of approval by the Attorney General will be published as soon as practicable, and the adopted emergency rule will be published in the manner provided for adopted rules under §14.18.

Department of Human Services

Adopted Permanent Rules Relating to the Licensing of Residential and Nonresidential Programs

The rules proposed and published at *State Register*, Volume 18, Number 35, pages 1927-1960, February 28, 1994 (18 SR 1927), are adopted with the following modifications:

Rules as Adopted

9525.0530 SCOPE.

Parts 9525.0500 to 9525.0660 apply to any person, organization, or association engaged in the operation and provision of semi-independent living services (SILS) to adults who have or may have mental retardation or related conditions, as provided and defined in part ~~9525.0185, subparts 8 and 9~~ 9525.0016, subpart 2, items A and B. These parts set forth the requirements for any individual, organization, or association providing SILS to more than four adults with mental retardation or related conditions to be licensed pursuant to *Minnesota Statutes*, chapter 245A.

Licensure under these parts does not require concurrent compliance with other Department of Human Services licensing rules or with Minnesota Department of Health supervised living facility standards promulgated under *Minnesota Statutes*, section 144.56.

These parts do not govern the living arrangement of clients. Semi-independent living services licensed under these parts may be provided to persons living in a variety of ordinary community settings other than state hospitals and residential programs licensed under parts 9525.0215 to 9525.0355 and supervised living facility standards. Community living arrangements in which SILS are provided may include the following, but not be limited to: client's own home, foster home, apartment, or rooming house.

9525.1510 PURPOSE AND APPLICABILITY.

Subp. 4. **Exemptions for regional centers.** The following provisions of parts 9525.1500 to 9525.1690 do not apply to a regional center that can document compliance with corresponding standards in parts 9525.0215 to 9525.0355 and *Code of Federal Regulations*, title 42, sections ~~441.516 to 442.400~~ 483.400 to 483.480, as amended ~~through October 1, 1985~~:

A. ~~part 9525.1540, subpart 1;~~

~~B.~~ part 9525.1550, subparts ~~3,~~ 4, ~~5, 9, 10, 11,~~ and 12;

~~C.~~ B. part 9525.1560; and

~~D.~~ C. part 9525.1670, subparts 4 and 6.

9525.2010 DEFINITIONS.

Subp. 29. **Qualified mental retardation professional (QMRP).** "Qualified mental retardation professional (QMRP)" means an individual who meets the qualifications specified in *Code of Federal Regulations*, title 42, section ~~442.401~~ 483.430, as amended.

9543.1020 APPLICATION AND LICENSE REQUIREMENTS.

Subp. 14. **Drug or alcohol use, prohibited.** To become licensed or to remain licensed, an applicant or license holder ~~must not be an individual, employ or subcontract with an individual, or use as a volunteer, an individual who while on duty:~~

~~A. abuses prescription drugs, uses controlled substances under *Minnesota Statutes*, chapter 152, or consumes alcohol; or~~

~~B.~~ ~~is~~ shall have a policy and provide training on that policy for individuals, employees, subcontractors, and volunteers that prohibit such individuals while directly responsible for individuals served by the program from abusing prescription medication or

being under the influence of a ~~drug~~ controlled substance under *Minnesota Statutes*, chapter 152, or alcohol in any manner that impairs or could impair the person's ability to provide care or services.

Subp. 15. **Residential programs, handling resident funds and property.** The license holder must ensure that residents retain the use and availability of personal funds or property unless restrictions are justified in the resident's treatment plan.

B. Whenever the license holder assists a resident with the safekeeping of funds or other property, the license holder must:

(2) provide a statement, at least ~~monthly~~ quarterly, itemizing ~~the monthly~~ receipts and disbursements of resident funds or other property; and

9543.1050 ADMINISTRATIVE LICENSING ACTIONS.

Subpart 1. **Issuance of correction orders.** The commissioner may issue a correction order for a license violation rather than probation or a negative licensing action if all of the following conditions are met:

A. the violation does not imminently endanger the health, safety, or rights of persons served by the program; and

B. ~~the violation is not serious or chronic; and~~

~~C.~~ the violation will be corrected within a reasonable time.

TERM CHANGE. Change IHP to IPP in the following parts: 9525.0245, subparts 1, 3, 4, and 8; 9525.0255, subpart 2; 9525.0275, subpart 1; 9525.0285, subparts 1 and 3; 9525.0355, subpart 7; 9525.2030, subparts 1, 2, and 3; 9525.2070, subpart 3; 9525.2110, subparts 1, 2, and 3; 9525.2130, subpart 2; and 9525.2140, subparts 2 and 3.

Public Utilities Commission

Adopted Permanent Rules Relating to Practice and Procedure

The rules proposed and published at *State Register*, Volume 16, Number 33, pages 1858-1871, February 10, 1992 (16 SR 1858), are adopted with the following modifications:

Rules as Adopted

7829.0400 SERVICE AND FILING REQUIREMENTS.

Subpart 1. **Filing.** Documents are filed with the commission when they are received in the commission offices during regular business hours. Specific documents may be filed by facsimile transmission or filed when mailed ~~or delivered in person, if the executive secretary so directs~~, with the consent of the executive secretary. Documents must be directed to the attention of the executive secretary.

Subp. 5. **Service.** A document filed with the commission must be served the same day on the persons listed on the appropriate service list, except when this chapter permits service of a summary of the filing. Service may be accomplished by first class mail or by delivery in person, unless otherwise provided by law or commission order. Service may also be accomplished by facsimile transmission, followed by first class mail. Service on the department is complete upon receipt by the department. For all other persons, service by mail or facsimile transmission plus mail is complete upon mailing, unless the executive secretary directs otherwise for specific documents. When a party or participant is represented by an attorney, service upon the attorney is considered service upon the party or participant.

7829.0600 GENERAL SERVICE LIST.

Subp. 4. **Jurisdiction unaffected.** The service lists established in this part are intended to provide the earliest possible notice to persons who may be interested in a particular filing. The requirements of this part do not displace or add to legal notice requirements, and a utility's failure to comply with this part does not deprive the commission of jurisdiction over a matter of which it would otherwise have jurisdiction, require dismissal of a filing, or invalidate any determination made by the commission in the matter.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

7829.0800 PETITION TO INTERVENE.

Subp. 2. **Grounds for intervention.** The petition must allege the grounds for intervention and must be granted upon a showing that: the person is specifically considered by statute to be interested in the particular type of matter at issue; the person is specifically declared by statute to be an interested party; or the outcome of the proceeding will bind or affect the person with respect to an interest peculiar to that person, as distinguished from an interest common to the public or other ratepayers in general, or the person's interests are not adequately represented by one or more other parties participating in the case.

7829.1000 REFERRAL FOR CONTESTED CASE PROCEEDING.

If a proceeding involves contested material facts and there is a right to a hearing under statute or rule, or if the commission finds that all significant issues have not been resolved to its satisfaction, the commission shall refer the matter to the Office of Administrative Hearings for contested case proceedings, unless:

7829.1300 MISCELLANEOUS TARIFF AND PRICE LIST FILINGS.

Subp. 5. **Rejection of filing.** The commission shall reject a filing found to be substantially out of compliance with this chapter or applicable statutory requirements. ~~A miscellaneous tariff filing or price list filing not rejected within 20 days of filing must be considered accepted as to form.~~

~~Subp. 6. **Initial comments.** A person wishing to comment on a miscellaneous tariff or price list filing shall do so within 30 days of its filing with the commission. A person wishing to comment on one of the following noncompetitive rate change filings shall do so within 20 days of its filing with the commission: a rate reduction filing, a cost increase filing, or a request for a significant change in a condition of telephone service. A person wishing to comment on a new telephone service, competitive or noncompetitive, shall do so within ten days of its filing with the commission. Comments must be served on the persons on the utility's general service list for the filing, as well as on the filing utility.~~

~~Subp. 7. **Petition to intervene.** If a person who files initial or reply comments is not entitled to intervene in commission proceedings as of right and desires full party status, the person shall file a petition to intervene before the initial or reply comment period expires. The intervention petition may be combined with the comments on the filing.~~

7829.1400 COMMENTS ON MISCELLANEOUS TARIFF OR PRICE LIST FILING.

Subpart 1. **Initial comments.** A person wishing to comment on a miscellaneous tariff or price list filing shall do so within 30 days of its filing with the commission. A person wishing to comment on one of the following noncompetitive rate change filings shall do so within 20 days of its filing with the commission: a rate reduction filing, a cost increase filing, or a request for a significant change in a condition of telephone service. A person wishing to comment on a new telephone service, competitive or noncompetitive, shall do so within ten days of its filing with the commission. Comments must be served on the persons on the utility's general service list for the filing, as well as on the filing utility.

Subp. 2. **Petition to intervene.** If a person who files initial or reply comments is not entitled to intervene in commission proceedings as of right and desires full party status, the person shall file a petition to intervene before the initial or reply comment period expires. The intervention petition may be combined with the comments on the filing.

~~Subpart 1.~~ Subp. 3. **Comments to include procedural recommendation.** A person commenting on a miscellaneous tariff or price list filing and recommending its rejection, denial, or modification shall specify whether the person believes the filing requires a contested case proceeding, informal proceeding, expedited proceeding, or some other procedural treatment, together with the person's reasons for recommending a particular procedural treatment.

Subp. ~~2.~~ 4. **Reply comments.** The utility and other persons have ten days from the expiration of the original comment period to file reply comments. Reply comments must be served on the utility and persons who have filed comments on the miscellaneous tariff filing. Reply comments must be limited in scope to the issues raised in the initial comments.

Subp. ~~3.~~ 5. **Additional comments.** If further information is required to make a fully informed decision, the commission shall require additional comments and identify specific issues requiring further development.

Subp. ~~4.~~ 6. **Comments on supplemental or corrected filings.** The commission shall provide opportunity for other parties to respond to supplemental or corrected filings when those filings raise new issues.

Subp. ~~5.~~ 7. **Comment periods varied.** Except for comment periods set by statute, the commission may vary the comment periods set by this chapter on its own motion or at the request of a person for good cause shown. The commission may delegate the authority to vary time periods to the executive secretary.

Subp. ~~6.~~ 8. **Comment periods extended at department's request.** At the request of the department, the commission shall extend the comment periods in parts 7829.1300 and 7829.1400 up to an additional 30 days, except for comment periods established by statute and except when the commission must act within 60 days to prevent proposed rate changes from going into effect.

Subp. 9. **Requests for contested case proceedings.** Upon receipt of initial comments requesting a contested case proceeding on

a miscellaneous tariff filing or price list filing, the commission shall immediately set the matter for consideration on a date after the time period for reply comments has run. If the commission finds a contested case proceeding is required, the commission shall refer the matter to the Office of Administrative Hearings pursuant to part 7829.1000, and the utility shall file its direct testimony in question and answer form within 20 days of the commission's notice and order for hearing.

7829.1600 TREATMENT OF INFORMAL COMPLAINT.

Commission staff shall try to help resolve informal complaints by correspondence, mediation, arbitration, and other informal means. If the complainant desires formal action by the commission, a formal complaint must be ~~filed~~ initiated by the commission, or filed by a qualified complainant.

7829.1700 FORMAL COMPLAINT.

Subp. 2. ~~Service~~ **Mailing and filing.** A formal complaint must be ~~served on~~ mailed to the respondent, the department, and the Residential Utilities Division of the Office of the Attorney General, as well as filed with the commission.

7829.1800 INITIAL CONSIDERATION OF FORMAL COMPLAINT.

Subp. 2. **Answer.** On concluding that it has jurisdiction over the matter and that investigation is warranted, the commission shall serve the complaint on the respondent, together with an order requiring the respondent to ~~grant the relief complainant requests or to show cause by answer why respondent should not be ordered to do so~~ file an answer either stating that it has granted the relief the complainant requests, or responding to the allegations of the complaint. The answer must be filed with the commission and served on the complainant, the department, and the Residential Utilities Division of the Office of the Attorney General within 20 days of service of the complaint and order.

Subp. 4. **Failure to answer.** If the respondent fails to answer a complaint served by the commission under subpart 2, the commission shall consider the allegations of the complaint denied~~, and issue is joined~~.

7829.2000 ELECTRIC SERVICE AREA COMPLAINT.

Subpart 1. **Content.** A complaint alleging violation of an electric utility's assigned service area must include a map that the complainant reasonably believes to be a copy of the official service area map of an area at issue, with the area of the alleged violation clearly marked.

7829.2500 CERTIFICATE OF NEED FILING.

Subp. 9. **Public hearing.** If the commission decides to act on the application through an informal proceeding, the commission shall hold a public hearing designed to encourage members of the public to express their views on the application, as required under *Minnesota Statutes*, section 216B.243, subdivision 4. If the commission refers the application to the Office of Administrative ~~Proceedings~~ Hearings for a contested case proceeding, the commission shall ensure that at least one public hearing is held.

7829.2600 STAFF COMMENTS.

Written comments on a filing by commission staff must be made available to those persons on the service list at the same time they are provided to the commission. If commission staff recommend action not advocated by any party, all parties must be granted oral ~~argument~~ comment at the request of any party.

7829.3000 PETITION FOR REHEARING, AMENDMENT, VACATION, RECONSIDERATION, REARGUMENT.

Subp. 7. **Second petition not entertained.** A second petition for rehearing, amendment, vacation, reconsideration, or reargument of a commission decision or order by the same party or parties and upon the same grounds as a former petition that has been considered and denied, will not be entertained.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." **ADOPTED RULES SECTION** — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

Emergency Rules

Proposed Emergency Rules

According to Minn. Stat. of 1984, §§14.29-14.30, state agencies may propose adoption of emergency rules if: 1) expressly required; 2) authorized by statute; or 3) if the manner permitted by a directive (given by statute, federal law or court order) does not allow for compliance with sections 14.14-14.28. The agency must, however, publish a notice of intent to adopt emergency rules, along with the rules themselves, in the *State Register*. The notice must advise the public:

1) that a free copy of the proposed emergency rule is available upon request from the agency;
2) that notice of the date that the rule is submitted to the attorney general will be mailed to persons requesting notification;
3) that the public has at least 25 days after publication of the proposed emergency rule to submit data and views in writing; and
4) that the emergency rule may be modified if the data and views submitted support such modification.

Adopted Emergency Rules

Emergency rules take effect five working days after approval by the attorney general, and after compliance with Minn. Stat. §§14.29-14.365. As soon as possible, emergency rules are published in the *State Register* in the manner provided for in section 14.18.

Emergency rules are effective for the period stated in the notice of intent to adopt emergency rules. This may not exceed 180 days.

Continued/Extended Emergency Rules

Adopted emergency rules may be continued in effect (extended) for an additional 180 days. To do this, the agency must give notice by: 1) publishing notice in the *State Register*: and 2) mailing the same notice to all persons who requested notification on rulemaking. No emergency rule may remain in effect 361 days after its original effective date. At that point, permanent rules adopted according to Minn. Stat. §§14.14-14.28 supercede emergency rules.

Department of Natural Resources

Notice of Continuation of Emergency Game and Fish Rules; Fish Toxicants, Controlled Hunting Zones, Big Game, Small Game, Pelting Fees, Turkey Hunting, Migratory Birds, Game Farms, Rough Fish, Lake Superior Fishing Guides, Minnows, Amphibians and Turtles, Crayfish, and Fishing Regulations and Requirements

NOTICE IS HEREBY GIVEN that the Department of Natural Resources is continuing the above entitled emergency rules in effect for an additional 180 days in accordance with *Minnesota Statutes*, section 14.35.

The notice adopting the emergency rules was published at *State Register*, Volume 18, Number 10, page 786 on September 7, 1993. (18 S.R. 786). The rules became effective on August 30, 1993. This notice of continuation will extend the effective life of the above-entitled rules through August 25, 1994.

Dated: 22 June 1994

Rodney W. Sando, Commissioner
Department of Natural Resources

Commissioners' Orders

Department of Transportation

Order No. 80212: Amended Order and Notice of Street and Highway Routes Designated and Permitted to Carry the Gross Weights Allowed under *Minnesota Statutes* § 169.825

Whereas, the Commissioner of Transportation has made his Order No. 80000, dated March 10, 1994 designating and permitting certain street and highway routes, or segments of those routes, to carry the gross weights allowed under *Minnesota Statutes* § 169.825, and

Whereas, the Commissioner has determined that the additional following routes, or segment of routes, should be designated to carry the gross weights allowed under *Minnesota Statutes* § 169.825.

IT IS HEREBY ORDERED that Commissioner of Transportation Order No. 80000 is further amended this date by adding the following designated streets and highway routes, or segment of routes, as follows:

COUNTY ROADS

Wright County

- C.S.A.H. 37 from T.H. 25 TO C.S.A.H. 12 (12 Month)

Dated: 17 June 1994

James N. Denn
Commissioner

Revenue Notices

The Department of Revenue began issuing revenue notices in July of 1991. Revenue notices are statements of policy made by the department that provide interpretation, detail, or supplementary information concerning a particular statute, rule, or departmental practice. The authority to issue revenue notices is found in *Minnesota Statutes* §270.0604.

Department of Revenue

Revenue Notice 94-13: Lawful Gambling - Annual Audit and Financial Reviews of Licensed Organizations

Minnesota Laws 1994 Chapter No. 633 Article 2 Section 7 Subdivision 4 requires the Commissioner of Revenue to prescribe standards for audits and financial reviews for certain organizations licensed to conduct lawful gambling. The Statute is an amendment and re-codification of *Minnesota Statute* Section 349.19 Subdivision 9. The new law will be re-codified as section 297E.06 subdivision 4. It is effective for reports first becoming due on or after August 1, 1994.

Pursuant to Revenue Notice 91-14 the department required that all annual financial audit reports were to be filed with the Department of Revenue no later than the last day of the sixth month following their fiscal year-end.

Organizations with fiscal years ending on or after February 1, 1994 who comply with the standards and requirements of the new legislation will be viewed as satisfying their annual audit or financial review filing requirement.

Dated: 27 June 1994

Patricia A. Lien
Assistant Commissioner for Tax Policy

Department of Revenue

Revenue Notice #94-14: MinnesotaCare: Health Care Providers/Patient Services - Who/What is taxable

This revenue notice:

- Further explains the definitions of "health care provider" and "patient services" (for further information on these terms, refer to Revenue Notice # 93-13 and # 94-3);
- Explains the difference between custodial services and medical services as related to the taxability of bed and board;

(This revenue notice does not provide an inclusive list of all the facilities and programs that are subject to the MinnesotaCare tax. Also, facilities that are listed as subject to tax may have no taxable receipts due to other exemptions in the MinnesotaCare law).

The MinnesotaCare tax is imposed on services that meet the definition of patient services and are provided by a health care provider or by an organization that employs health care providers.

1. A health care provider is defined as a person furnishing any of the goods or services listed in *Minnesota Statute* § 295.50 subd. 4 (e.g. medical, optical, dental) or any other goods or services that qualify for reimbursement under the medical assistance program as provided in chapter 256B.

2. Patient services are defined under § 295.50 subd. 9b to include health care goods and services provided to a patient or consumer. The list includes various services such as bed and board, use of facilities, and diagnostic or therapeutic services. Services that are covered under medical assistance, section 256B.0625 are taxable as well.

Following is an explanation of some of the terms used in the definition of patient services:

Medical Assistance. All services that are reimbursable by medical assistance under *Minnesota Statute* § 256B.0625 are included in the definition of patient services;

Bed and Board. Bed and board is included in patient services when it is part of the medical services given to a patient. Bed and board is not considered patient services when it is part of residential, custodial, habilitative or training services that are not reimbursable by medical assistance § 256B.0625;

Nursing Services. Nursing services are those services normally provided by nurses within the scope of their license, including administration of drugs and medications, health teaching, counseling, personal care, treatment and assessment of patients' needs and care requirements, and preparation of care plans for individual patients. All services provided by a nurse in a health care facility are patient services.

Medical Social Services. Medical social services are services that contribute to the treatment of a patient's condition such as assessment of the social and emotional factors related to a patient's condition and assessment of the patient's medical and nursing requirement as applied to his/her home situation, financial resources, and the community resources available to the patient; they include treatment of psychological dysfunctions caused by environmental and interpersonal factors;

Medical or Surgical Services. Medical or surgical services include all services that are provided within the scope of medical practice of a licensed or registered health care provider;

Diagnostic Services. Diagnostic services are services that determine the existence, nature, or extent of a disease, illness, interruption or disorder of body functions or organs, and services that enable a health care provider to identify a mental condition through critical scrutiny;

Therapeutic Services. Therapeutic services include services of a healing, curing, rehabilitative or remedial nature (i.e. massage therapy).

Custodial vs. Medical Services. Under the general test, services that do not qualify for reimbursement under medical assistance and are not provided by licensed or registered health care providers (or an entity that employs licensed or registered health care providers), are not taxable. This section deals with facilities that provide services that do not qualify for reimbursement under medical assistance but employ the services of a licensed or registered health care provider; this section does not deal with payments for services that are specifically exempt by the MinnesotaCare law.

- Custodial services mean training services, supervision, and other support activities designed to help a person maintain the highest possible level of independence and integration into the community where the person lives and works;
- Medical services mean rehabilitative services or other treatment given to a patient (e.g. services provided by a hospital, a medical clinic, a physical therapist or a drug/alcohol rehabilitation program);
- When the primary goal of the facility is to serve as a residence or provide custodial care rather than provide rehabilitative services or medical treatment, the amounts received for bed and board are not taxable (they are not deemed to be part of the health care services); only the portion of the receipts used for patient services other than bed and board is taxable. This includes services that meet the definition of patient services and are provided by licensed, as well as unlicensed providers that are employed by the facility. When the primary goal of the facility is to provide medical services, all services, including bed and board, are taxable;
- All receipts that are allocated to the services of a licensed or registered health care provider are taxable.

Examples of Custodial Care Facilities/Programs (these facilities/programs are not subject to tax unless they employ licensed or registered health care providers. Only receipts for patient services, excluding bed and board, are taxable).

- Adult day care;
- Chemical dependency halfway house (Rule 35, Category IV);

Examples of medical care facilities (all services, including bed and board, provided by these programs are taxable if the facility employs licensed or registered health care providers).

- Outpatient Chemical Dependency Treatment (Rule 43);
- Detoxification Centers; (Rule 35, Category I);
- Free standing treatment programs and residential free standing care facilities (Rule 35, Category II, III);
- Children's residential treatment centers (Rule 5);
- Mental health clinics (Rule 29) other than mental health centers defined in sec. 245.62 subd. 2;

PAYMENTS THAT ARE SPECIFICALLY EXEMPT FROM TAX

Payments received for services provided by the following facilities are excluded from the gross revenues subject to tax pursuant to* Minnesota Statutes, *sec. 295.53 subd. 1 (1994): *

- community residential mental health facilities (Rule 36);
- community support programs and family community support programs approved under *Minnesota Rules*, parts 9535.1700 to 9535.1760 (rule 78);
- community mental health centers as defined in section 245.62 subd. 2;
- supervised living facilities for persons with mental retardation;
- post-secondary educational institutions: payments received from student fees and other appropriations are exempt. Fee for service payments and payments for extended coverage are taxable;
- board and lodging facilities that provide custodial services (residential care homes).

Payments received for the following services are excluded from the gross revenues subject to tax pursuant to* Minnesota Statutes, *sec. 295.53 subd. 1 (1994)*

- home health care;
- hospice care;
- assisted living;
- congregate housing;
- other senior housing options.

* (This is not an exclusive list of all the MinnesotaCare exemptions; also, while the payments in this list are excluded from the tax, the facilities that provide these services are included in the definition of health care provider and are required to file an annual MinnesotaCare tax return).

Dated: 27 June 1994

Patricia A. Lien
Assistant Commissioner for Tax Policy

Official Notices

Pursuant to the provisions of Minnesota Statutes §14.10, an agency, in preparing proposed rules, may seek information or opinion from sources outside the agency. Notices of intent to solicit outside opinion must be published in the *State Register* and all interested persons afforded the opportunity to submit data or views on the subject, either orally or in writing.

The *State Register* also publishes other official notices of state agencies, notices of meetings, and matters of public interest.

Department of Health

Minnesota Health Data Institute

Notice of Appointment of a Consumer Advisory Group and Vacancies Open for Application

NOTICE IS HEREBY GIVEN that the Minnesota Health Data Institute will be appointing a Consumer Advisory Group to advise the Institute on issues of concern to consumers. The Advisory Group will consist of 13 individuals, representing enrollees from public and private health plan companies and programs and two uninsured consumers. The Advisory Group will have at least one member from each Regional Coordinating Board region of the state. The Advisory Group expires June 30, 1997. For further information, call 282-6304.

Dale Shaller, Executive Director
Minnesota Health Data Institute

Mary Jo O'Brien, Commissioner
Minnesota Department of Health

Department of Health

Health Care Delivery Systems Division

Notice of Vacancies on Health Care Advisory Committees and Task Forces

NOTICE IS HEREBY GIVEN that the Minnesota Department of Health is seeking persons to serve on the **Advisory Committee on the Universal Standard Benefits Set**. This committee will develop recommendations regarding the services other than dental services to be included in the universal standard benefits set. The committee must include representatives of health care providers, purchasers, consumers, health plan companies, and counties. The health care provider representatives must include both physicians and allied independent health care providers representing both physical and mental health conditions. The committee shall report these recommendations to the commissioner by October 1, 1994.

Persons interested in the **Advisory Committee on the Universal Standard Benefits Set** should send a resume by July 8, 1994 to: Gloria Gebhard, Minnesota Department of Health, P.O. Box 64975, St. Paul, MN 55164-0975. For further information, call (612) 282-6362.

NOTICE IS FURTHER GIVEN that the Minnesota Departments of Health and Commerce are seeking persons to serve on the **Advisory Task Force on Recodification and Reform of Regulatory Requirements**. This task force will advise the commissioners on the recodification, simplification, and standardization of all statutes, rules, regulatory requirements, and procedures relating to health plan companies. The task force must include representatives of health plan companies, consumers, counties, employers, labor unions, providers, and other affected persons.

Persons interested in the **Advisory Task Force on Recodification and Reform of Regulatory Requirements** should send a resume by July 8, 1994 to: Kent Peterson, Minnesota Department of Health, P.O. Box 64975, St. Paul, MN 55164-0975. For further information, call (612) 282-5616.

NOTICE IS FURTHER GIVEN that the Minnesota Department of Health is seeking persons to serve on the **Advisory Task Force on Medical Education and Research Costs**. The advisory task force will provide expertise and advice on the impact of state health care reform on the financing of medical education and research activities in the state.

The task force may include up to 20 members. The commissioner shall take under consideration representation of the following groups: The Minnesota Association of Public Teaching Hospitals and other nonteaching hospitals; private academic medical centers; the University of Minnesota medical school and its primary care residency programs; payer organizations including managed care, nonprofit health service plan organizations, and commercial carriers; other providers including the Minnesota Medical Association, the Minnesota Nurses Association, and others; a representative of the Health Technology Advisory Committee; employers; consumers; and medical researchers. The task force shall include representation of rural areas in the state.

Persons interested in the **Advisory Task Force on Medical Education and Research Costs** should send a resume by July 8, 1994 to: Lynn Blewett, Minnesota Department of Health, P.O. Box 64975, St. Paul, MN 55164-0975. For further information, call (612) 282-6361.

NOTICE IS FURTHER GIVEN that the Minnesota Department of Health will be convening a **Regulated All-Payer Fee Schedule Advisory Committee**. The advisory committee will be made up of a broad array of health care professionals that will be affected by the fee schedule as well as other interested parties. Recommendations of this committee must be submitted to the commissioner by November 15, 1994, and may be incorporated in the implementation report due to the legislature on January 1, 1995. For further information, call Sandra Keogh at 282-6354.

Mary Jo O'Brien
Commissioner of Health

Department of Health

Department of Commerce

Notice of Vacancies on a Risk Adjustment Expert Advisory Panel and Technical Work Groups

NOTICE IS HEREBY GIVEN that the Minnesota Departments of Health and Commerce are seeking persons to serve on a **Risk Adjustment Expert Advisory Panel** and **Technical Work Groups**. The **Expert Advisory Panel** shall assist and advise the commissioners of health and commerce in preparing the risk adjustment implementation report which must be submitted to the legislature by January 15, 1995. The report will contain recommendations on the process, organization, resource needs, and specific work plan to define, develop, and implement a risk adjustment system by July 1, 1997, and to continually improve risk adjustment over time. To the extent possible, the implementation report shall identify a specific methodology or methodologies that may serve

as a starting point for risk adjustment, explain the advantages and disadvantages of each such methodology, and provide a specific workplan for implementing the methodology. The **Expert Advisory Panel** shall be comprised of the board members of the Minnesota Risk Adjustment Association and experts in the fields of epidemiology, health services research and health economics. The **Technical Work Groups** will be convened on an as needed basis.

Persons interested in the **Risk Adjustment Expert Advisory Panel** and the **Technical Work Groups** should send a resume by July 8, 1994 to: Lynn Blewett, Minnesota Department of Health, P.O. Box 64975, St. Paul, MN 55164-0975. For further information, call (612) 282-6361.

Mary Jo O'Brien, Commissioner of Health
Jim Ulland, Commissioner of Commerce

Department of Human Services

Public Notice Regarding Changes in the Medical Assistance (MA) Program, the General Assistance Medical Care Program (GAMC), and the MinnesotaCare Program

NOTICE IS HEREBY GIVEN to recipients and providers of Minnesota Medical Assistance (MA), General Assistance Medical Care (GAMC), and the MinnesotaCare Program, and to the public of certain changes affecting the above programs that were enacted by the 1994 Legislature. This notice is published pursuant to *Code of Federal Regulations*, Title 42, section 447.205. The purpose of this notice is to inform the public of changes in the MA program due to changes in State law. The changes to the MA program are expected to result in no change in MA expenditures for the State Fiscal Year 1995. This notice also contains changes to the MinnesotaCare and General Assistance Medical Care (GAMC) programs that may be of interest to providers and recipients.

The actual text of these changes are contained in *1994 Minnesota Session Laws*, at the chapters cited below.

Information related to implementation of these provisions will be sent to local human services agencies through instructional and informational bulletins and manual updates, to MA, GAMC, and MinnesotaCare enrollees through written notice, and to health care providers through newsletters, bulletins and updates to the provider manuals.

MinnesotaCare Bill

LAWS OF MINNESOTA 1994, CHAPTER 625

• Effective July 1, 1994, only those MinnesotaCare enrollees who have received inpatient hospital services who are determined to have a basis of eligibility in Medical Assistance (MA) are required to apply for MA. An inpatient hospital must request inpatient hospital admission certification for MinnesotaCare enrollees within 30 days of the admission. If admission certification is not submitted within 30 days, the payment to the hospital for the hospital stay will be reduced by 5 percent. The hospital is prohibited from collecting that 5 percent from the enrollee. Chapter 625, article 8, sections 50 and 57.

• Effective May 11, 1994, language was enacted to clarify enrollee liability for cost-sharing when a MinnesotaCare enrollee incurs inpatient hospital expenses. (1) A MinnesotaCare enrollee who is not eligible for MA, with or without a spenddown, is responsible for copayments, and annual inpatient hospital costs in excess of $10,000. For an enrollee who is eligible for MA on a spenddown basis, MinnesotaCare pays the spenddown amount up to the $10,000 maximum and the enrollee is responsible for amounts that exceed the $10,000 maximum. Chapter 625, article 8, section 51.

• Effective May 11, 1994, the law is clarified to provide that a person may enroll in the MinnesotaCare Program even if he or she may be eligible for MA on a spenddown basis. Chapter 625, article 8, sections 52, 53 and 54.

• Effective May 11, 1994, a person may not be eligible for both MinnesotaCare and GAMC in the same month, except for the period of retroactive eligibility in GAMC. Chapter 625, article 8, section 55.

• Effective July 1, 1994, there is an exception to the rule that an enrollee must not have had access to employer-subsidized insurance within 18 months prior to application for MinnesotaCare. The exception is that when an individual loses access to employer subsidized coverage for a reason that would disqualify the individual from unemployment benefits under *Minnesota Statutes*, section 268.09, that individual's children are not ineligible for MinnesotaCare even if they had access to employer subsidized insurance within 18 months prior to application. Chapter 625, article 8, section 56.

• Effective July 1, 1994, *Minnesota Statutes*, section 256.9363 is amended to allow for the purchase of inpatient hospital services through managed care plans on a risk or a non-risk basis. Specifically, the changes eliminate a requirement that an enrollee must pay to the managed care plan (instead of the provider) for inpatient hospital costs in excess of the $10,000 benefit limit. Also, the change eliminates a requirement that the managed care plan must submit hospital claims to the Department for purposes of determining spenddowns. Chapter 625, Article 8, sections 58, 59 and 60.

• Effective July 1, 1994, all community integrated service networks (CISNs) are subject to the MA surcharge equal to six tenths of one percent of total premium revenue. Chapter 625, Article 8, section 61.

• Effective July 1, 1994, *Minnesota Statutes*, section 256B.0917, subd. 2 is amended to require that a long term care coordinating team conducting a Seniors Agenda for Independent Living (SAIL) project must include a representative of local nursing home providers, and a representative of local home care providers. Chapter 625, article 8, section 63.

• The Department is required to review rebased hospital payment rates to determine whether hospitals with exceptionally high cost admissions are paid at rates that are reasonable and adequate. The report is due February 15, 1995. Chapter 625, article 8, section 70.

• The Departments of Human Services and Health are required to develop a plan to take necessary steps to ensure that projected expenditures for the MinnesotaCare Program are contained within its expected revenues for Fiscal Year 1997. This plan must be submitted February 1, 1995. The Department is required to begin enrollment of single adults and households without children with income equal to or less than 125% of poverty, on October 1, 1994, even if expenditures are not contained within revenues for Fiscal Year 1997. Chapter 625, article 13, section 1.

• Enrollment of single adults and households without children shall begin on October 1, 1994, for families with incomes equal to or less than 125% of federal poverty guidelines, who meet other eligibility criteria. Beginning October 1, 1995, the income standard for single adults and households without children increases to the MinnesotaCare income standard for all other groups, if there is sufficient funding. Chapter 625, article 13, sections 2 and 5.

• Effective July 1, 1994, the MinnesotaCare program is required to determine an applicant's eligibility for MinnesotaCare no more than 30 days from the date the application is received by the Department. This requirement is not effective in the four months following the dates in which single adults and families without children become eligible for the program. Chapter 625, article 13, section 3.

• Effective July 1, 1994, there is an exception to the rule requiring four months of ineligibility when a person loses coverage due to nonpayment of premiums is created. The exception is for persons who have good cause for nonpayment. Good cause does not exist if a person chooses to pay other expenses instead of the MinnesotaCare premium. The Department is required to define good cause through administrative rulemaking. Chapter 625, article 13, section 4.

***Laws 1993*, chapter 1, 1st Special Session, article 5, section 99.**

• *Minnesota Statutes* regulating nursing facilities were amended during the 1993 legislative session. See 17 SR 3421 (June 28, 1993). One change affecting nursing facilities alters the methodology for computing the facility's efficiency incentive and is effective July 1, 1994. The commissioner shall determine a nursing facility's efficiency incentive by first computing the amount by which the facility's other operating cost limit exceeds its nonadjusted other operating cost per diem for that rate year. The commissioner shall then use the table in *Laws 1993*, chapter 1, 1st Special Session, article 5, section 99 to compute the nursing facility's efficiency incentive.

Department of Human Services

MinnesotaCare Division

Notice of Solicitation of Outside Information or Opinions Regarding Proposed Rules Governing MinnesotaCare

NOTICE IS HEREBY GIVEN that the State Department of Human Services is seeking additional information or opinions from sources outside the agency in preparing to propose the adoption of the permanent rule governing MinnesotaCare. The adoption of the rule is authorized by *Minnesota Statutes*, section 256.9352, subdivision 2, which permits the agency to adopt permanent rules to administer MinnesotaCare and section 256.9363, which authorizes the commissioner to contract with managed care plans to provide services to MinnesotaCare enrollees.

During the course of the rule development process the following issues may be considered: In addition to establishing standards and procedures governing eligibility; application, enrollment, and coverage; coordination of MinnesotaCare and medical assistance; covered health services; premium payments; copayments and provider reimbursement; quality control; and appeals, the rules will establish standards and procedures for providing health services to enrollees through managed care health plans.

The State Department of Human Services has formed an advisory task force to aid in the development of the rule that includes representatives from county agencies, Southern Minnesota Regional Legal Services, the Minnesota Academy of Pediatrics, the Minnesota Nurses Association, the Children's Defense Fund, the Minnesota Medical Association, Legal Aid Society, the Legal Services Advocacy Project, the Council on Asian Pacific Minnesotans, and the state departments of Finance and Health. In addi-

tion, the Department has sought and will be receiving advice from organizations that will be responsible for implementing the delivery of health services through managed care plans.

The Department anticipates that the rule adoption process will take approximately five months.

The State Department of Human Services requests information and opinions concerning the subject matter of the rule. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally. Written statements should be addressed to:

Martha N. O'Toole
Appeals and Regulations Division
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3816

Oral statements will be received by Martha N. O'Toole during regular business hours over the telephone at 612-296-7815 and in person at the above address.

All statements of information and opinions shall be accepted until further notice is published in the *State Register* or the Notice of Hearing or Notice of Intent to Adopt Rules Without a Hearing is published in the *State Register*. Any written material received by the State Department of Human Services shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that the rule is adopted.

Dated: 20 June 1994

Martha N. O'Toole
Appeals and Regulations Division

Department of Labor and Industry

Labor Standards Division

Notice of Prevailing Wage Certifications for Commercial Construction Projects

Effective June 27, 1994 prevailing wage rates were determined and certified for commercial construction projects in:

Benton County: New Middle School-Sauk Rapids; St. Cloud MTC Garage Expansion-St. Cloud.

Chisago County: Wyoming Elementary Remodeling-Wyoming.

Clay County: Moorhead State University Ballroom Partition Replacement & Ballard Hall Partial Tuck Pointing-Moorhead.

Dakota County: Farmington District Service Center Tunnel-Farmington; Kenwood Trails Jr. High Hardware Replacement-Lakeville.

Hennepin County: U of M Law Building 1994 Masonry Wall Repairs-Minneapolis; Normandale Community College ADA Compliance Upgrades-Bloomington.

Isanti County: Cambridge Community College-Cambridge.

Olmsted County: Rochester Fire Station No. 7-Rochester.

Ottertail County: Wastewater Treatment Facility Improvements Phase I-Fergus Falls.

Ramsey County: Mounds View Public Schools 1994 Reroofing-New Brighton/Shoreview.

Renville County: City of Buffalo Lake Pretreatment Wastewater Facility-City of Buffalo.

St. Louis County: Biwabik Municipal Mixed Use Complex-Biwabik; U of M/Duluth Annual Boiler Cleaning, Duluth Central High Asbestos Fireproofing Removal-Duluth.

Sherburne County: 1994 Big Lake Middle School Casework Installation & Parking Lay Overlay-Big Lake.

Washington County: Forest Lake & Scandia Elementary Remodeling.

Winona County: Winona Technical College Restroom Remodel-Winona.

Copies of the certified wage rates for these projects may be obtained by writing the Minnesota Department of Labor and Industry, Prevailing Wage Section, 443 Lafayette Road, St. Paul, Minnesota 55155-4306. The charge for the cost of copying and mailing are $1.36 per project. Make check or money order payable to the State of Minnesota.

John B. Lennes, Jr
Commissioner

State Grants

In addition to requests by state agencies for technical/professional services (published in the State Contracts section), the *State Register* also publishes notices about grant funds available through any agency or branch of state government. Although some grant programs specifically require printing in a statewide publication such as the *State Register*, there is no requirement for publication in the *State Register* itself.

Agencies are encouraged to publish grant notices, and to provide financial estimates as well as sufficient time for interested parties to respond.

Department of Agriculture

Energy and Sustainable Agriculture Program

Notice of Availability of Funds for Coordination of a GIS Project

The Minnesota Department of Agriculture, Planning Division, is accepting proposals for the coordination of a geographic information system (GIS) mapping project to build statewide GIS coverage of Conservation Reserve Program (CRP) lands.

The Division will award a contract of up to $40,000 for coordination of the project on or about July 18, 1994.

Eligible applicants are GIS firms, organizations, or programs that have experience coordinating large-scale projects and building large GIS coverages.

Proposals must follow the format and requirements addressed in the "Request for Proposal."

A copy of the complete "Request for Proposal" is available immediately and may be obtained from:

Debra Elias, CRP Project Coordinator
Minnesota Department of Agriculture
90 West Plato Blvd.
St. Paul, MN 55107
Telephone: 612-282-6831
Fax: 612-297-7678

Proposal deadline: 4:30 p.m., July 11, 1994.

Department of Corrections

Notice of Availability of Funds to Establish Community Advocacy Services for Battered Women in Rice County

The Minnesota Department of Corrections, Victim Services Unit, announces the availability of funds to establish community advocacy services for battered women in Rice County. One grant of up to $31,000 is available for the 10-month period September 1, 1994, through June 30, 1995. Nonprofit organizations and local units of government are eligible to apply under this RFP. Successful applicants may be eligible to apply for continued funding of $35,000 after the initial grant period.

The deadline for submission of grant proposals is 4:30 p.m. on Thursday, July 28, 1994. The application packet may be obtained from the contact listed below and must be completed according to the RFP and instructions. Interested applicants are welcome to call or visit the Issuing Office for more details. Those intending to make a visit should arrange an appointment in advance.

Cecilia Miller, Administrative Assistant
Department of Corrections, Victim Services Unit
450 North Syndicate, Suite 300
St. Paul, MN 55104
Phone: 612/642-0251, 800/657-3679 outside the Twin Cities metropolitan area, or TDD 612/643-3589.

Department of Economic Security

Request for Proposals for the Transitional Housing Program

The Minnesota Department of Economic Security seeks proposals from Community Action Agencies, Housing and Redevelopment Authorities, Indian Reservation Governments and other public and private non-profit agencies for projects to be funded under the State of Minnesota Transitional Housing Program. The Department of Economic Security has received an appropriation of $860,000 for the fiscal year 1995 program.

The purpose of the Transitional Housing Program (*Minnesota Statute* 268.38) is to initiate, maintain or expand programs which provide transitional housing and support services to homeless individuals. This funding is not intended for crisis overnight shelter services, but to provide support services to facilitate long-term independent living. Funds are to pay for the operating costs associated with the provision of transitional housing services and cannot be used for rehabilitation activities.

Application packages can be obtained by calling Judy Johnson at (612) 296-5759. An original and two copies of the completed application should be returned to:

Department of Economic Security
Community Based Services Division
390 North Robert Street, 1st Floor
St. Paul, MN 55101
Attn: Patrick Leary

Applications must be received by 3:00 p.m., Wednesday, August 3, 1994. An announcement of awards is expected by August 12, 1994.

For further information, contact Patrick Leary at (612) 297-3409, or Judy Johnson at (612) 296-5759.

Housing Finance Agency

Notice of Fund Availability and Request for Proposals Affordable Rental Investment Fund

The Minnesota Housing Finance Agency (MHFA) announces the availability of funds to eligible sponsors to assist them in the development, construction, acquisition, preservation and rehabilitation of permanent affordable rental housing. These funds were made available through state appropriation and MHFA resources.

Amount of Funds Available: $2,445,000

Form of Awards: 0%, 30 year deferred first or subordinated loans.

Location: Statewide

Allocation of Funds: Minneapolis and St. Paul - $489,000; Hennepin and Ramsey Counties (excluding the cities of Minneapolis and St. Paul), Anoka, Dakota, Washington, Scott and Carver Counties - $489,000; Greater Minnesota - $489,000; Statewide on a competitive basis - $978,000.

Eligible Applicants: Eligible applicants are limited profit and non-profit entities, Minnesota Cities, and Housing and Redevelopment Authorities. For profit entities are eligible for developments consisting of the rehabilitation of existing rental housing.

Eligible Projects: The funds will be used to provide loans for projects for the development, construction, acquisition, preservation and rehabilitation of permanent low income rental housing consisting of a minimum of four rental units. Single family and duplex properties are allowed in scattered site developments with a minimum of four units total.

All rental units which meet the rent and income requirements are eligible for assistance. In instances where not all units are eligible for assistance, funds will be provided on a prorata basis. Developments which provide for or maintain economic integration are encouraged.

New construction will be closely targeted to areas of economic growth or with sufficient market demand and with an emphasis on housing for large families and single individuals.

Assisted housing shall not be limited to persons 55 years and older.

Income Limits: 100% of assisted units must be initially occupied by households with incomes less than 60% of area median income adjusted by family size.

Gross Rent Limits: Maximum gross rents shall not exceed the lesser of 30% of 50% of area median income by unit size, or 30% of 50% of Statewide median income (see chart below) by unit size.

	OBR	1 BR	2BR	3BR	4BR
30% of 50% of Statewide Median Income ($43,500)	$380	$408	$489	$565	$631

Gross rents shall not be lower than 30% of 30% of area median income by unit size.

Procedures: Applicants should request packets from MHFA staff, write or call the MHFA at 400 Sibley Street, Suite 300, St. Paul, MN 55101, Attn: Multi-Family Division, (612) 297-5136.

Any questions should be directed to Brenda Nieland at (612) 297-5136, or Diane Bauleke at (612) 296-9829.

Applications are due by 4:30 p.m. on Friday, August 26, 1994. The MHFA will review the applications and will make recommendations for funding to the MHFA Board on October 27, 1994.

This request for proposals (RFP) is subject to all applicable federal, state, and municipal laws, rules, and regulations. MHFA reserves the right to modify or withdraw this RFP at any time and is not able to reimburse any applicant for costs incurred in the preparation or submittal of applications.

It is the policy of the Minnesota Housing Finance Agency (MHFA) to further fair housing opportunity in all Agency programs and to administer its housing programs affirmatively, so that all Minnesotans of similar income levels have equal access to Agency programs regardless of race, color, creed, religion, national origin, sex, marital status, status with regard to receipt of public assistance, disability, or familial status.

Housing Finance Agency

Notice of Fund Availability and Request for Proposals Housing Trust Fund Program

The Minnesota Housing Finance Agency (MHFA) and the Housing Trust Fund Advisory Committee (HTFAC) announce the availability of $1,200,000 in loan funds to eligible sponsors to assist them in the development, construction, acquisition, preservation and rehabilitation of affordable rental housing, limited equity cooperative housing, and homes for ownership by low income persons. These funds were generated by interest earnings on real estate brokers' trust accounts; interest accrued on revenue bond application fees and forfeited fees; and state appropriated funds.

Form of Awards: Funds are awarded to projects in the form of a zero interest deferred loan. To encourage the long term affordability of the housing provided under this program, a thirty year repayment schedule is used. The loan must be repaid in full if the project fails to operate as affordable housing for low income persons during the first ten years of the loan. During the next twenty years, five percent of the loan is forgiven each year provided that the housing remains affordable for low income persons and families.

Set Aside: Up to twenty percent (approximately $240,000) of the total funds available may be used for projects that are not compatible with the 30 year repayment schedule. Within the twenty percent set aside, up to $120,000 will be available for home ownership projects. The MHFA's and the HTFAC's intent is to use this set aside of funds to encourage innovative proposals which would otherwise not be possible to fund given the 30 year use commitment. Applications submitted under the set aside will be evaluated with all applications received in response to the Request for Proposals.

Eligible Applicants: Eligible applicants are individuals, for-profit entities, non-profit entities, Minnesota Cities, joint power boards established by two or more cities, and Housing and Redevelopment Authorities.

Eligible Projects: The legislation requires that the funds from the trust fund account be used "to provide loans or grants for projects for the development, construction, acquisition, preservation, and rehabilitation of low income rental and limited equity cooperative housing units and homes for ownership. At least 75 percent of the rental and cooperative units, and 100 percent of the homes for ownership in the development or all of the units funded by the housing trust fund account, must be rented to or cooperatively owned, or owned by persons and families whose income does not exceed 30 percent of the median family income for the metropolitan area." (*Minnesota Statutes* Sect. 462A.201 Subd. 2, as amended.) As of May 1994, 30 percent of the Minneapolis/St. Paul area median income was $15,300.

It is the desire of the MHFA and the HTFAC to use the Housing Trust Fund Housing Program to encourage and support innovative approaches to housing problems which provide affordable housing with strong local support. It is expected that these funds will be used to leverage other funds or to provide the final piece of a financing package. They can be used in conjunction with other MHFA, State, or Federal programs as appropriate.

The range of Housing Trust Fund awards from the smallest to the largest has been $3,000 to $190,000. The MHFA will not be accepting applications for proposals whose primary purpose is lead based paint abatement.

Application Process: Applicants should request application packets from MHFA staff:

Minnesota Housing Finance Agency
400 Sibley Street, Suite 300
St. Paul, MN 55101
(612) 297-3294

If after reviewing the application materials there are any questions concerning the Housing Trust Fund Housing Program or the application process they should be directed to Denise Holter (612) 297-4294.

The original and two (2) copies of the application are due by 4:30 p.m. on Friday, August 26, 1994. The Housing Trust Fund Advisory Committee will review the applications and should make funding recommendations to the MHFA Board by October 27, 1994.

This Request for Proposals (RFP) is subject to all applicable federal, state, and municipal laws, rules, and regulations. MHFA reserves the right to modify or withdraw this RFP at any time and is not able to reimburse any applicant for costs incurred in the preparation or submittal of applications.

It is the policy of the Minnesota Housing Finance Agency (MHFA) to further fair housing opportunity in all Agency programs and to administer its housing programs affirmatively, so that all Minnesotans of similar income levels have equal access to Agency programs regardless of race, color, creed, religion, national origin, sex, marital status, status with regard to receipt of public assistance, disability, or familial status.

Housing Finance Agency

Notice of Fund Availability and Request for Proposals Publicly Owned Transitional Housing Program and Battered Women's Facility Program

The Minnesota Housing Finance Agency (MHFA) announces the availability of $2,500,000 in loan funds to assist local units of government in the development, construction, acquisition, improvement, or rehabilitation of existing housing properties to be used as transitional housing for low and moderate income persons. $1,000,000 of the total is set aside for developments that provide housing for battered women or other crime victims.

Only local units of government are eligible to receive funds and to have title to the property. However, they may contract with service providers to manage the property and operate the program or they may lease the property to a non-profit organization which provides appropriate services. Local units of government may purchase the buildings of existing transitional housing program, battered women and other housing facilities serving crime victims and lease them back to the providers at some minimal charge thereby freeing up debt service funds for operating expenses.

Transitional Housing: The 1994 Legislative Capital Bonding Bill included $1.5 million for transitional housing. The Minnesota Housing Finance Agency is to allocate this money for the acquisition, improvement, or rehabilitation of existing structures or the acquisition, site improvement and development of new properties to be used as transitional housing for low and moderate income persons. Transitional Housing means housing provided for a limited duration not exceeding 24 months and available for occupancy on a continuous 24 hour basis. Operating costs are ***not*** eligible for funding.

Battered Women's Facilities: The 1994 Legislative Capital Bonding Bill included $1 million for the construction or rehabilitation of shelters or transitional housing for battered women or other crime victims. At least 25 percent of the $1 million must be used in conjunction with the State Youth Employment Program or the State Training and Housing Program for Homeless Adults or other employment and training programs. Eligible employment and training programs will demonstrate the ability and experience to operate a construction training program. Maximum grants under this Program are $200,000.

Eligible Applicants: Cities and Housing and Redevelopment Authorities are eligible applicants for either source of funds. The ability to develop and operate the proposed housing must be demonstrated by the applicant either directly or through their selected service provider.

Terms of Financing: Under this program, interest free, deferred loans are available for a maximum term of twenty (20) years. Applicants will be required to own the property and to operate the property as transitional housing for twenty (20) years, or until such time as the property is no longer usable or needed by the applicant to provide transitional housing. At the expiration of the twenty (20) year loan term the debt will be forgiven.

Should the property ***ever*** be sold, the sale price of the property must be for a ***fair market value*** as determined by an appraisal of the property, or the price bid by a purchaser under a public bid procedure after reasonable public notice.

Should the property be sold prior to the expiration of the twenty (20) year loan period, the sale price of the property must still be for a fair market value as determined by an appraisal of the property, or the price bid by a purchaser under a public bid procedure after reasonable public notice. Any net proceeds from the sale must be applied to reduce/repay any outstanding state bond financed debt. The applicant may change the use of the property provided that the state deferred loan is repaid in full.

NOTE: State statute affecting this program is currently under review for interpretation by the Attorney General's Office and the Commissioner of Finance. How statute is interpreted may result in significant changes to the program.

Funding Process: Applicants should request application packets from staff at MHFA by calling (612) 297-3294 or writing:

Minnesota Housing Finance Agency
400 Sibley Street, Suite 300
St. Paul, MN 55101
Attention: Dan Tempel

Applications are due by 4:30 p.m. on August 26, 1994. An interagency committee will review the applications and should make recommendations for funding to the MHFA Board by October 27, 1994. Any funds that remain uncommitted at that time will be available for funding proposals received on an ongoing basis after the August 26, 1994 deadline.

This Request for Proposals (RFP) is subject to all applicable federal, state and municipal laws, rules and regulations. MHFA reserves the right to modify or withdraw this RFP at any time and is not able to reimburse any applicant for costs incurred in the preparation or submittal of applications.

It is the policy of the Minnesota Housing Finance Agency (MHFA) to further fair housing opportunity in all Agency programs and to administer its housing programs affirmatively, so that all Minnesotans of similar income levels have equal access to Agency programs regardless of race, color, creed, religion, national origin, sex, marital status, status with regard to receipt of public assistance, disability, or familial status.

Housing Finance Agency

Notice of Funds Available and Request for Proposals for the Rental Assistance for Family Stabilization Program

The Minnesota Housing Finance Agency (MHFA) announces the availability of $3,000,000 in rental assistance funds for the **Rental Assistance for Family Stabilization (RAFS) Program.** RAFS is available for assisting families with dependent children (AFDC) receiving public assistance that are participating in a self-sufficiency, education or job training program.

Location:	The RAFS program is limited to counties in which the Section 8 existing fair market rents, as determined by HUD, are in the highest one-third of the average rents in the state.
Amount of Funds:	$3,000,000 in rental assistance. A maximum of $200 per month per program participant. Administrative fee may not exceed $40.00 per month per program participant. A maximum of $200 per program participant will be made available for security and utility deposits.
Type of Assistance:	Project-based and/or voucher option.
Term of Assistance:	A maximum of 36 months per program participant.
Eligible Applicants:	Self-sufficiency program administrators in partnership with non-profit and/or for-profit local housing organizations.
Eligible Unit:	Rental unit that is available in the community served by the local housing organization and meets federal Section 8 existing housing quality standards. Units shall have a self contained kitchen, bathroom and living/sleeping areas.
Eligible Projects: (project based option)	Rental property that is made available by a self-sufficiency program and meets federal Section 8 existing housing quality standards or that has received federal, state or local rental rehabilitation assistance since January 1, 1987, and meets federal Section 8 existing housing quality standards.
Rent Limits:	Not to exceed the Section 8 existing fair market rents.
Income Limits:	Gross family income of program participant is such that 30% of said income is less than the housing cost.
Program Participant:	For initial eligibility, a family with at least one dependent child must be receiving public assistance, be participating in a self-sufficiency program, not be receiving other rental assistance.
Other Requirements:	As addressed in the RAFS Procedural Guide, as amended.
Procedures:	Applicants should request application packets from the Agency. Write or call: the Minnesota Housing Finance Agency, 400 Sibley Street, Suite 300, St. Paul, MN 55101, Attn: RAFS, Multi-Family Division; (612) 296-9832.

Deadline: The original and two copies of the completed application should be sent to the above address by 5:00 PM on Friday, July 1, 1994.

Selection Process: All complete proposals which meet the basic requirements and the selecting criteria of the program and are received by the deadline will be considered. MHFA may request and consider information from an applicant in addition to that requested in the application.

Final selections should be made by the MHFA Board by August 25, 1994. All applicants are notified of the selections.

Disclaimer: This Request for Proposals (RFP) is subject to all applicable federal, state, and municipal laws, rules, and regulations. MHFA reserves the right to modify or withdraw this RFP at any time and is not able to reimburse any applicant for costs incurred in the preparation or submittal of applications.

The Minnesota Housing Finance Agency is an Equal Housing Opportunity and Equal Employment Agency.

Housing Finance Agency

Notice of Fund Availability and Request for Proposals Targeted Home Fund

The Minnesota Housing Finance Agency (MHFA) announces the availability of $1,000,000 in loan funds to assist eligible applicants in the development of rental or homeownership projects, for acquisition, rehabilitation, or new construction. Targeted HOME funds will be in the form of a deferred no interest loan for the affordability period required under the HOME regulations.

Total Targeted HOME Funds: $1,000,000

Program Description: The Targeted HOME Fund is a flexible fund for applicants with projects which do not fit into other MHFA programs.

Applicants will be required to meet the HOME regulations for the activity they are proposing. For example, a rental project must meet the HOME income and rent requirements for the affordability period. A home purchase project must include the HOME resale guidelines.

Because the HOME regulations are complicated, applicants are urged to contact the MHFA for technical assistance in designing a program that meets HOME requirements.

Eligible Applicants: Eligible applicants are private individuals, for-profit or non-profit organizations, community housing development organizations (CHDO's), housing and redevelopment authorities (HRA's).

Involvement of CHDO's: CHDO's may participate in the Targeted HOME Fund as developers of affordable housing projects. Priority in selection shall be given to eligible organizations that qualify as CHDO's.

Funding Process: Applicants should request application packets from MHFA staff:

Minnesota Housing Finance Agency
400 Sibley Street, Suite 300
St. Paul, MN 55101
Phone: (612) 297-3294

Applications are due by 4:30 p.m. on Friday, August 26, 1994. An interagency committee will review the applications and will make recommendations for funding to the MHFA Board October 27,1994.

This Request for Proposals (RFP) is subject to all applicable federal, state and municipal laws, rules and regulations. MHFA reserves the right to modify or withdraw this RFP at any time and is not able to reimburse any applicant for costs incurred in the preparation or submittal of applications.

For more detailed program information, please call Mike Haley (612) 297-2678 for home purchase projects; Darrick Metz (612) 297-5137 for rental projects.

It is the policy of the Minnesota Housing Finance Agency (MHFA) to further fair housing opportunity in all Agency programs and to administer its housing programs affirmatively, so that all Minnesotans of similar income levels have equal access to Agency programs regardless of race, color, creed, religion, national origin, sex, marital status, status with regard to receipt of public assistance, disability, or familial status.

Housing Finance Agency

Notice of Fund Availability and Request for Proposals for the Transitional Housing Program

The Minnesota Housing Finance Agency (MHFA) was established to assist in providing safe, appropriate, and affordable housing for low and moderate income residents of Minnesota. The Transitional Housing Program is designed to assist eligible applicants in the construction, acquisition, or rehabilitation of residential housing for this group of persons.

The Transitional Housing Program has three program options: (1) Temporary or transitional housing for individuals and families having an immediate need for housing; (2) Residential housing for migrant farmworkers; and (3) Homeless individuals and families. ***You must select the program under which you are requesting funds.***

Under the **Temporary or Transitional Housing** program option, individuals and families income cannot exceed 50% of the greater of the statewide or area median income adjusted for families of five or more.

Under the **Residential Housing for Migrant Farmworkers** program option, housing must contain cooking, sleeping, bathroom facilities, and hot/cold running water in the same structure.

Under the **Homeless Individuals and Families** program option, eligible applicants can apply for funds to provide housing (including SRO-type housing) for individuals and families whose incomes do not exceed thirty percent (30%) of the metropolitan area median income for a family of four adjusted for families of five or more.

For all the program options, the maximum loan/grant amount may not exceed 50% of Total Development Cost with the balance of the funds coming from other sources. The loan/grant may not exceed $25,000 per unit. Each project funded must be operated and maintained as housing for the target population for a minimum of five years.

Form of Awards: Loan/grants are awarded to projects in the form of a zero (0) interest deferred loan. A five year Deferred Loan Repayment Agreement and Mortgage Note must be executed prior to the disbursement of any funds. Five percent (5%) of the loan/grant is forgiven each year provided that the housing remains affordable for transitional housing.

Eligible Applicants: Eligible Applicants are individuals, for-profit entities, non-profit entities, Minnesota cities, joint power boards established by two or more cities, and Housing and Redevelopment Authorities.

Eligible Projects: The Legislation requires Transitional Housing funds be used "to provide loan/grant awards to projects for the construction, acquisition or rehabilitation of residential housing." The housing is to be provided for a limited duration not exceeding twenty-four (24) months and available for occupancy on a continuous twenty-four (24) hour basis. Loan/grants may ***not*** be used for residential care facilities, for facilities that provide housing for occupancy on less than a twenty-four (24) hour continuous basis, or for any residential housing that requires occupants to accept board as well as lodging.

Loan/grants may be used for specific work or improvements, such as:

- Land or building acquisition
- Building construction
- Building rehabilitation
- Costs that are associated with the project or project financing. These may include costs of financing such as processing and attorney fees, or building permits.

Loan/grants cannot be used for completed work or improvements, expenses incurred in the preparation of the proposal or project costs which are otherwise reimbursable from other private or public sources. Additionally, costs incurred prior to executing the Commitment Agreement are not eligible for reimbursement from loan/grant funds.

It is the desire of the MHFA to encourage and support innovative approaches to housing problems which provide affordable housing with strong local support. It is expected that these funds will be used to leverage other funds or to provide the final piece of a financing package. They can be used in conjunction with other MHFA, State, or Federal Programs as appropriate.

No maximum single loan/grant amount has been officially established other than $25,000 per unit.

Application Process: Applicants should request application packets from MHFA staff:

Minnesota Housing Finance Agency
400 Sibley Street, Suite 300
St. Paul, MN 55101
(612) 297-3294

If after reviewing the application materials there are any questions concerning the Transitional Housing Program or the application process they should be directed to Glory J. Hill (612) 296-9827. Applicants are encouraged to discuss the feasibility of their project proposal with MHFA staff prior to submitting an application for funds.

The original and one (1) copy of the application are due by 4:30 p.m. on August 26, 1994. The Transitional Housing Selection Committee will select applications and should make funding recommendations to the MHFA Board by October 27,1994.

The Request for Proposals (RFP) is subject to all applicable federal, state, and municipal laws, rules, and regulations. MHFA reserves the right to modify or withdraw this RFP at any time and is not able to reimburse any applicant for costs incurred in the preparation or submittal of applications.

It is the policy of the Minnesota Housing Finance Agency (MHFA) to further fair housing opportunity in all Agency programs and to administer its housing programs affirmatively, so that all Minnesotans of similar income levels have equal access to Agency programs regardless of race, color, creed, religion, national origin, sex, marital status, status with regard to receipt of public assistance, disability, or familial status.

Professional, Technical & Consulting Contracts

Department of Administration procedures require that notice of any consultant services contract or professional and technical services contract which has an estimated cost of over $10,000 be printed in the *State Register.* These procedures also require that the following information be included in the notice: name of contact person, agency name and address, description of project and tasks, cost estimate, and final submission date of completed contract proposal. Certain quasi-state agencies are exempted from some of the provisions of this statute.

In accordance with *Minnesota Rules* Part 1230.1910, certified Targeted Group Businesses and individuals submitting proposals as prime contractors shall receive the equivalent of a 6% preference in the evaluation of their proposal. For information regarding certification, call the Materials Management Helpline (612)296-2600 or [TDD (612)297-5353 and ask for 296-2600].

Department of Administration

State Designer Selection Board

Request for Proposal for a University of Minnesota Project

To Minnesota Registered Design Professionals:

The State Designer Selection Board has been requested to select designers for a University of Minnesota project. Design firms who wish to be considered for these projects should deliver proposals on or before 4:00 p.m., July 19, 1994, to:

George Iwan
Executive Secretary, State Designer Selection Board
Room G-10, Administration Building
St. Paul, Minnesota 55155-3000

The proposal must conform to the following:

1) Six (6) copies of the proposal will be required.

2) All data must be on 8 1/2" x 11" sheets, soft bound.

3) The cover sheet of the proposal must be clearly labeled with the project number, as listed in number 7 below, together with the designer's firm name, address, telephone number and the name of the contact person.

4) Mandatory Proposal contents in sequence:

a) Identity of firm and an indication of its legal status, i.e. corporation, partnership, etc. If the response is from a joint venture, this information must be provided for firms comprising the joint venture.

b) Names of the persons who would be directly responsible for the major elements of the work, including consultants, together with brief descriptions of their qualifications. Identify roles that such persons played in projects which are relevant to the project at hand. NOTE NEW REQUIREMENT: The proposal *must* contain a statement indicating whether or not the consultants listed have been contacted and have agreed to be a part of the design team.

c) A commitment to enter the work promptly, if selected, by engaging the consultants, and assigning the persons named 4b above along with adequate staff to meet the requirements of work.

d) A list of State and University of Minnesota current and past projects and studies awarded to the prime firm(s) submitting this proposal during the four (4) years immediately preceding the date of this request for proposal. The prime firm(s) shall list and total all fees associated with these projects and studies whether or not the fees have been received or are anticipated. In addition, the prime firm(s) shall indicate the amount of fees listed which were paid directly to engineers or other specialty consultants employed on the

projects and studies listed pursuant to the above. **NOTE:** Please call for a copy of the acceptable format for providing this information.

e) A section containing graphic material (photos, plans, drawings, etc.) as evidence of the firm's qualification for the work. The graphic material must be identified. It must be work in which the personnel listed in "c" have had significant participation and their roles must be clearly described. It must be noted if the personnel were, at the time of the work, employed by other than their present firms.

The proposal shall consist of no more than twenty (20) faces. Proposals not conforming to the parameters set forth in this request will be disqualified and discarded without further examination.

5) Statutory Proposal Requirements:

In accordance with the provisions of *Minnesota Statutes, 1981 Supplement,* Section 363.073; for all contracts estimated to be in excess of $50,000.00, all responders having more than 20 full-time employees at any time during the previous 12 months must have an affirmative action plan approved by the Commissioner of Human Rights before a proposal may be accepted.

The proposal will not be accepted unless it includes one of the following:

a) A copy of your firm's current certificate of compliance issued by the Commissioner of Human Rights; or

b) A statement certifying that the firm has a current certificate of compliance issued by the Commissioner of Human Rights; or

c) A statement certifying that the firm has not had more than 20 full-time employees in Minnesota at any time during the previous 12 months; or

d) A statement certifying that the firm has an application pending for a certificate of compliance.

6) Design firms wishing to have their proposals returned after the Board's review must follow one of the following procedures:

a) Enclose a self-addressed stamped postal card with the proposals. Design firms will be notified when material is ready to be picked up. Design firms will have two (2) weeks to pick up their proposals, after which time the proposals will be discarded; or

b) Enclose a self-addressed stamped mailing envelope with the proposals. When the Board has completed its review, proposals will be returned using this envelope.

In accordance with existing statute, the Board will retain one copy of each proposal submitted.

Any questions concerning the Board's procedures, their schedule for the project herein described or the fee format form may be referred to George Iwan at (612) 296-4656.

7) PROJECT - 16-94

University Archives & Overflow Center

University of Minnesota - Minneapolis

The University of Minnesota is planning to construct a University Archives and Overflow Center. The goal of the project is to address two important programmatic needs, archives and overflow, in a single facility. The Center will house several archives for the University Libraries, manuscripts and special collections. The Archive and Overflow Center will also accommodate general collections overflow from libraries throughout the University of Minnesota system, the Minnesota State University System, Metropolitan Area Public Libraries and private college libraries.

A pre-programming study has been completed defining the project concept, site and basic scope. It is anticipated that the facility will be located on the West Bank of the University of Minnesota, Minneapolis campus in underground mined space with an office facility for researchers and staff on the surface. The pre-program document identifies approximately 110,000 gross square feet of storage related space and 47,000 gross square feet of administrative area. The mined space will be accessed by tunnel from the river bluff and from the above grade administrative area located on the northeastern edge of the West Bank campus. The site is north of the current Studio Arts facility.

The initial scope of the project will include programming of the facility, schematic design, site investigation, design development and contract documents. Construction will be initiated upon receiving additional legislative funding from the Minnesota State Legislature at a future session.

The design team shall have demonstrated experience in high density or library storage facilities. Prior library experience is helpful, but archive facilities are primarily a materials handling and management facility. Since many of the collections are "primary" in nature, consisting of one-of-a-kind documents, security expertise for a well designed and an integrated system will be required. Documented experience and expertise in designing mined space facilities is expected. The design of the mechanical/electrical systems to maintain specific environmental conditions for preservation of these collections is critical. Cost control and cost estimating are important elements of the design effort.

The construction budget is anticipated to be approximately $35 million which will need to be analyzed by the selected consultant

as a part of the initial programming effort. Pre-programming documents were completed in 1991, which will be the basis of the programming effort (copy available at Kinko's, 306 15th Avenue Southeast, Minneapolis, MN 55455, for purchase). The maximum fee available for the completion of the programming phase of the project, including all travel and reimbursable, is approximately $25,000. The maximum fee available for site investigation and evaluation, including all travel and reimbursable is approximately $100,000. The anticipated future basic services fee for the proposed design team, including all travel and reimbursable, shall not exceed 7% of the construction cost, which will be determined after the programming phase. Additional construction phase services will be negotiated upon further definition of project scope and finalization of the funding/construction schedule. The University's contract form is available for reference.

Questions concerning this project may be referred to Charles Koncker at (612) 624-0828.

Maureen Steele Bellows, Chair
State Designers Selection Board

Department of Corrections

Request for an Independent Contractor – Institution Health Specialist, HIV/AIDS Prison Outreach Worker – for the Minnesota Correctional Facility – St. Cloud

POSITION: This is a part-time position for an independent contractor to provide HIV/STD prevention programs and sexual health education to the inmate population of the Minnesota Correctional Facility at St. Cloud.

DUTIES: To facilitate workshops and support groups for populations at risk. To facilitate our information/support program for PWA's who are sexually active and/or IVDU's. Assist with ongoing program evaluation and development.

REQUIREMENTS: Bachelors degree in public health, education, social work, human services, health sciences, nursing or related field preferred. Three years of related work experience or an equivalent combination of training and experience is also acceptable. Experience working with populations at risk, HIV prevention or other health issues preferred. Appropriate candidates will have skill and confidence with public speaking, be knowledgeable about HIV/STD infection, have skills in promoting sexual health options, be sensitive to the diversity of the inmate population, and be flexible and creative.

HOURS: Eight hours/week.

SALARY: Negotiable

CONTACT: Send resume and three letters of reference by July 8, 1994, to Dana Baumgartner, Health Care Administrator, 300 Bigelow Building, 450 North Syndicate Street, Saint Paul, Minnesota 55104. For additional information, contact Mr. Baumgartner at the above address or 612/642-0248.

Department of Corrections

Request for an Independent Contractor – Institution Health Specialist, HIV/AIDS Prison Outreach Worker – for the Minnesota Correctional Facilities – Shakopee and Lino Lakes

POSITION: This is a part-time position for an independent contractor to provide HIV/STD prevention programs and sexual health education to the inmate population of the Minnesota Correctional Facilities at Shakopee and Lino Lakes.

DUTIES: To facilitate workshops and support groups for populations at risk. To facilitate our information/support program for PWA's who are sexually active and/or IVDU's. Assist with ongoing program evaluation and development.

REQUIREMENTS: Bachelors degree in public health, education, social work, human services, health sciences, nursing or related field preferred. Three years of related work experience or an equivalent combination of training and experience is also acceptable. Experience working with populations at risk, HIV prevention or other health issues preferred. Appropriate candidates will have skill and confidence with public speak-

ing, be knowledgeable about HIV/STD infection, have skills in promoting sexual health options, be sensitive to the diversity of the inmate population, and be flexible and creative.

HOURS: 12 hours/week.

SALARY: Negotiable

CONTACT: Send resume and three letters of reference by July 8, 1994, to Dana Baumgartner, Health Care Administrator, 300 Bigelow Building, 450 North Syndicate Street, Saint Paul, Minnesota 55104. For additional information, contact Mr. Baumgartner at the above address or 612/642-0248.

Department of Corrections

Request for an Independent Contractor – Institution Health Specialist, HIV/AIDS Prison Outreach Worker – for the Minnesota Correctional Facilities Stillwater & Faribault

POSITION: This is a part-time position for an independent contractor to provide HIV/STD prevention programs and sexual health education to the inmate populations of the Minnesota Correctional Facilities at Stillwater and Faribault.

DUTIES: To facilitate workshops and support groups for populations at risk. To facilitate our information/support program for PWA's who are sexually active and/or IVDU's. Assist with ongoing program evaluation and development.

REQUIREMENTS: Bachelors degree in public health, education, social work, human services, health sciences, nursing or related field preferred. Three years of related work experience or an equivalent combination of training and experience is also acceptable. Experience working with populations at risk, HIV prevention or other health issues preferred. Appropriate candidates will have skill and confidence with public speaking, be knowledgeable about HIV/STD infection, have skills in promoting sexual health options, be sensitive to the diversity of the inmate population, and be flexible and creative.

HOURS: 16 hours/week.

SALARY: Negotiable

CONTACT: Send resume and three letters of reference by July 8, 1994, to Dana Baumgartner, Health Care Administrator, 300 Bigelow Building, 450 North Syndicate Street, Saint Paul, Minnesota 55104. For additional information, contact Mr. Baumgartner at the above address or 612/642-0248.

Department of Education

Notice of Request for Proposals: Communication Project for Results-Oriented Graduation Standards and Implementation of the Graduation Rule

The Minnesota Department of Education is soliciting proposals from qualified vendors to continue a major communications effort about the Graduation Standards and to help school communities prepare to implement the Graduation Rule.

SCOPE OF THE PROJECT:

a) provide effective communication about Graduation Standards and the Graduation Rule with the public; and

b) create usable resources for Department and school district personnel to communicate effectively about the Graduation Standards and preparing for implementing the Graduation Rule with parents, students, citizens, community, business, higher education, and others.

THE DEPARTMENT OF EDUCATION RESERVES THE RIGHT TO HIRE MULTIPLE VENDORS AND TO CONTRACT FOR THE WORK IN PHASES AS NEEDS ARE IDENTIFIED.

TIME FRAME AND PROJECT COSTS:

The anticipated time frame for this project is September 15, 1994 to June 30, 1995. Contingent upon funding, and with the agreement of both parties, the project may continue in FY 96 and FY 97.

Total expenditures during the period September 15, 1994 to June 30, 1995 will not exceed $500,000. The Department cannot

predetermine services needed and actual expenditures, therefore, no commitment is made to spending any given funds in any given fiscal year. Future expenditures are contingent upon funding.

COPIES OF RFP/SUBMISSION OF PROPOSALS:

Copies of the RFP may be obtained by contacting Michael Tillmann, 723 Capitol Square Building, 550 Cedar Street, St. Paul, MN 55101 – [612] 282-5983. **Proposals must be received by 4:30 P.M. on August 1,1994, by Michael Tillmann.** Late proposals will not be accepted.

Department of Health

Health Care Delivery Systems Division

Notice of Request for Proposals for Clinical Outcomes Research, Practice Guidelines, Health Care Quality Improvement Process and Related Support Activities

The purpose of this announcement is to solicit proposals from organizations with experience in the development and implementation of clinical outcomes research and practice guidelines, the management of the health care quality improvement process, and the development and implementation of the methods and systems used to support these activities. This solicitation was developed as part of the Data Analysis Program to further specify best methods of coordinating the design, development, funding, and completion of the clinical outcomes/effectiveness studies to be completed under the MinnesotaCare law. Public and private organizations desiring to collaborate with the Department in developing research designs, funding strategies, grant or contract applications to obtain funding for these studies, data collection and analysis strategies, as well as in the performance of specific services associated with these studies are encouraged to apply.

Details are contained in a request for proposals which may be obtained by contacting:

Barbara Favre
Department of Health
Health Care Delivery Systems
121 East Seventh Place
P.O. Box 64975
St. Paul, MN 55164-0975
(612) 282-6300

Proposals are due by 4:30 p.m. on July 18, 1994.

Minnesota Historical Society

Notice of Request for Bids for Interior Drainage Improvements and Embankment Stabilization at Historic Fort Snelling

The Minnesota Historical Society is seeking bids from qualified firms and individuals to provide all equipment, labor and materials to complete interior drainage improvements and embankment stabilization at Historic Fort Snelling.

The drainage improvements will generally consist of excavation and installation of storm sewer components (approximately 430 lineal feet) within the Historic Fort Snelling compound and a storm sewer outfall structure. Riprap installation for erosion control will be included in this component.

The bluff stabilization component of the work generally consists of shotcreteing for embankment stabilization (approx 110 cubic yards).

The Request for Bids is available by calling or writing Gary W. Goldsmith, Contracting Officer, Minnesota Historical Society, 345 Kellogg Blvd. West, St. Paul, MN 55102. Telephone (612) 297-5863.

Complete Specifications and details concerning submission requirements are included in the Request for Bids.

Minnesota Historical Society

Notice of Request for Bids for Rest Room Facility at Historic Fort Snelling

The Minnesota Historical Society is seeking bids from qualified firms to provide all equipment, labor and materials to construct, complete in all respects, a rest room facility at Historic Fort Snelling.

The work will generally consist of construction of a concrete block building and the provision and installation of specified plumbing and rest room fixtures.

The Request for Bids is available by calling or writing Gary W. Goldsmith, Contracting Officer, Minnesota Historical Society, 345 Kellogg Blvd. West, St. Paul, MN 55102. Telephone (612) 297-5863.

Complete Specifications and details concerning submission requirements and deadlines are included in the Request for Bids.

Department of Human Services

St. Peter Regional Treatment Center

Notice of Request for a Proposal for Psychiatric Services

NOTICE IS HEREBY GIVEN that the St. Peter Regional Treatment Center, Residential Facilities Administration, Department of Human Services, is seeking services which are to be performed as requested by the Administration of the St. Peter Regional Treatment Center. The following contract will be written for the period August 22, 1994 through June 30, 1995.

1. Psychiatric services needed to serve the needs of the clients at Minnesota Security Hospital.

Responses must be received by July 18, 1994. Direct inquiries to:

Cindy Zahratka, Contract Coordinator
St. Peter Regional Treatment Center
100 Freeman Drive
St. Peter, MN 56082
Phone: (507) 931-7715

Office of Strategic and Long Range Planning

Notice of Request for Proposal for a Computing Network Design and Implementation Plan

The Office of Strategic and Long Range Planning (MN Planning) seeks services from a qualified consultant for computer network and telecommunications analysis, design, and component specifications. This project is for consulting services and will not result in the purchase of any products. The outcome of this project will be a set of alternatives that will drive a network implementation for MN Planning.

The principal tasks required of the successful respondent are to:

1. Assess the network needs of the entire MN Planning office;
2. Develop at least three (3) network architecture designs;
3. Provide specifications for the components required to implement each alternative;
4. Prepare a written report describing the assessment, design, and specifications of components for each solution;
5. Prepare a proposal for installation, maintenance, and on-going support of the selected network design.

To receive a Request for Proposals, please contact Robert Meehl, MN Land Management Information Center, 330 Centennial Building, 658 Cedar Street, St. Paul, MN 55155, telephone: 612/296-2720, TDD: 612/297-5353, Internet: *bobm@lmic.state.mn.us*. Final proposals must be received by July 20, 1994.

Pollution Control Agency

Request for Proposals for Assessment of Total Quality Management at the Minnesota Pollution Control Agency

BACKGROUND

The Minnesota Pollution Control Agency (MPCA) requests proposals for an assessment of its efforts to implement Total Quality Management (TQM). Currently, MPCA senior management team members have diverse views on what TQM is and how they want to use it. The goals of the MPCA are: establishing a common sense of purpose and direction within the senior management team for its TQM effort, evaluating the status of the current MPCA efforts to implement TQM, and developing a plan for moving forward to make TQM a reality.

SCOPE OF THE PROJECT

The scope of the project includes the following:

1. Work with MPCA senior managers to clarify the purpose and direction of TQM at the MPCA.
2. Evaluate the status of the current TQM implementation effort.
3. Develop a plan to move implementation of TQM forward at the MPCA incorporating needed improvements or adjustments relative to staff orientation, training and communications.
4. Identify where different levels of leadership are critical to TQM and specific responses are required from MPCA management including how decisions made in a TQM environment should be made to encourage and ensure its success.
5. Clarify the interaction between TQM and strategic planning.

Note: This request for proposals does not obligate the MPCA to complete all tasks included in the scope of work.

CONTRACTOR QUALIFICATIONS

To be qualified, a prospective contractor must demonstrate expertise and understanding of TQM in government and processes for assessing a TQM effort. Preference will be given to prospective contractors with experience in applying TQM to government. The MPCA will select contractors based upon information provided in proposals, references, and interview information.

PROPOSAL CONTENTS

Proposals should contain the following information:

1. Summary of relevant experience and training.
2. List of references and telephone numbers.
3. Work plan for each of the 5 tasks described in the "Scope of Work" section. The work plan should describe specific actions, methodologies, work products and schedules for each task. Please note that MPCA would like to start the project upon execution of a contract and complete the project within 6 months.
4. Estimated costs for each task, and total cost of the proposal. Please note that the total estimated cost of the entire proposal should not exceed $20,000.

MPCA EVALUATION OF PROPOSALS

All proposals received by the deadline will be evaluated by representatives of the MPCA. Evaluations will be based upon the following criteria:

1. Relevant experience and training.
2. Clarity and logic of the work plan.
3. Reasonableness of estimated costs.

Note: Please note that interviews and references will be used if deemed necessary by MPCA to select a contractor.

SUBMITTAL DEADLINE

All proposals must be received by July 29, 1994, at 3:00 P.M. Late proposals will not be accepted.

Please submit 5 copies of the proposal to:

David Richfield
Minnesota Pollution Control Agency
Water Quality Division Manager's Office
520 Lafayette Road North
St. Paul, Minnesota 55155-4194

Proposals should be signed by an authorized member of the firm and sealed in mailing envelopes. The successful responder will be required to submit evidence of compliance with worker's compensation insurance coverage and affirmative action requirements.

QUESTIONS?

MPCA will provide a meeting for contractors who have questions regarding this Request For Proposals. The meeting will be held on July 18, 1994, from 9:00 to 11:00 a.m. in the Board Room at the MPCA office located at 520 Lafayette Road North, St. Paul. If you cannot attend the meeting you may call (612-296-7298) or write David Richfield.

Non-State Public Bids and Contracts

The *State Register* also serves as a central marketplace for contracts let out on bid by the public sector. The *Register* meets state and federal guidelines for statewide circulation of public notices. Any tax-supported institution or government jurisdiction may advertise contracts and requests for proposals from the private sector.

It is recommended that contracts and RFPs include the following: 1) name of contact person; 2) institution name, address, and telephone number; 3) brief description of project and tasks; 4) cost estimate; and 5) final submission date of completed contract proposal. Allow at least three weeks from publication date (four weeks from date article is submitted for publication). Surveys show that subscribers are interested in hearing about contracts for estimates as low as $1,000. Contact the editor for further details.

Minnesota Comprehensive Health Association

Request for Proposal for Writing Carrier Contract

The Board of Directors of the Minnesota Comprehensive Health Association (Association) has prepared a Request for Proposal in accordance with *Minnesota Statute* §62E.13, concerning the writing carrier contract to perform administrative and claims payment services for MCHA for the period January 1, 1995 through December 31, 1997. The writing carrier is also required to provide a statewide managed care network of providers for the Association's enrollees. This requirement can be fulfilled through the writing carrier's own provider network or through contract arrangement with outside entities.

State law requires the writing carrier to be a member of the Association. Selection of the writing carrier shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan.

The Request for Proposal will be available July 11,1994. Prospective responders who have questions or who would like a complete Request for Proposal may call or write:

Minnesota Comprehensive Health Association
Lynn R. Gruber
Executive Director
Suite 910
5775 Wayzata Boulevard
St. Louis Park, MN 55416
612-593-9609

STATE OF MINNESOTA
Department of Administration

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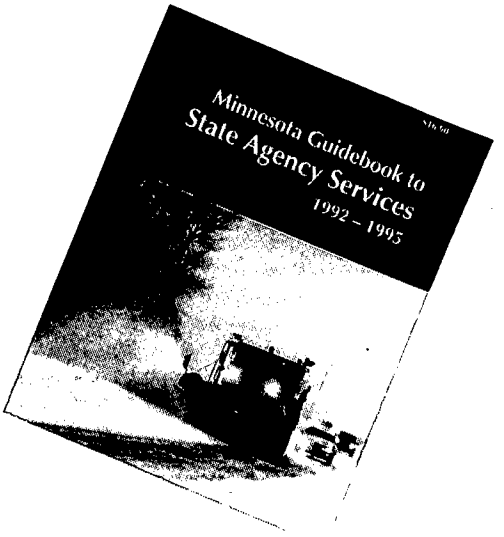

Minnesota Guidebook to State Agency Services 1992-95

An obvious "headliner" on any list for the business reference desk. The perfect "owner's manual" to Minnesota state government is a great reference tool for:

* applying for grants, bidding on contracts
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* gaining access to government services
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* understanding the structure of Minnesota government with detailed descriptions of state agencies, their functions and services.

A MUST for the Minnesota business person. 710 pp. ***Stock No. 1-11 SR REDUCED PRICE -- ~~$16.00~~ NOW $9.95***

Minnesota Manufacturer's Directory 1994

Lists companies alphabetically, by community, and by type of product manufactured. Includes name, address, phone number, sales volume, market products, area sales, marketing and purchasing. Also FAX numbers, data processing managers and chief engineers, when available. 742 pp. ***Stock No. 40-2 SR $95.00***

Healing Arts (Physician's) Directory 1991

Names and addresses in alphabetical order for licensed physicians, chiropractors, osteopaths, optometrists, podiatrists and registered physical therapists. 426 pp.
Stock No. 1-1 SR $19.95

State Agency Telephone Directory

This directory lists all State of Minnesota government agencies. Features a greatly expanded FAX section with over 250 numbers, alphabetical employee listings, a classified section, organized by department, and "yellow pages" listing state offices in Greater Minnesota. 264pp. ***Stock No. 1-87 SR $12.95***

Airport Directory 1993

List of airports throughout the state. Approaches, rivers, all detailed markings, and much more. 178 pp. (pocket-size)
Stock No. 1-8 SR $5.95

Law Enforcement Directory 1993

Directory of state law enforcement agencies, sheriffs and police departments 51pp. ***Stock No. 1-6 SR $ 7.00***

Directory of Chemical Dependency Programs '92-93

Comprehensive listing of chemical dependency treatment programs in Minnesota. Information on services provided, funding and staff, and a map are also included. 282 pp.
Stock No. 1-12 SR $17.00

Mailing Lists ---

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FAX 612/296-2265 Online computer access: 612/821-4096 (8-N-1, 1200/2400 bps)

STATE OF MINNESOTA
Department of Administration

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For Your Convenience, photocopy this order blank

Code No.	Quantity	Description	Item Price	Total

Name or Company			**Subtotal**	
Attention			6½% tax MN residents 7% St. Paul residents	
Address				
City	State	Zip	Shipping (per order)	**$3.00**
American Express/VISA/MasterCard/Discover No.			**TOTAL**	
Signature	Expiration Date	Telephone (During Day)		

If tax exempt, please provide ES number or send completed exemption form. SR-18