STATE REGISTER

STATE OF MINNESOTA

VOLUME 8, NUMBER 48

May 28, 1984

Pages 2509-2596

STATE REGISTER

Printing Schedule for Agencies

Issue Number	*Submission deadline for Executive Orders, Adopted Rules and **Proposed Rules	*Submission deadline for State Contract Notices and other **Official Notices	Issue Date
	SCHEDULE FOR VOLUME 8		
49	Friday May 18	Friday May 25	Monday June 4
50	Friday May 25	Monday June 4	Monday June 11
51	Monday June 4	Monday June 11	Monday June 18
52	Monday June 11	Monday June 18	Monday June 25

*Deadline extensions may be possible at the editor's discretion; however, none will be made beyond the second Wednesday (12 calendar days) preceding the issue date for rules, proposed rules and executive orders, or beyond the Wednesday (5 calendar days) preceding the issue date for official notices. Requests for deadline extensions should be made only in valid emergency situations.

**Notices of public hearings on proposed rules and notices of intent to adopt rules without a public hearing are published in the Proposed Rules section and must be submitted two weeks prior to the issue date.

Instructions for submission of documents may be obtained from the Office of the State Register, 506 Rice Street, St. Paul, Minnesota 55103, (612) 296-0930.

The *State Register* is published by the State of Minnesota, State Register and Public Documents Division, 117 University Avenue, St. Paul, Minnesota 55155, pursuant to Minn. Stat. § 14.46. Publication is weekly, on Mondays, with an index issue in September. In accordance with expressed legislative intent that the *State Register* be self-supporting, the subscription rate has been established at $130.00 per year, postpaid to points in the United States. Second class postage paid at St. Paul, Minnesota. Publication Number 326630. (ISSN 0146-7751) No refunds will be made in the event of subscription cancellation. Single issues may be obtained at $3.25 per copy.

Subscribers who do not receive a copy of an issue should notify the *State Register* Circulation Manager immediately at (612) 296-0931. Copies of back issues may not be available more than two weeks after publication.

The *State Register* is the official publication of the State of Minnesota, containing executive orders of the governor, proposed and adopted rules of state agencies, and official notices to the public. Judicial notice shall be taken of material published in the *State Register*.

Cover graphic: *Minnesota State Capitol*, ink drawing by Ric James.

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Volume 8, Number 48

NOTICE

How to Follow State Agency Rulemaking Action in the *State Register*

State agencies must publish notice of their rulemaking action in the *State Register*. If an agency seeks outside opinion before promulgating new rules or rule amendments, it must publish a NOTICE OF INTENT TO SOLICIT OUTSIDE OPINION. Such notices are published in the OFFICIAL NOTICES section. Proposed rules and adopted rules are published in separate sections of the magazine.

The PROPOSED RULES section contains:

- Calendar of Public Hearings on Proposed Rules.
- Proposed new rules (including Notice of Hearing and/or Notice of Intent to Adopt Rules without A Hearing).
- Proposed amendments to rules already in existence in the Minnesota Code of Agency Rules (MCAR).
- Proposed temporary rules.

The ADOPTED RULES section contains:

- Notice of adoption of new rules and rule amendments (those which were adopted without change from the proposed version previously published).
- Adopted amendments to new rules or rule amendments (changes made since the proposed version was published).
- Notice of adoption of temporary rules.
- Adopted amendments to temporary rules (changes made since the proposed version was published).

ALL ADOPTED RULES and ADOPTED AMENDMENTS TO EXISTING RULES published in the *State Register* and filed with the Secretary of State before September 15, 1982, are published in the *Minnesota Code of Agency Rules 1982 Reprint*. ADOPTED RULES and ADOPTED AMENDMENTS TO EXISTING RULES filed after September 15, 1982, will be included in a new publication, *Minnesota Rules*, scheduled for publication in spring of 1984. In the MCAR AMENDMENT AND ADDITIONS listing below, the rules published in the *MCAR 1982 Reprint* are identified with an asterisk. Proposed and adopted TEMPORARY RULES appear in the *State Register* but are not published in the *1982 Reprint* due to the short-term nature of their legal effectiveness.

The *State Register* publishes partial and cumulative listings of rule action in the MCAR AMENDMENTS AND ADDITIONS list on the following schedule:

Issues 1-13, inclusive
Issues 14-25, inclusive
Issue 26, cumulative for 1-26
Issue 27-38, inclusive
Issue 39, cumulative for 1-39
Issues 40-51, inclusive
Issue 52, cumulative for 1-52

The listings are arranged in the same order as the table of contents of the *MCAR 1982 Reprint*.

MCAR AMENDMENTS AND ADDITIONS

MINNESOTA RULES AMENDMENTS AND ADDITIONS

Executive Order No. 84-9

Proclaiming an Interim Allocation System for Industrial Development Bonds Pending Passage of a Federal Limitation Allocation Act

I, RUDY PERPICH, GOVERNOR OF THE STATE OF MINNESOTA, by virtue of the authority vested in me by the Constitution and the applicable statutes, do hereby issue this Executive Order:

WHEREAS, pending federal legislation, herein referred to as a Federal Limitation Allocation Act, as defined in Section 13, Subdivision 5 of H.F. 2186 if passed by the Congress and signed into law may establish a per capita limit on the amount of Industrial Development Bonds which may be issued in a calendar year within the State of Minnesota.

WHEREAS, a proposed Federal Limitation Allocation Act, provides that the Governor may proclaim an interim allocation system prior to the date of enactment of such Act to become effective only when such federal act becomes law and that such interim allocation system shall be effective until the State Legislature enacts a permanent allocation system after the date of enactment of a Federal Limitation Allocation Act.

WHEREAS, the Minnesota Legislature has passed and the Governor has signed H.F. 2186 which provides for an allocation system to become effective if and when a Federal Limitation Act becomes law.

WHEREAS, H.F. 2186 authorizes the Governor to provide for the allocation in accordance with the provisions of H.F. 2186.

NOW, THEREFORE, I order:

1. That the Commissioner of Energy and Economic Development (Commissioner) shall review applications and grant allocation of authority to issue bonds or other obligations subject to a Federal Limitation Act in accordance with the provisions of H.F. 2186 as enacted and signed into law.

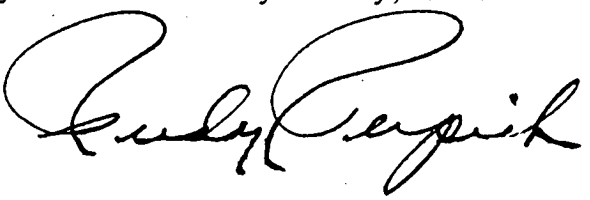
2. That in all other respects the allocation established by this Executive Order shall serve as the interim allocation of Industrial Development Bonds for the State of Minnesota as provided by the pending Federal Limitation Act.

3. That such interim allocation shall become effective upon the date that a Federal Limitation Act is signed into law.

4. That such interim allocation shall expire upon passage of a permanent allocation by the Minnesota Legislature in accordance with the final provisions of a Federal Limitation Act; or as modified by any subsequent Executive Order if promulgated prior to the start of the 1985 Legislative Session.

Pursuant to Minnesota Statutes 1982, Section 4.035, this Order shall be effective 15 days after publication in the *State Register* and filing with the Secretary of State and shall remain in effect until rescinded by proper authority or it expires in accordance with Section 4.035, Subdivision 3.

IN TESTIMONY WHEREOF I have set my hand this 9th day of May, 1984.



PROPOSED RULES

Pursuant to Minn. Stat. of 1980, §§ 14.21, an agency may propose to adopt, amend, suspend or repeal rules without first holding a public 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 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 §§ 14.13-14.20 which state that if an agency decides to hold a public hearing, it must publish in the *State Register* a notice of its intent to do so. This notice must appear at least 30 days prior to the date set for the hearing, along with the full text of the proposed rules. (If the agency has followed the provisions of subd. 4h and has already published the proposed rules, a citation to the prior publication may be substituted for republication.)

Pursuant to Minn. Stat. § 14.29, when a statute, federal law or court order to adopt, suspend or repeal a rule does not allow time for the usual rulemaking process, temporary rules may be proposed. Proposed temporary rules are published in the *State Register*, and for at least 20 days thereafter, interested persons may submit data and views in writing to the proposing agency.

Higher Education Coordinating Board

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Proposed Rules Governing the State Scholarships and Grants-in-Aid Dependency Standards

Notice of Hearing

A public hearing concerning the proposed rules will be held at Earle Brown Continuing Education Center, Room 135 AC, 1890 Buford Avenue, St. Paul, Minnesota 55108 on July 12, 1984, commencing at 10 a.m. and continuing until all interested persons have had an opportunity to be heard. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearings process. Authority to promulgate the proposed rule is provided in Minnesota Statutes Section 136A.111.

Following the Board's presentation at the hearing, all interested or affected persons will have an opportunity to ask questions and make comments. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted to Peter C. Erickson, Administrative Law Judge, Office of Administrative Hearings, 400 Summit Bank Building, 310 South Fourth Avenue, Minneapolis, Minnesota 55415, after the close of the hearing. The Administrative Law Judge may, at the hearing, order that the record be kept open for a longer period not to exceed to 20 calendar days. The rule hearing procedure is governed by Minnesota Statute §§ 14.02 to 14.56, and by 9 MCAR §§ 2.101-2.113 (Minnesota Code of Agency Rules to be codified Minnesota Rules 1400.0200-1400.6600). If you have any questions about the procedure, call or write the Administrative Law Judge.

Notice is hereby given that a Statement of Need and Reasonableness is available for review at the Board and will be available at least 25 days before the hearing at the Office of Administrative Hearings. This Statement of Need and Reasonableness will include all the evidence and argument which the Board anticipates presenting at the hearing justifying both the need for and the reasonableness of the proposed rule or rules. Copies of the Statement of Need and Reasonableness may be obtained from the Office of Administrative Hearings at a minimal charge.

The agency intends to present a summary of the Statement of Need and Reasonableness at the hearing and will answer questions raised by interested persons. You are urged to review the Statement of Need and Reasonableness before the hearing. Additional copies will be available at the hearing.

The proposed rule changes the definition of student dependency in the State Scholarship and Grants-in-Aid Program.

A copy of the proposed rules is attached hereto. One free copy may be obtained by writing to Rose Herrera Hamerlinck, Higher Education Coordinating Board, Suite 400 Capitol Square Building, 550 Cedar Street, St. Paul, Minnesota 55101. Additional copies will be available at the door on the date of the hearing. If you have any questions on the content of the proposed rules contact Rose Herrera Hamerlinck, (612) 296-7963.

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.

Notice: Any person may request notification of the date on which the Administrative Law Judge's Report will be available, after which date the Board 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 (in the case of the Administrative Law Judge's Report), or to the Board.

Minnesota Statutes Chapter 10A requires each lobbyist to register with the State Ethical Practices Board within five days he or she commences lobbying. A lobbyist is defined in Minnesota Statute § 10A.01, Subdivision 11 as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any one month or more than $250, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials, or

(b) Who spends more than $250, not including his own traveling expenses and membership dues, in any year for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, telephone (612) 296-5615.

May 3, 1984

David A. Longanecker
Acting Executive Director
Higher Education Coordinating Board

Rules as Proposed

4830.0200 SCOPE.

Parts 4830.0200 to 4830.0700 govern state scholarships and grants-in-aid.

4830.0300 ELIGIBLE SCHOOLS.

Subpart 1. ~~**Date of eligibility division**~~ **Annual list.** Annually the board shall adopt by resolution a list of schools at which a state scholarship or grant-in-aid may be used.

Subp. 2. Requirements. To be eligible a school must ~~meet the following requirements~~:

A. ~~is~~ be located in Minnesota;

B. ~~offers~~ offer at least one program that:

(1) is vocational or academic in nature;

(2) leads to a certificate or degree;

(3) is ten weeks long; and

(4) involves at least 12 academic credits or 300 clock hours; and

C. ~~is one of the following~~ be:

(1) accredited by a federally recognized accrediting agency or association;

(2) approved to offer degrees or use terms in its name according to part 4840.0500; or

(3) ~~is~~ licensed by an appropriate state agency.

4830.0400 APPLICATION DATES AND STUDENT ELIGIBILITY.

Subpart 1. Date. Annually the board shall adopt by resolution a date after February 14, by which all applications must be filed to ~~be given priority for~~ receive an award. ~~The date may not be before February 15.~~

Subp. 2. Minnesota resident. "Minnesota resident" means a student whose parent or legal guardian resides in Minnesota on the date of application if the student:

A. lives with the parent or legal guardian for at least six weeks; or

B. receives support from the parent or legal guardian; or

C. is claimed as a tax exemption by the parent or legal guardian in the calendar year prior to or during the calendar year in which the application is made.

"Minnesota resident" means a student who has resided in Minnesota for other than educational purposes for at least 12 consecutive months prior to becoming a full-time student, for a student who establishes the circumstances indicated in part 4830.0600, subpart 1, item B, subitem (1), (2), or (3).

Subp. 3. **Eligibility for initial scholarship.** To be eligible for an initial scholarship a student must be an eligible student, as defined in part 4830.0100, subpart 5, and must be all of the following:

A. ~~is~~ a Minnesota resident ~~on the priority application date~~;

B. ~~will be~~ applying as a first-year, first-time postsecondary student~~, without any previous post-secondary education~~; and

C. ~~ranks~~ ranked in the upper quarter of the class at the end of the junior year of senior high school, or the equivalent, based on the student's cumulative scholastic record in senior high school.

Subp. ~~3.~~ 4. **Eligibility for initial grant-in-aid.** To be eligible for an initial grant-in-aid a student must be an eligible student, as defined in part 4830.0100, subpart 5, and must be all of the following:

A. ~~is~~ a Minnesota resident ~~on the priority application date~~;

B. ~~has not earned~~ without a baccalaureate degree ~~and~~;

C. a student who has not completed the number of semesters or quarters normally required to complete a baccalaureate degree;

~~C.~~ ~~demonstrates~~ D. in financial need;

~~D.~~ E. if applying for a nursing grant, ~~is~~ enrolled or ~~will~~ to be enrolled in a program leading to licensure as a registered nurse or a licensed practical nurse; and

~~E.~~ F. if under 17 years old, a ~~recipient must have~~ holder of a high school diploma or the equivalent.

Subp. ~~4~~ 5. **Renewal awards.** A scholarship or grant-in-aid is renewable for a maximum of six semesters, nine quarters, or the equivalent. To be eligible to renew a scholarship or grant-in-aid a student must apply each year and continue to meet the requirements for an initial scholarship or grant-in-aid, except for subpart ~~2~~ 3, item B. A student must have made satisfactory progress as determined by the school and have been enrolled in a postsecondary school as a full-time student for no more than four years or the equivalent.

4830.0500 RANKING APPLICANTS.

Subpart 1. [Unchanged.]

Subp. 2. Priority of classes of applicants. Applicants renewing scholarships shall be given first priority. Applicants renewing grants-in-aid shall be given second priority. Applicants for initial scholarships shall be given third priority. Applicants for initial grants-in-aid shall be given fourth priority. Awards shall be made on a funds available basis. Once an award is made it ~~shall~~ may not be withdrawn in order to award an applicant of higher priority.

Subp. 3. [Unchanged.]

4830.0600 AWARDS.

Subpart 1. Monetary awards. The amount of a scholarship or grant-in-aid financial stipend ~~shall~~ may not exceed an applicant's cost of attendance, as defined in Minnesota Statutes, section ~~136.121~~ 136A.121, subdivision 6, after deducting the following:

A. A contribution by the applicant of at least 50 percent of the cost of attending the institution of the applicant's choosing~~;~~.

B. A contribution by the applicant's parents, as determined by a ~~standardized~~ financial need analysis~~; and~~. The parental contribution will be considered in determining the state award, unless:

(1) The applicant has been involuntarily separated from parental support because the applicant is an orphan or a ward of the state, the applicant's parents cannot be located, or the applicant has suffered mental or physical abuse necessitating the separation. The conditions must be established by court document or by an affidavit from a member of the clergy, social worker, lawyer, or physician.

(2) The applicant is 22 years of age or older on October 1 of the state fiscal year for which aid is received, and establishes

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that she or he is not dependent upon parental support, based on the following evidence for the applicant's parents' tax year ending during that fiscal year, and the preceding tax year:

(a) the parents did not and will not claim the student as an income tax exemption;

(b) the student did not and will not live with his or her parents more than six weeks in either calendar year; and

(c) the parents did not and will not provide direct or indirect support worth $750 or more in either calendar year.

The facts must be established by affidavit from the parents if possible, and by additional documentation, such as income tax returns, proof of residence, voter registration, or similar documentation that reasonably may be requested by the board or its agents and employees.

(3) The applicant is married, and meets the conditions in subitem (2), units (a), (b), and (c), in the applicant's parents' tax year ending during the state fiscal year for which aid is received.

C. An estimate of the amount of a federal Pell grant award for which the applicant is eligible.

The minimum financial stipend shall be $100.

Subp. 2. and 3. [Unchanged.]

4830.0700 METHOD OF PAYMENT.

Subpart 1. [Unchanged.]

Subp. 2. ~~Return and refund~~ Refunds. A scholarship and grant-in-aid is awarded for full-time attendance at a specified school for the academic year ~~which commences with the fall term~~ of nine months within a state fiscal year. If a recipient fails to enroll or ceases to be a full-time student, the school must ~~return~~ refund the unused portion of the award. Refunds to the board are determined as follows:

A. Determine the percentage that the state scholarship or grant award represents of the student's total financial aid package for the applicable term;

B. Multiply that percentage by the amount determined to be refunded to the student under the school's refund policy. The result yields the amount to be refunded to the board.

A refunded award must be sent by the school to the board's scholarship or grant-in-aid account. Refunded awards are available for reassignment to other qualified applicants.

Subp. 3. School accounting requirements. Schools shall maintain separate accounts for scholarship and grant-in-aid funds. Refunds to the board ~~shall~~ must be made by separate checks for scholarships and grants-in-aid. Schools ~~shall~~ must provide evidence, prepared according to generally accepted accounting principles, that all awards have either been distributed or ~~returned~~ refunded to the board. Books and records relating to state scholarships and grants-in-aid must be made available for audit by representatives of the board or the state auditor.

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Department of Labor and Industry

Proposed Rules Relating to Workers' Compensation; Fees for Medical Services

Notice of Hearing

Notice is hereby given that a public hearing will be held in the above-captioned matter pursuant to Minn. Stat. § 14.14, subd. 1 (1982) (as amended at Minn. Laws 1984, ch. 640, § 8). The hearing will take place at 112 State Capitol Building, St. Paul, Minnesota on June 29, 1984 commencing at 8:00 a.m., and continuing until all interested persons and groups have had an opportunity to be heard. Interested persons or groups are encouraged to participate in the hearing process by submitting oral or written statements, data, and arguments before, during, and after the hearing. The proposed rules may be modified as a result of the hearing process.

After the department has completed its presentation of the evidence in support of the proposed rules at the hearing, interested persons and groups shall be invited to ask questions, to comment orally or in writing, and to submit written material. In addition, written material may be recorded in the hearing record if submitted before the hearing or within 5 working days after the public hearing ends. The comment period may be extended for a longer period not to exceed 20 calendar days if ordered by the administrative law judge at the hearing. Written material may be submitted to:

Jon Lunde
Administrative Law Judge
Office of Administrative Hearings
400 Summit Bank Building
310 Fourth Avenue South
Minneapolis, Minnesota 55415
Telephone (612) 341-7645

Statutory authority to promulgate these proposed rules appears in Minn. Stat. § 176.136 (Supp. 1983). These proposed rules establish the maximum fees payable to providers of workers' compensation health care services. Providers whose fees are covered by these rules include physicians, chiropractors, osteopaths, dentists, optometrists, audiologists, speech pathologists, physical therapists, occupational therapists, podiatrists, psychologists, social workers, and hospitals. Health care services which are covered by these rules include consultation, diagnostic testing, dental work, hospital room rates, ophthalmological services, otorhinolaryngologic services, audiologic testing, pulmonary services, neurology services, physical medicine services, surgery, radiology, pathology, laboratory tests, optometric services, audiology and speech pathology services, physical and occupational therapy, chiropractic services, and psychological services. The maximum fees established by these rules are based on the 75th percentile of usual and customary fees and charges for each class of health care provider. These rules will replace the temporary rules found at 4 MCAR §§ 1.0001-1.0032. In the promulgation of the proposed permanent rules, the commissioner has consulted with insurers, providers of treatment services and their representatives, and other appropriate groups.

A copy of the proposed rules follows this notice in the *State Register*. One free copy of the proposed rules may be obtained by contacting Steve Keefe, Commissioner, 444 Lafayette Road, St. Paul, Minnesota 55101. Additional copies will be available at the door on the date of the hearing.

Minn. Stat. Ch.10A requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minn. Stat. § 10A.01, Subd. 11 (1982) as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) Who spends more than $250, not including his own traveling expenses and membership dues, in any year for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

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The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, telephone (612) 296-5615.

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. Any person may request notification of the date on which the agency has adopted the rules and filed them with the secretary of state. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may direct your request to the administrative law judge (in the case of the administrative law judge's report) or to the agency (in the case of the agency's filing with the secretary of state).

A Statement of Need and Reasonableness is available for review at the agency. This Statement includes a summary of all the evidence and argument which the agency expects to present 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 obtained from the Department at a minimal charge. The Statement of Need and Reasonableness will be submitted to the Office of Administrative Hearings 25 days prior to the hearing. After that time, copies of the Statement of Need and Reasonableness may also be obtained from the Office of Administrative Hearings at a minimal charge.

Pursuant to Minn. Stat. § 14.115, subd. 1 (Supp. 1983) the impact on small business has been considered in the promulgation of the rules. Anyone wishing to present evidence or argument as to the effect of the rules on small business may do so. The Department's position regarding the impact of the rules on small business is set forth in the Statement of Need and Reasonableness.

The fiscal impact of these rules on local public bodies has been considered in the promulgation of these rules. The Department's position regarding the fiscal impact pursuant to Minn. Stat. § 14.11, subd. 1 (1982) is set forth in the Statement of Need and Reasonableness.

The rules hearing procedure is governed by the Administrative Procedure Act, particularly Minn. Laws 1984, ch. 640, § 9, and by Minnesota Rules, parts 1400.0200-1400.1200. Questions about procedure may be directed to Jon Lunde, Administrative Law Judge, at the above address.

May 16, 1984

Steve Keefe
Commissioner of Labor and Industry

Rules as Proposed (all new material)

5221.0100 DEFINITIONS.

Subpart 1. Scope. The following terms have the meanings given in parts 5221.0100 to 5221.3200 unless the context clearly indicates a different meaning.

Subp. 2. Bill or billing. "Bill" or "billing" means a provider's statement of charges and services rendered for treatment of a work related injury.

Subp. 3. Charge or fee. "Charge" or "fee" means the payment requested by a provider on a bill for a particular service.

Subp. 4. Code. "Code," in reference to the maximum fee schedule, means the alphabetic or numeric designation, including code modifiers if appropriate, for a particular type of service, or supply, or other reasonable method of catetorizing provider charges.

Subp. 5. Commissioner. "Commissioner" means the commissioner of the Department of Labor and Industry.

Subp. 6. Compensable or compensability. "Compensable" or "compensability," in reference to a service, means an employer is liable for the service pursuant to Minnesota Statutes, chapter 176.

Subp. 7. Excessive. "Excessive," in reference to a charge, means a charge which meets any of the standards of excessiveness described in part 5221.0500.

Subp. 8. Injury. "Injury" is as defined in Minnesota Statutes, section 176.011, subdivision 16 as a "personal injury."

Subp. 9. Maximum fee schedule. "Maximum fee schedule" means the list of codes, services, and corresponding 75th percentile dollar amounts established pursuant to part 5221.0900.

Subp. 10. Payer. "Payer" refers to all entities responsible for payment and administration of workers' compensation medical claims, including all insurer, self-insurer, and group self-insurer members of the workers' compensation reinsurance association, pursuant to Minnesota Statutes, section 79.34, subdivision 1, service companies licensed to provide claim administration services to self-insurers and group self-insurers pursuant to Minnesota Statutes, section 60A.23, subdivision 8, the reopened case fund, established by Minnesota Statutes, section 176.134, the special compensation fund established by Minnesota Statutes, section 176.129, and the assigned risk plan, established by Minnesota Statutes, sections 79.251 and 79.252.

Subp. 11. Provider. "Provider" is as defined in Minnesota Statutes, section 176.011, subdivision 24.

Subp. 12. Reasonable. "Reasonable," in reference to a charge, means a charge or portion of a charge which is not excessive.

Subp. 13. Service or treatment. "Service" or "treatment" means any procedure, operation, consultation, supply, product, or other thing performed or provided for the purpose of curing or relieving an injured worker from the effects of an injury or occupational disease, pursuant to Minnesota Statutes, section 176.135, subdivision 1.

5221.0200 AUTHORITY.

Parts 5221.0100 to 5221.3200 are promulgated under the authority of Minnesota Statutes, sections 176.136 and 176.83, subdivision 4.

5221.0300 PURPOSE.

Parts 5221.0100 to 5221.3200 are intended to prohibit health care providers treating employees with work related injuries from receiving excessive reimbursement for their services. These rules define when charges for health services are excessive.

5221.0400 SCOPE.

The following are subject to parts 5221.0100 to 5221.3200: all entities responsible for payment and administration of medical claims compensable under Minnesota Statutes, chapter 176; and providers of medical services or supplies for work related injuries or diseases pursuant to Minnesota Statutes, section 176.135, subdivision 1.

5221.0500 EXCESSIVENESS.

A charge is excessive if any of the following conditions apply to the charge, or to the service for which the charge was submitted:

A. the charge exceeds the maximum reasonable amount for the type of service as specified in the maximum fee schedule of parts 5221.0100 to 5221.3200;

B. the charge exceeds the employer's limits of liability specified in Minnesota Statutes, section 176.135, subdivision 3;

C. the charge wholly or partially duplicates another charge for the same service, such that the charge has been paid or will be paid in response to another billing;

D. the charge exceeds the provider's current charge for the same type of service in cases unrelated to workers' compensation injuries;

E. the charge or service does not comply with standards and requirements adopted pursuant to Minnesota Statutes, section 176.103 or 176.83, concerning the appropriateness, quality, coordination, and cost of treatment;

F. the service was performed by a provider prohibited from receiving reimbursement under Minnesota Statutes, chapter 176, pursuant to Minnesota Statutes, section 176.83;

G. the service does not comply with the requirements of Minnesota Statutes, section 176.135, subdivision 1a, concerning nonemergency surgery and a second surgical opinion;

H. the service does not comply with the requirements of rules adopted pursuant to Minnesota Statutes, section 176.135, subdivision 2, regulating change of physicians, podiatrists, or chiropractors; or

I. the service is not usual, customary, and reasonably required for the cure and relief of the effects of injury.

5221.0600 PAYER RESPONSIBILITIES.

Subpart 1. Compensability. Parts 5221.0100 to 5221.3200 do not require a payer to pay a charge which is not compensable or a charge which is the primary obligation of another payer.

Subp. 2. Payment of charges. Before paying a charge, the payer shall determine whether it is excessive. If a charge is determined to be excessive, the payer shall not pay the charge. As soon as reasonably possible, and no later than 21 calendar days after receiving the bill and any necessary reports, the payer shall pay the charge or deny all or part of the charge on the basis of excessiveness or noncompensability, with written notification to the provider of the determination, the reason for the determination, and the options of appeal. Failure to comply with the requirements of this paragraph subjects the payer to the penalties provided in Minnesota Statutes, sections 176.221 and 176.225.

Subp. 3. Determination of excessiveness. The payer shall ascertain whether a charge is excessive by evaluating the charge and service according to the standards of excessiveness specified in part 5221.0500. The payer shall also comply with the following procedures:

A. The payer shall ascertain whether or not a service is subject to the maximum fee schedule, pursuant to the maximum fee schedule instructions contained in part 5221.1000.

B. In determining whether the code or description submitted for a particular service is correct, the code to which a service should be assigned if no code or an incorrect code was submitted, or whether a charge is excessive because the service is not usual, customary, and reasonably required for the cure and relief of the effects of injury; the payer shall consider the professional judgment and standards of the relevant healing art, as necessary to make a sound determination. Professional judgment and standards may include but are not limited to any of the following, provided that final determinations shall remain the responsibility of the payer:

(1) the opinion of persons with expertise concerning the service;

(2) the findings of peer review panels, professional associations, and other expert evaluators of a healing art; and

(3) widely accepted publications concerning the procedures and standards of a healing art. These may include, but are not limited to, publications concerning the reasonable length of hospital stays for certain procedures, publications which compare the merits and necessity of inpatient and outpatient treatment for certain procedures, relative value scales, and other medical reference materials.

C. If a service is not included in the maximum fee schedule, the payer shall consider the reasonable value of the service.

Subp. 4. Collection of excessive payment. Any payment made to a provider which is determined to be wholly or partially excessive, according to the standards prevailing at the time of payment, may be collected from the provider by the payer in the amount that the reimbursement was excessive. The payer must demand reimbursement of the excessive payment within one year of the payment.

5221.0700 PROVIDER RESPONSIBILITIES.

Subpart 1. Usual charges. No provider shall submit a charge for a service which exceeds the amount which the provider charges for the same type of service in cases unrelated to workers' compensation injuries.

Subp. 2. Submission of information. Providers shall include on bills the patient's name, date of injury, and the employer's name, narratives and codes which accurately describe all services provided and all injuries or conditions treated, the date upon which each service was provided, and the providers' social security number. Where applicable, codes from the maximum fee schedules in parts 5221.0100 to 5221.3200 shall be used.

Subp. 3. Cooperation with payer. Pursuant to Minnesota Statutes, section 176.138, providers shall comply promptly with payers' reasonable requests for information concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of a service's compensability or a charge's reasonableness.

Subp. 4. Collection of excessive charges. No provider shall collect or attempt to collect payment from any party in excess of the amount determined to be reasonable by the payer or on appeal. If the determination of the payer is not finally upheld, the provider may collect charges found to be reasonable, but only from the payer, not from the injured employee, any other insurer, or government.

5221.0800 APPEALS PROCEDURE.

Pursuant to Minnesota Statutes, sections 176.103 and 176.271 and related statutes and rules, providers may request that the commissioner determine whether a charge is excessive. This determination may be appealed first to the medical services review board, and then to the workers' compensation court of appeals.

5221.0900 MAXIMUM FEE SCHEDULE.

Subpart 1. Contents. Parts 5221.0100 to 5221.3200 are the maximum fee schedule. The maximum fee schedule shall contain codes and descriptions of services compensable under Minnesota Statutes, section 176.135 and dollar amounts which fairly represent the 75th percentile of usual and customary charges for those services in Minnesota during the preceding calendar year.

Subp. 2. Revisions. The commissioner shall revise the maximum fee schedule annually to incorporate charge data from the preceding calendar year. Until revisions are adopted the current maximum fee schedule remains in force. The commissioner may revise the maximum fee schedule at any time to (1) improve the schedule's accuracy, fairness, or equity; (2) simplify the use and administration of the schedule; (3) encourage providers to develop and deliver services; or (4) to accommodate improvements or correct deficiencies of the data base.

5221.1000 MAXIMUM FEE SCHEDULE FOR REIMBURSEMENT OF WORKERS' COMPENSATION MEDICAL SERVICES.

Subpart 1. Maximum fee schedule instructions. The instructions in this part and parts 5221.0100 to 5221.3200 govern the use and application of fees in parts 5221.0100 to 5221.3200.

Subp. 2. Applicability of the fee schedule. The payer shall undertake investigations that it considers reasonable to ascertain whether a service is subject to the maximum fee schedule. A service is subject to the maximum fee schedule if it conforms to a description contained in the maximum fee schedule in the section for the appropriate kind of medical provider. The standards of excessiveness contained in part 5221.0500 apply whether or not a service is subject to the maximum fee schedule.

Subp. 3. Coding. For services which are or which may be subject to the maximum fee schedule, the payer shall undertake investigations that it considers reasonable to ascertain whether or not the code assigned to a service by the provider is correct. If no code has been assigned the payer shall determine the appropriate code, and shall evaluate the service on the basis of that code. A broad, inclusive service description may be divided into its component services, charges, and codes, if the inclusive service is not subject to the maximum fee schedule but some of the component services are.

Subp. 4. Ambiguity. If, despite the payer's reasonable investigations, the payer is uncertain whether a particular service is subject to the maximum fee schedule or what the correct code for a particular service is, the payer shall decide the issue in favor of the provider or refer the issue to the commissioner for determination. If the commissioner determines that a service is not subject to the maximum fee schedule, the commissioner shall order the payment of the reasonable value of that service pursuant to Minnesota Statutes, section 176.135, subdivision 3.

Subp. 5. Code modifiers. The codes for services in parts 5221.1100 to 5221.2400 may be submitted with two-digit suffixes, called "modifiers." Modifiers indicate that a service differs in some material respect from the service's basic description. Services submitted with modifiers, or which should be submitted with modifiers, shall be evaluated according to the standards in items A to R.

A. Modifier number 20 denotes microsurgery. This modifier is appropriate to surgical services performed using the techniques of microsurgery, including the aid of an operating microscope. This modifier is not warranted for surgery done with the aid of a magnifying loupe or magnifying binoculars worn by the surgeon. Services with this modifier are not subject to the maximum fee schedule.

B. Modifier number 22 denotes unusual services. This modifier is appropriate where the service provided is significantly greater than what is usually required for the listed procedure, or where service was provided under highly unusual circumstances. Unusual circumstances include major complications or difficulties associated with the patient's condition, the medical facilities, or other causes. Unusual circumstances do not include common differences among services of a kind or magnitude which is typical within a particular code category. This modifier does not exempt a service from the maximum fee for the five-digit code, except where the increased services or unusual circumstances may be reasonably expected to significantly increase the provider's cost.

C. Modifier number 23 denotes unusual anesthesia. This modifier is appropriate to services which usually require no anesthesia or local anesthesia only, where unusual circumstances require that surgery be done under general anesthesia. Services with this modifier are not subject to the maximum fee schedule.

D. Modifier number 26 denotes professional component. This modifier is appropriate to services which are a combination of a physician and a technical component, (for example, laboratory, radiology, electrocardiogram, specific diagnostic and therapeutic services), where the physician component only is provided. This modifier does not exempt a service from the maximum fee for the five-digit code. If a separate maximum fee is provided for a five-digit code with the number 26 modifier, the separate maximum fee applies.

E. Modifier number 47 denotes anesthesia by surgeon. This modifier is appropriate to services where regional or general, not local, anesthesia is provided by the surgeon. Services with this modifier are not subject to the maximum fee schedule.

F. Modifier number 50 denotes multiple or bilateral procedures. This modifier is appropriate to secondary services when multiple or bilateral procedures are provided at the same operative session. The first major procedure shall be reported as listed. This modifier does not exempt the secondary services from the maximum fee for the five-digit code.

G. Modifier number 52 denotes reduced services. This modifier is appropriate where the service provided is significantly less

than is usually required for the listed procedure. This modifier does not exempt the service from the maximum fee for the five-digit code.

H. Modifier number 54 denotes surgical care only. This modifier is appropriate to services where the physician performs a surgical procedure, but does not provide preoperative or postoperative management. This modifier does not exempt the service from the maximum fee for the five-digit code.

I. Modifier number 55 denotes postoperative management only. This modifier is appropriate to services where the physician provides postoperative management, but does not perform the surgical procedure. This modifier does not exempt the service from the maximum fee for the five-digit code.

J. Modifier number 56 denotes preoperative management only. This modifier is appropriate to services where the physician provides preoperative management, but does not perform the surgical procedure. This modifier does not exempt the service from the maximum fee for the five-digit code.

K. Modifier number 66 denotes surgical team. This modifier is appropriate to highly complex services carried out under the surgical team concept. These services require the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment. Services with this modifier are not subject to the maximum fee schedule.

L. Modifier number 75 denotes concurrent care. This modifier is appropriate to services where the patient's condition requires the additional services of more than one physician. This modifier does not exempt the service from the maximum fee for the five-digit code.

M. Modifier number 76 denotes repeat procedure by same physician. This modifier is appropriate to a service repeated subsequent to the original service by the same physician. This modifier does not exempt the service from the maximum fee for the five-digit code.

N. Modifier number 77 denotes repeat procedure by another physician. This modifier is appropriate to a service repeated subsequent to the original service by another physician. This modifier does not exempt the service from the maximum fee for the five-digit code.

O. Modifier number 80 denotes assistant surgeon. This modifier is appropriate to services where a physician provides significant assistance to another physician performing a surgical procedure. This modifier does not exempt the service from the maximum fee for the five-digit code.

P. Modifier number 81 denotes minimum assistant surgeon. This modifier is appropriate to services where a physician provides minimal assistance to another physician performing a surgical procedure. This modifier does not exempt the service from the maximum fee for the five-digit code.

Q. Modifier number 90 denotes reference or outside laboratory. This modifier is appropriate to laboratory services performed by a party other than the treating physician. This modifier does not exempt the service from the maximum fee for the five-digit code.

R. Modifier number 99 denotes multiple modifiers. This modifier is appropriate to services where two or more modifiers may be necessary to completely describe the service. This modifier does not exempt the service from the maximum fee for the five-digit code, unless one or more of the component modifiers is exempt from the maximum fee schedule.

5221.1100 PHYSICIAN SERVICES; MEDICINE.

Subpart 1. Scope. The codes, service descriptions, and maximum fees in this rule apply to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Subp. 2. Definitions. The terms defined in this subpart have the meanings given them when used in subparts 3, 4, and 5 unless the context clearly indicates a different meaning.

A. New patient. "New patient" means a patient who is new to the physician and whose medical and administrative records need to be established.

B. Established patient. "Established patient" means a patient whose medical and administrative records are available to the physician.

C. Level of service. "Level of service" refers to the quantity or quality of skill, effort, time, responsibility, or medical knowledge required for the diagnosis and treatment of injuries, and is appropriate to examinations, evaluations, treatment, conferences with or concerning patients, and similar services. The levels of service are, in increasing order of complexity, minimal, brief, limited, intermediate, extended, and comprehensive. The minimal level of service does not apply to new patient office services or hospital services. The comprehensive level of service does not apply to emergency department services.

D. Minimal service. "Minimal service" means a level of service supervised by the physician but not necessarily requiring the physician's presence, including but not limited to services similar to the following in level:

(1) routine immunization for tetanus;

(2) removal of sutures from laceration; or

(3) blood pressure determination for adequacy of control.

E. Brief service. "Brief service" means a level of service pertaining to the evaluation and treatment of a condition requiring only an abbreviated history and examination, including but not limited to services similar to the following in level:

(1) examination of patient with subconjunctival hemorrhage;

(2) examination of minor trauma;

(3) review of recent x-ray report and abbreviated discussion with patient under study;

(4) concurrent hospital care for a minor secondary diagnosis;

(5) examination for acute tonsilitis; or

(6) abbreviated evaluation of a hospitalized patient in stage of recovery from an uncomplicated renal colic.

F. Limited service. "Limited service" means a level of service pertaining to the evaluation of a circumscribed acute illness or to the periodic reevaluation of a problem including an interval history and examination, the review of effectiveness of past medical management, the ordering and evaluation of appropriate diagnostic tests, the adjustment of therapuetic management as indicated, and the discussion of findings or medical management, including, but not limited to, services similar to the following in level:

(1) treatment of acute respiratory infection;

(2) review of interval history, physical status, and control of a diabetic patient;

(3) review of hospital course, studies, orders, and chest examination of patient with rheumatic heart disease recovering from acute congestive failure; revision of orders and limited exchange with nursing staff;

(4) review of interval history, physical status, and adjustment of medication in patient with compensated arteriosclerotic heart disease on chronic diuretic therapy;

(5) review of mental status findings, limited team conference for an exchange with nursing and ancillary personnel, and revision of medical management orders on a patient with a toxic psychosis; or

(6) review of recent history, determination of blood pressure, auscultation of heart and lungs, and adjustment of medication in essential hypertension.

G. Intermediate service. "Intermediate service" means a level of service pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or management problem, not necessarily relating to the primary diagnosis, that necessitates the obtaining and evaluation of pertinent history and physical or mental status findings, diagnostic tests and procedures, and the ordering of appropriate therapeutic management; or a formal patient, family, or hospital staff conference regarding patient medical management and progress, including, but not limited to, services similar to the following in level:

(1) the evaluation of a patient with arteriosclerotic heart disease with recent onset of unstable angina previously on an adequate therapeutic program involving a detailed interval history and physical examination and ordering of appropriate diagnostic tests and discussion of new therapeutic management;

(2) review of hospital studies and course in conjunction with a team conference for a formal meeting with nursing and ancillary personnel regarding medical management of a patient with acute schizophrenic symptoms;

(3) review of interval history, reexamiantion of musculoskeletal systems and abdomen, discussion of findings, and adjustment of therapeutic program in a patient with arthritic disorders with recently developed gastric complaints;

(4) review of recent illness, reexamination of pharynx, neck, axilla, groin, and abdomen, interpretation of laboratory tests, and prescription of treatment in a patient with chronic lymphocytic leukemia not responding to a previous management plant; or

(5) conference with patient family to review studies, hospital course, and findings in a teenager with acute hepatitis secondary to drug abuse.

H. Extended service. "Extended service" means a level of service requiring an unusual amount of effort or judgment including a detailed history, review of medical records, examination, and a formal conference with patient, family, or staff; or a comparable medical diagnostic or therapeutic service, including, but not limited to, services similar to the following in level:

(1) reexamination of neurological findings, detailed review of hospital studies and course, and formal conference with patient and family jointly concerning findings and plans in a diagnostic problem of suspected intracranial disease in a young adult;

(2) detailed intensive review of studies and hospital course and thorough reexamination of pertinent physical findings of a patient with a recent coronary infarct with complications requiring constant physician bedside attention;

(3) review of results of diagnostic evaluation, performance of a detailed examination and a thorough discussion of physical findings, laboratory studies, x-ray examinations, diagnostic conclusions, and recommendations for treatment of complicated chronic pulmonary disease;

(4) detailed review of studies and hospital course and thorough reexamination of pertinent physical findings of a patient with a recent coronary infarct and formal conference with patient or family to review findings and prognosis;

(5) reevaluation of a psychotic delusional patient who develops severe and acute abdominal pain involving a mental status reassessment but not a psychiatric diagnostic interview, and a conference with the consulting surgeon and nursing personnel; or

(6) detailed intensive review of studies and hospital course and thorough reexamination of pertinent findings of a patient with a recently diagnosed uterine adenocarcinoma who also has a pulmonary coin lesion under consideration for thoracotmy. This service involves several abbreviated conferences with consultants, and family or patient.

I. Comprehensive service. "Comprehensive service" means a level of service providing an in-depth evaluation of a patient with a new or existing problem requiring the development or complete reevaluation of medical data. This procedure includes the recording of a chief complaint, the present illness, family history, past medical history, personal history, system review, a complete physical examination, and the ordering of appropriate diagnostic tests and procedures.

J. Brief initial hospital care. "Brief initial hospital care" includes brief history and treatment programs, and preparation of hospital records, and signifies a level of service for a condition involving variables for which neither comprehensive nor intermediate initial hospital care services are appropriate. This procedure includes documentation of the need for inpatient medical care, abbreviated history, pertinent examination, and a plan of investigation or medical management.

K. Intermediate initial hospital care. "Intermediate initial hospital care" includes intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records. It is a service involving the evaluation or reevaluation of a patient with an acute or active problem that requires hospitalization. This procedure includes the recording of the chief complaint, present illness or current medical history, an appropriate physical examination related to the acute or active problem in a patient who has had a previously documented evaluation current and available to the physician, and the ordering of appropriate medical diagnostic tests and procedures.

L. Comprehensive initial hospital care. "Comprehensive initial hospital care" includes comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records, and signifies a level of service consistent with the definition of comprehensive service.

Subp. 3. Office services. The following codes, service descriptions and maximum fees apply to services provided at the physician's office.

Code	Service	Maximum Fee
90000	New patient—brief service	$ 25.00
90010	New patient—limited service	34.00
90015	New patient—intermediate service	50.00
90017	New patient—extended service	78.00
90020	New patient—comprehensive service	129.00
90030	Established patient—minimal service	15.00
90040	Established patient—brief service	19.00
90050	Established patient—limited service	21.00
90060	Established patient—intermediate service	28.00
90070	Established patient—extended service	42.00
90080	Established patient—comprehensive service	67.00

Subp. 4. Hospital services. The following codes, service descriptions and maximum fees apply to services provided at a hospital. Initial hospital care shall be categorized under codes 90200 to 90220. Subsequent hospital care shall be categorized under codes 90240 to 90280.

Code	Service	Maximum Fee
90200	Brief initial hospital care	53.00
90215	Intermediate initial hospital care	72.00
90220	Comprehensive initial hospital care	102.00
90240	Subsequent hospital care—brief service	23.50
90250	Subsequent hospital care—limited service	30.00
90270	Subsequent hospital care—extended service	60.00
90280	Subsequent hospital care—comprehensive service	88.00

Subp. 5. Emergency department services. The following codes, service descriptions, and maximum fees apply to services provided in an emergency room, or when the physician is assigned to the emergency department.

Code	Service	Maximum Fee
90500	New patient—minimal service	26.00
90505	New patient—brief service	30.00
90510	New patient—limited service	38.00
90515	New patient—intermediate service	45.00
90517	New patient—extended service	65.00
90530	Established patient—minimal service	20.10
90540	Established patient—brief service	30.00
90550	Established patient—limited service	33.00
90560	Established patient—intermediate service	37.00
90570	Established patient—extended service	55.00

5221.1200 CONSULTATIONS.

Subpart 1. Scope. The codes, service descriptions, and maximum fees in this part apply to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Subp. 2. Definitions. For the purposes of this part the following terms have the meanings given them unless the context clearly indicates a different meaning.

A. Consultation. "Consultation" includes services rendered by a physician whose opinion or advice is requested by a physician or other appropriate source for the further evaluation or management of the patient. When the consulting physician assumes responsibility for the continuing care of the patient, any subsequent service rendered by the physician will cease to be a consultation. A referral does not constitute a consultation if the effect of the referral is to transfer the total or specific care of the patient from one physician to another.

B. Limited consultation. "Limited consultation" means a consultation where the physician confines the service to the examination or evaluation of a single organ system. This procedure includes documentation of the complaint, present illness, pertinent examination, review of medical data, and establishment of a plan of management relating to the specific problem, including, but not limited to, services similar in level to a dermatological opinion about an uncomplicated skin lesion.

C. Intermediate consultation. "Intermediate consultation" means a consultation where the physician examines or evaluates an organ system, partially reviews the general history, and prepares recommendations and a report, including, but not limited to, services similar in level to the evaluation of the abdomen for possible surgery that does not proceed to surgery.

D. Extensive consultation. "Extensive consultation" means a consultation where the physician evaluates problems that do not require a comprehensive evaluation of the patient as a whole, but includes the documentation of a history of the chief complaint, past medical history and pertinent physical examination, review and evaluation of the past medical data, establishment of a plan of investigative or therapeutic management, and the preparation of an appropriate report. This includes, but is not limited to, services similar in level to the examination of a cardiac patient who needs assessment before undergoing a major surgical procedure or general anesthesia.

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.

E. Comprehensive consultation. "Comprehensive consultation" means a consultation that involves an in-depth evaluation of a critical problem that requires unusual knowledge, skill, and judgment on the part of the consulting physician, and the preparation of an appropriate report. This includes, but is not limited to, services similar in level to a consultation for a young person with fever, arthritis, and anemia or a comprehensive psychiatric consultation that may include a detailed present illness history, and past history, a mental status examination, exchange of information with primary physician or nursing personnel or family members or other informants, and preparation of a report with recommendations.

F. Complex consultation. "Complex consultation" means an uncommonly performed consultation that involves an in-depth evaluation of a critical problem that requires unusual knowledge, skill, and judgment on the part of the consulting physician, and the preparation of an appropriate report. This includes, but is not limited to, services similar in level to a consultation for a person with acute myocardial infarction with major complication or a young psychotic adult unresponsive to extensive treatment efforts under consideration for residential care.

Subp. 3. Fees. The following codes, service descriptions, and maximum fees apply to consultations.

Code	Service	Maximum Fee
90605	Intermediate consultation	64.00
90610	Extensive consultation	77.00
90620	Comprehensive consultation	115.00
90630	Complex consultation	132.50

5221.1300 PSYCHIATRIC THERAPY.

The following codes, service descriptions, and maximum fees apply to psychiatric therapeutic procedures, and to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Code	Service	Maximum Fee
	General Clinical Psychiatric Diagnostic or Evaluative Interview Procedures	
90801	Psychiatric diagnostic interview examination including history, mental status, or disposition	$100.00
90843	Individual medical psychotherapy with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; approximately 20 to 30 minutes	50.00
90844	approximately 45 or 50 minutes	85.00

5221.1400 BIOFEEDBACK.

The following codes, service descriptions, and maximum fees apply to biofeedback procedures, and to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Code	Service	Maximum Fee
90900	Biofeedback training; by electromyogram application, as with tension headache or muscle spasm	$ 70.00
90906	Regulation of skin temperature or peripheral blood flow	70.00

5221.1500 OPHTHALMOLOGICAL SERVICES.

Subpart 1. Scope. The codes, service descriptions, and maximum fees in this part apply to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Subp. 2. Definitions. The terms defined in this part have the meanings given them for the purposes of this part unless the context clearly indicates a different meaning.

A. New patient and established patient. "New patient" and "established patient" have the meanings given them in part 5221.1100.

B. Level of service. "Level of service" for the purpose of this rule has the meaning given it in 5221.1100.

C. Intermediate ophthalmological service. "Intermediate ophthalmological service" means a level of service pertaining to the evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination, and other diagnostic procedures as indicated and may include the use of mydriasis. Intermediate ophthalmological services do not usually include determination of the refractive state but may do so in an established patient who is under continuing active treatment. Intermediate ophthalmological services include, but are not limited to, services similar to the following in level:

(1) review of history, external examination, ophthalmoscopy, biomicroscopy for an acute complicated condition not requiring comprehensive ophthalmological services; or

(2) review of interval history, external examination, ophthalmoscopy, biomicroscopy, and tonometry in established patient with a known cataract not requiring comprehensive ophthalmological services.

D. Comprehensive ophthalmological service. "Comprehensive ophthalmological service" means a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmological examination, gross visual fields, and basic sensorimotor examination. It often includes biomicroscopy, examination with cycloplegia or mydriasis, tonometry, and determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation. It always includes initiation of diagnostic and treatment programs as indicated. Comprehensive ophthalmological services include, but are not limited to, service similar to diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract, or retinal disease, or to rule out disease of the visual system, in a new or established patient.

E. Determination of the refractive state. "Determination of the refractive state" means the quantitative procedure that yields the refractive data necessary to determine visual acuity with lenses and to prescribe lenses. It is not a separate medical procedure, or service entity, but is an integral part of the general ophthalmological services, carried out with reference to other diagnostic procedures. The evaluation of the need for and the prescription of lenses is never based on the refractive state alone. Determination of the refractive state is not reported separately. It is usually part of the comprehensive ophthalmological services, but may occasionally be a part of intermediate ophthalmological services to an established patient who, under continuing active treatment with periodic observation, may not require comprehensive reevaluation.

Subp. 3. Ophthalmological services and fees. The following codes, service descriptions, and maximum fees apply to ophthalmological services. General ophthalmological services, codes 92002 to 92014, constitute integrated services in which medical diagnostic evaluation cannot be separated from the examining techniques used. The components of the services should not be itemized, except where the service goes beyond what is normally provided. Minimal, brief, and limited levels of service should be submitted under the appropriate code. Routine ophthalmoscopy, codes 92225 to 92250, is part of general and special ophthalmological services wherever indicated, and shall not be reported separately.

Code	Service	Maximum Fee
	General Services	
92002	Intermediate ophthalmological service: medical evaluation with initiation of diagnostic and treatment program—new patient	$ 43.00
92004	Comprehensive ophthalmological service: medical evaluation with initiation of diagnostic and treatment program—new patient, one or more visits	46.00
92014	Comprehensive ophthalmological service: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program—established patient, one or more visits	46.00
	Special Services	
92065	Orthoptic or pleoptic training, with continuing medical direction and evaluation	$ 20.00
92082	Quantitative perimetry, for example, several isopters on Goldmann perimeter, or equivalent	45.00
92100	Serial tonometry with medical diagnostic evaluation as a separate procedure, one or more sessions, same day	20.00
92140	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography	25.00
	Ophthalmoscopy	
92225	Ophthalmoscopy, extended as for retinal detachment with medical diagnostic evaluation; initial	$ 24.00
92235	Ophthalmoscopy, including medical diagnostic with fluorescein angiography and multiframe photography and medical interpretation	112.00
92250	with fundus photography	28.00
	Other Specialized Services	
92265	Oculoelectromyography, one or more extraocular muscles, one or both eyes, with medical diagnostic evaluation	$ 66.00
92280	Visually evoked potential or response study, with medical diagnostic evaluation	125.00

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5221.1600 OTORHINOLARYNGOLOGIC SERVICES.

The codes, service descriptions, and maximum fees in this part apply to otorhinolaryngologic services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. Diagnostic or treatment procedures usually included in a comprehensive otorhinolaryngologic evaluation or office visit, which do not include the following, should be reported as an integrated medical service using the appropriate code from the 90000 series. Component services such as otoscopy, rhinoscopy, or tuning fork test, should not be itemized separately. All of the following services include medical diagnostic evaluation. Technical procedures, which may or may not be performed by the physician personally, are often part of the service, but do not constitute the service itself.

Code	Service	Maximum Fee
92506	Medical evaluation of speech, language, or hearing problems	$ 51.00
92508	Speech, language, or hearing therapy, with continuing medical supervision group	23.75
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording	47.00
92544	Optokinetic nystagmus test, bidirectional, foveal, or peripheral stimulation, with recording	33.00
92545	Oscillating tracking test, with recording	27.00

5221.1700 AUDIOLOGIC TESTS.

The codes, service descriptions, and maximum fees in this part apply to audiologic function tests with medical diagnostic evaluation, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. The tests involve use of calibrated electronic equipment. Other hearing tests such as whispered voice, tuning fork which are usually included in a comprehensive otorhinolaryngologic evaluation or office visit shall not be itemized, but shall be included in the basic office visit or consultation. The following codes refer to testing of both ears.

Basic Audiometry

Code	Service	Maximum Fee
92551	Screening test, pure tone, air only	$ 12.00
92552	Pure tone audiometry (threshold); air only	17.00
92555	Speech audiometry; threshold only	12.00
92556	threshold and discrimination	30.00
92557	Basic comprehensive audiometry (92553 and 92556 combined), (pure tone, air and bone, and speech, threshold and discrimination)	48.50

Audiologic Tests

92562	Loudness balance test, alternate binaural or monaural	$ 16.00
92563	Tone decay test	14.00
92564	Short increment sensitivity index	17.00
92566	Impedance testing	17.75
92567	Tympanometry	13.00
92568	Acoustic reflex testing	25.00
92569	Acoustic reflex decay test	14.00
92575	Sensorineural acuity level test	8.25
92581	Evoked response audiometry	150.00
92582	Conditioning play audiometry	24.00
92583	Select picture audiometry	24.00
92591	Hearing aid examination and selection binaural	66.00

5221.1800 CARDIOGRAPHY.

The codes, service descriptions, and maximum fees in this part apply to cardiographic services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Code	Service	Maximum Fee
93000	Electrocardiogram (ECG); with interpretation and report, routine ECG with at least 12 leads	$ 36.00
93005	tracing only, without interpretation and report	25.00
93010	interpretation and report only	16.50
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise; continuous electrocardiographic monitoring, with interpretation and report	145.00

93017	tracing only without interpretation and report	107.00
93018	interpretation and report only	90.00
93040	Rhythm ECG, one to three leads; with interpretation	20.00
93220	Vectorcardiogram (VCG), with or without ECG; with interpretation and report	36.10
93270	Electrocardiographic monitoring utilizing a system such as magnetic tape for up through 12 hours; includes recording, scanning analysis, interpretation, and report	155.00
93274	Electrocardiographic monitoring utilizing a system such as magnetic tape, 12 through 24 hours; includes recording, scanning analysis, interpretation, and report	183.00
93277	physician review and interpretation, with report	85.00

5221.1900 PULMONARY.

The codes, service descriptions, and maximum fees of this part apply to pulmonary services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. The services include laboratory procedures, interpretation, and physician services, except surgical and anesthesia services.

Code	Service	Maximum Fee
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement or maximal voluntary ventilation	$ 28.00
94060	Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral) or exercise	36.00
94150	Vital capacity, total (separate procedure)	15.00
94160	Vital capacity screening tests: total capacity, with timed forced expiratory volume (state duration), and peak flow rate	15.00
94200	Maximum breathing capacity, maximal voluntary ventilation	21.50
94375	Respiratory flow volume loop	22.00
94656	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day	96.50
94640	Nonpressurized inhalation treatment for acute airway obstruction	19.00
94664	Aerosol or vapor inhalations for sputum mobilization, bronchodilation, or sputum induction for diagnostic purposes; initial demonstration and/or evaluation	17.10

5221.2000 NEUROLOGY AND NEUROMUSCULAR.

The codes, service descriptions, and maximum fees of this part apply to neurology and neuromuscular services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. Services performed as part of and included in the definition of an office visit, hospital visit, or consultation shall not be listed separately, but shall be submitted under the appropriate code.

Code	Service	Maximum Fee
95819	Electroencephalogram (EEG) including recording awake, drowsy, and asleep, with hyperventilation or photic stimulation; standard or portable, same facility	$ 112.00
95822	Electroencephalogram (EEG); sleep only	128.25
95823	physical or pharmacological activation only	112.00
95851	Range of motion measurements and report (separate procedure); each extremity, excluding hand	30.00
95860	Electromyography; one extremity and related paraspinal areas	145.00
95861	two extremities and related paraspinal areas	170.00
95863	three extremities and related paraspinal areas	133.30
95864	four extremities and related paraspinal areas	184.10
95900	Nerve conduction, velocity, or latency study; motor, each nerve	48.00
95904	sensory, each nerve	48.00
95925	Somatosensory testing, for example, cerebral evoked potentials, one or more nerves	162.00
95935	"H" reflex, by electrodiagnostic testing	35.00
95950	Ambulatory 24-hour EEG monitoring	400.00

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5521.2100 PHYSICAL MEDICINE.

The following codes, service descriptions and maximum fees apply to physical medicine services, and to a provider licensed as a doctor of medicine or a doctor of osteopathy. Physical medicine office visits as listed under "modalities" and "procedures" shall be submitted under the appropriate code from this paragraph. Modalities and procedures require supervision by the physician, and constant attendance by the physician or therapist.

Special Dermatological Procedures

Code	Service	Maximum Fee
96900	Actinotherapy (ultraviolet light)	$ 7.00
96912	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment)	20.00

Modalities

97000	Office visit with one of the following modalities to one area: 1. Hot or cold packs 2. Traction, mechanical 3. Electrical stimulation (unattended) 4. Vasopneumatic devices 5. Paraffin bath 6. Microwave 7. Whirlpool 8. Diathermy 9. Infrared 10. Ultraviolet	15.00
97012	Physical medicine treatment to one area; traction mechanical	13.50
97050	Office visit with two or more modalities to same area	25.35

Procedures

97100	Office visit with one of the following procedures to one area: 1. Therapeutic exercises 2. Neuromuscular reeducation 3. Functional activities 4. Gait training 5. Electrical stimulation (manual) 6. Iontophoresis 7. Traction, manual 8. Massage 9. Contrast baths 10. Ultrasound; initial 30 minutes	$ 18.00
97101	each additional 15 minutes	10.00
92700	Office visit, including combination of any modality and procedure; initial 30 minutes	31.00
97201	each additional 15 minutes	10.00
97260	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one area	21.00
97261	each additional area	5.00

Tests and Measurements

97740	Kinetic activities to increase coordination, strength, and/or range of motion, one area, any two extremities, initial 30 minutes	28.50

5221.2200 SPECIAL SERVICES

Critical care services (codes 99160 to 99173) apply to a provider licensed as a doctor of medicine or a doctor of osteopathy, and include the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician, for example, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, or critically ill neonate. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The critical care services include, but are not limited to, cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate

procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, or electrical conversion of arrhythmia, are not permitted when critical care services are billed on a per hour basis.

Code	Service	Maximum Fee
99000	Collection, handling, or conveyance of specimen for transfer from the physician's office to a laboratory	$ 7.50
99075	Medical testimony	Reasonableness of charges reviewable by commissioner
99080	Special reports like insurance forms, or the review of medical data to clarify a patient's status more than the information conveyed in the usual medical communications or standard reporting form	Reasonableness of charges reviewable by commisioner
	Surgical Procedures	
99025	Initial, new patient visit when asterisk (*) surgical procedure constitutes major service at that visit	$ 15.00
	Prolonged Services	
99155	Medical conference by physician regarding medical management with patient, or relative, guardian, or other (may include counseling by a physician); approximately 25 minutes	$ 40.00
99156	approximately 50 minutes	112.50
	Critical Care	
99160	Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour	$100.00
99170	Gastric intubation, and aspiration or lavage for treatment (i.e., ingested poisons)	40.00
99172	Critical care, subsequent follow-up visit; limited examination, evaluation, or treatment for same or new illness	47.00
99173	intermediate examination, evaluation, or treatment, same or new illness	79.00

5221.2250 PHYSICIAN SERVICES—SURGERY.

Subpart 1. Scope. The codes, service descriptions, and maximum fees of this part apply to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Subp. 2. Instructions. The instructions in items A to E govern the assignment of codes and the evaluation of services described in this part.

A. With the exception of services designated with an asterisk (*), all services include the operation per se, local infiltration, digital block, or topical anesthesia when used, and the normal uncomplicated follow-up care, both pre- and postoperative. This concept is referred to as a "package" for surgical procedures.

B. Follow-up care includes reports and records as the operation requires and the physician commonly provides. This includes special reports concerning the medical appropriateness of a service for services which are rarely provided, unusual, variable, or new. Information included in these reports is an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service.

C. Follow-up care for diagnostic procedures, such as endoscopy or injection procedures for radiography, includes only that care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.

D. Follow-up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services should be reported with the identification of appropriate procedures.

E. Certain minor surgical services involve a readily identifiable surgical procedure but include variable preoperative and postoperative services. Because of the indefinite pre- and postoperative services the usual package concept for surgical services cannot be applied. These procedures are identified by an asterisk (*) following the code number. When an asterisk follows a surgical procedure code, the following rules apply.

(1) The service as listed includes the surgical procedure only. Associated pre- and postoperative services are not included in the service as listed.

(2) Preoperative services shall be listed when:

(a) the asterisk procedure is carried out at the time of an initial visit (new patient) and this procedure constitutes the major service at that visit, procedure number 99025 is listed in lieu of the initial visit as an additional service;

(b) the asterisk procedure is carried out at the time of an initial or other visit involving significant identifiable services, for example, removal of a small skin lesion at the time of a comprehensive history and physical examination, the appropriate visit is listed in addition to the asterisk procedure and its follow-up care;

(c) the asterisk procedure is carried out at the time of a follow-up of an established patient visit and this procedure constitutes the major service at that visit, no visit service shall be added; and

(d) the asterisk procedure requires hospitalization, an appropriate hospital visit is listed in addition to the asterisk procedure and its follow-up care.

(3) All postoperative care is added on a service-by-service basis.

(4) Complications are added on a service-by-service basis as with surgical procedures.

Subp. 3. Integumentary system. The following codes, service descriptions, and maximum fees apply to surgical procedures of the integumentary system. Excision of benign lesions (codes 11200 to 11442) includes a simple closure and local anesthesia for treatment of benign lesions of skin or subcutaneous tissues, for example, cicatricial, fibrous, inflammatory, congenital, or cystic lesions. Treatment of burns (codes 16000 to 16020) refer to local treatment of the burned surface only. Simple repair (codes 12001 to 12013) shall be used for superficial wounds involving skin or subcutaneous tissues, without significant involvement of deeper structures, and which requires simple suturing. Wounds which require closure with adhesive strips only shall be listed according to the appropriate office visit. Intermediate repair (codes 12031 to 12051) shall be used for the repair of wounds that, in addition to simple repair, require layer closure. These wounds usually involve deeper layers such as fascia or muscle, to the extent that at least one of the deeper layers requires separate closure. Complex repair (codes 13121 to 13132) shall be used for the repair of wounds which require reconstructive surgery, complicated wound closures, skin grafts, or unusual and time consuming techniques of repair to obtain the maximum functional and cosmetic result. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions. The instructions in items A to C also apply to coding of repair services (codes 12001 to 13132):

A. When multiple wounds are repaired, the lengths of those of the same classifications shall be added together and reported as a single item. When more than one classification of wounds is repaired, the most complicated shall be listed as the primary procedure and the less complicated as the secondary procedure, using modifier number 50.

B. Only when gross contamination requires prolonged cleansing is decontamination or debridement to be considered a separate procedure. Debridement is considered a separate procedure only when appreciable amounts of devitalized or contaminated tissue are removed.

C. Involvement of nerves, blood vessels, and tendons shall be reported under the appropriate system for repair of these structures. The repair of the associated wound shall be included in the primary procedure, unless it qualifies as a complex wound, in which case modifier number 50 applies. Simple ligation of vessels in an open wound is considered as part of any wound closure. Simple exploration of nerves, blood vessels, or tendons exposed in an open wound is also considered part of the essential treatment of the wound and is not a separate procedure unless appreciable dissection is required.

Incision

Code	Service	Maximum Fee
10000*	Incision and drainage of infected or noninfected sebaceous cyst; one lesion	$ 42.50
10003*	Incision and drainage of infected or noninfected epithelial inclusion cyst with complete removal of sac and treatment of cavity	50.00
10020*	Incision and drainage of furuncle	30.00

10060*	Incision and drainage of abscess, for example, carbuncle, suppurative hidradenitis, and other cutaneous or subcutaneous abscesses; simple	43.50
10080	Incision and drainage of piloridial cyst; simple	45.50
10100*	Incision and drainage of onychia or paronychia single or simple	42.00
10120*	Incision and removal of foreign body, subcutaneous tissues; simple	44.00
10140	Incision and drainage of hematoma; simple	43.50
10160*	Puncture aspiration of abscess, hematoma, bulla, or cyst	35.00
	Excision-Debridement	
11000	Debridement of extensive eczematous or infected skin; up to ten percent of body surface	30.00
	Paring or Curettement	
11050*	Paring or curettement of benign lesion with or without chemical cauterization (such as verrucae or clavi); single lesion	$ 24.50
11051	two to four lesions	30.80
11052	more than four lesions	50.00
	Biopsy	
11100	Biopsy of skin, subcutaneous tissue, or mucous membrane, including simple closure, unless otherwise listed (separate procedure); one lesion	$ 52.50
	Excision—Benign Lesions	
11200*	Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15 lesions	$ 47.00
11400	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter up to 0.5 centimeter	56.50
11401	lesion diameter 0.5 to 1.0 centimeter	66.00
11402	lesion diameter 1.0 to 2.0 centimeters	78.00
11403	lesion diameter 2.0 to 3.0 centimeters	96.00
11404	lesion diameter 3.0 to 4.0 centimeters	120.00
11420	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter up to 0.5 centimeter	65.00
11421	lesion diameter 0.5 to 1.0 centimeter	75.00
11422	lesion diameter 1.0 to 2.0 centimeters	99.00
11423	lesion diameter 2.0 to 3.0 centimeters	71.00
11440	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter up to 0.5 centimeter	70.00
11441	lesion diameter 0.5 to 1.0 centimeter	90.00
11442	lesion diameter 1.0 to 2.0 centimeters	108.00
	Nails	
11700*	Debridement of nails, manual; five or less	$ 25.00
11730*	Avulsion of nail plate, partial or complete, simple; single	55.00
11740	Evacuation of subungual hematoma	29.00
11760	Reconstruction of nail bed; simple	68.50
	Repair—Simple	
12001*	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, or extremities, including hands and feet; up to 2.5 centimeters	$45.00
12002*	2.5 to 7.5 centimeters	65.00
12004*	7.5 to 12.5 centimeters	90.00
12011*	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, or mucous membranes; up to 2.5 centimeters	65.00
12013*	2.5 to 5.0 centimeters	84.00

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12014	5.0 to 7.5 centimeters	82.00
	Repair—Intermediate	
12031*	Layer closure of wounds of scalp, axillae, trunk, or extremities excluding hands and feet; up to 2.5 centimeters	$ 60.00
12034	7.5 to 12.5 centimeters	145.00
12041*	Layer closure of wounds of neck, hands, feet, or external genitalia; up to 2.5 centimeters	90.00
12042	2.5 to 8.5 centimeters	105.00
12051*	Layer closure of wounds of face, ears, eyelids, nose, lips, or mucous membranes up to 2.5 centimeters	100.00
12052	2.5 to 5.0 centimeters	127.20
	Repair—Complex	
13150	Repair, complex, eyelids, nose, ears, or lips; up to 1.0 centimeter	$180.00
13151	1.0 to 2.5 centimeters	360.00
13152	2.5 to 7.5 centimeters	575.00
	Adjacent Tissue Transfer or Rearrangement	
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet; defect up to 10 square centimeters	552.00
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears, or lips; defect up to 10 square centimeters	720.00
	Free Skin Grafts	
15050	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area except on face, up to defect size 2 centimeters diameter	$120.00
15100	Split graft, trunk, scalp, arms, legs, hands, or feet except multiple digits; up to 100 square centimeters, or each one percent of body area of infants and children (except 15050)	450.00
	Burns, Local Treatment	
16000	Initial treatment, first degree burn, when no more than local treatment is required	$ 44.00
16010	Dressings or debridement, initial or subsequent; under anesthesia, small	30.00
16020*	Dressings or debridement, initial or subsequent; without anesthesia, office or hospital, small	30.00
16025*	office or hospital, small without anesthesia, medium, for example, whole face or whole extremity	42.00
	Destruction	
17000*	Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia; one lesion	$ 35.00
17100*	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia; one lesion	31.50
17200*	Electrosurgical destruction of multiple fibrocutaneous tags; up to 15 lesions	35.00
17250*	Chemical cauterization of a wound	25.05
17430*	Cryotherapy (CO_2 slush, liquid N_2)	22.00

Subp. 4. Musculoskeletal system. The following codes, service descriptions and maximum fees apply to surgical procedures of the musculoskeletal system. Rereduction of a fracture or dislocation performed by the primary physician may be identified by the addition of the modifer number 76 to the usual procedure number to indicate "repeat procedure by same physician."

	Excision—General	
Code	Service	Maximum Fee
20205	Biopsy, muscle; deep	$200.00
20220	Biopsy, bone, trocar, or needle; superficial for example ilium, sternum, spinous process, ribs	137.00
20225	Biopsy, bone, trocar, or needle; superficial, deep, (vertebral body, Femur)	375.00
	Introduction or Removal—General	
20501*	Injection of sinus tract; diagnostic (sinogram) (separate procedure	$ 47.00
20550*	Injection, tendon sheath, ligament, or trigger points	37.00
20600*	Arthrocentesis, aspiration, or injection; small joint or bursa, for example, fingers, toes	40.00
20605*	intermediate joint or bursa, for example, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon burse	44.00
20610*	major joint or bursa, for example, shoulder, hip, knee joint, subacromial bursa	45.00

20670*	Removal of implant; superficial, for example, buried wire, pin or rod (separate procedure)	70.00
20680	deep, for example, buried wire, pin screw, metal band, nail, rod, or plate	268.00
	Head—Fracture or Dislocation	
21315*	Manipulative treatment, nasal bone fracture; without stabilization	$ 95.00
21320	with stabilization	240.00
	Neck (Soft Tissues) and Thorax—Fracture or Dislocation	
Code	Service	Maximum Fee
21800	Treatment of rib fracture; closed, uncomplicated, each	$ 55.00
	Spine (Vertebral Column)—Manipulation	
22500*	Manipulation of spine, any region	17.00
	Shoulders—Fracture or Dislocation	
23350	Injection procedure for shoulder Arthrography	58.30
23500	Treatment of closed clavicular fracture; without manipulation	79.00
23505	Treatment of closed clavicular fracture; with manipulation	175.00
23550	Open treatment of closed or open acromioclavicular dislocation, acute or chronic	785.00
23650	Treatment of closed shoulder dislocation, with manipulation; without anesthesia	105.00
23655	requiring anesthesia	120.00
	Shoulder—Manipulation	
23700*	Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded)	$125.00
	Humerus (Upper Arm) and Elbow—Fracture or Dislocation	
24505	Treatment of closed humeral shaft fracture; with manipulation	315.00
24650	Treatment of closed radial head or neck fracture without manipulation	100.00
	Forearm and Wrist—Incision and Excision	
25000	Tendon sheath incision; at radial styloid for DeQuervain's Disease	314.00
25111	Excision of ganglion, wrist (dorsal or volar); primary	322.00
	Forearm and Wrist—Fracture or Dislocation	
25505	Treatment of closed radial shaft fracture; with manipulation	264.00
25560	Treatment of closed radial and ulnar shaft fractures; without manipulation	163.00
25565	Treatment of closed radial and ulnar shaft fractures; with manipulation	350.00
25600	Treatment of closed distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	150.00
25605	with manipulation	265.00
25610	Treatment of closed, complex, distal radial fracture (for example, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal fixation or percutaneous pinning	360.00
25611	with external skeletal fixation or percutaneous pinning	475.00
	Hand and Fingers—Incision, Excision, Repair, Revision, or Reconstruction	
26055	Tendon sheath incision for trigger finger	$315.00
26160	Excision of lesion of tendon sheath or capsule	176.00
26418	Extensor tendon repair, dorsum of finger, single, primary, or secondary; without free graft, each tendon	250.00
	Hands and Fingers—Fractures or Dislocations	
26600	Treatment of closed metacarpal fracture, single; without manipulation, each bone	$ 75.00
26605	with manipulation, each bone	162.00

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26615	Open treatment of closed or open metacarpal fracture, single, with or without internal or external skeletal fixation, each bone	420.00
26720	Treatment of closed phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	54.00
26725	with manipulation, each	116.00
26735	Open treatment of closed or open phalangeal shaft fracture, finger or thumb, with or without internal or external skeletal fixation, each	300.00
26750	Treatment of closed distal phalangeal fracture, finger or thumb; without manipulation, each	45.00
26770	Treatment of closed interphalangeal joint dislocation, single, with manipulation; without anesthesia	45.00
	Hand and Fingers—Amputation	
26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	$ 209.50
27130	Arthroplasty, Acetabular and proximal femoral prosthetic replacement; simple	2,700.00
27236	Open treatment of closed or open femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	1,450.00
27244	Open treatment of closed or open intertrochanteric or pertrochanteric femoral fracture, with internal fixation	1,325.00
27252	Treatment of closed hip dislocation, traumatic; with anesthesia	350.00
	Femur (Thigh Region) and Knee Joint—Excision	
27331	Arthrotomy, knee; with joint exploration, with or without biopsy, with or without removal of loose bodies	857.00
27332	Arthrotomy, knee, for excision of semilunar cartilage (meniscectomy); medial or lateral	898.00
27345	Excision of synovial cyst of popliteal space (Baker's cyst)	505.00
	Femur (Thigh Region) and Knee Joint—Introduction or Removal	
27370	Injection procedure for knee arthrography	$ 53.50
27373	Arthroscopy, knee, diagnostic (separate procedure)	350.00
27374	Arthroscopy, knee, surgical; debridement with cartilage shaving or drilling or resection of reactive synovium	1,220.00
27376	with synovial biopsy	650.00
27377	with removal of loose body	1,136.00
27378	with partial meniscectomy	1,270.00
27379	with plica resection or shelf resection	998.00
	Femur (Thigh Region) and Knee Joint— Repair, Revision, or Reconstruction	
27422	Reconstruction for recurrent dislocating patella; with extensor realignment or muscle advancement or release (Campbell, Goldwaite, type procedure)	900.00
27444	Arthroplasty, knee, total; fascial	2,810.00
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee replacement)	2,582.00
	Femur (Thigh Region) and Knee Joint—Manipulation Fractures and Dislocations	
27506	Open treatment of closed or open femoral shaft fracture (including supracondylar), with or without internal or external skeletal fixation	1,350.00
27524	Open treatment of closed or open patellar fracture, with repair and/or excision	850.00
	Leg (Tibula and Fibula) and Ankle Joint— Fractures or Dislocations	
27650	Suture, primary, ruptured achilles tendon	737.00
27752	Treatment of closed tibial shaft fracture; with manipulation	$316.00
27786	Treatment of closed distal fibular fracture (lateral malleolus); without manipulation	150.00
27792	Open treatment of closed or open distal fibular fracture (lateral malleolous) with fixation	600.00
27802	Treatment of closed tibia and fibula fractures, shafts; with manipulation	427.00

27814	Open treatment of closed or open bimalleolar ankle fracture, with or without internal or external skeletal fixation	800.00
27822	Open treatment of closed or open trimalleolar ankle fracture, with or without internal or external skeletal fixation, medial, or lateral malleolus; only	953.00
27880	Amputation leg, through tibia and fibula	800.00
	Foot—Fracture or Dislocation	
28090	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglian) foot	$260.00
28285	Hammertoe operation; one toe (e.g. interphallangeal fusion, filleting, phalangectomy) (separate procedure)	310.00
28290	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple extostectomy (silver type procedure)	335.00
28292	Keller, McBride or Mayo type procedure	520.00
28296	with metatarsal osteotomy (Mitchell or Lapidus type procedure)	635.00
28470	Treatment of closed metatarsal fracture; without manipulation, each	100.00
28475	with manipulation, each	127.60
28490	Treatment of closed fracture great toe, phalanx, or phalanges; without manipulation	47.00
28510	Treatment of closed fracture, phalanx or phalanges, other than great toe; without manipulation, each	39.00
28515	with manipulation, each	70.00
28820	Amputation, metatarsal, with toe, single	275.00

Subp. 5. Casts and strapping. The following codes, service descriptions, and maximum fees apply to procedures associated with the application of casts and strapping. The services include the application and removal of the first cast or traction device only. Subsequent replacement of cast or traction device requires an additional listing. Codes for cast removal shall be employed only for casts applied by another physician.

Body and Upper Extremity Casts

Code	Service	Maximum Fee
29035	Application of body cast, shoulder to hips	$159.00
29065	shoulder to hand (long arm)	70.00
29075	elbow to finger (short arm)	60.00
29085	hand and lower forearm (gauntlet)	60.00
	Splints	
29105	Application of long arm splint (shoulder to hand)	$ 39.00
29125	Application of short arm splint (forearm to hand); static	33.00
29130	Application of finger splint; static	23.00
	Strapping—Any Age	
29200	Strapping; thorax	$ 20.00
29220	low back	20.00
29260	elbow or wrist	20.00
29345	Application of long leg cast (thigh to toes)	100.00
29355	walker or ambulatory type	105.00
29358	Application of long leg cast brace	$234.00
29365	Application of cylinder cast (thigh to ankle)	78.00
29405	Application of short leg cast (below knee to toes)	71.00
29425	walking or ambulatory type	79.00
29435	Application of patellar tendon bearing (PTB) cast	102.00
29440	Adding water to previously applied cast	29.00

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29450	Application of clubfoot cast with molding or manipulation, long or short leg; unilateral	44.00
29455	bilateral	87.50
	Splints	
29505	Application of long leg splint (thigh to ankle or toes)	$ 51.00
29515	Application of short leg splint (calf to foot)	40.00
	Strapping—Any Age	
29540	Strapping; ankle	23.00
29580	Unna boot	25.00
	Removal or Repair	
29700	Removal or bivalving; gauntlet, boot, or body cast	$ 21.00
29720	Repair of spica, body cast, or jacket	17.00

Subp. 6. Respiratory system. The following codes, service descriptions, and maximum fees apply to surgical procedures of the respiratory system.

Nose—Removal Foreign Body

Code	Service	Maximum Fee
30300*	Removal foreign body, intranasal; office type procedure	$ 35.00
	Nose—Repair	
30420	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, or elevation of nasal tip, including major septal repair	$ 1,695.00
30520	Septoplasty with or without cartilage implant (separate procedure)	800.00
	Other Procedures	
30901	Control nasal hemorrhage, anterior, simple (cauterization); unilateral	$40.00
30903	Control nasal hemorrhage, anterior, complex (cauterization with local anesthesia and packing); unilateral	55.00

Subp. 7. Cardiovascular system. The following codes, service descriptions, and maximum fees apply to surgical procedures of the cardiovascular system. Injection procedures include necessary local anesthesia, introduction of needles or catheter, injection of contrast medium with or without automatic power injection, or necessary pre- and postinjection care specifically related to the injection procedure. Catheters, drugs, and contrast media are not included in the listed service for the injection procedures.

Vascular Injection Procedures—Venous

Code	Service	Maximum Fee
36410*	Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture	$ 40.50
36425	Venipuncture, cutdown, age 1 or over	18.00
36471	multiple veins, same leg	32.50
36480*	Catheterization, subclavian, external jugular or other vein, for central venous pressure determination; percutaneous	103.00
	Vascular Injection Procedures—Arterial	
36600	Arterial puncture, withdrawal of blood for diagnosis	$126.00
36620	Arterial catheterization or cannulation for sampling, monitoring, or transfusion (separate procedure); percutaneous	110.00

Subp. 8. Digestive system. The following codes, service descriptions, and maximum fees apply to surgical procedures of the digestive system.

Abdomen, Peritoneum, and Omentum—
Repair, Hernioplasty, Herniorrhaphy, Herniotomy

Code	Service	Maximum Fee
49505	Repair inguinal hernia, age 5 or over; unilateral	$ 600.00
49506	bilateral	1,000.00
49515	with excision of hydrocele or spermatocele	709.50

49520	recurrent	710.00
49550	Repair Femoral hernial groin incision	495.00
49560	Repair ventral (incisional) hernia (separate procedure)	726.00
49581	Repair umbilical hernia; age 5 or over	495.00

Supb. 9. Nervous system. The following codes, service descriptions, and maximum fees apply to surgical procedures of the nervous system.

Spine and Spinal Cord—
Puncture for Injection, Drainage, or Aspiration

Code	Service	Maximum Fee
62270*	Spinal puncture lumbar diagnostic	$ 74.00
62273*	Injection lumbar epidural, of blood or clot patch	164.00
62274*	Injection of anesthetic substance, diagnostic or therapeutic; subarachnoid or subdural simple	75.00
62278*	epidural or caudal single	75.00
62284*	Injection procedure for myelography and computerized axial tomography, spinal or posterior fossa	
62289	Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural or caudal	176.00
62292	Injection procedure for chemonucleolysis, intervertebral disk, single or multiple levels; lumbar	1,530.00

Spine and Spinal Cord—
Laminectomy or Laminotomy, for Exploration or Decompression

Code	Service	Maximum Fee
63020	Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root; one interspace, cervical, unilateral	$1,800.00
63030	one interspace, lumbar, unilateral	1,675.00
63042	Laminotomy (hemilaminectomy), for herniated intervertebral disk, or decompression of nerve root, any level, extensive or re-exploration; lumbar	2,108.00

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System—
Introduction or Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic, Sympathetic Nerves

Code	Service	Maximum Fee
64510*	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	$126.00

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System—
Exploration, Neurolysis, or Nerve Decompression (Neuroplasty)

64718	Neurolysis or transposition; ulnar nerve at elbow	$798.00
64721	median nerve at carpal tunnel	609.00

Eye and Ocular Adnexa—Removal of Ocular Foreign Body

65205*	Removal foreign body, external eye; conjunctival superficial	$ 33.00
65210*	conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating	42.00
65220*	corneal, without slit lamp	40.00
65222*	corneal, with slit lamp	54.00

Subp. 10. Auditory system. The following codes, service descriptions, and maximum fees apply to surgical procedures of the auditory system.

External Ear—Removal Foreign Material

Code	Service	Maximum Fee
69200	Removal foreign body from external auditory canal; without general anesthesia	$23.00

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5221.2300 PHYSICIAN SERVICES—RADIOLOGY.

Subpart 1. General. The following codes, service descriptions, and maximum fees apply to a provider licensed as a doctor of medicine or a doctor of osteopathy. The suffix number 26 modifier indicates only the professional component of a combined technical and professional procedure applies. Absence of the suffix indicates the complete procedure, professional and technical.

Subp. 2. Diagnostic radiology. The following codes, service descriptions, and maximum fees apply to diagnostic radiology procedures.

Head and Neck

Code	Service	Maximum Fee
70110	Radiologic examination, mandible; complete, minimum of four views	$ 60.00
70110-26	professional component only	19.20
70130	Radiologic examination, mastoids; complete, minimum of three views per side	70.00
70130-26	professional component only	21.25
70140	Radiologic examination, facial bones; less than three views	40.50
70140-26	professional component only	16.75
70150	complete, minimum of three views	56.50
70150-26	professional component only	20.50
70160	Radiologic examination, nasal bones, complete, minimum of three views	39.00
70160-26	professional component only	12.00
70200	Radiologic examination; orbits, complete, minimum of four views	53.00
70200-26	professional component only	19.20
70210	Radiologic examination, sinuses, paranasal, less than three views	32.00
70210-26	professional component only	13.00
70220	Radiologic examination, sinuses, paranasal, complete, minimum of three views; without contrast studies	55.70
70220-26	professional component only	18.00
70250	Radiologic examination, skull; less than four views, with or without stereo	42.00
70250-26	professional component only	20.75
70260	complete, minimum of four views, with or without stereo	73.00
70260-26	professional component only	24.75
70330	Radiologic examination, temporomandibular joint, open and closed mouth; bilateral	56.00
70330-26	professional component only	21.25
70355-26	Orthopantogram; professional component only	15.25
70360	Radiologic examination; neck, soft tissue	27.00
70360-26	professional component only	12.00
70450	Computerized axial tomography, head; without contrast material	268.00
70450-26	professional component only	70.00
70460	with contrast material	318.00
70460-26	professional component only	75.00
70470	without intravenous contrast material, followed by contrast material and further sections	353.00
70470-26	professional component only	95.00

Chest

71000	Radiologic examination, chest, minifilm	$ 25.25
71010	Radiologic examination, chest; single view, posteroanterior	30.00
71010-26	professional component only	11.00
71015	stereo, posteroanterior	29.20
71015-26	professional component only	29.20
71020	two views, posteroanterior and lateral	42.00
71020-26	professional component only	16.50
71021	apical lordotic procedure	38.30
71100	Radiologic examination, ribs, unilateral; two views	47.00
71100-26	professional component only	16.50
71101-26	including posteroanterior chest, minimum of three views, professional component only	20.20
71110	Radiologic examination, ribs, bilateral; three views	57.00
71250-26	Computerized axial tomography, thorax; without contrast material, professional component only	87.25

Spine and Pelvis

72010	Radiologic examination, spine, entire, survey study, anteroposterior, and lateral	$116.10
72010-26	professional component only	25.00
72020	Radiologic examination, spine, single view, specify level	34.50
72020-26	professional component only	15.00
72040	Radiologic examination, spine, cervical; anteroposterior and lateral	45.00
72040-26	professional component only	17.00
72050	minimum of four views	64.20
72050-26	professional component only	21.50
72052	complete, including oblique and flexion or extension studies	78.00
72052-26	professional component only	27.00
72070	Radiologic examination, spine; thoracic, anteroposterior and lateral	50.00
72070-26	professional component only	19.10
72080	thoracolumbar, anteroposterior and lateral	48.00
72080-26	professional component only	12.50
72090	scoliosis study, including supine and erect studies	42.00
72090-26	professional component only	35.00
72100	Radiologic examination, spine, lumbosacral; anteroposterior and lateral	53.50
72100-26	professional component only	19.75
72110	complete, with oblique views	72.00
72110-26	professional component only	25.75
72114	complete, including bending views	87.00
72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	52.00
72120-26	professional component only	17.25
72145	Computerized axial tomography, spine; with or without contrast material	380.00
72145-26	professional component only	100.00
72170	Radiologic examination, pelvis; anteroposterior only	35.00
72170-26	professional component only	13.60
72180	stereo	38.70
72180-26	professional component only	17.80
72190	complete, minimum of three views	48.50
72190-26	professional component only	21.50
72220	Radiologic examination, sacrum and coccyx, minimum of two views	41.00
72220-26	professional component only	14.75
72241-26	Myelography, cervical; complete procedure professional component only	204.25
72265-26	Myelography, lumbosacral; supervision and interpretation only, professional component only	59.75
72266-26	complete procedure, professional component only	192.50

Upper Extremities

73000	Radiologic examination; clavicle, complete	$ 30.00
73000-26	professional component only	10.50
73010	scapula, complete	35.00
73010-26	professional component only	13.00
73020	Radiologic examination, shoulder; one view	30.00
73020-26	professional component only	10.50
73030	complete, minimum of two views	41.30
73030-26	professional component only	13.00
73040-26	Radiologic examination, shoulder, arthrography; supervision and interpretation only, professional component only	12.00
73050	Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction	40.00
73050-26	professional component only	14.25

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73060	humerous, minimum of two views	35.00
73060-26	professional component only	12.00
73070	Radiologic examination, elbow; anteroposterior and lateral views	33.00
73070-26	professional component only	12.00
73080	complete, minimum of three views	36.00
73080-26	professional component only	14.25
73090	Radiologic examination; forearm, anteroposterior and lateral views	35.00
73090-26	professional component only	12.00
73100	Radiologic examination, wrist; anteroposterior and lateral views	30.50
73100-26	professional component only	12.00
73110	complete, minimum of three views	39.00
73110-26	professional component only	13.25
73120	Radiologic examination, hand; two views	32.00
73120-26	professional component only	12.00
73130	minimum of three views	36.00
73130-26	professional component only	13.00
73140	Radiologic examination, finger or fingers, minimum of two views	29.50
73140-26	professional component only	10.00

Lower Extremities

73500	Radiologic examination, hip; unilateral, one view	$ 31.30
73500-26	professional component only	12.00
73510	complete, minimum of two views	47.00
73510-26	professional component only	17.00
73520	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteroposterior view of pelvis	54.50
73520-26	professional component only	21.00
73550	Radiologic examination, femur, anteroposterior, and lateral views	39.00
73550-26	professional component only	12.00
73560	Radiologic examination, knee; anteroposterior and lateral views	35.00
73560-26	professional component only	12.00
73562	anteroposterior and lateral, with oblique, minimum of three views	44.50
73562-26	professional component only	13.00
73564	complete, including oblique, or tunnel, or patellar, or standing views	47.20
73564-26	professional component only	15.00
73580	Radiologic examination, knee, arthrography; supervision and interpretation only	99.00
73581	complete procedure	182.00
73581-26	professional component only	122.70
73590	Radiologic examination; tibia and fibula, anteroposterior and lateral views	36.50
73590-26	professional component only	12.00
73600	Radiologic examination, ankle; anteroposterior and lateral views	30.00
73600-26	professional component only	12.00
73610	complete, minimum of three views	38.00
73610-26	professional component only	13.50
73620	Radiologic examination, foot; anteroposterior and lateral views	32.00
73620-26	professional component only	12.00
73630	complete, minimum of three views	36.00
73630-26	professional component only	12.50
73650	Radiologic examination; calcaneus, minimum of two views	33.00
73650-26	professional component only	10.50
73660	toe or toes, minimum of two views	29.50
73660-26	professional component only	10.25

Abdomen

Code	Service	Maximum Fee
74000	Radiologic examination, abdomen; single anteroposterior view	$ 34.50
74000-26	professional component only	14.00

74010	anteroposterior and additional oblique and cone views	44.00
74010-26	professional component only	17.50
74020	complete, including decubitus or erect views	45.00
74020-26	professional component only	20.00
74150-26	Computerized axial tomography, abdomen; without contrast material, professional component only	90.00
74170	without contrast material followed by contrast material and further sections	403.00
74170-26	professional component only	115.50

Gastrointestinal Tract

74220	Radiologic examination; esophagus	$ 77.75
74220-26	professional component only	43.25
74240	Radiologic examination, gastrointestinal tract, upper; with or without delayed films, without KUB	93.00
74240-26	professional component only	44.00
74241	with or without delayed films, with KUB	57.00
74241-26	professional component only	37.75
74245	with small bowel, includes multiple serial films	130.60
74245-26	professional component only	64.60
74250	Radiologic examination, small bowel, includes multiple serial films	117.70
74250-26	professional component only	38.50
74270	Radiologic examination, colon; barium enema	94.20
74270-26	professional component only	42.95
74280	air contrast with specific high density barium, with or without glucagon	125.00
74280-26	professional component only	66.80
74290	Cholecystography, oral contrast	64.00
74290-26	professional component only	22.00
74291	additional, repeat examination or, multiple day examination	38.50
74291-26	professional component only	13.75
74300-26	Cholangiography; during surgery, professional component only	28.40
74305-26	postoperative, professional component only	34.50

Urinary Tract

74400	Urography (pyelography), intravenous, including kidneys, ureters, and bladder	$109.00
74400-26	professional component only	43.00
74405	with special hypertensive contrast concentration or clearance studies	135.00
74405-26	professional component only	44.00
74410	Urography, infusion, drip technique;	86.50
74410-26	professional component only	32.50
74415	with nephrotomography	124.60
74415-26	professional component only	47.25
74429-26	Urography, retrograde, with or without kidneys, ureters, and bladder, professional component only	16.50
74430-26	Cystography, minimum of three views; supervision and interpretation only, professional component only	17.75
74431	complete procedure	107.20
74431-26	professional component only	56.55
74450-26	Urethrocystography, retrograde; supervision and interpretation only, professional component only	15.50
74455	Urethrocystography, voiding; supervision and interpretation only	66.00
	professional component only	22.70
74456	complete procedure	117.10
74456-26	professional component only	50.50

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	Aorta and Arteries	
75754-26	Angiography, coronary, bilateral selective injection, including left ventricular and supravalvular angiogram and pressure recording; supervision and interpretation only, professional component only	$161.50
	Veins and Lymphatics	
75821-26	Venography, extremity, unilateral; complete procedure professional component only	$108.25
	Miscellaneous	
76000-26	Fluoroscopy (separate procedure), other than 71034 professional component only	$ 36.95
76020	Bone age studies	37.50
76020-26	professional component only	21.00
76040	Bone length studies (orthoroentgenogram, scanogram)	50.00
76040-26	professional component only	21.25
76090	Mammography; unilateral	60.00
76090-26	professional component only	30.00
76091	bilateral	93.90
76091-26	professional component only	39.50
76100	Radiologic examination, single plane body section (for example, tomography), other than kidney	100.00
76100-26	professional component only	54.00
76300	Thermography	45.00

Subp. 3. Diagnostic ultrasound. The following codes, service descriptions, and maximum fees apply to diagnostic ultrasound procedures. In C, "A-mode" implies a one-dimensional ultrasonic measurement procedure; "M-mode" implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures; "B-scan" implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display; and "Real-time scan" implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

	Head and Neck	
Code	Service	Maximum Fee
76505-26	Echoencephalography, A-mode; complete (diencephalic midline and ventricular size), professional component only	$ 62.50
76506-26	Echoencephalography, B-mode (gray scale) complete (for determination of ventricular size, delineation of cerebral contents and detection of fluid, masses, or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated, professional component only	130.00
76516	Echography, ophthalmic, ultrasonic biometry;	150.00
76535-26	Echography, thyroid; B-scan, professional component only	54.50
	Chest	
76620	Echocardiography, M-mode; complete	$206.80
76620-26	professional component only	60.00
	Abdomen and Retroperitoneum	
76700	Echography, abdominal, B-scan; complete	$135.00
76700-26	professional component only	65.00
76705	limited (for example, follow-up or limited study)	115.00
76705-26	professional component only	46.00
76770	Echography, retroperitoneal (for example, renal, aorta, nodes), B-scan; complete	148.00
76770-26	Professional component only	57.25
	Pelvis	
76805	Echography, pelvic, B-scan (for example, real-time), in obstetrics, gynecology, or transplants; complete	$ 90.00
76805-26	professional component only	58.00
76815	limited (fetal growth rate, heart beat, anomalies, placental location)	65.00
76815-26	professional component only	40.00
76855	Echography, pelvic area (Doppler)	117.20

76855-26	professional component only	60.50
76856	Echography, pelvic, real-time	72.00
76856-26	professional component only	57.25

Subp. 4. Therapeutic radiology. The following codes, procedures and maximum fees apply to therapeutic radiology procedures. Listings for teletherapy and brachytherapy include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services, and clinical treatment management procedures. They include normal follow-up care during the course of treatment and for three months following its completion.

Except where specified, clinical treatment management assumes treatment on a daily basis (four or five fractions per week) with the use of megavoltage photon or high energy particle sources. Daily and weekly clinical treatment management are mutually exclusive for the same dates. "Simple" means a single treatment area, single port or parallel opposed ports, simple blocks. "Intermediate" means two separate treatment areas, three or more ports on a single treatment area, use of special blocks. "Complex" means three or more separate treatment areas and highly complex blocking (mantle, inverted Y, tangential ports, wedges, compensators, or other special beam considerations).

Code	Service	Maximum Fee
77400-26	Daily megavoltage treatment management; simple professional component only	$ 18.50
77405	intermediate	85.00
77405-26	professional component only	54.00
77410	complex	29.50
77410-26	professional component only	45.00
77415-26	Therapeutic radiology treatment port film interpretation and verification, per treatment course, professional component only	36.00
77420	Weekly megavoltage treatment management; simple	20.00
77465	Daily kilovoltage treatment management	45.00

Subp. 5. Nuclear medicine. The following codes, service descriptions and maximum fees apply to nuclear medicine procedures. Procedures may be performed independently or in the course of overall medical care. The services listed do not include the provision of radium or other radioelements.

Diagnostic—Endocrine System

Code	Service	Maximum Fee
78000	Thyroid uptake; single determination	$ 14.00
78000-26	professional component only	19.00
78006-26	Thyroid imaging, with uptake; single determination, professional component only	51.20
78010-26	Thyroid imaging; only, professional component only	42.05

Diagnostic—Gastrointestinal System

78201-26	Liver imaging only; professional component only	$ 65.00
78215-26	Liver and spleen imaging; professional component only	61.00

Diagnostic—Musculoskeletal System

78300-26	Bone imaging; limited area (for example, skull, pelvis), professional component only	70.00
78305-26	multiple areas, professional component only	70.00
78306	whole body	238.00
78306-26	professional component only	70.00

Diagnostic—Cardiovascular System

78403-26	Cardiac blood pool imaging; with determination of regional ventricular function including ejection fraction and wall motion (for example, gated blood pool images), professional component only	75.50

Diagnostic—Respiratory System

78580-26	Pulmonary perfusion imaging; particulate, professional component only	$ 70.00

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	Diagnostic—Nervous System	
78601-26	Brain imaging, limited procedure; with vascular flow professional component only	$ 56.00
	Diagnostic—Genitourinary System	
78704-26	Kidney imaging; with function study (imaging renogram), professional component only	$ 70.00

5221.2400 PHYSICIAN SERVICES: PATHOLOGY AND LABORATORY.

Subpart 1. Scope. The following codes, service descriptions, and maximum fees apply to a provider licensed as a doctor of medicine or a doctor of osteopathy.

Subp. 2. Automated, multichannel tests. The following codes, service descriptions, and maximum fees apply to tests that can be and are frequently done as groups and combinations on automated multichannel equipment. For any combination of three or more tests among those listed below, the appropriate code from 80003-80019 shall apply. Automated, multichannel tests do not include multiple tests performed individually for immediate or "stat" reporting.

Albumin
Albumin/globulin ratio
Bilirubin, direct
Bilirubin, total
Calcium
Carbon dioxide content
Chloride
Cholesterol
Creatinine
Globulin
Glucose (sugar)
Lactic dehydrogenase (LDH)
Phosphatase, alkaline
Phosphorus (inorganic phosphate)
Potassium
Protein, total
Sodium
Transaminase, glutamic oxaloacetic (SGOT)
Transaminase, glutamic pyruvic (SGPT)
Urea nitrogen (BUN)
Uric acid

Automated Multichannel Tests

Code	Service	Maximum Fee
80003	Automated multichannel tests; 3 clinical chemistry tests	$ 30.00
80004	4 clinical chemistry tests	24.50
80005	5 clinical chemistry tests	31.00
80006	6 clinical chemistry tests	28.00
80007	7 clinical chemistry tests	24.00
80008	8 clinical chemistry tests	30.00
80009	9 clinical chemistry tests	31.00
80010	10 clinical chemistry tests	33.00
80011	11 clinical chemistry tests	29.10
80012	12 clinical chemistry tests	28.00
80016	13-16 clinical chemistry tests	31.90
80018	17-18 clinical chemistry tests	34.00
80019	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	30.65

Subp. 3. Urinalysis. The following codes, service descriptions, and maximum fees apply to urinalysis procedures.

Code	Service	Maximum Fee
81000	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy	$9.20
81002	routine, without microscopy	6.00
81004	components, single, not otherwise listed, specify	5.50
81005	chemical, qualitative, any number of constituents	5.00
81010	concentration and dilution test	6.50
81015	microscopic only	7.00

Subp. 4. Chemistry and toxicology. The following codes, service descriptions, and maximum fees apply to chemistry and toxicology procedures. The material for examination may be from any source. Examination is quantitative unless otherwise specified.

Code	Service	Maximum Fee
82011	Acetylsalicylic acid; quantitative	$ 19.00
82012	qualitative	15.25
82150	Amylase, serum;	16.00
82250	Bilirubin; blood, total OR direct	12.00
82270	Blood; occult, feces, screening	5.75
82310	Calcium, blood; chemical	12.50
82372	Carbamazepine, serum	27.85
82375	Carbon monoxide, (carboxyhemoglobin); quantitative	20.00
82435	Chlorides; blood (specify chemical or electrometric)	14.00
82465	Cholesterol, serum; total	11.50
82480	Cholinesterase; serum	18.00
82565	Creatinine; blood	11.50
82570	urine	13.00
82575	clearance	25.50
82607	Cyanocobalamin (Vitamin B-12); RIA	30.00
82643	Digoxin, RIA	30.00
82660	Drug screen (amphetamines, barbiturates, alkaloids	31.00
82756	Free thyroxine indes (T-7)	27.40
82947	Glucose; except urine (for example, blood, spinal fluid, joint fluid)	12.00
82948	blood, stick test	9.00
82950	post glucose dose (includes glucose)	12.00
82951	tolerance test (GTT), three specimens (includes glucose)	38.00
82977	Glutamyl transpeptidase, gamma (GGT)	12.00
82996	Gonadotropin, chorionic, bioassay; qualitative	14.50
82997	quantitative	17.00
82998	Gonadotropin, chorionic, RIA	26.00
83000	Gonadotropin, pituitary, follicle stimulating hormone (FSH); bioassay	40.00
83001	RIA	37.00
83002	Gonadotropin, pituitary, luteinizing hormone (LH) (ICSH), RIA	39.00
83020	Hemoglobin; electrophoresis	6.00
83540	Iron, serum; chemical	16.00
83545	automated	13.75
83550	Iron binding capacity, serum; chemical	23.75
83555	automated	21.90
83725	Lithium, blood, quantitative	15.75
84030	Phenylalanine (PKU), blood; Guthrie	9.00
84035	Phenylketones; blood, qualitative	10.00
84037	urine, qualitative	4.50
84045	Phenytoin	26.50
84060	Phosphatase, acid; blood	19.00
84065	prostatic fraction	22.00
84075	Phosphatase, alkaline, blood;	13.50
84078	heat stable (total not included)	18.00
84080	isoenzymes, electrophoretic method	35.00
84100	Phosphorus (phosphate); blood	12.00
84105	urine	12.50

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84132	Potassium; blood	11.75
84133	urine	10.00
84136	Pregnanediol; other method (specify)	16.00
84139	Pregnanetriol; other method (specify)	12.00
84165	Protein, total, serum; electrophoretic fractionation and quantitation	25.00
84180	Protein, urine; quantitative, 24-hour specimen	13.00
84190	electrophoretic fractionation and quantitation	21.30
84295	Sodium; blood	10.25
84300	urine	10.00
84420	Theophylline, blood, or saliva	31.00
84442	Thyroxine binding globulin (TBG)	21.50
84443	Thyroid stimulating hormone (TSH), RIA	35.00
84450	Transaminase, glutamic oxaloacetic (SGOT), blood; timed kinetic ultraviolet method	12.90
84455	colorimetric or fluorometric	11.50
84460	Transaminase, glutamic pyruvic (SGPT), blood; timed kinetic ultraviolet method	16.50
84478	Triglycerides, blood	14.50
84520	Urea nitrogen, blood (BUN); quantitative	11.75
84550	Uric acid; blood, chemical	12.00
84555	uricase, ultraviolet method	13.00
84560	Uric acid, urine	13.50

Subp. 5. Hematology. The following codes, service descriptions, and maximum fees apply to hematology procedures.

Code	Service	Maximum Fee
85005	Blood count; basophil count, direct	$ 16.00
85007	differential WBC count (includes RBC morphology and platelet estimation)	9.00
85009	differential WBC count, buffy coat	12.25
85012	eosinophil count, direct	12.00
85014	hematocrit	7.00
85018	hemoglobin, colorimetric	7.00
85021	hemogram, automated (RBC, WBC, Hgb, Hct and indices only)	14.00
85022	hemogram, automated, with platelet count	20.00
85027	hemogram, automated, and differential WBC count (CBC)	20.25
85031	hemogram, manual, complete CBC (RBC, WBC, Hgb, Hct, differential and indices)	19.00
85041	red blood cell (RBC)	6.50
85044	reticulocyte count	11.00
85095	Bone marrow; aspiration only	54.00
85102	biopsy core (needle)	72.00
85210	Clotting; factor II, prothrombin, specific	10.00
85580	Platelet; count (Rees-Ecker)	11.70
85585	estimation on smear, only	9.00
85590	phase microscopy	12.00
85595	electronic technique	10.40
85610	Prothrombin time	10.00
85650	Sedimentation rate (ESR); Wintrobe type	8.25
85651	Westergren type	8.50
85660	Sickling of RBC, reduction, slide method	8.00

Subp. 6. Immunology. The following codes, service descriptions, and maximum fees apply to immunology procedures.

Code	Service	Maximum Fee
86006	Antibody, qualitative, not otherwise specified; first antigen, slide or tube	$ 15.30
86008	Antibody, quantitative titer, not otherwise specified; first antigen	17.50
86016	Antibodies, RBC, saline; high protein and antihuman globulin technique	14.00
86017	with ABO + Rh(D) typing (for holding blood instead of complete crossmatch)	16.00
86060	Antistreptolysin O; titer	19.00
86063	screen	10.00

86080	Blood typing; ABO only	9.50
86096	Blood typing, RBC antigens other than ABO or Rho(D); direct, slide or tube, including Rh subtypes, each antigen	10.00
86100	Blood typing; Rho(D) only	14.00
86105	Rh genotyping, complete	10.35
86140	C-reactive protein	11.25
86255	Fluorescent antibody; screen	27.55
86256	titer	26.50
86280	Hemagglutination inhibition tests (HAI), each (for example, amebiasis, rubella, viral)	17.00
86287	Hepatitis B surface antigen (HB_xAg) (Australian antigen, HAA); RIA method	20.00
86300	Heterophile antibodies; screening (includes monotype test), slide or tube	11.00
86305	quantitative titer	16.00
86430	Rheumatoid factor, latex fixation	14.00
86580	Skin test; tuberculosis, patch, or intradermal	7.50
86585	tuberculosis, tine test	6.25

Subp. 7. Microbiology. The following codes, service descriptions, and maximum fees apply to microbiology procedures.

Code	Service	Maximum Fee
87040	Culture, bacterial, definitive, aerobic; blood (may include anaerobic screen)	$ 15.00
87045	stool	21.35
87060	throat or nose	10.00
87072	Culture, presumptive, pathogenic organisms, by commercial kit, any source except urine	20.00
87076	Culture, bacterial, any source; definitive identification, including gas chromatography in addition to anaerobic culture	17.75
87081	Culture, bacterial, screening only, for single organisms	11.50
87082	Culture, presumptive, pathogenic organisms, screening only, by commercial kit (specify type); for single organisms	10.00
87083	multiple organisms	17.50
87084	with colony estimation from density chart (includes throat cultures)	19.25
87086	Culture, bacterial, urine; quantitative, colony count	15.00
87087	commercial kit	8.75
87088	identification, in addition to quantitative or commercial kit	18.00
87101	Culture, fungi, isolation; skin	15.00
87102	other source	8.00
87106	definitive identification, by culture, per organism, in addition to skin or other source	21.90
87140	Culture, typing; fluorescent method, each antiserum	12.65
87163	Culture, special extensive definitive diagnostic studies, beyond usual definitive studies	29.00
87164	Dark field examination, any source (for example, penile, vaginal, oral, skin); includes specimen collection	6.00
87181	Sensitivity studies, antibiotic; agar diffusion method, each antibiotic	15.50
87184	disc method, each plate (12 or less discs)	15.00
87186	microtiter, minimum inhibitory concentration (MIC), 8 or less antibiotics	20.00
87188	tube dilution method, each antibiotic	19.00
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types	10.00
87206	fluorescent and/or acid fast stain for bacteria, fungi, or cell types	11.80
87210	wet mount with simple stain and interpretation, for bacteria, fungi, ova, or parasites	9.30
87211	wet and dry mount, with interpretation, for ova and parasites	9.80
87220	Tissue examination for fungi (for example, KOH slide)	10.30

Subp. 8. Anatomic pathology. The following codes, service descriptions, and maximum fees apply to anatomic pathology procedures.

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Cytopathology

Code	Service	Maximum Fee
88104	Cytopathology, fluids, washings or brushings, with centrifugation except cervical or vaginal; smears and interpretation	$ 26.90
88109	smears and cell block with interpretation	45.00

Subp. 9. Surgical pathology. The following codes, service descriptions, and maximum fees apply to surgical pathology procedures. The services listed include accession, handling, and reporting. Only one of the codes listed (88302-88307) should be used in reporting specimens (single or multiple) that are removed during a single surgical procedure.

Code	Service	Maximum Fee
88300	Surgical pathology, gross examination only	$ 25.00
88302	Surgical pathology, gross and microscopic; examination for identification and record purposes (for example, uterine tubes, vas deferens, sympathetic ganglion)	30.00
88304	diagnostic exam, small or uncomplicated specimen (for example, skin lesion, needle biopsy)	35.00
88305	diagnostic exam, larger specimen or multiple small specimens (for example, prostate clippings, uterine curetings segment of stomach)	70.00
88307	complex diagnostic exam, large specimen, organs or multiple tissues requiring multiple slides	80.00
88312	Special stains; Group I stains for microorganisms (for example, Gridley, acid fast, methenamine silver, Levaditi)	16.40
88313	Group II, all other special stains, except immunoperoxidase stains	15.00

Subp. 10. Miscellaneous. The following codes, service descriptions, and maximum fees apply to miscellaneous pathology and laboratory services.

Code	Service	Maximum Fee
89007	Test combinations assigned individual procedure numbers for secretarial convenience only; CBC, urinalysis, serology, blood typing, and Rh grouping (includes codes 85022 or 85031, 81000, 86592, 86082, and 86100)	$ 38.50
89050	Cell count, miscellaneous body fluids (for example, CSF, joint fluid, except blood)	$ 15.00
89180	Microscopic examination for eosinophils, nasal secretions, sputum, bronchoscopic aspiration, mucus of stools, others (specify)	10.00

5221.2500 DENTISTS.

Subpart 1. Scope. The codes, service descriptions, and maximum fees in this part apply to persons licensed as doctors of dental surgery or a comparable degree.

Subp. 2. Diagnostic. The following codes, service descriptions, and maximum fees apply to diagnostic services.

Clinical Oral Examinations

Code	Service	Maximum Fee
00110	Initial oral examination	$ 11.00
00120	Periodic oral examination	10.00
00130	Emergency oral examination	12.00

Radiographs

00210	Intraoral complete series (including bitewings)	$ 34.00
00220	Intraoral; periapical, single, first film	5.00
00230	periapical, each additional film	4.00
00240	occlusal, film	7.00
00250	Extraoral; single, first film	5.00
00260	each additional film	4.00
00270	Bitewing; single film	6.00
00272	two films	9.00
00274	four films	13.00
00330	Panoramic; maxilla and mandible, film	30.00
00335	maxilla and mandible, film, with bitewings	37.00
00340	Cephalometric film	34.00

Tests and Laboratory Examinations

00460	Pulp vitality tests	$ 10.00
00470	Diagnostic casts, with report	25.00
00471	Diagnostic photographs	17.00

Subp. 3. Restorative. The following codes, service descriptions, and maximum fees apply to restorative procedures. Amalgam restorations include polishing.

Amalgam Restorations

Code	Service	Maximum Fee
02110	Amalgam; one surface, deciduous	$ 20.00
02120	two surfaces, deciduous	31.00
02130	three surfaces, deciduous	40.00
02131	four surfaces, deciduous	48.00
02140	one surface, permanent	20.00
02150	two surfaces, permanent	32.00
02160	three surfaces, permanent	42.00
02161	four or more surfaces, permanent	50.00
02190	Pin retention, exclusive of amalgam	10.00

Silicate Restorations

02210	Silicate cement per restoration	$ 20.00

Acrylic or Plastic Restorations

02310	Acrylic or plastic	$ 24.00
02330	Composite resin; one surface	26.00
02331	two surfaces	40.00
02332	three surfaces	51.00
02334	Pin retention, exclusive of composite resin	10.00
02335	Composite resin (involving incisal angle)	50.00

Crowns—Single Restorations Only

02711	Plastic, prefabricated	$ 80.00
02830	Stainless steel	60.00
02840	Temporary (fractured tooth)	52.00
02892	Steel post and composite or amalgam in addition to crown	65.00

Other Restorative Services

02910	Recement inlays	$ 17.00
02920	Recement crowns	20.00
02940	Fillings (sedative)	20.00
02950	Crown buildups, pin retained	60.00

Subp. 4. Endodontics. The following codes, service descriptions, and maximum fees apply to endodontic procedures. Pulpotomy procedures exclude final restoration. Root canal therapy includes treatment plan, clinical procedures, and follow-up care.

Pulpotomy

Code	Service	Maximum Fee
03220	Vital pulpotomy	$ 34.00

Root Canal Therapy

03310	Anterior (excludes final restoration)	$ 150.00

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03320	Bicuspid (excludes final restoration)	175.00
03330	Molar (excludes final restoration)	220.00
	Periapical Services	
03410	Apicoectomy; performed as separate surgical procedure (per root)	$ 97.50
03420	performed in conjunction with endodontic procedure (per root)	85.00
03430	Retrograde filling	90.00
03440	Apical curettage	75.00

Subp. 5. Periodontics. The following codes, service descriptions, and maximum fees apply to periodontic procedures. Surgical services include usual post-operative services.

Surgical Services

Code	Service	Maximum Fee
04210	Gingivectomy or gingivoplasty, per quadrant	$ 100.00
04220	Gingival curettage and root planing	70.00
04260	Osseous surgery (including flap entry and closure), per quadrant	200.00
	Adjunctive Periodontal Services	
04330	Occlusal adjustment; limited	$ 35.00
04331	complete	100.00

Subp. 6. Prosthodontics, removable. The following codes, service descriptions, and maximum fees apply to removable prosthodontics. Complete and partial denture procedures include six months post-delivery care.

Complete Dentures

Code	Service	Maximum Fee
05110	Complete upper	$ 400.00
05120	Complete lower	400.00
05130	Immediate upper	400.00
05140	Immediate lower	400.00
05151	Identification, upper prosthesis	10.00
05161	Identification, lower prosthesis	10.00
	Partial Dentures	
05211	Upper, without clasps, acrylic base	$ 200.00
05216	Upper, with two chrome clasps with rests, acrylic base	420.00
05218	Lower, with chrome clasps with rests, acrylic base	450.00
05231	Lower, with chrome lingual bar and two clasps, acrylic base	450.00
05241	Lower, with chrome lingual bar and two clasps, cast base	475.00
05251	Upper, with chrome palatal bar and two clasps, acrylic base	450.00
05261	Upper, with chrome palatal bar and two clasps, cast base	475.00
05292	Full cast partial, with two chrome clasps (upper)	475.00
05294	Full cast partial, with two chrome clasps (lower)	475.00
	Adjustments to Dentures	
05410	Complete denture	$ 15.00
05421	Partial denture (upper)	15.00
05422	Partial denture (lower)	15.00
	Repairs to Dentures	
05610	Repair broken complete or partial denture, no teeth damaged	$ 45.00
05620	Repair broken complete or partial denture, replace one broken tooth	47.00
05630	Replace additional teeth, each tooth	20.00
05640	Replace broken tooth or denture, no other repairs	40.00
05650	Adding tooth to partial denture to replace extracted tooth; each tooth (not involving clasp or abutment tooth)	50.00
05660	each tooth (involving clasp or abutment tooth)	75.00
05670	Reattaching damaged clasp on denture	50.00

05680	Replacing broken clasp with new clasp on denture	61.00
05690	Each additional clasp with rest	50.00
	Denture Duplication	
05710	Duplicate upper or lower complete denture	$ 185.00
05720	Duplicate upper or lower partial denture	175.00
	Denture Relining	
05730	Relining upper or lower complete denture (office recline)	$ 110.00
05740	Relining upper or lower partial denture (office recline)	80.00
05750	Relining upper or lower complete denture (laboratory)	125.00
05760	Relining upper or lower partial denture (laboratory)	125.00
	Other Prosthetic Services	
05820	Denture, temporary (partial-stayplate), upper	$ 130.00
05850	Tissue conditioning	24.00

Subp. 7. Prosthodontics, fixed. The following codes, service descriptions, and maximum fees apply to fixed prosthodontics.

Repairs

Code	Service	Maximum Fee
06620	Replace broken facing where post is intact	$ 40.00
06640	Replace broken facing with acrylic	50.00
	Other Prosthetic Services	
06930	Recement bridge	$ 30.00

Subp. 8. Oral surgery. The following codes, service descriptions, and maximum fees apply to oral surgery procedures. Surgical extractions include local anesthesia and routine post-operative care. Surgical excisions apply to excision of reactive inflammatory lesions (scar tissue or localized congenital lesions).

Extractions

Code	Service	Maximum Fee
07110	Single tooth	$ 25.00
07120	Each additional tooth	25.00
	Surgical Extractions	
07210	Extraction of tooth, erupted	$ 55.00
07220	Impaction that requires incision of overlying soft tissue and the removal of the tooth	70.00
07230	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and the removal of the tooth	89.00
07240	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and sectioning of the tooth for removal	100.00
07241	Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and presents unusual difficulties and circumstances	110.00
07250	Root recovery (surgical removal of residual root)	50.00
	Other Surgical Procedures	
07280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including wire attachment where indicated	$ 95.00
07285	Biopsy of oral tissue (hard)	50.00
07286	Biopsy of oral tissue (soft)	70.00

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	Alveoloplasty (surgical preparation of ridge for dentures)	
07310	Per quadrant, in conjunction with extractions	$ 50.00
07320	Per quadrant, not in conjunction with extractions	60.00
	Surgical Excision	
07410	Radical excision; lesion diameter up to 1.25 centimeters	$ 50.00
07425	Excision pericoronal gingiva	30.00
	Removal of Cysts and Neoplasms	
07450	Removal of odontogenic cyst or tumor, up to 1.25 centimeters diameter	$ 85.00
	Surgical Incision	
07510	Incision and drainage of abscesses, intraoral	$ 35.00
	Other Repair Procedures	
07960	Frenulectomy, separate procedure (frenectomy or frenotomy)	$ 70.00

Subp. 9. Orthodontics. The following codes, service descriptions, and maximum fees apply to orthodontic procedures.

	Diagnostic Procedures	
Code	Service	Maximum Fee
08010	Examination, OIS sheet, photos	$ 25.00
08020	Full ortho case study	80.00

Subp. 10. Miscellaneous. The following codes, service descriptions, and maximum fees apply to miscellaneous dental procedures not listed elsewhere.

Code	Service	Maximum Fee
09110	Palliative (emergency) treatment of dental pain, minor procedures	$ 18.00
	Anesthesia	
09220	General	$ 50.00
09230	Analgesia	10.00
	Professional Consultation	
09310	Consultation, per session	$ 20.00
	Professional Visits	
09410	House calls	$ 15.00
09420	Hospital calls	12.00
09430	Office visit, during regularly scheduled office hours (no operative services performed)	12.00
09440	Office visit, after regularly scheduled office hours (no operative services performed and no other services rendered)	25.00
	Drugs	
09610	Therapeutic drug injection (excluding drug cost)	$ 10.00
	Miscellaneous Other Services	
09910	Application of desensitizing medicaments (where not included or implied in associated procedure)	$ 10.00

5221.2600 OPTOMETRISTS, OPTICIANS.

Subpart 1. Scope. The codes, service descriptions, and maximum fees in this part apply to licensed optometrists and opticians.

Subp. 2. Basic optometric services. The following codes, service descriptions, and maximum fees apply to basic optometric services.

Code	Service	Maximum Fee
80101	Basic vision examination and diagnosis, to include the following minimum procedures: case history; visual acuity, distance and near; internal and external eye health examination; subjective refraction for distance and near; phorometric tests of accommodation, convergence, and binocular coordination at far and near point; visual skills; and case analysis and presentation	$ 32.00

80102	Basic vision examination and diagnosis, presbyopic (over 30) to include the following procedures: all included in 80101, except visual skills may be deleted; and tonometry and field screening	36.00
80103	Single vision prescription service (includes frame measurements, computation of lens specifications and verification of completed prescription)	25.00
80104	Single vision dispensing services (includes frame selection, fitting, and servicing)	23.00
80113	Multifocal prescription service (includes frame measurements, computation of lens specifications and verification of completed prescription)	27.00
80114	Multifocal dispensing services (includes frame selection, fitting, and servicing)	24.00
80105	Office call: visual screening or evaluation of patient's complaint to determine need for further examination	15.00
80106	Out of office call	10.00

Subp. 3. Low vision prescription device. The following codes, service descriptions, and maximum fees apply to low vision prescription devices. The services and codes listed are to be employed in place of 80103 and 80104.

Code	Service	Maximum Fee
80403	Prescription services, including: frame measurement, vertex distance measurement; computation of lens specifications; and verification of completed prescription	$ 40.00
80404	Dispensing services, including: frame selection; and fitting and servicing	25.00

Subp. 4. Miscellaneous services. The following codes, service descriptions, and maximum fees apply to miscellaneous services not listed elsewhere. The services listed shall not be employed for follow-up services included in prior charges to established patients. The services listed do not include laboratory or materials charges.

Code	Service	Maximum Fee
80801	Minor refitting	$ 5.00
80811	Complete refitting	4.60
80802	Frame replacements with necessary adjustments	17.00
80803	Front replacements with necessary adjustments	12.00
80804	One or both temple replacements with necessary adjustments	8.00
80805	Hinge repair	5.50
80807	Minor frame repair and readjustment of frame, including: replacement of screws; supply of new nose pads; supply of temple covers; supply of pad covers; soldering; and other miscellaneous minor repairs	5.00
80808	Neutralization of lenses for copy of prescription	4.00
80809	Lens replacement; one lens, single vision	12.00
80810	both lenses, single vision	27.00
80819	one lens, multifocal vision	19.00
80820	both lenses, multifocal vision	42.40

Subp. 5. Materials, supplies. The following codes, service or supply descriptions, and maximum fees apply to materials and supplies. The services listed do not include associated office visits or other professional services.

Code	Service	Maximum Fee
80107	Frames	$ 12.00
80108	Single vision lenses	17.50
80111	Multifocal lenses	30.00
80118	Lenses for aphakia	58.00

5221.2700 AUDIOLOGISTS AND SPEECH PATHOLOGISTS.

Subpart 1. Scope. The codes, service descriptions, and maximum fees in this part apply to audiologists and to speech pathologists certified by the American Speech and Hearing Association.

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Subp. 2. Audiology. The following codes, service descriptions, and maximum fees apply to audiology services.

Code	Service	Maximum Fee
21020	Basic hearing evaluation	$ 45.00
21021	Limited hearing evaluation	32.00
21022	Extended hearing evaluation	64.00
21031	Limited site of auditory lesion evaluation	16.00
21032	Extended site of auditory lesion evaluation	32.00
21050	Basic prescription hearing aid evaluation	40.00
21052	Extended prescription hearing aid evaluation	45.00
21053	Performance evaluation of specific hearing aid	15.00
21081	Hearing screening, group	9.50

Subp. 3. Speech pathology. The following codes, service descriptions, and maximum fees apply to speech pathology services.

Code	Service	Maximum Fee
22010	Basic speech, language, or voice evaluation	$ 80.00
22012	Extended speech, language, or voice evaluation	43.50
22060	Basic consultation	30.00
22070	Rehabilitation one-fourth hour, individual	16.50
22071	Rehabilitation one-half hour, individual	30.00
22072	Rehabilitation one hour, individual	58.00
22073	Rehabilitation one-half hour, group	20.00
22074	Rehabilitation one hour, group	30.00

5221.2800 PHYSICAL THERAPISTS AND OCCUPATIONAL THERAPISTS.

Subpart 1. Scope. The codes, service descriptions, and maximum fees in this part apply to registered physical therapists and occupational therapists.

Subp. 2. Physical therapy. The following codes, service descriptions, and maximum fees apply to physical therapy procedures.

Evaluations

Code	Service	Maximum Fee
24001	Physical function evaluation; initial 15-minute unit	$ 16.00
24010	Perceptual, sensory, or motor evaluation; initial 15-minute unit	15.50
24011	additional 15-minute units	15.50
24015	Activities of daily living evaluation; initial 15-minute unit	25.00
24016	additional 15-minute units	25.00

Physical Restoration Procedures

97000	Office visit with one of the following modalities to one area; 1. Hot or cold packs 2. Traction, mechanical 3. Electrical stimulation 4. Ultrasound 5. Vasopneumatic devices 6. Paraffin bath 7. Microwave 8. Whirlpool 9. Diathermy 10. Infrared 11. Ultraviolet	$ 27.50
97050	Office visit with two or more modalities to the same area	34.00
97100	Office visit with one of the following procedures to one area; initial 30 minutes 1. Therapeutic exercises 2. Neuromuscular reeducation 3. Functional activities	

4. Gait training
5. Orthotics training
6. Prosthetics training
7. Electrical stimulation (manual)
8. Iontophoresis
9. Traction, manual
10. Massage
11. Contract baths
12. Muscle testing (manual)
13. Range of motion measurements
14. TENS

97101	each additional 15 minutes	22.00 10.00
97200	Office visit including combination of any modality and procedure; initial 30 minutes	29.50
97201	each additional 15 minutes	11.50

Maintenance Therapy Procedures

24201	Maintenance therapy procedures; initial 15-minute unit	$ 7.75
24202	additional 15-minute units	7.75
24301	Consultation with report—for specific individual patient; initial 15-minute unit	8.25
24302	additional 15-minute units	14.00

Subp. 3. Occupational therapy. The following codes, service descriptions, and maximum fees apply to occupational therapy procedures.

Evaluations

Code	Service	Maximum Fee
23010	Perceptual, sensory, or motor evaluation; initial 15-minute unit	$ 17.00
23011	additional 15-minute units	17.00
23015	Activities of daily living evaluation; initial 15-minute unit	12.50
23016	additional 15-minute units	12.50

Physical Restoration Procedures

23100	Activities of daily living training; initial 15-minute unit	$ 12.50
23101	additional 15-minute units	12.50
23115	Dexterity or coordination training; initial 15-minute unit	12.50
23116	additional 15-minute units	12.50
23135	Neurodevelopmental training; initial 15-minute unit	14.00
23136	additional 15-minute units	13.50
23150	Perceptual, sensory, or motor training; one hour group session	25.00
23151	initial 15-minute unit, individual	14.60
23152	additional 15-minute units, individual	13.50

Consultation Services

23300	Consultation with report, for specific individual patient; initial 15-minute unit	$ 14.60
23301	additional 15-minute units	13.50

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5221.2900 CHIROPRACTORS.

Subpart 1. Scope. The codes, service descriptions and maximum fees in this part apply to licensed doctors of chiropractic medicine.

Subp. 2. Medicine. The following codes, service descriptions, and maximum fees apply to medical services.

Code	Service	Maximum Fee
09510	Routine initial examination, history and diagnosis	$ 30.00
09501	Intermediate examination, history and diagnosis	30.00
09502	Extensive examination with history and diagnosis, complete history and physical examination of one or more systems, with report	60.00
09506	Intermediate examination or evaluation, same illness, established patient, progress examination, with report	27.00
09509	Home or nursing home visit with routine chiropractic examination and/or treatment which includes adjustment, manipulation, and/or one unit of conjunctive therapy for the same or new condition	50.00
09503	Office visit with cast application to one area, for example, short arm, short leg, knee, or elbow, excluding materials	21.00
09508	Office visit with cast application to one area, for example, long leg, thoracolumbar, lumbosacral, or full body corset type, excluding materials	27.00
09009	Same visit, each additional conjunctive or manipulative therapy per anatomical area of diagnosis, for example, neck, back, extremities—anatomical areas include associated soft tissues and nerves. Includes office visit	10.00
09504	Treatment, one unit of manipulative or conjunctive therapy (specify). Includes office visit	18.00
09505	Treatment, one unit of manipulative and one unit of conjunctive therapy (specify). Includes office visit	27.00
09194	Thermography, initial or subsequent, used for evaluative purposes	30.00
09507	Ambulation traction application	10.00

Subp. 3. Radiology. The following codes, service descriptions, and maximum fees apply to radiology services, and include both the technical and professional (interpretive) components of the service.

Code	Service	Maximum Fee
	Chest	
71010	Radiologic examination, chest; (single view, posteroanterior)	$ 25.00
	Spine and Pelvis	
72010	Radiologic examination, spine, entire, survey study (14 × 36, anteroposterior and lateral)	$ 50.00
72040	Radiologic examination, spine, cervical; limited (anteroposterior and lateral)	30.00
72050	comprehensive (minimum of four views)	48.00
72052	comprehensive (minimum of seven views including flexion and extension)	39.00
72070	Radiologic examination, spine; thoracic, (anteroposterior and lateral)	39.00
72080	thoracic, limited (anteroposterior and lateral)	35.00
72090	scoliosis study, comprehensive	34.00
72100	Radiologic examination, spine; lumbar, limited (anteroposterior and lateral)	40.00
72110	lumbosacral, comprehensive (minimum of five views)	60.00
72120	Radiologic examination, spine, lumbosacral, bending views only (minimum of four views)	40.00
72170	Radiologic examination, pelvis; limited (minimum of two views)	40.00
	Upper Extremities	
73020	Radiologic examination, shoulder; limited (one projection)	$ 25.00
73030	comprehensive, complete study	30.00
73070	Radiologic examination, elbow; limited (anteroposterior and lateral)	25.00
73100	Radiologic examination, wrist; limited (anteroposterior and lateral)	30.00
73120	Radiologic examination, hand	25.00
	Lower Extremities	
73500	Radiologic examination, hip; limited (one view)	$ 25.00
73560	Radiologic examination, knee; limited (two views)	30.00
73570	Radiologic examination, knee; comprehensive (minimum of three views)	35.00
73600	Radiologic examination, ankle; limited (two views)	30.00

73610	comprehensive (minimum of three views)	55.00
73620	Radiologic examination, foot; limited (two views)	25.00
73630	complete routine study (minimum of three views)	35.00
	Miscellaneous	
76140	Consultation on x-ray examination made elsewhere, written report	$ 25.00

Subp. 4. Laboratory. The following codes, service descriptions, and maximum fees apply to laboratory procedures. Automated, standard chemistry profiles (codes 8003-80019) include the following tests:

Albumin
Bilirubin, direct
Bilirubin, total
Calcium
Carbon dioxide content
Cephalin flocculation
Chlorides
Cholesterol
Creatinine
Hemoglobin
Hematocrit
Lactic dehydrogenase
Phosphatase, acid
Phosphatase, alkaline
Phosphorus
Potassium
Protein, total
Red blood cell count
Sodium
Sugar (glucose)
Thymol turbidity
Transaminase, gluten, exalic (SGOT)
Transminase, gluten, pyruvic (SGPT)
Triglycerides
Urea nitrogen
Uric acid
White blood cell count

Code	Service	Maximum Fee
80003	Standard profile (up to and including 12 tests) for arthritic, bone, lipid and thyroid	$ 74.00
80019	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)	71.00
81000	Urinalysis; routine (pH, specific gravity, protein, tests for reducing substances as glucose), with microscopy	10.00
81002	routine, without microscopy	15.00
85022	Blood count; hemogram, automated (CBC) with differential WBC count	22.00

5221.3000 PODIATRISTS.

Subpart 1. Scope. The codes, service descriptions, and maximum fees in this part apply to licensed doctors of podiatric medicine.

Subp. 2. Medicine. The following codes, service descriptions, and maximum fees apply to medical services.

Patient Visits

Code	Service	Maximum Fee
09000	Initial office visit, routine, new patient or new illness, history and examination	$ 28.00
09003	Follow-up office visit, brief, for example, routine injection, minimal dressing	15.00
09004	Follow-up office visit, routine	18.00
09005	Follow-up office visit necessitating professional care over and above routine visit	24.00
09006	Follow-up office visit, prolonged, over and above 09005	23.00
09001	Initial hospital visit, limited	35.00
09002	Comprehensive hospital visit	24.00
09010	Initial home or convalescent home visit, routine, new patient or new illness, history and examination	18.00

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Physical Medicine

09440	Office visit with one or more of the following modalities to one area:	
	Hot or cold packs	Paraffin bath
	Traction, mechanical	Microwave
	Electrical stimulation	Whirlpool
	Ultrasound	Diathermy
	Vasopneumatic devices	Infrared
	Ultraviolet	$ 18.00

Subp. 3. Surgery. The following codes, service descriptions, and maximum fees apply to surgical services. An asterisk (*) indicates that the service includes the surgical procedure only. All other services include the operation per se, and normal uncomplicated pre- and postoperative follow-up care.

Integumentary System

Code	Service	Maximum Fee
00125*	Drainage of onychia or paronychia	$ 20.00
00160*	Debridement of extensively eczematized or infected skin up to ten percent of the body surface	18.00
00162*	Debridement of nails, any method; five or less	18.00
00163*	each additional five nails or major portion thereof	9.00
00164	Debridement of abrasions	20.00
00171	Biopsy, excision of skin, subcutaneous tissue or mucous membrane for biopsy including simple closure as an independent procedure	25.00
00225*	Avulsion, nail, partial or complete, simple	17.00
00228	Excision of nail or nail matrix, partial or complete, for example, ingrown or deformed nail for permanent removal	159.00
00403*	Electro-surgical destruction or cemocantery or cryocautery of benign or pre-malignant lesion with or without curettement, one lesion	27.00

Subp. 4. Radiology. The following codes, service descriptions, and maximum fees apply to radiology services.

Code	Service	Maximum Fee
07308	Radiologic examination, ankle; complete minimum of three views	$ 30.00
07309	Radiologic examination, foot; two views	30.00
07310	complete routine study, minimum of three views	45.00

Subp. 5. Material, supplies. The following codes, service or supply descriptions, and maximum fees apply to materials and supplies. The services listed do not include associated office visits or other professional services, unless explicitly stated.

Code	Service	Maximum Fee
01209	Fitted orthotic balanced appliance: metal, thermoplastic, or other; unilateral	$ 66.00
01259	bilateral	150.00
01509	Negative impression for fitted orthotic, unilateral	25.50
01809	Post-surgical splint (Reece surgical shoe)	16.50
01909	Strappings for partial immobilization of foot or ankle	15.00
02009	Foot, ankle, leg measurements (bio-mechanical evaluation) for orthotics, prosthetics for foot deformities	25.00
06600	Sterile surgical tray set-up (supplies)	40.00

5221.3100 PSYCHOLOGISTS AND SOCIAL WORKERS.

Subpart 1. Scope. The codes, service descriptions, and maximum fees of this part apply to licensed psychologists and social workers with the master of social work degree or a comparable degree.

Subp. 2. Psychological services. The following codes, service descriptions, and maximum fees apply to psychological services.

Code	Service	Maximum Fee
09046	Initial office visit with evaluation and history, one hour	$ 70.00
09048	Initial inpatient hospital visit, including history and evaluation, per hour	70.00
09066	Psychotherapy (inpatient, outpatient, office or home) one hour, or biofeedback performed by a licensed consulting psychologist, one hour	70.00
09067	Psychotherapy, group (maximum ten persons per group) 1½ hours per person	35.00

09068	Psychotherapy (inpatient, outpatient, office or home) half hour, or biofeedback performed by a licensed consulting psychologist, one-half hour	45.00
09070	Family members psychotherapy, conjoint, two or more members, family group, evaluation and therapy per hour (per family charge)	65.00

Subp. 3. Social workers counseling. The following codes, service descriptions, and maximum fees apply to counseling by social workers.

Code	Service	Maximum Fee
25210	Individual client counseling; initial 30-minute unit	$ 30.00
25211	additional 30-minute units	30.00
25215	Family counseling; initial 30-minute unit	23.10
25216	additional 30-minute units	23.10

5221.3200 HOSPITAL—SEMI-PRIVATE ROOM CHARGES.

Subpart 1. Scope. The following service descriptions and maximum fees apply to daily charges for semi-private rooms at the hospitals listed below. The maximum fees do not apply to semi-private rooms for which a rate higher than the hospital's normal rate applies and which require an unusually high level of service, such as emergency or intensive care rooms. The maximum fees apply to daily semi-private room charges only. The maximum fees do not apply to private or ward rooms, and to not apply to hospital charges for services not customarily included in the daily room charge.

Subp. 2. Group 1. The following hospitals make up group 1:

A. Abbott Northwestern Hospital, Minneapolis
B. Bethesda Lutheran Medical Center, St. Paul
C. The Children's Hospital, St. Paul
D. Divine Redeemer Memorial Hospital, South St. Paul
E. Eitel Hospital, Minneapolis
F. Fairview Hospital, Minneapolis
G. Fairview-Deaconess Hospital, Minneapolis
H. Fairview-Southdale Hospital, Minneapolis
I. Gillette Children's Hospital, St. Paul
J. Golden Valley Health Center, Golden Valley
K. Mercy Medical Center, Coon Rapids
L. Methodist Hospital, St. Louis Park
M. Metropolitan Medical Center, Minneapolis
N. Midway Hospital, St. Paul
O. Miller-Dwan Medical Center, Duluth
P. Minneapolis Children's Hospital, Minneapolis
Q. Mounds Park Hospital, St. Paul
R. Mount Sinai Hospital, Minneapolis
S. North Memorial Medical Center, Robbinsdale
T. Saint Cloud Hospital, St. Cloud
U. St. John's Hospital, St. Paul
V. St. Joseph's Hospital, St. Paul
W. St. Luke's Hospital, Duluth
X. St. Mary's Hospital, Duluth
Y. St. Mary's Hospital, Minneapolis
Z. The Samaritan Hospital, St. Paul
AA. Sister Kenny Institute, Minneapolis
BB. United Hospital, St. Paul
CC. Unity Medical Center, Fridley

Service		Maximum Fee
Group 1	semi-private room charge for one day	$ 200.86

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Subp. 3. Group 2. The following hospitals make up group 2:

A. A. L. Vadheim Memorial Hospital, Tyler
B. Ada Municipal Hospital, Greenbush
C. Aitkin Community Hospital, Aitkin
D. Albany Community Hospital, Albany
E. Appleton Municipal Hospital, Appleton
F. Arlington Municipal Hospital, Arlington
G. Arnold Memorial Hospital, Adrian
H. Buffalo Memorial Hospital, Buffalo
I. Caledonia Community Hospital, Caledonia
J. Canby Community Hospital, Canby
K. Central Mesabi Medical Center, Hibbing
L. Chippewa County-Montevideo Hospital, Montevideo
M. Chisago Lakes Hospital, Chisago City
N. Clarkfield Memorial Hospital, Clarkfield
O. Clearwater County Memorial Hospital, Bagley
P. Cloquet Community Memorial Hospital, Cloquet
Q. Comfrey Hospital, Comfrey
R. Community Hospital—Cannon Falls, Cannon Falls
S. Community Hospital—St. Peter, St. Peter
T. Community Memorial Hospital—Deer River, Deer River
U. Community Memorial Hospital—Spring Valley, Spring Valley
V. Community Memorial Hospital—Winona, Winona
W. Community Mercy Hospital—Onamia, Onamia
X. Cook Community Hospital, Cook
Y. Cook County Northshore Hospital, Grand Marais
Z. Cuyuna Range District Hospital, Crosby
AA. Dr. Henry Schmidt Memorial Hospital, Westbrook
BB. District Memorial Hospital—Forest Lake, Forest Lake
CC. Divine Providence Hospital, Ivanhoe
DD. Douglas County Hospital, Alexandria
EE. Ely-Bloomenson Community Hospital, Ely
FF. Eveleth Fitzgerald Community Hospital, Eveleth
GG. Fairmont Community Hospital, Fairmont
HH. Fairview Princeton Hospital, Princeton
II. Fosston Municipal Hospital, Fosston
JJ. Gaylord Community Hospital, Gaylord
KK. Glacial Ridge Hospital, Glennwood
LL. Glencoe Municipal Hospital, Glencoe
MM. Granite Falls Municipal Hospital, Granite Falls
NN. Grant County Hospital, Elbow Lake
OO. Greenbush Community Hospital, Greenbush
PP. Harmony Community Hospital, Harmony
QQ. Hendricks Community Hospital, Hendricks
RR. Heron Lake Municipal Hospital, Heron Lake
SS. Holy Trinity Hospital, Graceville
TT. Hutchinson Community Hospital, Hutchinson
UU. Immanuel-St. Joseph's Hospital, Mankato
VV. International Falls Memorial Hospital, International Falls
WW. Itasca Memorial Hospital, Grand Rapids
XX. Jackson Municipal Hospital, Jackson
YY. Johnson Memorial Hospital, Dawson
ZZ. Kanabec Hospital, Mora
AAA. Karlstad Health Facilities, Karlstad
BBB. Kittson Memorial Hospital, Hallock
CCC. Lake City Hospital, Lake City

DDD. Lake Region Hospital, Fergus Falls
EEE. Lake View Memorial Hospital, Two Harbors
FFF. Lakefield Municipal Hospital, Lakefield
GGG. Lakeview Memorial Hospital, Stillwater
HHH. Littlefork Municipal Hospital, Littlefork
III. Long Prairie Memorial Hospital, Long Prairie
JJJ. Luverne Community Hospital, Luverne
KKK. Madelia Community Hospital, Madelia
LLL. Madison Hospital, Madison
MMM. Mahnomen County-Village Hospital, Mahnomen
NNN. Meeker County Memorial Hospital, Litchfield
OOO. Melrose Hospital, Melrose
PPP. Memorial Hospital—Cambridge, Cambridge
QQQ. Memorial Hospital—Perham, Perham
RRR. Memorial Community Hospital—Bertha, Bertha
SSS. Mercy Hospital, Moose Lake
TTT. Milaca Area Hospital, Milaca
UUU. Minnesota Valley Memorial Hospital, Le Sueur
VVV. Minnewaska District Hospital, Starbuck
WWW. Monticello-Big Lake Community Hospital, Monticello
XXX. Mountain Lake Community Hospital, Mountain Lake
YYY. Murray County Memorial Hospital, Slayton
ZZZ. Naeve Hospital, Albert Lea
AAAA. North Country Hospital, Bemidji
BBBB. Northern Itasca Hospital, Big Fork
CCCC. Northfield City Hospital, Northfield
DDDD. Northwestern Hospital, Thief River Falls
EEEE. Olmsted Community Hospital, Rochester
FFFF. Ortonville Hospital, Ortonville
GGGG. Owatonna City Hospital, Owatonna
HHHH. Parkers Prairie District Hospital, Parkers Prairie
IIII. Paynesville Community Hospital, Paynesville
JJJJ. Pelican Valley Health Center, Pelican Valley
KKKK. Pipestone County Hospital, Pipestone
LLLL. Queen of Peace Hospital, New Prague
MMMM. Redwood Falls Municipal Hospital, Redwood Falls
NNNN. Renville County Hospital, Olivia
OOOO. Rice County District One Hospital, Faribault
PPPP. Rice Memorial Hospital, Willmar
QQQQ. Riverview Hospital, Crookston
RRRR. Roseau Area Hospital, Roseau
SSSS. Rush City Hospital, Rush City
TTTT. St. Ansgar Hospital, Moorhead
UUUU. St. Elizabeth Hospital, Wabasha
VVVV. St. Francis Hospital, Breckenridge
WWWW. St. Francis Medical Center, Shakopee
XXXX. St. Gabriel's Hospital, Little Falls
YYYY. St. John's Hospital, Browerville
ZZZZ. St. John's Hospital, Red Lake Falls

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AAAAA. St. John's Hospital, Red Wing
BBBBB. St. Joseph's Hospital, Brainerd
CCCCC. St. Joseph's Hospital, Park Rapids
DDDDD. St. Mary's Hospital, Detroit Lakes
EEEEE. St. Mary's Hospital, Winstead
FFFFF. St. Michael's Hospital, Sauk Centre
GGGGG. St. Olaf Hospital, Austin
HHHHH. Sandstone Area Hospital, Sandstone
IIIII. Sanford Memorial Hospital, Farmington
JJJJJ. Sioux Valley Hospital, New Ulm
KKKKK. Sleepy Eye Municipal Hospital, Sleepy Eye
LLLLL. Springfield Community Hospital, Springfield
MMMMM. Stevens County Memorial Hospital, Morris
NNNNN. Swift County-Benson Hospital, Benson
OOOOO. Tracy Municipal Hospital, Tracy
PPPPP. Tri-County Hospital, Wadena
QQQQQ. Trimont Community Hospital, Trimont
RRRRR. Trinity Hospital, Baudette
SSSSS. Tweeten Memorial Hospital, Spring Grove
TTTTT. United District Hospital, Staples
UUUUU. United Hospital, Blue Earth
VVVVV. Virginia Regional Medical Center, Virginia
WWWWW. Waconia Ridgeview Hospital, Waconia
XXXXX. Warren Community Hospital, Warren
YYYYY. Waseca Area Memorial Hospital, Waseca
ZZZZZ. Weiner Memorial Medical Center, Marshall
AAAAAA. Wells Municipal Hospital, Wells
BBBBBB. White Community Hospital, Aurora
CCCCCC. Windom Area Hospital, Windom
DDDDDD. Zumbrota Community Hospital, Zumbrota

Service		Maximum Fee
Group 2	semi-private room charge for one day	$ 155.00

Subp. 4. Group 3. The following hospitals make up group 3:

A. Hennepin County Medical Center, Minneapolis
B. St. Paul Ramsey Medical Center, St. Paul
C. University of Minnesota Hospitals and Clinics, Minneapolis

Service		Maximum Fee
Group 3	semi-private room charge for one day	$ 266.30

Subp. 5. Group 4. The following hospitals make up group 4:

A. Rochester Methodist Hospital, Rochester
B. St. Mary's Hospital, Rochester

Service		Maximum Fee
Group 4	semi-private room charge for one day	$ 151.86

EFFECTIVE DATE. These rules are effective October 1, 1984, and apply to all health care services or supplies governed by parts 5221.0100 to 5221.3200 provided after October 1, 1984.

524

Waste Management Board

Proposed Emergency Rules Governing Hazardous Waste Processing and Collection Facilities and Services Development Grants

Notice of Intent to Adopt Emergency Rules

Notice is hereby given that the Minnesota Waste Management Board proposes to adopt the above entitled emergency rules. The Chairman of the Waste Management Board will follow the procedures set forth in Minnesota Statutes, sections 14.29-14.36 in adopting these rules.

Persons interested in these emergency rules shall have 25 days from the date the rules are published in the *State Register* to submit comments on the proposed rules. The proposed rules may be modified if the modifications are supported by the data and views submitted to the department.

Persons who wish to submit oral or written comments should submit the comments to:

Waste Management Board
Jerry Johnson
123 Thorson Building
7323 - 58 Avenue North
Crystal, MN 55428
(612) 536-0816

Authority to adopt these rules is contained in laws of Minnesota 1984, chapter 644, section 11. The Board is authorized by these sections to adopt emergency rules for the administration of the hazardous waste processing and collection facilities and services development grants. The grants are intended to help determine the feasibility of developing and operating specific types of commercial facilities and services for collecting and processing hazardous waste. Accordingly, the proposed emergency rules include eligibility criteria, information which shall be included with an application, procedures for initial review of applications, procedures and criteria for evaluating grant applications, provisions related to the awarding of grants, procedures for applying for a development grant relating to the request for proposals for development of collection and transportation services and required content of grant agreements.

Upon adoption of the emergency rules, the proposed rules, this Notice, all written comments received, and the emergency Rules as Adopted, will be delivered to the Attorney General for review as to form and legality.

In accordance with laws of Minnesota 1984, chapter 644, section 11, these emergency rules will be effective for 360 days or until permanent rules are adopted, whichever occurs first.

One free copy of this Notice, the proposed emergency rules or notice of the date of submission of the proposed emergency rule to the attorney general may be obtained by contacting Mr. Johnson. Persons who wish to receive a copy of the emergency rules as adopted should also request it from Mr. Johnson.

May 14, 1984

Robert G. Dunn, Chairman
Waste Management Board

Emergency Rules as Proposed (all new material)

9200.6000 [Emergency] SCOPE AND AUTHORITY.

Parts 9200.6000 to 9200.6009 [Emergency] govern the administration of development grants for waste processing and collection facilities and services as provided under Laws of Minnesota 1984, chapter 644, section 11 and the administration of development grants for requests for proposals for development of collection and transportation services as provided under Laws of Minnesota 1984, chapter 644, section 13.

9200.6001 [Emergency] DEFINITIONS.

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Subpart 1. Scope. For the purposes of parts 9200.6000 [Emergency] to 9200.6009 [Emergency], the following terms have the meanings given them unless the context requires otherwise.

Subp. 2. Board. "Board" means the Minnesota Waste Management Board established in Minnesota Statutes, section 115A.04.

Subp. 3. Chairperson. "Chairperson" means the chairperson of the board.

Subp. 4. Collection. "Collection" has the meaning given it in Minnesota Statutes, section 115A.03, subdivision 5.

Subp. 5. Commercial. "Commercial" has the meaning given it in Minnesota Statutes, section 115A.03, subdivision 6.

Subp. 6. Generator. "Generator" means a person who produces a hazardous waste listed in rules as proposed 6 MCAR §§ 4.9128-4.9137 published in the *State Register*, volume 8, page 732 (October 24, 1983) as corrected in errata and amended in the *State Register*, volume 8, page 1579 (January 2, 1984).

Subp. 7. Person. "Person" means a natural person or a corporation, association, operation, firm, partnership, trust, or other form of organization.

Subp. 8. Processing. "Processing" has the meaning given it in Minnesota Statutes, section 115A.03, subdivision 25.

Subp. 9. Proposal. "Proposal" means the work that is intended to be conducted with the grant funds.

Subp. 10. Service. "Service" means work done or duty performed for others.

9200.6002 [Emergency] ELIGIBILITY CRITERIA.

Subpart 1. Eligible applicants. The following are eligible to apply for a development grant:

A. a person who proposes to develop and operate specific commercial collection and processing facilities or services to serve generators of hazardous waste in the state;

B. an association of two or more Minnesota generators who propose to develop and operate specific commercial collection and processing facilities or services to serve generators of hazardous waste in the state; or

C. a person who responds to the request for proposals for development of commercial hazardous waste collection and transportation services as specified in part 9200.6008 [Emergency].

Subp. 2. Eligible proposals. Proposals for the following types of work to determine the feasibility of developing and operating specific types of commercial facilities and services for collecting and processing hazardous waste are eligible:

A. market assessment, including generator surveys;

B. conceptual design and preliminary engineering;

C. financial and business planning necessary to address sources of funding, financial security, liability, pricing structure, and related matters required for the development and proper operation of a facility or service;

D. environmental impact and site analysis, preparation of permit applications, and environmental and permit reviews;

E. analysis of methods to overcome identified technical, institutional, legal, regulatory, market, or other problems in developing or operating a facility or service; and

F. analysis of other factors affecting development, operation, and use of the proposed facility or service.

Subp. 3. Eligible costs. Eligible costs are limited to the costs of conducting studies and analyses consistent with subpart 2.

Subp. 4. Ineligible costs. Grant money awarded through this program may not be spent for capital improvements or equipment.

Subp. 5. Matching funds. To be eligible to receive a grant under this program a recipient shall agree to provide matching funds as specified in part 9200.6007 [Emergency].

9200.6003 [Emergency] GRANT APPLICATION.

An applicant shall submit an application in the form specified by the board. An application must include the following information:

A. A description of the applicant's financial, managerial, and technical ability to carry out the work described in the proposal, including the applicant's experience in carrying out similar work.

B. A description of the applicant's financial, managerial, and technical ability to develop and operate the proposed facility or service.

C. A statement as to whether the applicant will or is planning to apply for future grants under this program, or whether the

applicant has submitted or is planning to submit a response to the board's requests for proposals (RFP) for hazardous waste processing and collection and transportation services or has applied or is planning to apply for a hazardous waste processing facility loan administered by the Minnesota Energy and Economic Development Authority.

D. An applicant shall review the evaluation factors in Laws of Minnesota 1984, chapter 644, section 11, subdivision 3, and those factors listed in part 9200.6006 [Emergency] and provide the information needed by the board when it considers those factors.

9200.6004 [Emergency] APPLICATION PROCESS.

Subpart 1. Deadline. An application for a development grant must be received by the board on or before September 1, 1984.

Subp. 2. Additional applications. The board may solicit additional applications at a later date by notification in the *State Register*.

9200.6005 [Emergency] INITIAL APPLICATION REVIEW.

Subpart 1. Application review. The chairperson or his or her designee shall review all applications.

Subp. 2. Eligibility and documentation review. The chairperson or his or her designee shall review each application to determine the eligibility of the applicant, the eligibility of the costs specified in the application, the eligibility of the proposal specified in the application, and the adequacy of the supporting documentation. Documentation is considered adequate if it enables the board to determine whether:

A. the proposal is feasible at the costs indicated in the application;

B. the applicant has the financial, managerial, and technical ability and experience to carry out the proposal;

C. the applicant has the financial, managerial, and technical ability to develop and operate the proposed facility or service; and

D. the proposal meets the evaluation factors listed in part 9200.6006 [Emergency].

Subp. 3. Notice of determination. Within 14 days after receiving the application, the chairperson shall notify each applicant of the chairperson's determinations. If the chairperson determines that the applicant, project, and costs are eligible and that the documentation in the application is adequate, the application is considered final and the applicant shall be so notified. The application must then be referred to the board to be evaluated as provided in part 9200.6006 [Emergency]. If the chairperson determines that any of the costs or any part of the proposals are not eligible or that the documentation in the application is inadequate, the application must be returned with a statement of the reasons for rejecting the application. The applicant has 14 days after receipt of the rejection to correct the inadequacies. If the inadequacies are corrected within the time allowed, the application is considered final and the applicant shall be so notified. The application must then be referred to the board to be evaluated as provided in part 9200.6006 [Emergency].

9200.6006 [Emergency] EVALUATION OF PROPOSALS.

Subpart 1. Evaluation schedule. Within 60 days of the completion of the eligibility and documentation review, the board shall evaluate the proposal and set a date for action.

Subp. 2. Evaluation factors. In evaluating each proposal the board shall consider the following factors:

A. The factors listed in Laws of Minnesota 1984, chapter 644, section 11, subdivision 3.

B. The importance of the proposal to the eventual development and operation of the proposed facility or service.

C. The likelihood that the proposed facility or service will be developed.

D. Whether an applicant is submitting a proposal under the board's RFP programs. In considering this factor, the board may give preference to an applicant who is also submitting a proposal under the RFPs.

E. Whether an applicant is an association of two or more generators. In considering this factor, the board may give preference to an association of two or more generators if the board determines that the association significantly contributes to cooperation among generators in solving hazardous waste management problems.

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9200.6007 [Emergency] AWARD OF GRANTS.

Subpart 1. General procedure. The board shall award grants for those proposals which in the board's judgment best meet the factors identified in part 9200.6006 [Emergency].

Subp. 2. Amount of grants. The board shall determine the amount of a grant based on a review of the factors identified in this part and based upon the availability of funds. Grants are limited to $50,000 per study.

Subp. 3. Matching funds required. A recipient other than an association of generators in the state shall agree to provide at least 50 percent of the cost of the proposal. An association of two or more generators in the state shall agree to provide at least 20 percent of the cost of the proposal.

9200.6008 [Emergency] APPLICATION FOR DEVELOPMENT GRANT FOR RFP FOR DEVELOPMENT OF COLLECTION AND TRANSPORTATION SERVICES.

The board may award a grant to a respondent to the RFP for the development and operation of a statewide collection and transporatation system which may include temporary storage and transfer facilities. The following requirements apply only to a development grant application submitted in conjunction with the RFP:

A. An applicant shall submit both the RFP and a development grant application.

B. Applications are due on or before November 1, 1984.

C. An applicant may apply for a grant up to $350,000.

D. An applicant may be required to provide up to ten percent of the grant amount.

E. The board's evaluation of the grant application must be based on information provided in both the grant application and the proposal in response to the RFP.

9200.6009 [Emergency] GRANT AGREEMENT.

The board and a grant recipient shall enter into a grant agreement. The grant agreement must:

A. Establish the term of the grant. Unless otherwise determined by the board, all grants awarded under this part must have a maximum term of one year, except grants awarded under the RFP program for development of collection and transportation services that will have a maximum term of two years.

B. Provide that the recipient is authorized to enter into contracts to complete the work specified in the agreement.

C. Identify the product of the proposal and provide that the results of all studies or analyses performed under this agreement are made available to the board.

Subp. 2. Cancellation of grants. The board shall cancel a grant that is not completed in accordance with the terms and conditions of the respective agreements, including time schedules, unless the board determines that variances from the respective agreements are in order.

Subp. 3. Termination. The board may terminate a grant upon 30 days notice if it determines that the project is not feasible. A request for termination may be initiated by either the board or a grant recipient. The procedure for determining that a proposal is not feasible shall be specified in the grant agreement.

Subp. 4. Disbursement. The board shall disburse grants in accordance with the payment schedule set out in the grant agreement. At the discretion of the board, this may include a phased disbursement or final holdback of a percentage of funds.

Subp. 5. Return of unspent funds. Upon completion of the proposal, cancellation of the grant, or termination of the proposal the applicant shall return the state's share of the unspent funds. The procedure for determining the amount of funds returned shall be specified in the grant agreement.

ADOPTED RULES

The adoption of a rule becomes effective after the requirements of Minn. Stat. § 14.13-14.28 have been met and five working days after the rule is published in the *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 a 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 strike outs and new language will be underlined, and the rule's previous *State Register* publication will be cited.

A temporary rule becomes effective upon 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 temporary rule will be published in the manner provided for adopted rules under § 14.18.

Department of Human Services (formerly Public Welfare) Bureau of Income Maintenance

468 T

Adopted Temporary Rules Governing the Certification of Admission Programs for Inpatient Hospitals Participating in the Medical Assistance Program

The rules proposed and published at *State Register*, Volume 8, Number 30, pages 1738-1743, January 23, 1984 (8 S.R. 1738) are adopted with the following modifications:

Temporary Rules as Adopted

12 MCAR § 2.0481 [Temporary] Authority and applicability.

A. Authority

2. The provisions of 12 MCAR §§ 2.0481-2.0484 [Temporary] are to be read in conjunction with Code of Federal Regulations, titles XVIII and XIX and Minnesota Statutes, chapters 256.256B, and 256D. ~~The Minnesota Department of Public Welfare, the state agency responsible for the administration of the medical assistance and general assistance medical care programs, may issue instructional bulletins, manual materials, and forms, as necessary to assist in compliance with these rules.~~

12 MCAR § 2.0482 [Temporary] Definitions.

E. Against medical advice or AMA. "Against medical advice" or "AMA" means the patient leaves a hospital against the advice of the provider.

F. Commissioner. "Commissioner" means the commissioner of the Minnesota Department of Public Welfare or a designated representative.

~~F~~ G. Department. "Department" means the Department of Public Welfare.

~~G~~ H. General assistance medical care or GAMC. "General assistance medical care" or "GAMC" means payment of part or all of the cost of care and services not provided by title XVIII, XIX, or XX of the Social Security Act for eligible individuals whose income and resources are insufficient to meet all such costs.

~~H~~ I. Hospital. "Hospital" means an institution properly staffed and equipped which provides services, facilities, and beds for the reception and care for a continuous period longer than 12 hours of one or more nonrelated persons who require diagnosis, treatment, or care for illness, injury, or pregnancy. A hospital regularly makes available clinical laboratory services, diagnostic x-ray services, and treatment facilities for (a) surgery, (b) obstetrical care, or (c) other definitive medical treatment of similar extent as defined in 7 MCAR § 1.076.

~~I~~ J. Inpatient hospital services. "Inpatient hospital services" means those items and services ordinarily furnished by a hospital for the care and treatment of inpatients; and which are provided under the direction of a physician or dentist in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis. The hospital offering services must be licensed or formally approved as a hospital by the Minnesota Department of Health; and must be qualified to

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participate under title XVIII of the Social Security Act or is determined currently to meet the requirements for such participation under 7 MCAR § 1.076.

~~J~~ K. Local welfare agency. "Local welfare agency" means the local agency under the authority of the county welfare board or county human service board which is responsible for determining medical assistance and general assistance medical care eligibility.

~~K~~ L. Medical assistance or MA. "Medical assistance" or "MA" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

~~L~~ M. Medical emergency. "Medical emergency" means a medical condition that, if not immediately diagnosed and treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death.

~~M~~ N. Medically necessary. "Medically necessary" means a service or treatment appropriate and consistent with the recipient's diagnosis and which in accordance with accepted medical standards in Minnesota, cannot be provided on an outpatient basis.

~~N~~ O. Medical review agent. "Medical review agent" means an agency contracting with the department to perform admission certification.

~~O~~ P. Peer review task force. "Peer review task force" means the peers practicing in a speciality of the admitting provider, who are appointed to the review force by the medical review agent. The peer review task force hears reconsideration for a denied admission certification.

~~P~~ Q. Prior authorization. "Prior authorization" means prior approval under 12 MCAR §§ 2.047 and 2.058 of services and items of care by the department prior to the provision of service.

~~Q~~ R. Recipient. "Recipient" means a person who has made application to the local welfare agency and meets the eligibility criteria for medical assistance or general assistance medical care.

~~R~~ S. Reconsideration. "Reconsideration" means a review, based on additional information from the admitting provider of denied admission certifications. The review is conducted by the peer review task force of the medical review agent.

12 MCAR § 2.0483 [Temporary] Inpatient admission certification process.

All medical assistance (MA) and general assistance medical care (GAMC) admissions to hospitals must receive admission certification by the commissioner or a medical review agent if designated, prior to admission in order for the admitting provider or the hospital to receive MA or GAMC funds.

A. Admitting provider responsibilities. The admitting provider that seeks MA or GAMC reimbursement for hospital services to be provided to a recipient shall:

1. Request admission certification by contacting the commissioner or, if directed, a medical review agent, underprocedures specified by the commissioner through provider bulletins. Admission certification will be denied unless the admitting provider requests it prior to the time the recipient is admitted to a hospital, except in the case of medical emergencies ~~or~~. Deliveries of newborn babies~~, which~~ within a hospital are exempt from the admission certification process.

6. Receive prior authorization from the Professional Services Section of the department for any service requiring prior authorization under 12 MCAR §§ 2.047 and 2.058. Certification without prior authorization when needed or prior authorization without certification will result in denial of MA or GAMC reimbursement, excluding dental procedures. In-patient dental procedures require prior authorization under 12 MCAR §§ 2.047 and 2.058 and therefore are exempt from 12 MCAR §§ 2.0481-2.0484.

7. Provide the following accurate and complete information to the medical review agent or commissioner:

c. admitting provider MA provider number and address;

d. operating physician and primary procedure code, if applicable;

B. Hospital responsibilities. Hospitals may not receive MA or GAMC reimbursement for any services or treatment provided to MA or GAMC recipients admitted to the hospital unless:

2. The hospital has informed the commissioner or medical review agent of all emergency admissions within ~~one working day~~ 24 hours exclusive of weekends and holidays. The hospital shall inform the admitting provider of the admission certification number and provide the information under A.7. to the medical review agent or the commissioner.

6. The hospital must inform the commissioner or medical review agent, within 24 hours exclusive of weekends and holidays, of an against medical advice or AMA recipient.

C. Medical review agent responsibility. The medical review agent shall:

1. Determine within ~~one working day~~ 24 hours exclusive of weekends and holidays whether admission certification is appropriate based on the criteria in 12 MCAR § 2.0484 [Temporary].

3. Mail or deliver a written notification of the admission certification determination on forms specified by the commissioner, the admitting provider, hospital, and the department within five working days, exclusive of weekends and holidays.

5. On a monthly basis, mail or deliver data and reports to the commissioner.

6. Provide for a reconsideration of an admission certification denial through a peer review task force. The determination of the peer review task force is binding on the admitting provider, hospital, and commissioner.

D. Commissioner responsibility. Upon receipt of admission certification forms from the medical review agent the commissioner shall:

3. Deny payment of MA or GAMC funds to the admitting provider and hospital if the admission certification has been denied or the ~~procedure performed~~ prior authorization was not ~~authorized~~ obtained as required;

Board of Medical Examiners

304

Adopted Rule Regarding Changes in the Continuing Medical Education Requirement Necessary for Physicians and Osteopaths to Retain Their Licenses to Practice Medicine

The rules proposed and published at *State Register*, Volume 8, Number 26, pages 1509-1513, December 26, 1983 (8 S.R. 1509) are adopted as proposed.

Board of Medical Examiners

363

Adopted Rule Regarding Changes in the Initial Licensure Requirements, Specifically Regarding the Use of Examinations and the Citizenship Requirements, for Those Physicians and Osteopaths Seeking Licensure to Practice Medicine in Minnesota

The rules proposed and published at *State Register*, Volume 8, Number 26, pages 1513-1521, December 26, 1983 (8 S.R. 1513) are adopted as proposed.

Board of Medical Examiners

Adopted Rule Regarding the Practice of Physical Therapy

185

The rules proposed and published at *State Register*, Volume 8, Number 26, pages 1521-1524, December 26, 1983 (8 S.R. 1521) are adopted with the following modifications:

Rules as Adopted

7 MCAR § 4.025 Prescriptions

~~Every physical therapist shall retain all patient records including prescriptions received~~ All patient records including directions and orders within the controls of the physical therapist shall be retained for at least seven years, or six years after the patient's majority. The physical therapist shall provide access to these records to the board.

7 MCAR § 4.026 Delegation of duties.

The physical therapist may delegate patient treatment procedures only to a physical therapist assistant who has sufficient

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didactic and clinical preparation. The registered physical therapist may not delegate the following activities to the physical therapist assistant or to other supportive personnel: patient evaluation, treatment planning, initial treatment, change of treatment, and initial or final documentation.

The registered physical therapist must observe the patient's status before and after the treatment administered by ~~an~~ a physical therapy aide. The physical therapy aide may perform tasks related to preparation of patient and equipment for treatment, housekeeping, transportation, clerical duties, departmental maintenance, and selected treatment procedures. The tasks must be performed under the direct supervision of a registered physical therapist who is readily available for advice, instruction, or immediate assistance.

OFFICIAL NOTICES

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 6, 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 Economic Security

Outside Opinion Sought Concerning Proposed Rules Governing Weatherization Assistance for Low-Income Persons (Minnesota Rules, Parts 3300.1000, 3300.1100, and 3300.1300)

Notice is hereby given that the Department of Economic Security is seeking information or opinions from sources outside the agency in preparing to amend rules governing the Weatherization Assistance for Low-Income Persons Program pursuant to the Administrative Procedure Act, Minnesota Statutes, section 14.10.

The amendment of these rules is authorized by Minnesota Statutes section 268.021, which permits the Department of Economic Security to adopt rules with respect to programs the commissioner administers under chapter 268.

The Department requests information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit statements of information or comment orally or in writing.

Written comments should be addressed to Roger Williams, 690 American Center Building, 150 East Kellogg Blvd., St. Paul, MN., 55101. Any written material received by the Department shall become part of the record in the event that the rules are amended.

Oral statements will be received during regular business hours over the telephone at (612) 296-5744 and in person at the above address.

All statements of information and comment shall be accepted for thirty (30) days, or until June 27, 1984.

Michael Fratto
Rules Coordinator
Department of Economic Security

Department of Human Services
Health Care Programs Division

Notice of Hospital Cost Index

Pursuant to 12 MCAR § 2.05401, D. 1. (Temporary) hospitals participating in the Medical Assistance and General Assistance Medical Care programs are subjected to a Health Cost Index (HCI) that is to be used in the calculation of prospective inpatient hospital rates. Each hospital whose fiscal year starts during a given calendar quarter shall be notified of the HCI to be used 30 days prior to the start of that quarter. It has been determined that the HCI is 6.8% according to an independent source, Data

Resources, Inc. for Health Care Costs. However, pursuant to Senate File 1234, Article 5, Section 9 (1983), the HCI is subjected to the legislatively imposed limit of 5%. Consequently, the HCI is 5% for hospitals whose fiscal years begin during the calendar quarter beginning July 1, 1984.

Board of Investment
Investment Advisory Council

Notice of Regular Meeting

The State Board of Investment will meet on Wednesday, June 6, 1984 at 9:00 A.M. in Room 112, State Capitol.

The Investment Advisory Council will meet at 7:30 A.M. on Tuesday, June 5, 1984 in the MEA Building Conference Room, 41 Sherburne Avenue, Saint Paul.

Department of Labor and Industry
Prevailing Wage Division

Notice of Prevailing Wage Rates for Highway and Heavy Construction

On June 1, 1984 the commission will certify prevailing wage rates for the following Minnesota counties: Olmstead, St. Louis, Itasca, Goodhue, Ramsey, Pennington, Roseau, Ottertail, Washington, Carlton, Lake, Pine, Stearns, Kandiyohi, Lincoln, Lyon, Mower, Washington and Traverse.

A copy of the determined wage rates for Minnesota counties may be obtained by writing to the State Register and Public Documents Division, 117 University Avenue, St. Paul, Minnesota 55155. The charges for the cost of copying and mailing are $.50 for the first county and $.30 for any subsequent copies of the same or other counties. For all 87 counties the charge is $25.00. A $1.50 handling charge must be included for each order. Minnesota sales tax of 6% must be added to all orders.

A check or money order payable to the State of Minnesota must accompany each request.

Steve Keefe, Commissioner
Department of Labor and Industry

Department of Labor and Industry
Worker's Compensation Division
Rehabilitation Review Panel
and Medical Services Review Board

Outside Opinion Sought Concerning Proposed Joint Rules of Procedure of the Rehabilitation Review Panel and Medical Services Review Board

Notice is hereby given that the Rehabilitation Review Panel and Medical Services Review Board are seeking information or opinions from sources outside the agency in preparing to promulgate new rules governing Joint Rules of Procedure of the Rehabilitation Review Panel and the Medical Services Review Board. The promulgation of these workers' compensation rules is authorized by Minn. Laws of 1984, Chapter 432, Sections 13 and 15, which authorize the adoption of joint rules of procedure by the Panel and the Board.

The Rehabilitation Review Panel and the Medical Services Review Board request information and comments concerning the subject matter of these rules. Interested or affected persons or groups may submit written or oral information. Written statement should be addressed to:

Cynthia Thompson
Office of Public Affairs
Fifth Floor, Space Center
444 Lafayette Road
St. Paul, MN 55101

Oral statements will be received during regular business hours over the telephone at (612) 297-3467 and in person at the above address.

Information will be accepted until June 12, 1984. Any written material submitted in response to this notice will become part of the record in the event that the rules are promulgated.

Minnesota State Agricultural Society Minnesota State Fair

Meeting Notice

The board of managers of the Minnesota State Agricultural Society, governing body of the Minnesota State Fair, will conduct a general business meeting at 10 a.m. Thursday June 14 at the Administration Building on the fairgrounds, St. Paul. Preceding the general meeting will be a meeting of the board's space rental committee at 9:30 a.m.

Office of the Secretary of State

Notice of Vacancies in Multi-Member State Agencies

Notice is hereby given to the public that vacancies have occurred in multi-member state agencies, pursuant to Minn. Stat. § 15.0597, subd. 4. Application forms may be obtained at the Office of the Secretary of State, 180 State Office Building, St. Paul 55155-1299; (612) 296-2805. Application deadline is June 19, 1984.

ADVISORY COUNCIL TO THE MEDICAL SERVICES REVIEW BOARD has 12 vacancies open immediately for health professionals other than physicians or chiropractors who are involved in the clinical care of injured workers receiving compensation, including but not limited to physical therapists, nurses, qualified rehabilitation consultants, psychologists, dentists and vocational rehabilitation consultants. The advisory council will assist the Workers' Compensation Medical Services Review Board in developing rules and procedures for a medical monitoring system which will monitor both medical fees and clinical outcomes. Also assist in looking at individual Workers' Compensation cases to possibly discover providers whose fees are excessive and/or whose clinical results are substandard. Members are appointed by the Commissioner of Labor and Industry. Members receive $35 per diem. For specific information contact the Advisory Council to the Medical Services Review Board, Cynthia Thompson, 444 Lafayette Road, St. Paul 55101; (612) 297-3467.

BOARD OF PRIVATE DETECTIVE AND PROTECTIVE AGENCY SERVICES has 2 vacancies open immediately for 1 public member and 1 licensed protective agent. The board licenses private detectives and protective agents. Members are appointed by the Governor. Members must file with EPB. Monthly meetings; members receive $35 per diem plus expenses. For specific information contact the Board of Private Detective and Protective Agent Services, 1246 University Avenue, St. Paul 55104; (612) 296-8399.

CHARITABLE GAMBLING CONTROL BOARD has 11 vacancies open immediately. Members must have been Minnesota residents for at least 5 years, not more than 6 members may belong to the same political party. At least 4 members must reside outside of the seven-county metropolitan area. The board shall regulate legal forms of gambling to prevent their commercialization, to insure integrity of operations and to provide for the use of net profits only for lawful purposes. Members are appointed by the Governor; members teams' are staggered. Members receive $35 per diem plus expenses. For specific information contact Charitable Gambling Control Board, Roberta Schneider, 130 Capitol, St. Paul 55155; (612) 296-0055.

ADVISORY COUNCIL ON BARGAINING IMPASSE RESOLUTION has 6 vacancies open for public members. The advisory council shall study collective bargaining as it relates to public schools. Members are appointed by the Governor. Members receive $35 per diem plus expenses. For specific information contact the Advisory Council on Bargaining Impasse Resolution, Dan Loritz, Assistant Commissioner, Dept. of Education, 709 Capitol Square Bldg., St. Paul 55101; (612) 296-3271.

MINNESOTA MANUFACTURING GROWTH COUNCIL has 18 vacancies open for the following: 7 members who represent manufacturing labor; 7 members who represent manufacturing management; 1 economist; 2 public members and at least one member representing manufacturing businesses owned or managed by women. The council shall recommend objectives and goals for manufacturing growth; monitor plant closings, relocations, out of state expansions by firms with headquarters or significant facilities in Minnesota; identify and promote Minnesota's competitive position in the national and international marketplace and to create a center for productivity. Members are appointed by the Governor. For specific information contact the Minnesota Manufacturing and Growth Council, David Reed, Dept. of Energy and Economic Development, 900 American Center Bldg.; 150 E. Kellogg Blvd., St. Paul 55101; (612) 296-8341.

MINNESOTA CONVENTION FACILITY COMMISSION has 15 vacancies open immediately for 1 member from each

congressional district and up to 7 additional members. Members are appointed by the Governor. Members receive $35 per diem plus expenses. The commission shall make a report not later than February 5, 1985 to the Governor and Legislature containing the Commission's findings and recommendations and a proposal for the construction, operation, maintenance, promotion, location and financing of a Minnesota convention facility. For specific information contact the Minnesota Convention Facility Commission, Linda Kerner, Dept. of Energy and Economic Development, 900 American Center Bldg., 150 E. Kellogg Blvd., St. Paul 55101; (612) 297-4699.

MINNESOTA EDUCATIONAL COMPUTING CORPORATION has 9 vacancies open immediately. Members shall be knowledgeable about the use of computing in elementary, secondary, vocational education and public and private higher education or the business community. Members are appointed by the Governor. Terms are staggered. The corporation shall provide cost-effective computing and technology related products and services to the educational programs of educational institutions and agencies in Minnesota and elsewhere. For specific information contact the Minnesota Educational Computing Corporation, Roberta Schneider, 130 Capitol, St. Paul 55155; (612) 296-0055.

MINNESOTA TELECOMMUNICATIONS COUNCIL has 20 vacancies open immediately for: 4 members representing elementary and secondary education, vocational technical education, public and private higher education and librarians; 4 members representing state agencies; 2 members representing the telecommunications industry; 2 members of labor organizations which represent telecommunications workers; 2 public members who are not employed in the telecommunications industry and 6 public members. Members are appointed by the Governor. Members receive $35 per diem plus expenses. The council shall promote coordination and establish leadership in the use of advanced telecommunications resources in the public and private sectors. For specific information contact the Minnesota Telecommunications Council, Roberta Schneider, 130 Capitol, St. Paul 55155; (612) 296-0055.

HIGHER EDUCATION FACILITIES AUTHORITY has 2 vacancies open for members residing outside of the metropolitan area. The authority issues tax exempt revenue bonds for capital improvements at non-profit private post-secondary educational institutions. Members are appointed by the Governor and confirmed by the Senate. Monthly meetings; members receive $35 per diem. For specific information contact the Higher Education Facilities Authority, 278 Metro Square Bldg., St. Paul 55101; (612) 296-4690.

Department of Transportation

Petition of Chisago County for a Variance from State Aid Standards for Design Speed

Notice is hereby given that the County Board of Chisago County has made a written request to the Commissioner of Transportation for a variance from minimum design speed standards for a bridge replacement and approaches on Township Road 300 from the East limits of Wyoming to TH 98 (Bridge L 0165 over the Sunrise River).

The request is for a variance from Minnesota Rules (1983), § 8820.3300, Rules for State Aid Operations under Minnesota Statutes, Chapters 161 and 162 so as to permit a design speed of 20 miles per hour instead of a required design speed of 30 miles per hour.

Any person may file a written objection to the variance request with the Commissioner of Transportation, Transportation Building, St. Paul, Minnesota 55155.

If a written objection is received within 20 days from the date of this notice in the *State Register*, the variance can be granted only after a contested case hearing has been held on the request.

May 17, 1984

Richard P. Braun
Commissioner of Transportation

STATE CONTRACTS

Pursuant to the provisions of Minn. Stat. § 16.098, subd. 3, an agency must make reasonable effort to publicize the availability of any consultant services contract or professional and technical services contract which has an estimated cost of over $2,000.

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.

Commodities contracts with an estimated value of $5,000 or more are listed under the Procurement Division, Department of Administration. All bids are open for 7-10 days before bidding deadline. For bid specifics, time lines, and other general information, contact the appropriate buyers by calling 296-2513. If the appropriate buyer is not available, contact Harvey Leach or Barbara Jolly at 296-3779.

Department of Administration Printing and Mailing Services Division

Request for Proposals for Graphic Arts Design

The Minnesota Department of Administration, Printing and Mailing Services Division, is accepting bid proposals for Graphic Arts Design work. Those persons interested in receiving a detailed copy of the request for proposal may write to the address below or contact Robert Collins at 612-296-3277.

Minnesota Department of Administration
Printing and Mailing Services Division
117 University Avenue
St. Paul, MN 55155

About $20,000 has been budgeted for this project. Proposals are due by 4:30 p.m., June 18, 1984.

Department of Administration Procurement Division

Commodities Contracts Currently Open for Bidding

Requisition #	Item	Ordering Division	Delivery Point	Estimated Dollar Amount
26-070-10358	Purchase of Microcomputer	Bemidji State University	Bemidji	Contact buyer
78-890-01499	Truck Glider Kit	Willow River Camp	Duluth	Contact buyer
26-070-10384	Video Equip. Rebid	Bemidji State University	Bemidji	Contact buyer
26-073-16282, Rebid	Dry Film Coating & Processing Facility	St. Cloud State University	St. Cloud	Contact buyer
79-000-41654, etc.	Tandem Trailers	Various	Various	Contact buyer
78-620-16417, etc.	Axle Bearing	MN Correctional Facility	Stillwater	Contact buyer
55-000-87938	Purchase of Portable Computer	Public Welfare	St. Paul	Contact buyer
77-000-08198	Box & Pan Type Hand Brake	MN Zoo	Apple Valley	Contact buyer
26-175-05615	Purchase of Printers and Accessories	Southwest State Univ.	Same	Contact buyer
79-000-40735	Motor Graders	Transportation	Various	Contact buyer
Contract	Photo Film Processing for Football Season 1984	Various	Various	10,000.-11,000.
29-000-35782	Power Till Interseeder	Natural Resources	New Ulm	Contact buyer
79-000-41780	Conversion of Aerial Device	Transportation	Golden Valley	Contact buyer
Various	Medical Oxygen	Various		Contact buyer
Sch 152	Carriage & Plow Bolts	Transportation	Various	Contact buyer

Requisition #	Item	Ordering Division	Delivery Point	Estimated Dollar Amount
07-500-29714	State Patrol Uniforms—Addendum #1	State Patrol	St. Paul	Contact buyer
78-620-16410	Wrought Steel Pipe	MN Correctional Facility	Stillwater	Contact buyer
Contract	Rubber Footwear	Various	Various	15,000.-20,000.
26-137-02783	Purchase of Memory Boards	Moorhead State Univ.	Moorhead	Contact buyer
Contract	Safety Containers	Various	Various	5,000.-8,000.
02-430-44048	Automatic Network Polling Device	Admin/Telecomm	St. Paul	Contact buyer
02-514-43214, etc.	Trucks	Various	Various	Contact buyer
79-000-41739	Truck with Rotary Snowplow	Transportation	St. Paul	Contact buyer
07--500-29765, 07-200-29763	Upgrade Barrister W.P. System	Public Safety	St. Paul	Contact buyer
26-070-10375	Purchase of Computer Aided Design & Drafting System	Bemidji State Univ.	Bemidji	Contact buyer
Contract	Snow Removal—Willmar Comm. College Rebid	Willmar Community College	Willmar	Contact buyer
29-001-07048	Replace logs on Clubhouse	DNR Field Serv.	St. Paul	Contact buyer

Contact the receptionist at 296-2513 for referral to specific buyers.

Department of Agriculture
Office of the Commissioner

Submission of Applications for Agricultural Market Development Projects Under the Agricultural Development Grant Prrogram

Notice is hereby given that the Minnesota Department of Agriculture is accepting applications for agricultural development grants as provided for in Laws of Minnesota 1983, Chapter 293, Sections 5 and 29; and in 3 MCAR §§ 1.4060-1.4070. Applications are being received and will continue to be received until August 1, 1984.

Organizations or individuals wishing to apply for a grant should request a copy of the rules governing the program. The rules describe eligibility criteria, application content and application procedures. Separate proposals must be submitted for each grant being sought. Other information may be obtained by contacting:

Rollin Dennistoun, Ph.D.
Deputy Commissioner
Minnesota Department of Agriculture
90 West Plato Boulevard
(612) 296-9310

Applicants are to submit their proposal(s) to Dr. Dennistoun at the above address on or before 4:30 P.M., August 1, 1984. A maximum grant of $70,000 per biennium is available per organization. The applying organization must provide 25% of the funds.

Department of Economic Security
Office of Budget and Management

Request for Proposals for Auditing Services

The Office of Budget and Management of the Department of Economic Security is seeking Certified Public Accounting firms to perform General Accounting Office Financial and Compliance Audits of certain federal Job Training Partnership Act (JTPA) subgrants in various Minnesota locations. Thirteen audit reports are due by October 31, 1984.

A copy of the Request for Proposals is available upon request. Inquiries and requests should be directed to:

Marvin McNeff
Minnesota Department of Economic Security
Office of Budget and Management
Grants Management Unit
690 American Center Building
150 E. Kellogg Boulevard
St. Paul, Minnesota 55101
(612) 296-6069

The audit contract to be awarded is expected to be between $35,000 and $70,000. Proposals must be received by the Department of Economic Security, Office of Budget and Management—Grants Management Unit, no later than 4:00 p.m. on June 26, 1984.

Department of Energy and Economic Development/Governor's Council on Rural Development

Grant Program Opportunities for Economic Development Demonstration Projects in Rural Minnesota

The Minnesota Department of Energy and Economic Development/Governor's Council on Rural Development (MN DEED/GCRD) is accepting grant applications from qualified organizations interested in implementing economic development demonstration projects in rural Minnesota during Fiscal Year 1985.

The MN DEED/GCRD will accept applications for specific new rural economic development demonstration projects, and requests for continued support of demonstration projects funded during Fiscal Years 1983 and 1984, which address the Council's goals in the priority issue areas of: family farms and agricultural land protection; value-added processing and marketing of agricultural and forest resources; and small business assistance in rural areas.

Grant requests for new rural economic development demonstration projects need not approach, but shall not exceed, $60,000.00. A total of $500,000.00 will be available for new and continuing demonstration grants during Fiscal Year 1985.

Applications must be received by MN DEED/GCRD no later than 4:30 p.m., Friday, August 3, 1984. Demonstration grant program guidelines and application form requests and inquiries should be directed to:

Governor's Council on Rural Development
Minnesota Department of Energy and Economic Development
900 American Center Building
150 Kellogg Boulevard East
St. Paul, Minnesota 55101
Phone: 612/296-3993

Department of Human Services Chemical Dependency Program Division

Request for Proposals for American Indian Women's Resource and Training Services

The Chemical Dependency Program Division (CDPD) of the Department of Human Services is soliciting proposals for the development of a single statewide resource and training center providing services to Indian and non-Indian chemical dependency programs to improve chemical dependency treatment services for American Indian women. A total of $100,000 is available to a single grantee. The funded program will begin on or about July 1, 1984 and continue through June 30, 1985.

All requests for information or copies of complete RFP form can be obtained by contacting Dorrie Hennagir at 612/296-4617.

Proposals in response to this RFP must be submitted on the CDPD grant application form. A copy of the application form can be obtained by contacting Dorrie Hennagir at the above phone number. Six copies of the proposal must be in the CDPD office, 4th Floor, Centennial Office Building, 658 Cedar Street, St. Paul, MN 55155, no later than 4:20PM on June 19, 1984.

Department of Human Services
Fergus Falls State Hospital

Request for Proposals for Psychiatric Services to be Performed on a Contractual Basis

Notice is hereby given that the Fergus Falls State Hospital, Mental Health Bureau, Department of Human Services is seeking the following services which are to be performed as requested by the Administration of the Fergus Falls State Hospital. Contract will be written for the period July 1, 1984, through June 30, 1985. Maximum amount of contract is $35,000.00.

Provide the services of psychiatrists for psychiatric evaluation and diagnosis, and therapeutic direction for individual patients/residents therapeutic plans and care unit programs. Contractor will provide such staff education and program development as necessary to assure high quality psychiatric care for patients/residents of the psychiatric services of this facility. Such education development may require more than the usual consultative attention to clinical detail and it is expected that some of the time spent on campus will be for purposes of such administrative detail. It is further anticipated that the consultants provided by the contractor will be available for telephone contacts by the appropriate program staff regarding information related to on-campus activities as, from time to time, such communication becomes necessary. In addition, contractor shall provide professional services such as to aid the Medical Staff of this facility with diagnostic and therapeutic counseling to promote, in turn, their provision of quality care for patients/residents of the mental retardation, chemical dependency and mental illness programs.

Deadline for requests for proposals is June 19, 1984. Contact Richard C. Baker, M.D. Medical Director, Fergus Falls State Hospital, Box 157, Fergus Falls, MN. 56537 Phone 218-739-7224.

Department of Human Services
Fergus Falls State Hospital

Request for Proposals for Pharmacy Services to be Performed on a Contractual Basis

Notice is hereby given that the Fergus Falls State Hospital, Mental Health Bureau, Department of Human Services is seeking the following services which are to be performed as requested by the Administration of the Fergus Falls State Hospital. Contract will be written for the period July 1, 1984, through June 30, 1985. Maximum amount of contract is $10,700.00.

CONSULTATIVE PHARMACY SERVICES

1. Serve as primary pharmacy consultant on the units for the mentally ill, and other units upon request.
2. Serve as general drug information resource person for physicians, pharmacists, nurses and other hospital staff members.
3. Provide consultation regarding individual patients upon request of the hospital staff.
4. Follow-up on medication recommendations.
5. Evaluate psychotropic and anticonvulsant medication prescribing patterns to ascertain medication effectiveness and appropriateness therapy; publish material of clinical interest.
6. Provide hospital-wide inservice education on a regularly scheduled basis and conduct periodic Health Services Technician (HST) medication education classes.
7. Coordinate discharge medication counseling activities.

Deadline for requests for proposals is June 19, 1984. Contact Richard C. Baker, M.D. Medical Director, Fergus Falls State Hospital, Box 157, Fergus Falls, MN. 56537. Phone 218-739-7224.

State Designer Selection Board

Request for Proposals for State Projects

TO ARCHITECTS AND ENGINEERS REGISTERED IN MINNESOTA:

The State Designer Selection Board has been requested to select designers for a number of State Projects. Design firms who wish to be considered for this project should submit proposals on or before 4:00 P.M., June 19, 1984, to George Iwan, Executive Secretary, State Designer Selection Board, Room G-10, Administration Building, St. Paul, Minnesota 55155-1495.

The proposals must conform to the following:

1. Six copies of the proposal will be required.

2. All data must be on 8½" × 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. The proposal should consist of the following information in the order indicated below:

a) Number and name of project.

b) Identity of firm and an indication of its legal status, i.e. corporation, partnership, etc.

c) 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. If the applicant chooses to list projects which are relevant in type, scale, or character to the project at hand, the person's role in the project must be identified.

d) A commitment to enter the work promptly and to assign the people listed in "C" above and to supply other necessary staff.

e) A list of design projects in process or completed in the three (3) years prior to the date of this request for agencies or institutions of the State of Minnesota, including the University of Minnesota, by the firm(s) listed in "b" together with the approximate fees associated with each project.

f) A section of not more than fourteen (14) faces 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.

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. In accordance with the provisions of Minnesota Statutes, 1981 Supplement, Section 363.073; for all contracts estimated to be in excess of $50,000, 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. Your 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 your firm has a current certificate of compliance issued by the Commissioner of Human Rights; or

c) A statement certifying that your firm has not had more than 20 full-time employees in Minnesota at any time during the previous 12 months.

6. Design firms wishing to have their proposals 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.

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 or their schedule for the project herein described may be referred to George Iwan at (612) 296-4656.

7a) **PROJECT—11-84**
Addition to Livingston Lord Library
Moorhead State University
Moorhead, Minnesota
Plans Only

Purpose and Type of Project: This project will add a new third and fourth floor above the existing two floors on the east half of Livingston Lord Library. That portion of the library was constructed so that a third and fourth floor could be added. The third floor will provide additional space for Library Services and the fourth floor will house the University's Computer Service Center.

Site: Livingston Lord Library is located in the center of the University's main academic mall.

Appropriation: $205,000.00 for the preparation of architectural plans and specifications for construction at an estimated cost of $3,440,000.00.

Program Summary: The gross square footgage in this proposed addition is 28,208 square feet. The net assignable square feet would be as follows:

Audio-visual Services	— $ 1,638.00
Northwest Historical Center	— 600.00
Collection expansion	— 6,000.00
Student seating	— 5,000.00
Computer Services	— 10,000.00
TOTAL	— $23,238.00

Building Construction: The addition of a third and fourth floor to the Library shall be designed to fit harmoniously with the existing building. Livingston Lord Library is a steel frame, concrete wall, with brick exterior structure. The fourth floor must be designed to provide an environment to support an extensive computer facility. This addition should be energy efficient and accessible to the handicapped.

Architectural Responsibilities: The architect shall be responsible for but not limited to, such tasks as: space programming, preparation of preliminary schematics and cost estimates, project design, and the preparation of final working drawings and specifications required for bidding.

Planning and Construction Schedule: Planning on this project should begin in the summer of 1984, so that construction could commence in the 1985 season.

Architectural Fee: Legislative appropriation assumed fees at 6% of construction costs.

University Contact:

Name: Earl Herring, Vice President
for Administrative Affairs
Address: Moorhead State University
Moorhead, Minnesota 56560
Phone: (218) 236-2156

State University System Contact:

Name: David Hardin
Address: 555 Park Street, Suite 230
St. Paul, Minnesota 55103
Phone: (612) 296-6624

7b) PROJECT—12-84
Addition to Alex Nemzek Hall
Moorhead State University
Moorhead, Minnesota

PROJECT SCOPE: Plan construct, equip and furnish an addition to Alex Nemzek Hall.

Purpose and Type of Project: This project will consist of two separate new additions to Nemzek Hall, the major physical education and athletic facility of the campus. One unit will consist of two new racquetball courts, and the other will contain facilities to provide more space for women's athletic programs.

Site: These two units will be added to the southeast and the northeast corners of Nemzek Hall which it is located.

Appropriation: $490,000.00 for construction and fees.

Program Summary: These two additions will provide two new racquetball courts with estimated net square footage of 1600 square feet and additional athletic space of approximately 2300 net assignable square feet. The total gross area is projected to be in excess of 4200 square feet.

Building Construction: The addition should conform in materials and design with the existing building. Nemzek Hall is constructed of steel frame, concrete block, and brick veneer.

Architectural Responsibilities: The architect shall be responsible for, but not limited to, the following: Space Programming, preparation of preliminary schematics and cost estimates, complete plans and specifications, all bid specifications and drawings,

bid evaluations, supplemental agreements, review and approval of shop drawings and payment requests, and oversight of the project construction and final acceptance.

Planning and Construction Schedule: Planning should begin in the summer of 1984, so that construction could commence in the 1985 season. Completion expected in September 1985.

Architectural Fee: Legislative appropriation assumed fees at 6% of construction costs.

University Contact:

Name: Earl Herring, Vice President
for Administrataive Affairs
Address: Moorhead State University
Moorhead, Minnesota 56560
Phone: (218) 236-2156

State University System Contact:

Name: David Hardin
Address: 555 Park Street, Suite 230
St. Paul, Minnesota 55103
Phone: (612) 296-6624

7c) **PROJECT—13-84**
Renovate Gray Campus Laboratory School
St. Cloud State University
St. Cloud, Minnesota

PROJECT SCOPE: Plan, renovate, equip, and furnish Gray Campus Laboratory School.

Purpose and Type of Project: The purpose of this project is to convert the existing 65,000 square foot Thomas Gray Campus School into a facility that will provide instructional space for expanding computer science, electrical engineering, and related technology programs. The building was constructed in 1955 as an elementary and junior high school.

The facility will include laboratories, computer center, and electrical engineering labs. In addition to the specialized space, planning must include accommodations for approximately seventy-five faculty ofjfices and redecorating of existing classrooms.

Site: The 65,000 square foot Thomas J. Gray Building is located on the northeast corner of Tenth Street and Third Avenue South in St. Cloud, Minnesota.

Appropriation Including Fees — $3,500,000.00

Program Summary: The primary objectives to be accomplished include the conversion of existing facilities into computer labs, engineering labs, and a day care center. Additionally, the project requires the construction of as many general purpose classrooms as possible, and at least seventy-five faculty offices. Specific project requirements are:

	No./Rooms	Estimated Size
Computer Space	5	16,000 Sq. Ft.
Electrical Engineering Lab	6	7,500 Sq. Ft.
Large Classrooms	3-6	40-60 students
Average-size Classrooms	8	25-35 students
Child Care Facility	3	4,000 Sq. Ft.
Offices	75+	100 Sq. Ft.
Auditorium	1	2,250 Sq. Ft.

A preliminary study indicates that these objectives can be accomplished. Copies of initial schematics will be made available upon request.

Building Construction: Project construction should be consistent with the existing facility and provide HVAC, electrical lighting and acoustic required for classrooms, technical support labs and offices, requiring space that is aesthetically appealing, well lit and good classroom-type acoustics. Special consideration must be given to environmental, acoustical and electrical requirements in the Academic Computer Center and the Electrical Engineering labs because of computer hardware.

The building should be energy efficient and accessible to the handicapped. Consideration must be given to projecting electrical and environmental needs as growth is expected in the technical support areas.

Architectural Responsibilities: The architect will be responsible for all phases of this project including working with University personnel in programming and planning. The architect will also be responsible for preliminary schematics, cost estimates,

project design, working drawings, bid specifications and drawings, bid evaluation, project coordination, supplemental agreements, review and approval of show drawings and payment requests, project supervision and oversight with the University and final acceptance of the project.

Architectural Fee: Legislative appropriation assumed fees at 6% of construction costs.

Project Schedule: Coordination and timing is critical. Many classes at the University are dependent on computer support. The following schedule will provide for the construction of the computer center during the summer of 1985.

A)	Selection of Architect	—July, 1984
B)	Space programming, preliminary schematics and cost estimates	—November, 1984
C)	Preparation of working drawing and bid document	—March 1985
D)	Contract Award	—April, 1985
E)	Begin Construction	—May, 1985
F)	Completion of Academic Computer Center	—August, 1985
G)	Completion of Total Project	—March, 1986

University Contact:

Name: William Radovich, Vice President
Administrative Affairs
Address: St. Cloud State University
St. Cloud, Minnesota 56301
Phone: (612) 255-2286

Bernard Lundstrom,
Director, Aux. Serv.
St. Cloud State University
St. Cloud, MN 56301
(612) 255-2266

State University System Contact:

Name: David Hardin
Address: 555 Park Street, Suite 230
St. Paul, Minnesota 55103
Phone: (612) 296-6624

7d) PROJECT 14-84
Renovate Somsen Hall
Winona State University
Winona, Minnesota

PROJECT SCOPE: Plan, renovate, equip, and furnish Somsen Hall.

Purpose and Type of Project: This project is intended to upgrade the administrative work areas, faculty offices and classrooms of the building so that the spaces more effectively support university operations, i.e. the building will be able to better accommodate the latest technologies, methods, and techniques which are a part of today's teaching/working environments. This project will also provide a more barrier free environment as well as correct certain fire/life safety code deficiencies. Additionally, all of the building utilities will be replaced.

The refinements purposed by this renovation will better accommodate the departments of Business Administration, Business Education and Office Administration, Foreign Language and Mass Communication and Photography. The administrative services to be accommodated are the President's Office, Academic Affairs, University Relations, the Registrar's Office, Computer Services, Administrative Affairs, Business Office, Regional Campus and A.V. Services.

The types of improvements to be accomplished by the project are: renovation of classrooms, offices and common areas, replace the building utilities, plumbing, electrical, and HVAC, remodel the auditorium, and redesign the fourth floor to accommodate faculty offices.

Site: Somsen Hall is located at the intersection of Johnson and Sanborn Streets.

Appropriation: $6,000,000.00 project—$4,000,000.00 appropriated in FY 1984 with $2,000,000.00 expected in FY 1985.

Program Summary: Somsen Hall gross square footage—168,000.

*Type of Space	Number	Estimated Size/Capacity
Auditorium	1	8,726 sq. ft./940
Faculty & Admin. Office	100-125	110-100 sq. ft.
Classrooms	14	780-1,7000/30-70
Instructional Lab.	10	870-2,000/10-35
Computer Center	1	3,500

* The above tabulation reflects existing conditions. Final plans may include the reconfiguration of existing offices, classrooms, or class labs, resulting in a change in this tabulation.

Building Construction: The construction will involve the renovation and restoration of a sixty year old building, with special emphasis on retaining the original architectural integrity of this structure. The entire HVAC system, plumbing and parts of the electrical system will need to be replaced, including the installation of a central air-conditioning unit and distribution system. Special attention will need to be given to the auditorium to correct existing acoustical, electrical and structural problems.

Architectural Responsibilities: The architect will be expected to meet with a university advisory committee and various building occupants to discuss such things as: space programming, special programmatic needs, and special design features.

Prior to preparing working drawings, the architect shall present preliminary drawings of the entire project and an appropriate cost estimate. This should include a plan for phasing construction to accommodate legislature appropriations. The architect will assist in a presentation of the preliminary plan to the President's Cabinet. Because of the widespread interest in this project throughout the community, the architect shall also be available to discuss plans with various community groups.

The architect shall be responsible for working drawings, and specifications, and all necessary bid documents, contract documents, supplemental agreements, contract change orders, and approval of all shop drawings and payment requests. The architect shall prepare a weekly progress report for the University. Architect will be responsible for the design execution supervision and approval of the project.

Planning and Construction Schedule:

Coordination and timing is important. Some functions may be relocated while construction is underway while other functions must continue in-place. The following schedule will provide for construction to commence in spring, 1985 and be completed by summer, 1986.

A) Selection of Architect	—July, 1984
B) Space programming, prelininary schematics, and cost estimates	—November, 1984
C) Preparation of working drawings and bid documents	—March, 1984
D) Contract Award	—April, 1985
E) Begin Construction	—May, 1985
F) Completion of Construction	—Summer, 1986

Architectural Fee: Legislative appropriation assumed fees at 6% of construction costs.

University Contact:
Name: Norman Decker
8th & Johnson Streets
Winona, Minnesota 55987
Phone: (507) 457-5051

John Burros
8th & Johnson Streets
Winona, Minnesota 55987
(507) 457-5052

State University System Contact:
Name: David Hardin
Address: 555 Park Street, Suite 230
St. Paul, Minnesota 55103
Phone: (612) 296-6624

7c) PROJECT—15-84
Combined Services Facility
Program and Feasibility Study

I DESCRIPTION OF THE PROJECT

A) GENERAL:

1) Aid the agency in the development of user activity and relationship statements and prepare separate architectural programs for physical plant maintenance; grounds maintenance; Motor Pool service; Records Management and Information Services Bureau.

2) Evaluate and provide a feasibility study of combining all or part of the above programs into one facility.

3) Provide cost estimates for each program and the combined facility.

B) Consultant's Fee for this Work

The contract for this work will be on a hourly basis not to exceed $70,000.00. Surveys and site evaluations, if done, will be by separate contract.

C) The designer shall complete the program, feasibility study and cost estimates by January 1, 1985.

The designer will work through the Division of Building Construction, Department of Administration and questions relative to this project will be referred to the division (612) 296-4640.

Roger D. Clemence, Chairman
State Designer Selection Board

SUPREME COURT

Decisions of the Court of Appeals Filed Tuesday, May 15, 1984

Compiled by Wayne O. Tschimperle, Clerk

C3-83-1691 Calvin Schmidt, Petitioner, Appellant, v. Independent School District No. 1, Aitkin, Minnesota. Board of Independent School District No. 1 Aitkin, Minnesota.

By referring to Minn. Stat. § 125.12, subd. 6b as grounds for termination, the written notice of proposed termination given to the teacher in this case sufficiently conveyed lack of pupils and financial limitations so as to comply with the procedural requirements of Minn. Stat. § 125.12, subd. 4 (1982).

Absent unusual or extenuating circumstances, an independent hearing examiner must be hired for a teacher termination proceeding.

The extensive participation of the District's counsel both as prosecutor and advisor to the Board Chairman who heard the case deprived the teacher of a meaningful hearing.

Reversed and remanded. Popovich, C.J.

C7-83-1970 Harry Kozak, Appellant, v. John N. Weis. Sherburne County.

The trial court did not abuse its discretion by directing a verdict at the close of plaintiff's case where plaintiff failed to establish an essential element of his case.

The order of the trial court denying plaintiff's motion for a new trial was proper. A private land survey establishing the boundary line by a newly retained surveyor after the verdict was directed for failure to establish the boundary line does not constitute newly discovered evidence.

Affirmed. Popovich, C.J.

C1-84-310 State of Minnesota v. Elmer Carl Andren, Appellant. Scott County.

The trial court's refusal to depart from the Guidelines and place appellant on probation was not error.

The trial court's refusal to depart from the Guidelines was error because it relied upon the same factors used in setting the presumptive sentence.

Affirmed in part, reversed in part, and remanded. Popovich, C.J.

C8-83-1315 John T. Uldrich v. Datasport, Inc., Appellant. Hennepin County.

The trial court did not abuse its discretion in ordering a corporation to allow shareholder, who was a business competitor,

access to its corporate books and records, with certain protective restrictions prohibiting competitive use of the information by the shareholder.

Affirmed. Parker, J.

C1-83-1737 American Druggists Insurance, Appellant, v. Thompson Lumber Company, et al. Hennepin County.

An appeal with a supersedeas bond does not affect the finality of the judgement for the purpose of application of the doctrine of collateral estoppel to a companion case.

Under the doctrine of accounts stated, the contractor agreed to pay for finance charges. However, the interest cannot be compounded because there was no specific agreement allowing compound interest.

A change order was not a separate contract; thus, a surety on a contractor's bond was liable for the increased contract price made necessary by the change.

Attorney's fees are allowable in suits brought to enforce contractor's bonds, and on appeal.

Affirmed in art, modified in part and remanded for consideration of attorney's fees. Parker, J.

C2-83-1326 Jerold E. Murphy v. Country House, Inc., Appellant. Washington County.

Payment by a corporation of "bonuses" to certain shareholders only when the corporation had surplus profits constituted payment of dividends. Murphy, who owned one-ninth of the stock, is entitled to one-ninth of the dividends paid, not a percentage based on his original cash investment.

Reversed and remanded. Wozniak, J.

C5-84-178 State of Minnesota v. Joy M. Turcotte, Appellant. Hennepin County.

Pursuant to Minn. Stat. § 244.09(11) (Supp. 1983), the November 1, 1983 reductions in minimum mandatory sentences do not automatically apply retroactively. Repetition of crimes resulting in injury to the victim was a substantial and compelling factor that justified maintaining the original sentence.

Affirmed. Wozniak, J.

C3-83-1500 Kelly John Frost, petitioner, Appellant, v. the Commissioner of Public Safety for the State of Minnesota. Hennepin County.

Minn. Stat. § 169.123, subd. 3 (1982), does not require an arresting officer to hold a person arrested for DWI in custody until an additional test can be administered. Once released the person is free to obtain any kind of additional test at any place the person chooses.

Affirmed. Sedgwick, J.

C7-84-280 State of Minnesota v. Thomas Hardin Hamilton, Appellant. Dakota County.

Where the sentencing court provides sufficient departure reasons to justify maintaining defendant's originally imposed sentence, the original sentence may stand, notwithstanding Minn. Stat. § 244.09, subd. 11 (1983).

Affirmed. Sedgwick, J.

C7-83-1368 Prior Lake Aggregates, Inc., et al., Petitioners, Appellants, v. City of Savage, et al. Scott County.

The Savage City Council properly interpreted its zoning ordinance when it denied a special use permit for an asphalt plant in an R-Rural District.

An earlier incorrect interpretation of a zoning ordinance does not estop the City Council from making a correct application.

Zoning ordinances must operate uniformly; appellants have not shown unequal treatment of similarly situated parties.

Affirmed. Lansing, J.

C3-84-96 Minnesota Mutual Fire and Casualty Company v. Constance Rudzinski, Appellant, Barbara Buck, et al. Hennepin County.

A no-fault insurer may recover payments which it made to an insured under a mutual mistake of law unless circumstances have so changed that it would be inequitable to require full restitution.

Minn. Stat. § 65B.54, subd. 4 (1982), does not preclude recovery of benefits which were paid as the result of a mutual mistake of law.

Affirmed. Lansing, J.

C5-84-116 Rosemary E. Flannigan, Relator, v. Meadow Lane Health Care Center, and Commissioner of Economic Security. Department of Economic Security.

An employee's conduct in leaving a discussion with her employer after 15 minutes, despite the employer's insistence on the employee's continued attendance, is not "misconduct" disqualifying her from receiving unemployment benefits, when it was an isolated instance in over 13 years of employment and there was no adverse effect on the employer's business.

Reversed. Lansing, J.

C1-83-1222 Alexandria Lake Coalition, Inc., petitioner v. Douglas County, and Robert M. Wheeland, Appellant. Douglas County.

The County Board did not act arbitrarily or unreasonably in granting the developer of a cluster development project a conditional use permit despite the developer's failure to secure approval of his plans from the Planning Advisory Commission before applying for the permit, and thus issuance of a writ of mandamus directing the Board to rescind the permit was improper.

Reversed. Forsberg, J.

C8-83-1461 State of Minnesota v. Thomas Thorne Ward, Appellant. St. Louis County.

Newspaper attribution of guilt to defendant following arrest, not prominently displayed or disseminated, did not create prejudicial atmosphere requiring change of venue for trial 3 and 1/2 months later.

Trial court did not abuse its discretion in ruling 7-year-old convictions for assault and burglary admissible for impeachment purposes in a prosecution for burglary.

Appellant was in a "custody status" for purposes of calculating criminal history score when he was released four days prior to expiration date with postdated discharge papers.

Affirmed. Forsberg, J.

Concurring in part, and dissenting in part, Randall, J.

C0-83-1390 In Re the Marriage of: Evelyn B. Lammi, petitioner, v. Ronald Duane Lammi, Appellant. Scott County.

The trial court did not abuse its discretion by valuing the homestead based on credible evidence from a competent realtor, by awarding personal property to the wife when the husband remained liable on the debt, or by denying spousal maintenance and attorney's fees to the wife.

Affirmed. Huspeni, J.

C6-84-495 In the Matter of the Welfare of Craig Allan Udstuen. Ramsey County.

The trial court did not err in terminating the parental rights of a father convicted and imprisoned for abuse of his child when his conviction was on appeal and he declined to take the stand to testify in his own behalf.

Affirmed. Huspeni, J.

Decisions of the Supreme Court Filed Friday, May 18, 1984

Compiled by Wayne O. Tschimperle, Clerk

C7-83-608 Joseph F. Berg, et al., v. Steven Carlstrom, Appellant, and City of North Mankato, et al., Steven L. Carlstrom, Appellant, v. Joseph F. Berg, et al. Nicollet County.

Reformation to include the name of the proper parties will be granted where the parties intended to convey a valid easement but the deed did not contain the name of the proper grantor.

The doctrine of unclean hands applies to representations made after the original easement grant transaction where those representations related directly to the subject matter of the original agreement.

The doctrine of equitable estoppel applies to take the easement agreement out of the statute of frauds because the easement owner's affirmative statements about limiting the use and about being a man of his word, statements which were reasonably relied upon, were arguably akin to fraud.

Affirmed. Amdahl, C.J.

C6-83-51 State of Minnesota v. Felipe Lugo-Diaz, Appellant. Ramsey County.

Trial court did not err in failing to grant defendant a continuance so that he could try to obtain substitute counsel or in denying a defense motion to depart from the presumptive sentence.

Affirmed. Amdahl, C. J.

C7-82-1604 State of Minnesota v. Arvid R. Dulak, Appellant. Hennepin County.

Defendant received a fair trial and was properly found guilty of offense of aggravated robbery.

Affirmed. Peterson, J.

C7-83-155 State of Minnesota v. Charles L. Greensky, Appellant. Carlton County.

Defendant received a fair trial and was properly found guilty of assault in the first degree.

Affirmed. Peterson, J.

C8-83-102 State of Minnesota v. Robert J. Jungbauer, Appellant. Dakota County.

Examination of record reveals that defendant's confession was voluntary.

Affirmed. Scott, J.

C8-83-83 State of Minnesota v. Arnulfo Luis Ponte-Alfonzo, Appellant. Hennepin County.

Defendant received a fair trial and was properly found guilty of charges against him, but one of his two sex convictions is vacated pursuant to Minn. Stat. § 609.04 (1982).

Affirmed as modified. Simonett, J.

C8-83-567 State of Minnesota v. Camelia J. Casby, Appellant. Rice County.

The evidence supports defendant's conviction of attorney misconduct for participation in the client's deception of the court.

The defendant attorney's participation in the deceit is not excused or protected by either the attorney-client privilege, the code of professional ethics, or the client's fifth and sixth amendment constitutional rights.

Affirmed. Simonett, J.

C3-83-590 In Re the Marriage of: John J. Rudolf, Jr., Petitioner, Appellant, v. Dolores M. Rudolf. Hennepin County.

The full faith and credit clause does not preclude Minnesota from modifying future alimony installments in a Nevada divorce decree.

Reversed in part and remanded with directions. Simonett, J.

C0-82-522 State of Minnesota v. James Edward Cermak, Appellant. Goodhue County.

Unless the Supreme Court otherwise determines by granting a writ of prohibition, Minn. R. Crim. P. 24.03 prevails over Minn. Stat. § 542.16, subd. 1 (1982) in determining which judge shall preside at a criminal trial.

The trial court did not abuse its discretion in ruling child victims competent to testify in a criminal case charging the accused with criminal sexual conduct of the children.

The accused's privately-retained attorney reasonably and effectively represented him at the trial.

Failure to object to alleged prosecutorial misconduct in the trial court forfeits an accused's right to raise the issue on appeal. Even if properly raised, the record shows the alleged misconduct did not deprive appellant of a fair trial.

Alleged cumulative trial errors were insufficient to require reversal and a new trial.

One convicted of multiple charges of criminal sexual conduct in the first degree and of multiple charges of criminal sexual conduct in the second degree arising out of the same acts with the same victim is entitled to have criminal sexual conduct in the second degree convictions vacated.

The evidence was sufficient to support the jury's verdict on all charges.

Though the trial court erroneously departed as to consecutive service without written reasons, the record contains sufficient aggravating circumstances which, had they been considered by the sentencing judge, justified the consecutive service departure.

The convictions and sentences on the first-degree sexual conduct counts and one second-degree sexual conduct count are affirmed. The 11 convictions for second-degree criminal sexual conduct are vacated.

Kelley, J.

Concurring Specially, Wahl, J.

C1-83-927 Wallace Napper v. Boise Cascade Corporation, Self-insured, Relator. Workers' Compensation Court of Appeals.

The Workers' Compensation Court of Appeals' denial of the employer's petition to vacate an award on stipulation on the ground of mistake was an abuse of that court's discretion.

Reversed. Kelley, J.

C6-83-681 Cascade Motor Hotel, Inc. v. City of Duluth, a Municipal Corporation., Appellant. St. Louis County.

In absence of lien or contract, municipal utility may not impose obligation of payment for utility services on someone other than the one who actually incurred the debt.

Affirmed. Coyne, J.

C9-82-1636 State of Minnesota v. John L. Brown, Appellant. Ramsey County.

Evidence that defendant committed felony murder was sufficient.

Prosecutor improperly used leading questions in impeaching own witness, trial court erred in refusing to give a limiting instruction concerning jury's use of impeachment evidence, and prosecutor committed misconduct in closing argument, but errors were nonprejudicial.

Trial court erred in concluding that a defendant is not entitled to a credit against his sentence for time spent in jail in another state awaiting extradition and time spent in jail in Minnesota awaiting trial.

Remanded. Coyne, J.

TAX COURT

Pursuant to Minn. Stat. § 271.06, subd. 1, an appeal to the tax court may be taken from any official order of the Commissioner of Revenue regarding any tax, fee or assessment, or any matter concerning the tax laws listed in § 271.01, subd. 5, by an interested or affected person, by any political subdivision of the state, by the Attorney General in behalf of the state, or by any resident taxpayer of the state in behalf of the state in case the Attorney General, upon request, shall refuse to appeal. Decisions of the tax court are printed in the *State Register*, except in the case of appeals dealing with property valuation, assessment, or taxation for property tax purposes.

State of Minnesota Tax Court

Cyril T. Mader, Appellant, v. the Commissioner of Revenue, Appellee, Docket No. 3627

Findings of Fact, Conclusions of Law, and Order for Judgement

The above entitled matter came before the Honorable Earl B. Gustafson, Judge of the Minnesota Tax Court, on November 22, 1983, at the Stearns County Courthouse, St. Cloud, Minnesota. Post-trial briefs were filed and the case was submitted to the Court for decision on February 23, 1984.

Cyril T. Mader appeared pro se on behalf of Appellant.

Neil F. Scott, Special Assistant Attorney General, appeared on behalf of Appellee.

Appellant is appealing an Order of the Commissioner of Revenue dated June 11, 1982, determining the income tax of Appellant for the calendar year 1979.

After considering the evidence adduced at trial, the post-trial briefs and all of the files and records herein, the Court now makes the following:

FINDINGS OF FACT

1. Appellant, a dairy farmer, is a cash basis taxpayer residing in Stearns County, Minnesota.
2. Appellant failed to file a timely Minnesota Income Tax Return for the calendar year 1979.

3. After making a proper demand that Appellant file a return, the Appellee, under the authority of Minn. Stat. § 290.47, prepared and filed a 1979 return on Appellant's behalf.

4. On December 12, 1981, Appellant filed his own return showing a loss with no income tax due.

5. Appellee allowed various business expense deductions claimed by Appellant and disallowed other business expense deductions and issued an Order dated June 11, 1982, assessing Appellant's income tax liability, including interest and penalty, at $13,309.08.

6. Appellant appeals this Order dated June 11, 1982.

7. The Court finds Appellant's total gross income for 1979 to be $80,476.00, business deductions to be $73,644.00 and net income to be $6,812.00.

8. The attached Memorandum which discusses the individual items in dispute is made a part of these Findings of Fact.

CONCLUSIONS OF LAW

1. The Appellant's net income for 1979 is $6,812.00.

2. Appellee's Order dated June 11, 1982, should be modified accordingly.

LET JUDGMENT BE ENTERED ACCORDINGLY.

May 14, 1984

By the Court,
Earl B. Gustafson, Judge
Minnesota Tax Court

ERRATA

Department of Administration Application Services

Amendment to Request for Proposal for Back-Up Programming Services for the Information Services Bureau

Previously published in *State Register*, Vol. 8, Issue 46, May 14, 1984

All vendors, in their Request for Proposal, must submit the names of socially, economically disadvantaged small business to whom they will subcontract ten percent (10%) of the dollar amount of their award if they are a successful bidder. If your proposal is already completed, it can be amended by a letter signed by the same authorized member of the firm that signed the proposal.

Inquiries and responses should be directed to:

Norbert Bohn, Director
Application Services Division
Information Services Bureau
658 Cedar Street
Centennial Office Building
St. Paul, MN 55155
(612) 296-6326

Department of Administration Application Services

Notice of Deadline Extension for Back-Up Programming Proposal

Previously published in *State Register*, Vol. 8, Issue 46, May 14, 1984

The Deadline date for submitting proposals in answer to the Request for Proposal for Back-up Programming submitted by the Information Services Bureau has been extended to 4:00 p.m. on June 1, 1984.

Department of Public Safety
Driver and Vehicle Services Division
State Patrol Division

Addendum to Notice of Intent to Adopt Rules without a Public Hearing

Proposed Rules Published May 21, 1984 Governing Drivers' Licenses and Motor Vehicle Records

In the matter of proposed adoption of rules of the State Department of Public Safety governing drivers' licenses and motor vehicle records and name of applicant published at *State Register*, Volume 8, Number 47, page 2465 May 21, 1984 (8 S.R. 2465), and rules governing requirements for the approval of motor vehicle equipment used and sold in Minnesota published at *State Register*, Volume 8, Number 47, page 2467, May 21, 1984 (8 S.R. 2467), and the following notification is added pursuant to Laws 1984, Chapter 640, Section 12:

—If 25 (not 7) or more persons submit a written request for a public hearing within the 30 day comment period, a public hearing will be held under the provisions of sections 14.14 to 14.20.

—Any person commenting on the rules or requesting a hearing should identify the portion of the rules addressed, give the reason for comment or hearing request, and specify any change proposed.

—Any person requesting a public hearing should state his or her name and address in addition to the foregoing information.

The comment period is extended to June 29, 1984.

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