

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

STATE OF MINNESOTA

Office of the Attorney General

TO : PAM ZEMBAL
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul

DATE : October 12, 1992

FROM : MARY-JO MURRAY
Special Assistant
Attorney General

PHONE : 296-3258

SUBJECT : In the Matter of the Adopted Rule Relating to Workers' Compensation; Managed Care

The above-referenced rule has been approved as to its legality by the Attorney General on October 12, 1992.

Enclosed is your copy of the approved rule. This office has already filed two copies with the Secretary of State, who will forward one copy to the Revisor of Statutes. The fourth is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submissions or comments along with any extra copies of documents which you submitted to the Attorney General.

Your next step is to arrange for publication of the Notice of Adoption in the State Register. In a day or two, you should receive from the Revisor's Office three copies of the notice of adoption of your rule. You should submit two copies of the Notice of Adoption to the State Register for publication. A permanent rule without a hearing does not become effective until five days after a notice of adoption is published in the State Register in accordance with Minn. Stat. § 14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. § 14.34.

If you have any questions in this regard, please contact me.

Enclosures
cc: Gilbert S. Buffington
William Brown, Chief Judge
MaryAnn Hruby

MJM:jj.rules.bb7

Department of Labor and Industry

Adopted Emergency Rules Relating to Workers' Compensation; Managed Care

Rules as Adopted

5218.0100 [Emergency] DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 5218.0100 to 5218.9000 [Emergency] have the meanings given them in this part.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Labor and Industry or a designee.

Subp. 3. **Emergency care.** "Emergency care" means ~~professional-health-services-necessary-to-preserve-life-or-limb~~ those medical services that are required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain.

Subp. 4. **Employee.** "Employee" means an employee entitled to treatment of a ~~work~~ personal injury under Minnesota Statutes, section 176.135.

~~Subp.-5.--Geographical-service-area.--"Geographical-service area"-means-those-counties-in-which-a-managed-care-plan-has-been certified-to-provide-comprehensive-health-care-services-to injured-employees.~~

Subp. ~~6.~~ 5. **Health care provider.** "Health care provider" has the meaning given in Minnesota Statutes, section 176.011, subdivision 24.

Subp. ~~7.~~ 6. **Insurer.** "Insurer" means the insurer providing workers' compensation insurance required by Minnesota Statutes, chapter 176, and includes a self-insured employer.

Subp. ~~8.~~ 7. **Managed care plan.** "Managed care plan" means a plan certified by the commissioner that provides for the management of treatment to injured employees under Minnesota

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Statutes, sections 176.135 and 176.1351.

Subp. ~~9.~~ 8. **Participating health care provider.** "Participating health care provider" means any person, provider, company, professional corporation, organization, or business entity with which the managed care plan has contracts or other agreements for the delivery of medical services or supplies to injured employees.

Subp. ~~10.~~ 9. **Physician.** "Physician" has the meaning given in Minnesota Statutes, section 176.135, subdivision 2a.

Subp. ~~11.~~ 10. **Revocation.** "Revocation" means ~~a permanent revocation~~ the termination of a managed care plan's certification to provide services under parts 5218.0100 to 5218.9000 [Emergency].

Subp. ~~12.~~ 11. **Suspension.** "Suspension" means ~~a stopping by the commissioner of~~ the managed care plan's authority to enter into new or amended contracts with insurers has been suspended by the commissioner for a specified period of time.

5218.0210 [Emergency] AUTHORITY.

Parts 5218.0100 to 5218.9000 [Emergency] are adopted under the commissioner's emergency rulemaking authority under Minnesota Statutes, section 176.1351, subdivision 6.

5218.0220 [Emergency] PURPOSE AND SCOPE.

The purpose of parts 5218.0100 to 5218.9000 [Emergency] is to establish procedures and requirements for certification as a managed care plan relating to the delivery of medical services to injured employees within the workers' compensation system ~~under a managed care plan certified by the commissioner~~ under Minnesota Statutes, sections 176.135, subdivision 1, paragraph (f), and 176.1351.

5218.0230 [Emergency] ~~EFFECTIVE DATE~~ PROVISIONAL CERTIFICATION.

A managed care plan certified under the emergency rulemaking authority will receive provisional certification that will expire 60 days after adoption of the permanent rules unless otherwise provided for in the permanent rules.

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5218.1000 [Emergency] APPLICATION FOR CERTIFICATION.

Subpart 1. **Provisional certification.** Except as provided in part 5218.2000 [Emergency], subpart 3, any person or entity may make written application to the commissioner to provide managed care to injured employees for injuries and diseases compensable under Minnesota Statutes, chapter 176, under a plan certified by the commissioner. To obtain provisional certification of a plan, the requirements in items A to D must be complied with and documented.

A. The plan must identify any directors and officers of the managed care plan; the title and name of the person to be the day-to-day administrator of the managed care plan; the title and name of the person to be the administrator of the financial affairs of the managed care plan; and the name, address, and telephone number of a contact person.

B. The plan must report the total annual compensation paid to an administrator, director, or executive officer of the managed care plan ~~shall not exceed~~ if it exceeds ten times the average annual wage as calculated in Minnesota Statutes, section 176.011, subdivision 20. The ~~limit on~~ total annual compensation under this subpart does not include payment received by a health care provider for actual medical services rendered to an employee under Minnesota Statutes, chapter 176. When a managed care plan is certified, the commissioner shall report any annual compensation that exceeds ten times the average annual wage to the Legislative Reference Library in accordance with Minnesota Statutes, section 3.302.

C. Each application for certification must be accompanied by a nonrefundable fee of $1,500.

D. Additional documentation must be submitted as specified in subitems (1) to (11).

(1) The managed care plan must provide a list of the names, addresses, and specialties of the participating health care providers who will provide services under the managed care plan~~, together with~~; the type of license,

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registration, or certification held by each participating provider; and a statement that all licensing, registration, or certification requirements have been met and are current for the health care provider to practice in Minnesota.

(2) The managed care plan must provide a description of the times, places, and manner of providing services under the plan~~,-including-a-description-of-the-initial-geographical-service-area,-designated-by-county~~. The plan must comply with units (a) and (b).

(a) The managed care plan must ~~provide~~ ensure provision of quality services that meet all uniform treatment standards ~~prescribed~~ adopted by the commissioner under Minnesota Statutes, section 176.83, subdivision 5, and all medical and health care services that may be required by Minnesota Statutes, chapter 176, in a manner that is timely, effective, and convenient for the employee.

(b) The managed care plan may not discriminate against or exclude from participation in the plan any category of health care providers and must include an adequate number of each category of health care providers to give employees convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan, consistent with subitem (3), provided that the treatment is medically appropriate.

(3) The managed care plan must include ~~a procedure~~ procedures to ensure that the employee will:

(a) receive initial evaluation or treatment by a participating ~~physician~~ health care provider licensed in Minnesota within 24 hours of ~~a~~ the employee's request for treatment, following a work injury; ~~the-managed-care-plan-may-permit-initial-evaluations-by-a-participating-chiropractor,-in-which-case-the-employee-may-decide-whether-the-evaluation-will-be-by-a-physician-or-a-chiropractor;~~

(b) receive initial evaluation or treatment by a participating ~~physician~~ health care provider licensed in

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Minnesota within five working days of ~~a~~ the employee's request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan under part 5218.5000 [Emergency], subpart 1, item A.~~--The managed care plan may permit an initial evaluation by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or chiropractor~~;

(c) be initially allowed to choose from at least three health care providers to whom the employee has been referred by the evaluating provider under unit (a) or (b) for treatment, and allow the employee to change providers within the managed care plan at least once. The evaluating provider may be one of the three providers. The procedure to allow the employee to select ~~a~~ from three health care ~~provider~~ providers must ~~provide~~ allow direct access to all health care profession disciplines if the treatment is determined to be appropriate for the condition ~~by the evaluating health care provider under unit (a) or (b)~~ under the managed care plan's standards and the provider's scope of practice, or if the insurer approves the treatment;

(d) receive ~~treatment or~~ consultation by a managed care plan physician in cases requiring emergency in-patient hospitalization at a hospital that is not a participating provider;

(e) receive information ~~or advice~~ on a 24-hour basis regarding the availability of necessary medical services available within the managed care plan. The information may be provided through recorded telephone messages. However, the message must include information on how the employee can obtain emergency services or other urgently needed care and how the employee can access an evaluation within 24 hours of the injury as required under unit (a); and

(f) have access to treatment from health care providers within 30 miles of either the employee's place of employment or residence~~, or the distance the employee normally~~

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~~travels-to-work,-considering-the-normal-patterns-of-travel,~~ ~~whichever-is-furthest~~ if the residence or place of employment is within the seven-county metropolitan area. The seven-county metropolitan area includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. If the employee's residence and place of employment are outside the seven-county metropolitan area the allowable distance is 50 miles. If the employee requires specialized care that is not available within the stated mileage restriction, the managed care plan may refer the employee to a provider outside of the stated mileage restriction.

(4) The managed care plan must designate the procedures and criteria for approval of services from a health care provider outside the managed care plan according to part 5218.5000 [Emergency].

(5) The application must include copies of contract agreements or other documents signed by each participating health care provider. Contractual provisions must be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency]. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts submitted must include a list of signatories to the contract.

(6) The managed care plan must designate the name, address, and phone number of a communication liaison for the department ~~and~~, the insurer, the employer, and the employee.

(7) The managed care plan must include a procedure for peer review, utilization review, and internal dispute resolution in accordance with Minnesota Statutes, section 176.1351, subdivision 2, paragraph (4), including a method to resolve complaints by injured employees, medical providers, and insurers.

(8) The managed care plan must include a procedure to notify the commissioner of the commencement or termination of participating health care providers.

(9) The managed care plan must describe how

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employers and insurers will be provided with information that will inform employees of all choices of medical service providers within the plan and how employees can gain access to those providers.

(10) The managed care plan must describe how it will provide aggressive case management for injured employees, and a program for early return to work and cooperative efforts by the employees, the employer, and the managed care plan to promote workplace health and safety consultative and other services. The program for early return to work must provide for cooperation with an employee's qualified rehabilitation consultant.

(11) The managed care plan must submit any treatment standards it has developed for medical services that have not already been prescribed by the commissioner and that are reasonably likely to be used in the treatment of workers' compensation injuries. All managed care plan health care providers and ~~health-care-providers-described-in~~ those providing services under part 5218.5000 [Emergency] ~~will~~ shall be governed by these standards and by the standards prescribed by the commissioner under Minnesota Statutes, section 176.83, subdivision 5.

Subp. 2. **Notification; approval or denial.** The commissioner shall notify the applicant in writing of the approval or denial of certification. If certification is granted, the commissioner shall notify the managed care plan applicant of the effective date of the certification ~~and-the initial-geographical-service-area-approved~~. If the certification is denied, the applicant will be provided in writing with the reason for the denial. If the commissioner ~~must-require~~ is unable to determine whether the proposed plan complies with all statutory and rule requirements from the documents submitted, an in-person meeting ~~an-if-necessary-to determine-compliance-with-parts-5218.0100-to-5218.9000 [Emergency]~~ with the managed care plan applicant shall be held. Modification of the plan as certified shall require approval

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before it may be implemented.

Subp. 3. **Review of decision.** Any person aggrieved by a denial of certification by the commissioner may request in writing, within 30 days of the date the denial is served and filed, the initiation of a contested case proceeding under Minnesota Statutes, chapter 14. Following receipt of the administrative law judge's findings and recommendations, the commissioner shall issue a final decision in accordance with Minnesota Statutes, section 14.62. An appeal from the commissioner's final decision and order may be taken to the workers' compensation court of appeals pursuant to Minnesota Statutes, sections 176.421 and 176.442.

5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN.

Subpart 1. **Scope.** A managed care plan shall provide comprehensive medical services according to its certification and Minnesota Statutes, chapter 176, and all other applicable statutes and rules.

Subp. 2. ~~**Geographical service area; expansion.** The commissioner shall designate a managed care plan's initial geographical service area and approve any expansions to the managed care plan's service area. Injured employees shall not be covered by a managed care plan until the commissioner has approved the proposed expansion of the geographical service area.~~

~~Subp. 3.~~ **Contracts and coverage.** ~~When~~ A managed care plan ~~contracts~~ must contract with ~~an~~ the insurer liable under Minnesota Statutes, chapter 176, to provide services, to employees with a personal injury. The contract shall specify those employers covered by the contract and the estimated number of covered employees. The managed care plan contract must include the terms and conditions in items A to F.

~~A. The employer's place of employment must be within the authorized geographical service area.~~

~~B.~~ Insurers may contract with multiple managed care plans to provide coverage for employers. When ~~insurers contract~~

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an insurer contracts with multiple managed care plans to cover the same employer, each employee shall have the initial choice at time of injury to select the managed care plan that will manage the employee's care. The employee shall select a managed care plan from those that have a contract with the insurer liable for the personal injury under Minnesota Statutes, chapter 176, and that provide services within the mileage restrictions under part 5218.1000 [Emergency], subpart 1, item D, subitem (3), unit (f).

~~C.~~ B. An employee with a compensable personal injury under Minnesota Statutes, chapter 176, occurring on or after the effective date of the managed care plan contract with the insurer liable for the injury under Minnesota Statutes, chapter 176, shall receive medical services in the manner prescribed by the terms and conditions of the managed care plan contract.

~~D.~~ C. The requirements established in parts 5218.0100 to 5218.9000 [Emergency] do not apply to an employee with a compensable injury under Minnesota Statutes, chapter 176, that occurred before the effective date of the managed care plan contract, until the employee requests a change of doctor. At that time, further services shall be provided by the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by health care providers who are not participating providers must be delivered according to part 5218.5000 [Emergency].

~~E.~~ D. To ensure continuity of care, the managed care plan contract shall specify the manner in which an injured employee with a compensable injury will receive medical services when a managed care plan contract or a contract with a health care provider terminates. When a contract with a health care provider terminates, or when managed care plan coverage for an injured employee is being transferred from one managed care plan to another, the employee may continue to treat with the ~~employee's original~~ health care provider under the terminated contract until the employee requests a change of doctor. At

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that time further services shall be provided under the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by providers who are not participating providers must be performed according to part 5218.5000 [Emergency].

~~F.~~ E. Except as provided in part 5218.5000 [Emergency], an employer may require an employee who is claiming a workers' compensation injury to receive treatment from a managed care plan before the employer accepts or denies liability for the injury. In such cases the employer is liable for the cost of any treatment related to the claimed personal injury that is given by a participating health care provider before notice is given to the employee of a denial of liability, even if the employer is later determined to be not liable for the claimed injury. If liability is denied, the employer cannot pursue reimbursement from the employee. This item does not limit the employer's right to pursue any other applicable subrogation or reimbursement rights it may have against parties.

F. The employee may receive treatment from any health care provider chosen by the employee after a notice of denial of liability has been given to the employee, or if the employer does not require the employee to receive treatment from a managed care plan prior to accepting liability for a claimed injury. If the employer later accepts liability or is determined by the commissioner, a compensation judge, or an appellate court to be liable for the claimed injury, the employer is responsible for the cost of all reasonable and necessary medical treatment received by the employee. ~~Once~~ If the employer ~~has admitted~~ admits liability for the claimed injury ~~or once the employer has been determined to be liable for the claimed~~ within 14 days after receiving notice of the injury, the employer may require that further medical treatment be received through the managed care plan unless the employee had a documented history of treatment with the health care provider as described in part 5218.5000 [Emergency], before the injury. If

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liability is admitted or determined later than 14 days after notice of the injury and the employee has been receiving treatment from a nonparticipating provider under this item, the employee is not required to receive further treatment under the managed care plan, if the health care provider agrees to comply with part 5218.5000 [Emergency], subpart 2.

Subp. ~~4.~~ 3. **Restrictions.** When an insurer contracts with a single managed care plan for coverage for an employer, the plan may not be formed, operated, or administered by the same employer or insurer. When an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, formed, or administered by the employer or insurer. No employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota Statutes, chapter 176. At the time such a plan is offered, the employer shall give written notice of the affiliation and that no employee is required to obtain services under a managed care plan operated, formed, or administered by the employer or insurer.

5218.3000 [Emergency] REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN.

Subpart 1. **Contracts; modifications.** A managed care plan shall provide the commissioner with a copy of a managed care plan insurer contract and managed care plan participating provider contract agreements, signed by the parties, within 30 days of execution of the contracts. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts shall include a list of signatories. Amendments and addendums to the contracts shall also be submitted to the commissioner within 30 days of execution. Contract provisions shall be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency].

Subp. 2. **Requirements.** Within six months of provisional

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certification, each managed care plan shall provide the following information ~~in a form and format prescribed by the commissioner~~:

A. a current listing of participating health care providers, including provider names, specialty, business address, and phone number, and for any new health care provider the information required by part 5218.1000 [Emergency], subpart 1, item D, subitem (1);

B. a listing of all health care providers outside of the managed care plan who provided services to employees under part 5218.5000 [Emergency], subpart 1, item C;

C. a listing of all employers covered by each contract including the employer's names, unemployment insurer's identification number, and estimated number of employees governed by the managed care plan contract;

D. a summary of any sanctions or punitive actions taken by the managed care plan against its ~~members~~ participating providers;

E. a report that summarizes peer review ~~and~~, utilization review ~~performed~~, and dispute resolution proceedings showing cases reviewed, issues involved, and any action taken. The peer and utilization review must include~~, but is not limited to,~~ evaluation of compliance with applicable treatment standards adopted by the commissioner; and

F. any proposed changes to the certified managed care plan ~~as certified by the commissioner~~.

Subp. 3. **Insurers; data.** The managed care plan must report to the insurer any data regarding medical services and supplies related to the workers' compensation claim required by the insurer to determine compensability, in accordance with Minnesota Statutes, sections 176.135, subdivision 7 and 176.138, and any other data required by rule.

Subp. 4. **Monitoring.** The commissioner shall require additional information from the managed care plan ~~as necessary to monitor~~ if the information is relevant to determining the managed care plan's compliance with parts 5218.0100 to 5218.9000

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[Emergency] and Minnesota Statutes, section 176.1351.

5218.4000 [Emergency] COMMENCEMENT AND TERMINATION OF CONTRACT WITH PARTICIPATING PROVIDERS.

Subpart 1. **Commencement.** Prospective new participating health care providers under a managed care plan shall submit an application to the managed care plan. A director, executive director, or administrator may approve the application under the requirements of the managed care plan. The managed care plan shall verify that each new participating health care provider meets all licensing, registration, and certification requirements necessary to practice in Minnesota.

Subp. 2. **Termination.** A participating provider may elect to terminate participation in the managed care plan or be subject to cancellation by the managed care plan under the requirements of the managed care plan. Upon termination of a provider contract, the managed care plan shall make alternate arrangements to provide continuing medical services for an affected injured employee under the plan in accordance with part 5218.2000 [Emergency], subpart 2, item D.

5218.5000 [Emergency] HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subpart 1. **Authorized services.** ~~The managed care plan shall authorize~~ A health care provider who is not a participating health care provider ~~to~~ may provide medical services to an employee covered by a managed care plan in any of the following circumstances:

A. if the health care provider maintains the employee's medical records ~~and~~, has a documented history of treatment of that employee at least twice in the four years before the date of injury, and complies with Minnesota Statutes, section 176.1351, subdivision 2, clause (8). The employee must provide the insurer with copies of medical records documenting the previous treatment. The insurer must treat the medical records as private data. If the employee requests a change of doctor, further services shall be provided by the managed care

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plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c);

B. for emergency treatment; ~~or~~

C. when the employee is referred outside the managed care plan for medical services by the managed care plan; or

D. when the employee has received treatment for a claimed injury from a nonparticipating provider under part 5218.2000 [Emergency], subpart 2, item F, and liability for the injury is admitted or established later than 14 days after the employer received notice of the injury.

Subp. 2. **Requirements.** A health care provider who is not a participating health care provider must:

A. agree to comply with the managed care plan treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures; and

B. agree to refer the covered employee to the managed care plan for specialized care, ~~which includes, but is not limited to,~~ physical therapy, and diagnostic testing, except for minor diagnostic testing that may be done in the provider's office. The provider referring the employee may continue to provide direct treatment.

Subp. 3. **Disputes.** Any dispute under subpart 1 or 2 relating to the employee's selection of a health care provider who is not a managed care plan participating health care provider shall be resolved according to part 5218.7000 [Emergency]. Any dispute relating to a health care provider's compliance with the managed care plan standards and procedures or treatment standards adopted by the commissioner shall be resolved according to part 5218.7000 [Emergency] ~~or~~. A health care provider who does not comply with the requirements in subpart 2 is subject to denial of payment for the services in accordance with the procedures in part 5218.7000 [Emergency] and sanctions under Minnesota Statutes, section 176.103.

5218.6000 [Emergency] CHARGES AND FEES.

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Billings for medical services under a managed care plan shall be submitted in the form and format as prescribed in part 5221.0700, subpart 2. The payment by the insurer or the managed care plan to participating and nonparticipating health care providers for medical services shall be according to the timeframes and procedures in part 5221.0600, subpart 3, and Minnesota Statutes, section 176.135, subdivision 6, and shall be equal to the maximum amount allowed under Minnesota Statutes, section 176.136, subdivisions 1a and 1b. A managed care plan may not require a health care provider to accept a lesser payment or pay a fee as a condition of receiving referrals from or becoming a participating provider in the plan.

5218.7000 [Emergency] DISPUTE RESOLUTION.

Disputes that arise between the employee and the managed care plan related to the delivery of health services under this chapter shall first be processed through the dispute resolution process of the managed care plan. The managed care plan dispute resolution process must be completed within 30 days of receipt of a request. If the dispute cannot be resolved, the commissioner ~~may issue an order to resolve the dispute~~ shall proceed under Minnesota Statutes, sections 176.106 and 176.305 or 176.2615.

5218.8000 [Emergency] MONITORING.

Subpart 1. **Audits.** The commissioner shall monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements.

Subp. 2. **Records.** All records of the managed care plan and its participating health care providers ~~shall be disclosed on request of the commissioner when necessary to ensure~~ relevant to determining compliance with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency] shall be disclosed upon request of the commissioner. ~~These~~ Records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes. The release of

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records filed with the commissioner is subject to Minnesota Statutes, sections 13.37, 145.61 to 145.67, 176.231, subdivisions 8 and 9, 176.234, and 176.138.

5218.9000 [Emergency] SUSPENSION; REVOCATION.

Subpart 1. **Complaints; investigation.** Complaints pertaining to violations of parts 5218.0100 to 5218.9000 [Emergency] or Minnesota Statutes, section 176.1351, by the managed care plan shall be directed in writing to the commissioner. On receipt of a written complaint, or after monitoring the managed care plan operations, the department shall investigate the alleged ~~rule~~ violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the ~~department determines on completion of the~~ investigation ~~that~~ reveals reasonable cause to believe that there has been a ~~rule~~ violation warranting suspension or revocation of provisional certification, the commissioner shall initiate a contested case proceeding under Minnesota Statutes, chapter 14.

Subp. 2. **Criteria.** Under Minnesota Statutes, section 176.1351, subdivision 5, the provisional certification of a managed care plan issued by the commissioner shall be suspended or revoked by the commissioner if:

A. service under the plan is not being provided according to the terms of the certified plan;

B. the plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of parts 5218.0100 to 5218.9000 [Emergency] or Minnesota Statutes, section 176.1351;

C. the managed care plan fails to comply with Minnesota Statutes, section 176.1351, parts 5218.0100 to 5218.9000 [Emergency], ~~and~~ or requirements of utilization and treatment standards adopted under Minnesota Statutes, section 176.83;

D. any false or misleading information is submitted by the managed care plan or ~~a member of the plan~~ participating

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provider; or

E. the managed care plan continues to use the services of a health care provider whose license, registration, or certification has been suspended or revoked ~~by the licensing board~~, or under Minnesota Statutes, section 176.103, or who is ineligible to provide treatment to an injured employee under Minnesota Statutes, section 256B.0644.

Subp. 3. **Effects.** ~~All contracts with insurers are void~~ No employee is covered by a contract between a managed care plan and insurer if ~~a~~ the managed care plan's provisional certification is revoked. The managed care plan may reapply for certification as specified in the order of revocation. Upon suspension of certification, the managed care plan may continue to provide services under contracts in effect if the commissioner determines injured employees will continue to receive necessary medical services under Minnesota Statutes, section 176.135.

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by Revisor _____

APPROVED AS TO FORM AND LEGALITY

Oct 12 19 92

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY _____
SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED

OCT 12 1992

Joan Anderson Growe
Secretary of State

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RC

Department of Labor and Industry

Proposed Emergency Rules Relating to Workers' Compensation; Managed Care

Rules as Proposed (all new material)

5218.0100 [Emergency] DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 5218.0100 to 5218.9000 [Emergency] have the meanings given them in this part.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Labor and Industry or a designee.

Subp. 3. **Emergency care.** "Emergency care" means professional health services necessary to preserve life or limb.

Subp. 4. **Employee.** "Employee" means an employee entitled to treatment of a work injury under Minnesota Statutes, section 176.135.

Subp. 5. **Geographical service area.** "Geographical service area" means those counties in which a managed care plan has been certified to provide comprehensive health care services to injured employees.

Subp. 6. **Health care provider.** "Health care provider" has the meaning given in Minnesota Statutes, section 176.011, subdivision 24.

Subp. 7. **Insurer.** "Insurer" means the insurer providing workers' compensation insurance required by Minnesota Statutes, chapter 176, and includes a self-insured employer.

Subp. 8. **Managed care plan.** "Managed care plan" means a plan certified by the commissioner that provides for the management of treatment to injured employees under Minnesota Statutes, sections 176.135 and 176.1351.

Subp. 9. **Participating health care provider.** "Participating health care provider" means any person, provider, company, professional corporation, organization, or business entity with which the managed care plan has contracts or other

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agreements.

Subp. 10. **Physician.** "Physician" has the meaning given in Minnesota Statutes, section 176.135, subdivision 2a.

Subp. 11. **Revocation.** "Revocation" means a permanent revocation of a managed care plan's certification to provide services under parts 5218.0100 to 5218.9000 [Emergency].

Subp. 12. **Suspension.** "Suspension" means a stopping by the commissioner of the managed care plan's authority to enter into new contracts with insurers for a specified period of time.

5218.0210 [Emergency] AUTHORITY.

Parts 5218.0100 to 5218.9000 [Emergency] are adopted under the commissioner's emergency rulemaking authority under Minnesota Statutes, section 176.1351, subdivision 6.

5218.0220 [Emergency] PURPOSE AND SCOPE.

The purpose of parts 5218.0100 to 5218.9000 [Emergency] is to establish procedures and requirements relating to the delivery of medical services to injured employees within the workers' compensation system under a managed care plan certified by the commissioner under Minnesota Statutes, sections 176.135, subdivision 1, paragraph (f), and 176.1351.

5218.0230 [Emergency] EFFECTIVE DATE.

A managed care plan certified under the emergency rulemaking authority will receive provisional certification that will expire 60 days after adoption of the permanent rules unless otherwise provided for in the permanent rules.

5218.1000 [Emergency] APPLICATION FOR CERTIFICATION.

Subpart 1. **Provisional certification.** Any person or entity may make written application to the commissioner to provide managed care to injured employees for injuries and diseases compensable under Minnesota Statutes, chapter 176, under a plan certified by the commissioner. To obtain provisional certification of a plan, the requirements in items A to D must be complied with and documented.

A. The plan must identify any directors and officers

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of the managed care plan; the title and name of the person to be the day-to-day administrator of the managed care plan; the title and name of the person to be the administrator of the financial affairs of the managed care plan; and the name, address, and telephone number of a contact person.

B. The total annual compensation paid to an administrator, director, or executive officer of the managed care plan shall not exceed ten times the average annual wage as calculated in Minnesota Statutes, section 176.011, subdivision 20. The limit on compensation under this subpart does not include payment received by a health care provider for actual medical services rendered to an employee under Minnesota Statutes, chapter 176.

C. Each application for certification must be accompanied by a nonrefundable fee of $1,500.

D. Additional documentation must be submitted as specified in subitems (1) to (11).

(1) The managed care plan must provide a list of the names, addresses, and specialties of the participating health care providers who will provide services under the managed care plan, together with a statement that all licensing, registration, or certification requirements have been met for the health care provider to practice in Minnesota.

(2) The managed care plan must provide a description of the times, places, and manner of providing services under the plan, including a description of the initial geographical service area, designated by county. The plan must comply with units (a) and (b).

(a) The managed care plan must provide quality services that meet uniform treatment standards prescribed by the commissioner and all medical and health care services that may be required by Minnesota Statutes, chapter 176, in a manner that is timely, effective, and convenient for the employee.

(b) The managed care plan may not discriminate against or exclude from participation in the plan

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any category of health care providers and must include an adequate number of each category of health care providers to give employees convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan, provided that the treatment is medically appropriate.

(3) The managed care plan must include a procedure to ensure that the employee will:

(a) receive initial evaluation by a participating physician within 24 hours of a request for treatment, following a work injury; the managed care plan may permit initial evaluations by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or a chiropractor;

(b) receive initial evaluation by a participating physician within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan under part 5218.5000 [Emergency], subpart 1, item A. The managed care plan may permit an initial evaluation by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or chiropractor;

(c) initially choose from at least three health care providers to whom the employee has been referred by the evaluating provider under unit (a) or (b) for treatment, and allow the employee to change providers within the managed care plan at least once. The procedure to allow the employee to select a health care provider must provide direct access to all health care profession disciplines if the treatment is determined to be appropriate for the condition by the evaluating health care provider under unit (a) or (b) or if the insurer approves the treatment;

(d) receive treatment or consultation by a managed care plan physician in cases requiring emergency

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in-patient hospitalization;

(e) receive information or advice on a 24-hour basis regarding medical services available within the managed care plan; and

(f) have access to health care providers within 30 miles of the employee's place of employment or residence, or the distance the employee normally travels to work, considering the normal patterns of travel, whichever is furthest.

(4) The managed care plan must designate the procedures and criteria for approval of services from a health care provider outside the managed care plan according to part 5218.5000 [Emergency].

(5) The application must include copies of contract agreements or other documents signed by each participating health care provider. Contractual provisions must be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency]. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts submitted must include a list of signatories to the contract.

(6) The managed care plan must designate the name, address, and phone number of a communication liaison for the department and the insurer.

(7) The managed care plan must include a procedure for peer review, utilization review, and internal dispute resolution in accordance with Minnesota Statutes, section 176.1351, subdivision 2, paragraph (4), including a method to resolve complaints by injured employees, medical providers, and insurers.

(8) The managed care plan must include a procedure to notify the commissioner of the commencement or termination of participating health care providers.

(9) The managed care plan must describe how employers and insurers will be provided with information that will inform employees of all choices of medical service

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providers within the plan and how employees can gain access to those providers.

(10) The managed care plan must describe how it will provide aggressive case management for injured employees, and a program for early return to work and cooperative efforts by the employees, the employer, and the managed care plan to promote workplace health and safety consultative and other services.

(11) The managed care plan must submit treatment standards for medical services not already prescribed by the commissioner. All managed care plan health care providers and health care providers described in part 5218.5000 [Emergency] will be governed by these standards.

Subp. 2. **Notification; approval or denial.** The commissioner shall notify the applicant in writing of the approval or denial of certification. If certification is granted, the commissioner shall notify the managed care plan applicant of the effective date of the certification and the initial geographical service area approved. If the certification is denied, the applicant will be provided with the reason for the denial. The commissioner must require an in-person meeting if necessary to determine compliance with parts 5218.0100 to 5218.9000 [Emergency]. Modification of the plan as certified shall require approval before it may be implemented.

5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN.

Subpart 1. **Scope.** A managed care plan shall provide comprehensive medical services according to its certification and Minnesota Statutes, chapter 176, and all other applicable statutes and rules.

Subp. 2. **Geographical service area; expansion.** The commissioner shall designate a managed care plan's initial geographical service area and approve any expansions to the managed care plan's service area. Injured employees shall not

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be covered by a managed care plan until the commissioner has approved the proposed expansion of the geographical service area.

Subp. 3. **Contracts.** When a managed care plan contracts with an insurer to provide services, the contract shall specify those employers covered by the contract and the estimated number of covered employees. The managed care plan contract must include the terms and conditions in items A to F.

A. The employer's place of employment must be within the authorized geographical service area.

B. Insurers may contract with multiple managed care plans to provide coverage for employers. When insurers contract with multiple managed care plans to cover the same employer, each employee shall have initial choice at time of injury to select the managed care plan that will manage the employee's care.

C. An employee with a compensable injury under Minnesota Statutes, chapter 176, occurring on or after the effective date of the managed care plan contract shall receive medical services in the manner prescribed by the terms and conditions of the managed care plan contract.

D. The requirements established in parts 5218.0100 to 5218.9000 [Emergency] do not apply to an employee with a compensable injury under Minnesota Statutes, chapter 176, that occurred before the effective date of the managed care plan contract, until the employee requests a change of doctor. At that time, further services shall be provided by the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by health care providers who are not participating providers must be delivered according to part 5218.5000 [Emergency].

E. To ensure continuity of care, the managed care plan contract shall specify the manner in which an injured employee with a compensable injury will receive medical services when a managed care plan contract terminates. When managed care plan coverage for an injured employee is being transferred from

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one managed care plan to another, the employee may continue to treat with the employee's original health care provider until the employee requests a change of doctor. At that time further services shall be provided under the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by providers who are not participating providers must be performed according to part 5218.5000 [Emergency].

F. Except as provided in part 5218.5000 [Emergency], an employer may require an employee who is claiming a workers' compensation injury to receive treatment from a managed care plan before the employer accepts or denies liability for the injury. In such cases the employer is liable for the cost of any treatment given before notice is given to the employee of a denial of liability, even if the employer is later determined to be not liable for the claimed injury.

The employee may receive treatment from any health care provider chosen by the employee after a notice of denial of liability has been given to the employee, or if the employer does not require the employee to receive treatment from a managed care plan prior to accepting liability for a claimed injury. If the employer later accepts liability or is determined by the commissioner, a compensation judge, or an appellate court to be liable for the claimed injury, the employer is responsible for the cost of all reasonable and necessary medical treatment received by the employee. Once the employer has admitted liability for the claimed injury or once the employer has been determined to be liable for the claimed injury, the employer may require that further medical treatment be received through the managed care plan unless the employee had a documented history of treatment with the health care provider as described in part 5218.5000 [Emergency], before the injury.

Subp. 4. **Restrictions.** When an insurer contracts with a single managed care plan for coverage for an employer, the plan may not be formed, operated, or administered by the same

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employer or insurer. When an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, formed, or administered by the employer or insurer. No employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota Statutes, chapter 176.

5218.3000 [Emergency] REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN.

Subpart 1. **Contracts; modifications.** A managed care plan shall provide the commissioner with a copy of a managed care plan insurer contract and managed care plan participating provider contract agreements, signed by the parties, within 30 days of execution of the contracts. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts shall include a list of signatories. Amendments and addendums to the contracts shall also be submitted to the commissioner within 30 days of execution. Contract provisions shall be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency].

Subp. 2. **Requirements.** Within six months of provisional certification, each managed care plan shall provide the following information in a form and format prescribed by the commissioner:

A. a current listing of participating health care providers, including provider names, specialty, business address, and phone number, and for any new health care provider the information required by part 5218.1000 [Emergency], subpart 1, item D, subitem (1);

B. a listing of all health care providers outside of the managed care plan who provided services to employees under part 5218.5000 [Emergency];

C. a listing of all employers covered by each contract including the employer's names, unemployment insurer's

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identification number, and estimated number of employees governed by the managed care plan contract;

D. a summary of any sanctions or punitive actions taken by the managed care plan against its members;

E. a report that summarizes peer review and utilization review performed showing cases reviewed, issues involved, and action taken. The review must include, but is not limited to, evaluation of compliance with treatment standards adopted by the commissioner; and

F. any proposed changes to the managed care plan as certified by the commissioner.

Subp. 3. **Insurers; data.** The managed care plan must report to the insurer any data regarding medical services and supplies required by the insurer to determine compensability, and any other data required by rule.

Subp. 4. **Monitoring.** The commissioner shall require additional information from the managed care plan as necessary to monitor the managed care plan's compliance with parts 5218.0100 to 5218.9000 [Emergency] and Minnesota Statutes, section 176.1351.

5218.4000 [Emergency] COMMENCEMENT AND TERMINATION OF PARTICIPATING PROVIDERS.

Subpart 1. **Commencement.** Prospective new participating health care providers under a managed care plan shall submit an application to the managed care plan. A director, executive director, or administrator may approve the application under the requirements of the managed care plan. The managed care plan shall verify that each new participating health care provider meets all licensing, registration, and certification requirements necessary to practice in Minnesota.

Subp. 2. **Termination.** A participating provider may elect to terminate participation in the managed care plan or be subject to cancellation by the managed care plan under the requirements of the managed care plan. Upon termination of a provider, the managed care plan shall make alternate

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arrangements to provide continuing medical services for an affected injured employee under the plan.

5218.5000 [Emergency] HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subpart 1. **Authorized services.** The managed care plan shall authorize a health care provider who is not a participating health care provider to provide medical services to an employee in the following circumstances:

A. if the health care provider maintains the employee's medical records and has a documented history of treatment of that employee before the date of injury. If the employee requests a change of doctor, further services shall be provided by the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c);

B. for emergency treatment; or

C. when referred outside the managed care plan for medical services by the managed care plan.

Subp. 2. **Requirements.** A health care provider who is not a participating health care provider must:

A. agree to comply with the managed care plan treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures; and

B. agree to refer the covered employee to the managed care plan for specialized care, which includes, but is not limited to, physical therapy and diagnostic testing.

Subp. 3. **Disputes.** Any dispute under subpart 1 or 2 relating to the employee's selection of a health care provider who is not a managed care plan participating health care provider shall be resolved according to part 5218.7000 [Emergency]. Any dispute relating to a health care provider's compliance with the managed care plan standards and procedures or treatment standards adopted by the commissioner shall be resolved according to part 5218.7000 [Emergency] or Minnesota Statutes, section 176.103.

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5218.6000 [Emergency] CHARGES AND FEES.

Billings for medical services under a managed care plan shall be submitted in the form and format as prescribed in part 5221.0700, subpart 2. The payment by the insurer or the managed care plan to participating and nonparticipating health care providers for medical services shall be according to the timeframes and procedures in part 5221.0600, subpart 3, and Minnesota Statutes, section 176.135, subdivision 6, and shall be the maximum amount allowed under Minnesota Statutes, section 176.136.

5218.7000 [Emergency] DISPUTE RESOLUTION.

Disputes that arise between the employee and the managed care plan related to delivery of health services shall first be processed through the dispute resolution process of the managed care plan. The managed care plan dispute resolution process must be completed within 30 days of receipt of a request. If the dispute cannot be resolved, the commissioner may issue an order to resolve the dispute under Minnesota Statutes, sections 176.106 and 176.305 or 176.2615.

5218.8000 [Emergency] MONITORING.

Subpart 1. **Audits.** The commissioner shall monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements.

Subp. 2. **Records.** All records of the managed care plan and its participating health care providers shall be disclosed on request of the commissioner when necessary to ensure compliance with Minnesota Statutes, section 176.1351. These records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes.

5218.9000 [Emergency] SUSPENSION; REVOCATION.

Subpart 1. **Complaints; investigation.** Complaints pertaining to violations of parts 5218.0100 to 5218.9000 [Emergency] by the managed care plan shall be directed in

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writing to the commissioner. On receipt of a written complaint, or after monitoring the managed care plan operations, the department shall investigate the alleged rule violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the department determines on completion of the investigation that there has been a rule violation warranting suspension or revocation of provisional certification, the commissioner shall initiate a contested case proceeding under Minnesota Statutes, chapter 14.

Subp. 2. **Criteria.** Under Minnesota Statutes, section 176.1351, subdivision 5, the provisional certification of a managed care plan issued by the commissioner shall be suspended or revoked by the commissioner if:

A. service under the plan is not being provided according to the terms of the certified plan;

B. the plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of parts 5218.0100 to 5218.9000 [Emergency] or Minnesota Statutes, section 176.1351;

C. the managed care plan fails to comply with Minnesota Statutes, section 176.1351, parts 5218.0100 to 5218.9000 [Emergency], and requirements of utilization and treatment standards adopted under Minnesota Statutes, section 176.83;

D. any false or misleading information is submitted by the managed care plan or a member of the plan; or

E. the managed care plan continues to use the services of a health care provider whose license has been suspended or revoked by the licensing board, or under Minnesota Statutes, section 176.103, or who is ineligible to provide treatment to an injured employee under Minnesota Statutes, section 256B.0644.

Subp. 3. **Effects.** All contracts with insurers are void if a managed care plan's provisional certification is revoked. Upon suspension of certification, the managed care plan may

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continue to provide services under contracts in effect if the commissioner determines injured employees will continue to receive necessary medical services under Minnesota Statutes, section 176.135.

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Office of the Revisor of Statutes

Administrative Rules

TITLE: Proposed Emergency Rules Relating to Workers' Compensation; Managed Care

AGENCY: Department of Labor and Industry

MINNESOTA RULES: Chapter 5218

The attached rules are approved for publication in the State Register

Marie O'Neill

Marie E. O'Neill
Assistant Revisor

Emergency Rules MJM 9/29/92

RULE REVIEW CHECKLIST

10 Working Days

File No. 1953

DATE RECEIVED 9/28/92

REVIEW DATE

DUE DATE 10/12/92

~~(DIS)~~APPROVED 10/12/92

WITHDRAWN

Docket No. OS.0009.0600

ADOPTED W/O HEARING

EMERGENCY RULE ✓

TO REVISOR ON 10-29-92

REVISOR (DIS)APPROVED 10/5/92

FILED W/SEC. OF STATE 10-12-92

RETURNED TO AGENCY 10-12-92

✓ Rule as adopted (4 copies)

✓ Notice to Solicit Outside Information/Opinion (if applicable)

June 29, 1992 Date published in State Register

✓ Comments

Petition for Adoption of a Rule

Board's Authorizing Resolution

Date adopted

✓ Proposed Rule

✓ Revisor's Certificate

✓ Notice of Intent to Adopt Rule Attached

176.1351 subd 6 Statutory Authority 1992 Laws of MN Chapter 510

no statement Small Business Statement Article 4 § 13

Expenditure of public money statement

John Tennes Jr. Signature

N/A Statement of Need and Reasonableness (if applicable)

Small Business Statement

sent Fees - § 16A.128 sent letters to House appropriations Senate finance approval from finance

✓ Affidavit of Mailing Notice of Intent to Adopt Rule

July 24, 1992 Dated 30/(25) days before adoption

Notice attached indicates it is attached

Copy of rule or summary attached

✓ Publication in State Register

July 27, 1992 Date 30/(25) days before adoption

✓ 180-day deadline from:

✓ Effective date of law requiring rule (14.12) (both rules) amendments don't apply not mandated

✓ end of comment period (§ 14.26) (rules without hearing)

effective date of statutory authority (§ 14.29) (emergency rules)

Resolution Adopting

Date adopted

✓ Findings of Fact, Conclusions & Order Adopting

~~Sept 28, 1992~~ Date

✓ Written Requests, Submissions or Comments

Declaration of Attorney

Name of SAAG representing agency

Sept 28, 1992 Notice of Submission to Attorney General (if applicable)

Sept 28, 1992 Affidavit of Mailing Notice to Attorney General (if applicable)

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TELECOPY COVER SHEET

612/333-5970

DATE: October 12, 1992

TO: Mary Jo Murray

ATTN:

FAX NO: 297-2576

FROM: Mark G. Olive

WE ARE SENDING A TOTAL OF 2 PAGES, INCLUDING THIS COVER PAGE. IF YOU DO NOT RECEIVE ALL PAGES, OR ARE EXPERIENCING OTHER PROBLEMS IN TRANSMISSION, PLEASE CALL 612/333-4500, Ext. 781.

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October 12, 1992

Ms. Mary Jo Murray
Special Assistant Attorney General
Office of the Attorney General
Public Finance Division
Capitol Office Building
525 Park Street
St. Paul, MN 55103

VIA FACSIMILE AND U.S. MAIL

RE: Managed Care Emergency Rules

Dear Ms. Murray:

This letter is intended as a brief response to Ms. Kathryn Berger's letter to you of October 9, 1992 regarding the proposed Managed Care Rules. More specifically, Ms. Berger has inaccurately stated our objection to proposed Rule 5000, Subp. 1A. Her misstatement of our objection to this Rule and her representation therein can be found on page 5 of her letter. We did not state in our Comments that "a documented history of treatment" with a provider should not be limited to treatment before the date of injury. Rather, we intended to convey our objection to placing a "two times within four years of the injury date" restriction on the statutory definition. There is no basis to conclude that "two visits within four years of injury date" in any way reasonably defines "documented history of treatment" and is anything other than arbitrary and capricious.

Very truly yours,

Mark G. Olive

FOR THE FIRM

MGO/nkp

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Adoption of the Rules of the State of Minnesota Governing Workers' Compensation; Managed Care

FINDINGS OF FACT, CONCLUSIONS, AND ORDER ADOPTING EMERGENCY RULES

(1) Notice of the Commissioner's intent to adopt the above entitled emergency rules was published in the State Register on July 27, 1992 and was sent by United States Mail to all persons on the list maintained by the Agency pursuant to Minnesota Statutes, section 14.30 on July 24, 1992.

(2) All persons were given the opportunity to submit written comments on the rules for at least 25 days after notice of proposed rulemaking. (3) Based on the comments received and evidence in the record before the agency, I find that the nonsubstantial changes set forth in the Rules as Adopted, approved as to form by the Revisor of Statutes on September 22, 1992, incorporated by reference herein, are appropriate for the following reasons:

FINDINGS OF FACT

1. Part 5218.0100 [Emergency] DEFINITIONS.

   Subp. 3. Emergency care.

   The definition of emergency was originally taken from a definition used for the health maintenance organizations in Minn. Rules, part 4685.0100, subp. 5a. However, public comment received indicated concern about this definition, because many non-emergency medical services could be considered necessary to preserve life and limb in the broadest sense. For example, the definition as originally written could also include nonemergency follow-up services. Accordingly, the definition is modified. This definition is derived from Minn. Stat. § 256B.0625, subd. 4. The new definition reflects the original intent of the rule that emergency care should be treatment which is immediately necessary for a condition that, if not immediately treated, could lead to serious physical or mental disability or death. Emergency care is also appropriate if immediately necessary to alleviate severe pain. This is a more specific definition that will permit employees and managed care plans to more accurately determine when emergency care outside of the managed care network is appropriate. It is not a substantial change because the change is made directly in response to public comment about the definition as proposed.

2. Part 5218.0100 [Emergency] DEFINITIONS.

Subp. 4. Employee.

This change substitutes the term "personal" injury for "work" injury so that the rule is consistent with the definition of personal injury found in Minn. Stat. § 176.011, subd. 16.

3. Part 5218.0100 [Emergency] DEFINITIONS.

Subp. 5. Geographical Service Area.

Public comment indicated there is confusion regarding what is required for a geographical service area and how that requirement is coordinated with the mileage restrictions found in part 5218.1000, subp. 1, item D, subitem 1, unit f. Public comment also indicated that access to care outside the geographical service area, particularly in rural areas, may be difficult. Furthermore, the geographical service area requirement in the proposed rule is of limited utility because it does not provide information as to how many employees will be ultimately covered by the plan; the contract between the managed care plan and the insurer is not entered into until after the plan has been certified by the commissioner. The mileage restrictions in part 5218.1000, subp. 1 item D, subitem 1, unit f should be adequate to ensure that the managed care plan provides the employees with access to necessary medical treatment.The insurer remains liable for any treatment this managed care plan does not provide. Accordingly, it is determined that, pending further analysis for the permanent rules, the mileage restrictions are adequate and the geographical service area is not necessary at this time. This is not a substantial change because it does not affect a new class of persons or a new subject matter and is merely made in response to concerns raised about the issue in public comment.

4. Part 5218.0100, [Emergency] DEFINITIONS.

Subp. ~~9~~ 8. Participating health care provider.

The definition of "participating health care provider" is amended to clarify that the contracts between the provider and the managed care plan are those for the delivery of medical services or supplies to injured employees. Several commentors noted that the definition as proposed is too broad, and could arguably include any person having any type of contract with the managed care plan, even if it is not related to the delivery of medical services to employees. This is not a substantial change because it is merely a clarification of the original intent of the rule and was raised by a public comment in response to the rule.

5. Part 5218.0100, [Emergency] DEFINITIONS.

Subp. ~~11~~ 10. Revocation.
Subp. ~~12~~ 11. Suspension.

Clarifications of these definitions are made in response to comments that indicated there is confusion about the distinction between the meaning of the two terms "revocation" and "suspension". It was suggested that even after revocation the managed care plan should be able to reapply for certification, so the term "permanent" revocation was confusing. As these are merely clarifications in response to public comment about the intent of the rules they are not a substantial change.

6. Part 5218.0220 [Emergency] PURPOSE AND SCOPE.

This change is one of semantic clarification only, to reflect that the rules establish procedures and requirements for certification of a managed care plan.

7. Part 5218.0230 [Emergency] ~~EFFECTIVE DATE~~ Provisional Certification

The heading is amended to accurately reflect the substantive nature of the rule.

8. Part 5218.1000 [Emergency] APPLICATION FOR CERTIFICATION

Subp. 1. Provisional Certification.

This change in the introductory paragraph reflects that there are limitations on the ability of persons to form managed care plans as set forth in part 5218.2000, subp. 3. It is not a substantial change as it merely refers the reader to existing restrictions elsewhere in the rules.

The public has expressed concern that item B, as proposed, which limits the annual compensation for plan administrators, is contrary to statutory authority and is difficult to enforce, because "compensation" paid to executives or administrators is easily manipulated. An additional concern raised is that some effective existing managed care organizations may be excluded by this rule.

Chapter 176 grants the commissioner broad authority to regulate workers' compensation medical costs and managed care plans. The intent of this provision as published was to prevent the workers' compensation system from subsidizing high compensation paid to managed care administrators.

It is determined that this result can also be achieved by changing the rule to require that managed care applicants report annual compensation paid to administrators that exceeds ten times the statewide average annual wage. If the plan is certified, the amount of the compensation will be filed with the Legislative Reference Library for review by legislators and parties to the workers' compensation system, who can then make a decision about whether the administrative costs are excessive. This change is not substantial because it is not a new subject matter, does not affect a new class, is responsive to public concerns, and is consistent with the purpose of the rule as proposed.

9. Part 5218.1000 [Emergency] APPLICATION FOR CERTIFICATION

Subpart 1. Provisional certification. Item D, subitem 1.

This change clarifies that the type of license, registration, or certification must be submitted to ensure that the department has enough information to verify with the credentialling agency, if necessary, that a particular provider has current authority to practice. This is appropriate because although the rule as proposed required each provider's specialty to be identified, this may not always reflect the nature of the license, certification, or registration held. This is not a substantial change because it merely requires identification of information the applicant needs to collect under the proposed rule, and is made in response to public comment.

10. Part 5218.1000 [Emergency] APPLICATION FOR CERTIFICATION

Subpart 1. Provisional certification. Item D, Subitem 2; units (a) and (b).

The geographical service area requirement is eliminated in the introductory paragraph for the reasons set forth in finding number 3.

The language in unit (a) is modified because the managed care plan does not actually provide the services; rather it must ensure provision of services through contracts with providers. The reference to Minn. Stat. § 176.83, subd. 5 is made in response to commentors who requested a clarification of the standards to which the rule is referring to.

The reference to subitem 3 is added to unit (b) in response to public comment requesting more specificity. Subitem 3 establishes minimum requirements for geographic and health care provider accessibility.

The changes in units (a) and (b) are not substantial changes because they are made to clarify the intent of rules as proposed. They do not affect a

new class of people or raise a new subject matter.

11. Part 5218.1000 [Emergency] APPLICATION FOR CERTIFICATION

Subpart 1. Provisional certification. Item D, Subitem 3, units (a)-(f).

Units (a) and (b) are modified to permit the initial evaluation to be performed by any licensed health care provider in Minnesota, at the managed care plan's option. This is in response to many comments protesting that the original language discriminated against doctors of chiropractic. Therefore, provider distinctions are eliminated from the rules, and left to the discretion of the managed care provider.

Allowing the managed care plan to distinguish between health care providers at the time of an initial evaluation does not constitute discrimination or a denial of equal access for treatment. Minn. Stat. § 176.1351, subd. 4 does not require direct access to all types of health care providers, but specifically identifies the provider's scope of practice and treatment standards as factors to be considered in providing access. Providers have differing scopes of practice and are found in varying concentrations throughout the state. Employees suffer from different types of injuries. The statute cannot reasonably be interpreted to expand any health care provider's scope of practice, or legislate the best treatment for any employee. The term "managed care" implies that decisions are necessary regarding the appropriateness of treatment for a given condition and employee. The rules as modified are intended to provide the managed care plan with flexibility to design the most effective system, unique to the employees served and the type of providers available. Items D (2) (b) and D (3) (c) prohibit the managed care plan from specifically discriminating against any provider group for reasons other than those based on the appropriateness of the treatment and scope of practice.

It is important to note that to the extent an employee is denied access to appropriate care from any given provider group, the employee may obtain authorization directly from the insurer or may proceed with the many dispute resolution mechanisms under the plan and Chapter 176. The workers' compensation insurer remains liable for any necessary treatment, and the managed care plan's certification may be suspended or revoked.

The rules are also amended to reflect that the evaluating provider may be one of the three treating health care providers. This is in response to comments that not every work injury requires ongoing treatment. For instance, minor injuries, such as a cut that needs a suture, may be taken care of in one visit, and it would be impractical and unnecessary to require

referral to three providers in addition to the initial treatment.

Unit (c) is modified to specify that the managed care plan must provide direct access to health care provider disciplines under the managed care plan's standards. This is in response to a number of comments which reflected concern that certain health care provider disciplines may be reluctant to refer to other disciplines.

The changes in units (a), (b), and (c) are not substantial changes because they do not affect a new class of people, they do not address a new subject matter, and the changes are made after careful and thorough consideration of the comments received in response to the rules as published. These emergency rules are designed to permit flexibility to accommodate the many and varied needs of employees, employers, insurers and health care providers. As the Department develops experience with certifying and evaluating managed care plans it is anticipated that more specific requirements will be proposed in permanent rules regarding this issue.

Unit (d) is modified because treatment by a participating provider may not be possible if the emergency occurs outside the 30/50 mile limitations. In these cases, a consultation is appropriate.

Unit (e) is modified to permit 24 hour information by recorded message; the original intent of the rule was not that a health care provider must be available in person to give medical advice on a 24 hour basis, which would be prohibitively expensive. Emergency care is already an exception to the requirement that the plan provide all treatment for a workers' compensation injury. This rule as modified requires information to be provided about how the employee can access health care, including the initial evaluation required in Unit (a). This is not a substantial change because it does not affect a new class of people or address a new subject matter, and is an attempt to respond to questions and concerns raised by the public.

Unit (f) is also modified in response to public inquiry about the extent of the mileage restriction. Specifically, concern was raised about rural areas, where it may be difficult to provide all necessary treatment required by Chapter 176 within 30 miles. It is not reasonable to require the managed care plan to provide significantly greater accessibility than exists naturally in the community. Accordingly, the rule is modified to ensure that services within the seven county metropolitan area must be within 30 miles, but for the rest of the state the mileage restriction is 50 miles. An exception in the rules is made for specialized services not available within the 30 or 50 mile limitation. If the employee needs treatment from a relatively unique

specialist who is not available within these mileage limitations, the plan may refer the employee to the specialist outside the limitations. The rule does not allow the plan to contract outside the mileage limitations for treatment that is available within the limitations. For instance, if an orthopaedic surgeon is available in a rural area within 50 miles, the plan would not be allowed to refer the employee to the Twin Cities for treatment by an orthopaedic surgeon.

This is not a substantial change because it does not affect a new class of people, is not a new subject matter, but is made in response to public comment on the effect of the rules as proposed.

12. Part 5218.1000 [Emergency] APPLICATION FOR CERTIFICATION

Subpart 1. Provisional certification. Item D, Subitem 6.

Subitem 6 is modified to provide that the managed care plan's liaison be available for employers and employees as well as the Department and insurer. All parties should be able to have questions and information about the plan answered by the liaison.

This is not a substantial change because a plan would reasonably expect to provide information to all parties affected by the plan, and does not raise a new subject matter or affect a new class of persons who would be expected to comment.

13. Part 5218.1000 [Emergency] APPLICATION FOR CERTIFICATION

Subpart 1. Provisional certification. Item D, Subitem 10.

Subitem 10 is modified in response to public comment on the interplay between this section and Minn. Stat. § 176.102, which provides for rehabilitation services by qualified rehabilitation consultants. This reflects that the rule is not intended to replace the statutory provisions regarding rehabilitation services, and is therefore not a substantial change.

15. Part 5218.1000 [Emergency] APPLICATION FOR CERTIFICATION

Subpart 1. Provisional certification. Item D, Subitem 11.

Public comment indicated there is confusion over whether the managed care plan must develop standards for every condition it may treat. This change clarifies the original intent; that all health care providers must comply with standards prescribed by the commissioner under Minn. Stat.

§ 176.83, subd. 5, and that if the plan has developed additional standards, those must be submitted for department review. A clarification is made that requires submission of only the standards that are reasonably likely to be used in the treatment of workers' compensation injuries. This reflects the fact that existing health maintenance organizations and preferred provider organizations treat a wide variety of patients, such as children and obstetrical patients, and these standards may not be relevant to the typical workers' compensation patient. These are not substantial changes because they are made in response to issues directly raised by the rule as proposed.

16. Part 5218.1000 [EMERGENCY] APPLICATION FOR CERTIFICATION

Subpart 2. Notification; approval or denial.

Geographical service area is deleted for the reasons set forth in finding 3. The language is modified to more accurately reflect the standard by which a meeting will be held to discuss the application for certification. This is not a substantial change because it merely clarifies the intent of the rule as published and is not a modification of the substance of the rule. Public comment requested that a time limit be established for the approval or denial of certification. However, because the Department has not implemented the certification system there is concern that a time limit may force a denial before it is possible to evaluate whether the plan meets the requirement of Minn. Stat. § 176.1351 and the rules. It may be necessary to set up a meeting, request additional information and evaluate the additional information before a decision is issued. Accordingly, while the Department is aware of the statutory mandate to proceed as quickly as possible with managed care, and the Department has every intention of doing so, there is concern that setting an arbitrary time limit may force a denial of certification unnecessarily. It is anticipated that a time limit for issuing a decision will be imposed in the permanent rules, after the Department has developed experience with certifying managed care plans under the emergency rules.

17. Part 5218.1000 [Emergency] APPLICATION FOR CERTIFICATION

Subp. 3. Review of decision.

Subpart 3 is added because by oversight a mechanism for contesting a denial of certification was omitted, and public comment requested such a mechanism. It is not a substantial change because the procedures of Chapter 14 are noted in Part 5218.9000, when the managed care plan certification may be revoked or suspended, and this is consistent with that

section and with the requirements set forth in the administrative procedures act.

18. Part 5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN

The geographical service area language is deleted in subpart 2 for the reason set forth in finding number 3.

19. Part 5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN

Subp. ~~3~~ 2. Contracts and coverage.

The introductory paragraph is amended to more clearly state the intent evidenced throughout the rules; that the managed care plan must contract with the insurer liable under Chapter 176 to provide services for particular employees. This is necessary to provide workers' compensation insurers and self insured employers with a mechanism to monitor the effectiveness of the plan in managing increasing medical costs associated with workers' compensation injuries. Requiring the contract with insurers permits the insurers and self-insured employers, who are ultimately responsible for payment of the medical costs, to terminate managed care plan contracts that are ineffective in achieving the statutory goals. Employers are required to obtain authority to self-insure from the Department of Commerce under Minn. Stat. § 176.181. To the extent an employer obtains this authority, it may contract with the managed care plan as a self-insured employer. This is not a substantial change because it merely more clearly states the intent expressed throughout this part and is added in response to public comment.

Item A as originally proposed is deleted for the reasons set forth in finding number 3.

20. Part 5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN

Subp. ~~3~~ 2, item ~~B~~ A

Additional language is added to clarify that the plan selected by the employee must be from among those that: 1) are offered by the insurer liable for the injury, and 2) that provide services within the 30/50 mile mileage parameters. This change is made in response to questions raised about employers who may have worksites in different parts of the state, and

who may wish to offer different plans for each site. For instance, it would not be medically appropriate for an employee in St. Paul to select a plan offered by the same insurer in Duluth. These are not substantial changes as they do not affect a new class of people, do not introduce a new subject matter and are made in direct response to public comment and suggestions.

21. Part 5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN

Subp. ~~3~~ 2, item ~~C~~ B

The reference to the statutory term personal injury is added for the reason set forth in Finding # 2. Specifically identifying the managed care plan contract with the insurer clarifies the rule for the reasons set forth in Findings 19 and 20.

22. Part 5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN

Subp. ~~3~~ 2, item ~~E~~ D.

This item is modified to reflect that when a contract between either the health care provider and managed care plan or an insurer and the managed care plan terminates, the employee has the right to continue treating with the same health care provider. This is not a substantial change because it is made in response to comments received that indicated confusion about what contracts are being referred to in this item.

23. Part 5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN

Subp. ~~3~~ 2, item ~~F~~ E.

This item is designed to address the problem of where an employee should receive treatment before a liability for a workers' compensation personal injury is admitted. Many employees are limited to a provider network by their personal health insurance plan. To require employees to go to the managed care plan after a claimed injury without providing for payment could result in the personal health plan also denying payment if liability for the work injury is denied. Therefore, the rule provides that the employer can initially determine whether the employee must receive treatment from a managed care plan after receiving notice of a claimed injury. If acceptance of liability for the work injury is likely, the employer can require

treatment from the managed care plan to ensure the most effective management. If the employer questions liability, the employer may permit the employee to seek treatment from the personal health insurance plan. Minn. Stat. § 176.191, subd. 3 requires a workers' compensation insurer to reimburse the personal health carrier if liability for the work injury is later determined.

This item is amended in response to concern expressed by the public that under the rule as proposed, treatment of any condition, not just the workers' compensation injury, might be the responsibility of the employer and insurer prior to admission of liability. Another concern addressed is that the employer or insurer should be able to make a claim against another entity, such as the employee's personal health carrier, if liability is denied for the work injury. This change does not extend the rights of the workers' compensation employer or insurer, or impose an obligation on any other entity; the change merely acknowledges that there may be other rights not addressed in the rule.

24. Part 5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN

Subp. ~~3~~ 2, item F.

Due to its length, the original item is divided into items E and F because the concepts expressed, although related, are distinct. Item F is amended to reflect the possibility that it may take weeks or months before liability is established, for instance if litigation is pending. It would be unfair to require an employee who has established a lengthy treating relationship with a provider to receive further treatment from the managed care plan when liability has initially been denied. However, the rule anticipates that if liability is accepted within 14 days, the time frame given to insurers for accepting or denying reportable workers' compensation claims under Minn. Stat. § 176.231, subd. 1, the employee may be required to receive further treatment under the plan.

These are not substantial changes because the general topic of the provision involves when an employee may be required to receive treatment from the managed care plan after a denial of liability. This is an attempt, in response to public comment, to reconcile the statutory provisions that require an employee to receive treatment from the managed care plan but that also require recognition of the importance of a preexisting relationship with the provider outside the plan.

25. Part 5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED

CARE PLAN.

Subp. ~~4.~~ 3. RESTRICTIONS

This provision attempts to reconcile the first two seemingly conflicting sentences in Minn. Stat. § 176.1351, subd. 1. The first sentence of that statute provides that no workers' compensation insurer or employer may form a managed care plan for their employees. However, the second sentence provides that "without limitation" a health maintenance organization or preferred provider organization is eligible for certification as a managed care plan. The second sentence permits any insurer or employer to circumvent the first sentence by forming a preferred provider organization or health maintenance organization. To illustrate the conflict, the first sentence alone would preclude certification of Mayo Health Plan for employees of Mayo Clinic. The employees thus could not receive treatment for a work injury from the Mayo Clinic. However, the second sentence would permit certification and treatment, because Mayo Health Plan is a health maintenance organization.

In order to reconcile this conflict, a reasonable interpretation of Minn. Stat. § 176.1351, subd. 1 is that it is intended to prevent an employee from being required to receive treatment from what may be perceived as "the company doctor". It is not reasonable to assume that if an employee of the Mayo Clinic prefers to receive treatment under the Mayo Health Plan, if certified, he or she may not do so. Accordingly, the rule requires that if a managed care plan is formed by an employer or insurer, the employer and insurer must also offer another managed care plan from which the employee may elect to receive treatment.

In response to concerns raised that an insurer or employer may pressure an employee to receive treatment from a managed care plan formed by an employer or insurer, language is added to the rule that requires written notice to the employee of the affiliation and of the employee's right to chose another plan. This is not a substantial change because it is not a new subject matter, does not affect a new class of people, and merely requires notice of the provision to employees in response to public comment on the rule.

26. Part 5218.3000 REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN

Subp. 2: Items B, D, E and F.

The requirement in the introductory paragraph that information must be

provided in a form and format prescribed by the commissioner is deleted. No requirement for the format of reporting is specified, because the reporting requirements are specific enough as written.

Item B is modified to require reporting only of health care providers outside the plan that the employee is referred to by the plan. Public comment raised concern that the plan may not be able to keep track of treatment by other health care providers if the employee is permitted by Minn. Stat. § 176.1351 to receive treatment outside the plan.

Item D is modified to use the terminology "participating providers" consistent with part 5218.0100, subp. 8.

Item E adds a requirement that dispute resolution proceedings also be reported, to assist the commissioner in monitoring the services provided by the plan. This is consistent with part 5218.1000, item D, subitem 7, which requires these activities to be performed. Vague language is modified to make the utilization and peer review requirement more specific.

The wording of item F is streamlined for clarity.

These are not substantial changes but rather clarifications in direct response to public comment.

27. Part 5218.3000 [Emergency] REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN.

Subp. 3. Insurers; data.

This subpart is amended to provide that the data is to be reported in accordance with relevant statutory provisions. Minn. Stat. § 176.135, subd. 7 specifies what data must be submitted with a health care provider's bill. Minn. Stat. § 176.138 specifies the insurer and health care provider responsibilities for requesting and releasing medical data related to a workers' compensation claim. Referring to existing statutory provisions does not constitute a substantial change.

28. Part 5218.3000 [Emergency] REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN.

Subp. 4. Monitoring.

This item is modified to specify the scope of information that can be requested to that which is authorized by Minn. Stat. § 176.1351: it must be

relevant to whether the plan complies with the applicable statutory and rule requirements. This is not a substantial change because it merely rephrases the rule to more clearly identify the intent and scope of monitoring.

29. Part 5218.4000 [Emergency] COMMENCEMENT AND TERMINATION OF CONTRACT WITH PARTICIPATING PROVIDERS

Subp. 2. Termination.

The wording of this subpart is changed to reflect that it is the contract between the managed care plan and the provider that is terminated. It is also modified to refer to the rule that specifies the employee's right to continue treating with the same treating provider with whom the employee has developed a relationship. These are non-substantial, minor changes made to clarify the original intent of the rule.

30. Part 5218.5000 [Emergency] HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS

Subp. 1. Authorized services.

The introductory paragraph is modified to state in positive terms the statutory right of an employee to receive treatment from a health care provider with whom the employee has an existing relationship. Other wording changes are made to clarify the original intent of the rule.

Item A specifies the criteria by which an employee is determined to have a documented history of treatment, in response to public comment requesting specificity. In addition to the criteria set forth by statute, the rule specifies that the employee must have received treatment twice in the past four years. It is determined that an employee must have been seen more than once to have developed a relationship significant enough to exclude the employee from the managed care plan. However, the standard also reflects that many people infrequently go to a doctor for treatment if relatively healthy before an injury. An employee who has seen another doctor fewer than twice in four years does not likely have such a close relationship that care from the managed care plan for a work injury should be excluded.

The requirement in item A that the employee must provide the insurer with copies of medical records to evidence the history is anticipated by the use of the term "documented" in Minn. Stat. § 176.1351, subd. 2 (8).

Item C is modified for clarity.

Item D is added to reflect the change in part 5218.2000, subp. 2, item F discussed in finding 24.

These are not substantial changes. Although specific criteria are added to item A, changes are not major and do not introduce a new subject matter but rather make the rule more specific in response to public comment requesting specificity.

31. Part 5218.5000 [Emergency] HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS

Subp. 2. Requirements.

Item B is modified to clarify that specialized care includes physical therapy and diagnostic testing, but does not include minor office procedures, for example, obtaining blood work, a urinalysis, or chest x-ray. These procedures are routinely done in the office of many providers, and to require referral to the managed care plan would be inefficient and counterproductive. In response to requests for clarification, the rules specify that the treating provider may continue to direct the employee's treatment. These changes make the rule as proposed more specific in response to public request and suggestion, and accordingly are not substantial changes.

32. Part 5218.5000 [Emergency] HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS

Subp. 3. Disputes.

A sentence is added to clarify the language as proposed. Part 5218.7000 refers to dispute resolution procedures within the managed care plan under Chapter 176, which can ultimately lead to denial of payment. A provider that renders excessive treatment or violates rules is subject to discipline under Minn. Stat. § 176.103. These more specific references to existing statutory authority are not substantial changes.

33. Part 5218.6000 [Emergency] CHARGES AND FEES.

This rule requires that the health care provider be reimbursed in the manner and at amounts set forth in Minn. Stat. § 176.136, subd. 1a and 1b. A number of comments received express concern about this provision. These comments likely indicate a misunderstanding of the statutory provisions referred to. Minn. Stat. § 176.136 specifies how health care providers are to be reimbursed: Subd. 1a provides that for services governed by the fee

schedule, either the maximum amount in the fee schedule applies, or the providers actual fee, if it is lower than the fee schedule amount. The 1992 legislature required a relative value fee schedule to be adopted, to be set so that there is a 15 percent overall reduction from the 1991 medical fee schedule. Subd. 1b of Minn. Stat. 176.136 provides that, except for small hospitals, services that are not included in the fee schedule are reimbursed at only 85 percent of the providers' usual and customary charge. Accordingly, the 1992 legislation already provides for significant reductions in reimbursement to health care providers, not only in the fee schedule maximum rate, but also for charges that are not included in the fee schedule. No exceptions are made in the legislation for health care providers in managed care plans.

At this time it is determined that to permit further reduction of reimbursement to providers could compromise the delivery of medical services and possibly limit the number of providers available to participate in the plans. Costs of administering the plan should be a matter of contract between the insurer and managed care plan; the providers should not be required to subsidize administrative costs as a condition of treating injured workers under the plan. The statutory reference to "financial incentives" to reduce costs and utilization without compromising patient care can be accomplished by adjusting the number of referrals or terminating the contract with the health care provider. Concern about health care providers who are salaried by a health maintenance organization is unnecessary; the health maintenance organization merely submits to the insurer its usual and customary charges as it now does for workers' compensation patients.

This clarification of the intent of the rule is not a substantial change, as most of the comments received were written in response to the rule as clarified.

34. Part 5218.7000 [Emergency] DISPUTE RESOLUTION

Minor non-substantial wording changes are made for clarity and for consistency with the cited statutory provisions, in response to suggestions made to the rules as proposed. The commissioner issues an order after the parties proceed under the referenced statutory provisions.

35. Part 5218.8000 [Emergency] MONITORING

Subp. 2. Records.

The scope of records monitoring is rephrased to clarify that only those

records relevant to determining compliance with the statutes and rules must be disclosed. In response to concerns raised about the privacy of the records, relevant workers' compensation statutory provisions are cited. Provisions are also cited regarding trade secret protection under the Data Privacy Act and protection of utilization review records. These changes are not substantial because they are made in response to public comment requesting clarification and merely refer to existing controlling statutory provisions.

36. Part 5218.9000 [Emergency] SUSPENSION; REVOCATION

The standard of reasonable cause for initiation of a contested case proceeding is identified in subpart 1.

In subpart 2, item C, wording is changed to clarify that any of the stated failures to comply are grounds for revocation or suspension.

In subpart 2, item D, the terminology is changed to "participating provider" so the language is consistent with the term as used elsewhere in the rules.

In subpart 2, item E the terms "registration" and "certification" are added to the term "licensure" for consistency with the terms used in part 5218.1000.

Subpart 3 is modified to eliminate the term "void" with respect to the contract between the insurer and the managed care plan. The effect of plan revocation is that the managed care plan cannot provide services to employees; the rule is not intended to interfere with the managed care plan/insurer contract as between those parties. Language is also added to provide that after revocation, the managed care plan may reapply as specified in the order of revocation.

These are not substantial changes because they are clarifications made in response to comments on the rules as proposed and do not affect a new class or introduce a new subject matter.

Based upon the Findings of Fact, I make the following:

Conclusions

1. That the Department gave proper notice of the proposed emergency rules to all interested persons and groups.

2. That the Department has fully complied with all procedural requirements of law or rule in adopting the proposed emergency rules.

3. That the Department has acted within its statutory authority in adopting these proposed emergency rules.

4. That the proposed emergency rules as modified are needed and reasonable and fully comply with substantive requirements imposed by law or rule.

NOW, THEREFORE, IT IS ORDERED that the rules identified as Part 5218.0100 to 5218.9000 (Emergency) is adopted as modified this 28th day of September, 1992, pursuant to the authority vested in me by Minn. Stat. § 176.1351, subd. 6.

JOHN B. LENNES, JR.
Commissioner

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October 9, 1992

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OCT 12 1992

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Re: Managed Care Emergency Rules

Dear Ms. Murray:

This letter is in response to the comments submitted to your office on the above rules. In determining whether the rules comply with the standards set forth in Minn. Rules 2010.1000, items A-J it is important to keep the intent of the 1992 legislature in mind as it attempted to reduce workers' compensation costs by 16%:

> Section 25 of Article 4 of SF 2307 provides as follows:
>
> "It is the intent of the legislature that the commissioner of labor and industry proceed with certifying managed care organizations as expeditiously as possible. Any rules or procedures the commissioner adopts must be designed to assist in the formation of managed care organizations while ensuring quality managed care to injured employees."

Our responses to the objections raised to the rules are as follows:

1. The Honorable Dee Long, Speaker of the House; The Honorable John Hottinger, Senator; The Honorable Marcel Frederick, Representative; The Honorable LeRoy Stumpf; Senator, and Gary Van Cleve, Attorney.

   OBJECTION: Part 1000, D (3) (a), (b), and (c). These provisions are illegal under Minn. Rules 2010.1000, subps. C,G & J because 1) they do not provide direct access to all types of health care providers, specifically chiropractors, under Minn. Stat. § 176.1351, subd. 2 (10) and subd. 4, and limit the employee's choice of doctor, and 2) they improperly delgate agency authority to managed care plans.

   RESPONSE: As discussed by the Commissioner in Finding 11, allowing the managed care provider to distinguish between health care providers at the time of an initial evaluation does not constitute discrimination or denial of equal access for treatment in conflict with

the authorizing legislation. MS 176.1351, subd. 4 provides that the commissioner may refuse to certify a plan if direct access to all categories of health care providers is "unfairly" restricted. The statute specifies that direct access is necessary only if the treatment is within the provider's scope of practice and appropriate for the condition.

Medical doctors have an essentially unlimited scope of practice; chiropractors, optometrists, podiatrists, psychologists, and others have limited scopes of practice. Many injuries, such as fractures, burns, lacerations and heart conditions cannot be treated by limited license practitioners. Allowing the employee direct access at the initial evaluation in the first 24 hours would require the plan to have all disciplines, including limited license practitioners and even medical specialists, "on call", to be seen at the employees option, regardless of the nature of the injury or the availability of the specialty in the community. The statute cannot reasonably be interpreted to expand any health care provider's scope of practice, or legislate the best treatment for any employee. The term "managed care" implies that decisions are necessary regarding the appropriateness of treatment for a given condition and employee. The rules do not prohibit any class of health care provider from being an evaluating provider. The rules as modified are intended to provide the managed care plan with flexibility to design the most effective system, unique to the employees served and injuries treated.

Items D (2) (b) and D (3) (c) prohibit the managed care plan from unlawfully discriminating against any provider group for reasons other than those based on the appropriateness of the treatment and scope of practice.

It is important to note that the employee is not precluded from treating with any type of provider. To the extent an employee is denied access to appropriate care from any given provider group, the employee may obtain authorization directly from the insurer or may proceed with the many dispute resolution mechanisms under the plan and Chapter 176. The workers' compensation insurer remains liable for any necessary treatment, and the managed care plan's certification may be suspended or revoked.

An argument is also raised that the rules improperly delegate treatment decisions to the managed care plan because adherence to the Department treatment standards is not referenced. However, subitem 11 of item D specifically requires that all providers under the plan are governed by treatment standards prescribed by the commissioner under MS 176.83, subd. 5. These treatment rules are being developed pursuant to 1992 emergency rulemaking authority. The additional contention that there is improper

delegation because the commissioner should make the decisions about who should provide initial evaluation and treatment is absurd; the commissioner cannot possibly make individual decisions about the appropriateness of treatment in every case, and MS 176.1351, subd. 4 specifically identifies the managed care plan's standards as relevant.

An agreement is also raised that the rules conflict with an employees unlimited right to choice of doctor. This is clearly a misstatement of law. MS 176.135, subd. 2 and MS 176.1351, subd. 1 (1), subd. 2 (8), (10) and (11) all place restrictions on the selection and choice of treating doctor.

2. Maria Gomez, Department of Employee Relations

A. OBJECTION: Part 1000, subp. 1 D, (7), (10) and (11). The peer review, case management, dispute resolution and treatment standard requirements are vague.

RESPONSE: MS 176.1351, subd. 2 (4) requires a plan to provide aggressive case management with a return to work focus, peer review, utilization review, and dispute resolution. Managed care plans may include large HMOs, PPOs, rural clinics and a variety of other types of organizations. Mandating identical, detailed procedures for all types, sizes and locations of managed care plans is not necessary or appropriate at this time. These are emergency rules, in an area that the Department does not have extensive experience. As the department gains this experience it is anticipated that more specific criteria will be included in the permanent rules. A plan applicant has the right to contest and adverse certification determination through the contested case procedures under chapter 14.

Subitem 11 states that providers under contract with a plan are governed by the plan's treatment standards and the commissioner's treatment standards. Any other interpretation suggested by this commentor would lead to an absurd, obviously unintended result. See also, Commissioner's Finding # 15.

B. OBJECTION: Part 2000, subp. 3A, B and C. Employees should not be allowed to select from multiple plans offered by an employer.

RESPONSE: Employers and insurers are not required to offer multiple plans, unless one of the plans is owned or operated by the employer or insurer liable for the injury. This rule is necessary to resolve the potentially conflicting statutory provisions. See also, Commissioner's Finding #25.

C. OBJECTION: Employees should be required to receive treatment from a plan after the effective date of the law regardless of the employee's date of injury.

RESPONSE: MS 176.1351, subd. 2 (8) allows the employee to continue receiving treatment from a health care provider with whom the employee has a prior treating relationship.

D. OBJECTION: Part 2000, subp. 2 E. The employer should not be liable for treatment under the managed care plan before liability for the injury is admitted.

RESPONSE: The employer can avoid this by not requiring the employee to receive treatment from a plan prior to admitting liability. The employee can then receive treatment from a provider covered by the employee's personal insurance in the event liability is denied. See also, Commissioner's Finding # 23 and 24.

E. OBJECTION: Part 2000, subp. 2 F. Allowing an employee to continue to treat with a non-plan provider when the employer admits liability or is determined liable later than 14 days after the injury is a substantial change.

RESPONSE: This is not a substantial change. A new class of persons is not affected, and the general subject matter of the rule as proposed included the circumstances under which an employee may be required to receive treatment under the plan after a denial of liability, and also included consideration of existing provider relationships. The change, in response to public comment, attempts to coordinate three statutory provisions requiring employees to receive treatment under a plan subject to an existing provider relationship, and requiring employers to admit or deny liability for an injury within 14 days. Simply because there is disagreement with a change in a proposed rule in response to public comment does not make the change substantial. Other changes recommended by this commentor would be more substantial than this one is.

F. OBJECTION: Part 1000, subp. 1 A. Defining a documented history of treatment as being twice in the past 4 years is too vague.

RESPONSE: As indicated by the examples in the comment, there are so many possible types of treatment and provider contacts that it would be impossible to identify every possible permutation. As with all factual determinations, some of these issues in individual cases may need to be resolved under the dispute resolution provisions of Chapter 176. See also, Commissioner's Finding # 30.

3. Mark Olive, Attorney

A. OBJECTION: Part 1000, subp. 1 D (3) (c). The employee should be able to change providers "under" rather than "within" a plan at least once.

RESPONSE: This change would restructure the rules to permit an employee to select a provider from any plan certified by the Commissioner. This is clearly contrary to the statutory intent in MS 176,135, Subd. 1 (f) and

MS 176.1351 that an employer/insurer may select the plan to cover its employees. It is also contrary to MS 176.1351, subd. 2 (11) which specifies that the employee must have the right to change under "the" plan at lease once.

B. OBJECTION: Part 2000, subp. 3 D. An employee injured before the date of the law should not be governed by managed care, even if the employee changes doctors.

RESPONSE: The employee's right to all necessary medical treatment under MS 176.135 is unaffected. As noted earlier, before this legislation there were statutory limitations on the selection and choice of provider in MS 176.135, subd. 2.

C. OBJECTION: Part 5000, subp. 1 A. A "documented history of treatment" with a provider should not be limited to treatment before the date of injury.

RESPONSE: Allowing an exception for a treating relationship established after the date of injury would completely frustrate the purpose of the law, as an employee could establish a relationship with any provider the employee chooses outside the plan.

4. Bernard Brommer, President AFL-CIO

OBJECTION: Initial evaluations by a chiropractor should be permitted; Managed care does not apply to earlier dates of injury; employers should not be allowed to form plans; the rules should be more specific in some areas.

RESPONSE: See above responses. Many of the changes recommended in this letter of August 20 have been incorporated into the final version of the rules.

Please contact me at (612) 297-4791 if you have any questions.

Sincerely,

Kathryn Berger

Kathryn Berger
Compensation Attorney

KB/cb

cc: The Honorable Dee Long, Speaker of the House
The Honorable John Hottinger, Senator
The Honorable LeRoy Stumpf, Senator
The Honorable Marcel Frederick
Gary Van Cleve
Maria Gomez
Mark Olive
Bernard L. Brommer

Minnesota
Department of Labor and Industry

443 Lafayette Road
St. Paul, Minnesota 55155
(612) 296-6107

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for the Deaf (612) 297-4198

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October 9, 1992

Mary Jo Murray
Special Assistant Attorney General
Office of the Attorney General
Public Finance Division
Capitol Office Building
525 Park Street
St. Paul, Minnesota 55103

Re: Managed Care Emergency Rules

Dear Ms. Murray:

This letter is in response to the comments submitted to your office on the above rules. In determining whether the rules comply with the standards set forth in Minn. Rules 2010.1000, items A-J it is important to keep the intent of the 1992 legislature in mind as it attempted to reduce workers' compensation costs by 16%:

> Section 25 of Article 4 of SF 2307 provides as follows:
>
> "It is the intent of the legislature that the commissioner of labor and industry proceed with certifying managed care organizations as expeditiously as possible. Any rules or procedures the commissioner adopts must be designed to assist in the formation of managed care organizations while ensuring quality managed care to injured employees."

Our responses to the objections raised to the rules are as follows:

1. Representative Dee Long, Senator John Hottinger, Senator Marcel Frederick, Senator LeRoy Stumpf, and Gary Van Cleve, Attorney.

   OBJECTION: Part 1000, D (3) (a), (b), and (c). These provisions are illegal under Minn. Rules 2010.1000, subps. C,G & J because 1) they do not provide direct access to all types of health care providers, specifically chiropractors, under Minn. Stat. § 176.1351, subd. 2 (10) and subd. 4, and limit the employee's choice of doctor, and 2) they improperly delgate agency authority to managed care plans.

   RESPONSE: As discussed by the Commissioner in Finding 11, allowing the managed care provider to distinguish between health care providers at the time of an initial evaluation does not constitute discrimination or denial of equal access for treatment in conflict with

the authorizing legislation. MS 176.1351, subd. 4 provides that the commissioner may refuse to certify a plan if direct access to all categories of health care providers is "unfairly" restricted. The statute specifies that direct access is necessary only if the treatment is within the provider's scope of practice and appropriate for the condition.

Medical doctors have an essentially unlimited scope of practice; chiropractors, optometrists, podiatrists, psychologists, and others have limited scopes of practice. Many injuries, such as fractures, burns, lacerations and heart conditions cannot be treated by limited license practitioners. Allowing the employee direct access at the initial evaluation in the first 24 hours would require the plan to have all disciplines, including limited license practitioners and even medical specialists, "on call", to be seen at the employees option, regardless of the nature of the injury or the availability of the specialty in the community. The statute cannot reasonably be interpreted to expand any health care provider's scope of practice, or legislate the best treatment for any employee. The term "managed care" implies that decisions are necessary regarding the appropriateness of treatment for a given condition and employee. The rules do not prohibit any class of health care provider from being an evaluating provider. The rules as modified are intended to provide the managed care plan with flexibility to design the most effective system, unique to the employees served and injuries treated.

Items D (2) (b) and D (3) (c) prohibit the managed care plan from unlawfully discriminating against any provider group for reasons other than those based on the appropriateness of the treatment and scope of practice.

It is important to note that the employee is not precluded from treating with any type of provider. To the extent an employee is denied access to appropriate care from any given provider group, the employee may obtain authorization directly from the insurer or may proceed with the many dispute resolution mechanisms under the plan and Chapter 176. The workers' compensation insurer remains liable for any necessary treatment, and the managed care plan's certification may be suspended or revoked.

An argument is also raised that the rules improperly delegate treatment decisions to the managed care plan because adherence to the Department treatment standards is not referenced. However, subitem 11 of item D specifically requires that all providers under

the plan are governed by treatment standards prescribed by the commissioner under MS 176.83, subd. 5. These treatment rules are being developed pursuant to 1992 emergency rulemaking authority. The additional contention that there is improper delegation because the commissioner should make the decisions about who should provide initial evaluation and treatment is absurd; the commissioner cannot possibly make individual decisions about the appropriateness of treatment in every case, and MS 176.1351, subd. 4 specifically identifies the managed care plan's standards as relevant.

An agreement is also raised that the rules conflict with an employees unlimited right to choice of doctor. This is clearly a misstatement of law. MS 176.135, subd. 2 and MS 176.1351, subd. 1 (1), subd. 2 (8), (10) and (11) all place restriction on the selection and choice of treating doctor.

2. Maria Gomez, Department of Employee Relations

A. OBJECTION: Part 1000, subp. 1 D, (7), (10) and (11). The peer review, case management, dispute resolution and treatment standard requirements are vague.

RESPONSE: MS 176.1351, subd. 2 (4) requires a plan to provide aggressive case management with a return to work focus, peer review, utilization review, and dispute resolution. Managed care plans may include large HMOs, PPOs, rural clinics and a variety of other types of organizations. Mandating identical, detailed procedures for all types, sizes and locations of managed care plans is not necessary or appropriate at this time. These are emergency rules, in an area that the Department does not have extensive experience. As the department gains this experience it is anticipated that more specific criteria will be included in the permanent rules. A plan applicant has the right to contest and adverse certification determination through the contested case procedures under chapter 14.

Subitem 11 states that providers under contract with a plan are governed by the plan's treatment standards and the commissioner's treatment standards. Any other interpretation suggested by this commentor would lead to an absurd, obviously unintended result. See also, Commissioner's Finding # 15.

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Please contact me at (612) 297-4791 if you have any questions.

Sincerely,

Kathryn Berger

Kathryn Berger
Compensation Attorney

KB/cb

STATE OF MINNESOTA

Office of the Attorney General

TO : CHRISTIE ELLER
Manager, Public Finance Division
Information Policy Office
Department of Administration

DATE : October 12, 1992

FROM : MARY JO MURRAY
Special Assistant
Attorney General

PHONE : 296-3258

SUBJECT : Labor and Industry
Worker's Comp Emergency Rules
Minn Rules Part 5218.0100 to 5218.9000

In reviewing whether the above-entitled emergency rules should be adopted, in conjunction with Minn Rule 2010.1000, I have taken into consideration the following:

A. The rules as submitted are a statement of general applicability and future effect adopted to implement/make specific Minn. Stat. 176.1351 (1992).

B. The agency has complied with all applicable provisions of the Administrative Procedure Act and Attorney General Rules.

C. The rules do not conflict with the statute or any other relevant law, and have a reasonable relationship to statutory purposes. Several comments asserted that the rules exceed the statutory authority conferred on the agency. Overall, the rules reflect the intent and the language of Minn. Stat. 176.1531 (1992), and do not exceed statutory authority. In response to comments which asserted the rule exceeded statutory authority, certain parts of the rule were given additional scrutiny:

1. 5218.1000 (1)(D)(3)(c). This section allows the employee to change providers "within" the managed care plan at least once. The statute allows the employee to change providers "under" the managed care plan at least once, and prohibits restricting access "within" the managed care plan. One comment asserted that the two words (under and within) could be read with different meanings. The statute prohibits restricting access within a plan, and the rule is consistent with the intent of the statute.

2. 5218.1000 (1)(D)(3)(c). The same section also mimics the language in Minn. Stat. 176.1351 subd. 4 to a certain point. The rule states that the employee can select a provider "if the treatment is determined to be appropriate for the condition under the managed care plan's standards and the provider's scope of practice, or if the insurer approves the treatment." The statute contains similar language requiring direct access, but also approves the treatment if it is included in standards for treatment adopted by the commissioner.

3. 5218.1000 (1)(D)(11). One commenter stated that was not clear what standards will govern those providing services, and that it appeared that if any managed care plan develops treatment standards it uses for medical services in conjunction with worker's comp injuries, it is to submit those to the commissioner, and then all providers will be governed by those standards in addition to Minn. Stat. §176.83, subd. 5 (Excessive Medical Services). A common sense reading of these provisions does not lead to such a conclusion, but rather means that the plan's treatment standards along with the Commissioner's uniform treatment standards will apply.

4. 5218.2000(2)(C). This provision allows an employee with an injury occurring prior to the effective date of the statute to remain with the original service provider; however, if the employee requests a change of doctor, the managed care plan applies to the employee. Many comments claimed that not only did this provision conflict with the requirement of direct access, it applied retroactively. The provision is consistent with the statute, which allows an employee to use a provider outside the managed care plan if the employee has a documented history of treatment with that provider. If the employee requests a change to another provider, it appears that the employee will lose the statutory "history of treatment" exception. This provision is consistent with such intent.

5. 5218.2000 (2)(E). Some concern has been raised with the provision whereby an employer can require an employee asserting a claim of a worker's comp injury to receive treatment through a managed care plan prior to the time the employer accepts or denies liability. The concern is that this conflicts with the worker's comp law.

   The rule also states that if the employer admits liability within 14 days of the notice of the injury, the employer may require the employee to receive further medical treatment under the managed care plan or through another health care provider with whom the employee has a documented history of treatment. This provision was the source of many comments, as it was read to prohibit the employee from seeing anyone but the "company doctor." The only "company doctor" requirement is found when the employee makes a worker's comp claim and the employer requires treatment through the managed care plan within the first 14 days. If liability is denied, the employee may go to any provider, and if liability is ultimately assessed, the employer must pay. If liability is admitted, the employee may still choose to see a provider with whom the employee has a "documented history." The employer, of course, is not mandated to require any treatment of the employee.

6. The statute allows an employee to choose a provider outside of the managed care plan if the employee has a "documented history of treatment" with that provider. The rule defines "documented history of treatment" as including, among other requirements, at least two visits to the provider in the last four years. It's clear that there must be some standard for determining if the statutory "documented history" has been established, and it is reasonable for this emergency rule to establish some type of guideline as to what constitutes a "documented history." The terms of the rule are not unreasonable.

D. There are no substantial changes in the rule. While there are numerous wording changes, there:

1) are no classes of persons who could not reasonably have been expected to comment on the proposed rule as originally noticed;

2) is no significant new subject matter which a reasonable person, on the basis of the proposed rule as originally noticed, would not have anticipated would occur during the rulemaking proceeding; and

3) are no major substantive changes not raised by the original rule in such a way as to invite reaction.

One comment claimed that the 14 day period in which the employer can admit or deny liability was a major substantive change; however, the original language accomplished the same objective but was vague as to the time limits. The change is not a major substantive change.

E. Does not apply to emergency rules.

F. No part of the rule goes beyond the discretion permitted the legislation.

G. The rule does not delegate the agency's powers to another agency.

H. Several provisions of the rule were claimed to be vague by commenters. These are sections which repeat terminology used in the statute, and will vary from plan to plan.

1. 5218.1000 (1)(D)(7). This section states that the managed care plan must include a procedure for "peer review, utilization review and internal dispute resolution," mimicking Minn. Stat. §176.1351, subd 2. (4) and (5). "Peer review," "utilization review" and "internal dispute resolution" are all undefined, but appear to be terms of common use, and are consistent with the statute.

2. 5218.1000 (1)(D)(10). Both the statute and rule require the managed care plan to describe aggressive case management for early return to work. This, along with (H)(1) above, cannot be so restrictive that mandated processes for every type of managed care plan would be required by rule. This assures that the statutory requirement is met while allowing the flexibility which is likely to be required by different plans.

I. The rule by its terms does not fail to have the force and effect of law.

J. The rule is not, as an emergency rule, unreasonable.

I have not addressed each and every comment in this memo, but I have reviewed all of the comments (both the ones timely filed before the Rule as Adopted was issued and the ones timely filed with the Attorney General's Office). Most of the concerns raised about the Rule as Proposed were addressed either in the Rule as Adopted or in the Findings of Fact and Conclusions of Law. Other comments, such as those submitted to the Attorney General's Office, do not raise any reason under the rule review procedures and requirements to reject the rule. Consequently, I believe this rule to be sufficient as emergency rule, and am recommending approval.

Stat Authority Attached
end of comment period August 21, 1992

Fees approval from finance sent letters to House appropriations and Senate finance

~~Findings of fact~~ J. (5)

~~statement that~~ rule is hereby ordered to be adopted - ~~findings~~ Stat rule is needed and reasonable

many changes - Substantial change?

Recheck #28 + #29 on list

#44

CHANGES

	SUBSTANTIAL 1. new class of person	2. new s/t mtr	3 major sub change
1. emergency care	N	N	N
	clarifies def		
2. personal injury	N	N	N
	const. w/statute		
3. delete geo service area	N	N	N
4. delivery of med supplies	N	N	N
	clarifies def.		
5. termination: delete 'perm. revoc.'	N	N	N
	clarifies def.		
6. "or amended" delete 'or stopped' add "has been suspended"	N adds amended" to type of contract to be suspended. not a SIGNIFICANT change. Makes sense.	Y	N
	better language		
7. add: for cert. as a managed care plan delete: similar leg.	N	N	N
	better language		
8. PROVISIONAL CERTIFICATION	N	N	N
	better title.		
9. Except as provided in .2000	N	N	N
	.2000 needs review if changed		
10. The plan must report, if it exceeds, total annual	N	N	N
	all reworded language		
.1000(1)(B) 11. When a m.c.p. ... 3.302.	N	Y	N
	adds a reporting requirement for the commissioner. N/affect anyone except CMSR.		
12. the type of license held, current	N	Y	N
	add a reporting requirement to managed care plan. Not a significant change - info should be easily available.		

		Significant? ① new people	② new sit mtr	③ ~~major~~ subst. change
	~~13.~~ change			
13	~~incl cpo service area~~	N	N	N
14.	ensure provision all uniform standards adopted, under MS 176	N	N	N
15.	consistent w/ subitem 3	N	N	N
.1006 (D)(3)(a)	16. procedures, evaluation or treatment, by a partc. ~~phys~~, health care prov.; ~~may permit eval by Chiropractor~~	N	N	Y
		deletes prov. allowing chiro evaluation = a subst chg, but not a "major" one		
(3)(b)	17. same as 16			
(3)(c)	18. he allowed to choose; the eval may be 1 of 3 providers; const w/ mgd health care plan's standard + prov's scope practice	N	N	N
			claif. lgc.	
	19. emerg. at hosp n/prov	N	N	N
			claif	
(3)(e)	20. rcv info on rec. med. services through phone messages w/ info on ~~24 hr~~ access w/i 24 hrs under (a)	N	Y	N
		by phone messages is new. It is not significantly new, but may n/h/been anticipated		
	21. treatment w/i 30 res or bus of empl. ~~cpo s. area~~; 50 miles outside of MSA.	N	N	N
		clarification		

③

	Change	①new people	②new subject (signif)	③major change
22.	MCP must design ~~emplr, employee~~	N	N	N
	new req but not signif or burdensome.			
23	Prog for early ret. to wk. must provide for coop w/ rehab consltnt	N	N	N
	adds rehab consultant cooperation.			
24.	MCP. tr stds wh. are reas likely to be used in W. comp injuries; gov'd by 176-83.	N	Y	N
	clarifies + requires notice of stds to be used. OK			
25.	If emer can't det. if plan complies, in person mtg	N	N	N
	clarif			
p8 subp.3	26 Reviews of decision. All new. CCH req. for denial; appeal to wk.c.c.	N	Y	N
	clarifies procedure if cert is denied. Adds resp. for wk. comp agencies, provides remedy for aggrieved persons. OK.			
.2000	27. ~~go service area~~.	N	N	N
Subp. B & 2 p8.	(28) MCP MUST contract w/ the insurer. liable under Ch. 176	N	Y	N
	adds requirement that MCP must contract.			
	(29) When insurer contracts.. The employee shall select a MCP from those N have K w insurer liable under Ch 176, prov that w/i mileage.	N	Y	N
	Designates generally what MCP employee can select both w/insurer + w/mileage limits. might not meet "anticipation" criteria.			

④

	Change	subst. ① new people	② new subject	③ major change
30	personal, w/insurer liable;	N	N	N
		language.		
31.	contract w/health care prov. terms	N	N	N
		provides clarif for continuity.		
32.	trmt before ↑/denial = emplr pays if neg trmt. If denied can get pre-reimb.	N	Y	N
		Makes employer liable for required trmt costs prior to liability determen. OK Clarifies		
33.	Admit in 14 days = MCP unless... Det. liab. >14 days.; emp. can stay out of MCP if h.c.p. complies w/ 5000 (2)	N	Y	N
		allows continuity for employee. Really = more process details. N signif. OK		
34.	~~format~~, subp. 1 (c); parte. provs.	N	N	N
		clarif		
p.12 e.	(35.) dispute resolution proceedings	N	N	N
		~~seems to be first mention of ADR.~~		
36	certified, related to w.c., = 176	N	N	N
		clarif.		
37.	if the info is relevant vague	N	N	N
		not a real change but change = still vague lang.		

(5)

	change	Signif ① new people	② new sjt	③ major change
38	contract, w/176 may prov. to emp: MCP	N	N	N
		reword		
13.5000(A) 39.	tmt at least 2x in 4yrs preinj; + compl w 176.1351 (2Xa). Employee must provide insurer w/doc. of prev. tmt. Private data.	N	Y	N
		CLARIFIES prior med tmt. Req. employee to provide doc. => burden on employee, but really a clarif of what employee should ~~do~~ do - not new. requirement.		
40.	emp refi or 14 day rule.	N	N	N
		consist. w/other rules.		
41.	~~which incl bnft~~ except for minor trt prov = direct tmt.	N	Y.	N
		changes/clarifies what can be done		
42.	HCP w/comply w/(2) = denied $.	N	Y	N
		says when hcp wont get reimbursed. Clarifies results of failure to comply w/.700		
43	may not require lesser fee.	N	N	N
7000	~~44.~~ (Dispute res:) ~~may issue order~~ proceed under 176. ..	N	N	N
		★ what exactly is drp of mcp?		
45.	records relevant, sjt to Ch. 13, 145, 176.	N	N	N
46.	reveals "reasonable cause" but what is it?	N	N	N
		Lg. word change		

6.

	Change	① new people	② subst new sit	③ major change
47	or, partcp. prov. regn cert,	N	N	N
48.	No employee covered if MCP's prov. cert revoked MCP reapply.	N	N	N

wording change

simultaneously submit a copy of its response to the person or associations that submitted the comments to the attorney general.

Subp. 2. **Comment period.** Written comments concerning a rule adopted without a public hearing must be received by the attorney general within eight calendar days after submission to the attorney general to assure time for the agency to respond. Written comments concerning an emergency rule must be received by the attorney general within seven working days after submission to the attorney general to assure time for the agency to respond. The address to submit comments to the attorney general is the same as set out in part 2010.0500 and the computation for the comment period is the same as for the rule review period computation in part 2010.0800.

Statutory Authority: *MS s 14.06; 14.09*

History: *11 SR 618*

2010.1000 STANDARDS OF REVIEW.

A rule must be disapproved by the attorney general if:

A. The rule as submitted is not a statement of general applicability and future effect adopted to implement or make specific the law enforced or administered by the agency or to govern the agency's organization or procedures.

B. The agency has failed to comply with the applicable provisions of the Administrative Procedure Act, Minnesota Statutes, chapter 14, the agency's enabling statute, the attorney general rule parts 2010.0200 to 2010.1400 or other applicable law.

C. The rule exceeds the statutory authority conferred on the agency, conflicts with the statutes or any other relevant law, or has no reasonable relationship to statutory purposes.

D. There is a substantial change in the rule as adopted from the proposed rule as noticed. A change, by additions or deletions or other modifications to a proposed rule, is substantial if it:

(1) affects classes of persons who could not reasonably have been expected to comment on the proposed rule as originally noticed;

(2) introduces significant new subject matter which a reasonable person, on the basis of the proposed rule as originally noticed, would not have anticipated would occur during the rulemaking proceeding; or

(3) makes a major substantive change that was not raised by the proposed rule as originally noticed in such a way as to invite reaction.

E. For a rule adopted without a public hearing, the record does not demonstrate a rational basis for the need for and reasonableness of the proposed rule. This criterion does not apply to emergency rules.

F. The rule grants the agency discretion beyond that permitted by its enabling legislation.

G. The rule improperly delegates the agency's powers to another agency, person, or body.

H. The rule is vague or ambiguous in violation of the constitutional principles of due process or equal protection.

I. The rule, by its terms, cannot have the force and effect of law.

J. The rule is unconstitutional or, in the case of emergency rules, is unreasonable.

Statutory Authority: *MS s 14.06; 14.09*

History: *11 SR 618*

A health care provider shall not collect, attempt to collect, refer a bill for collection, or commence an action for collection against the employee, employer, or any other party until the information required by this section has been furnished.

A United States government facility rendering health care services to veterans is not subject to the uniform billing form requirements of this subdivision.

Sec. 13. **[176.1351] MANAGED CARE.**

Subdivision 1. **APPLICATION.** Any person or entity, other than a workers' compensation insurer or an employer for its own employees, may make written application to the commissioner to have a plan certified that provides management of quality treatment to injured workers for injuries and diseases compensable under this chapter. Specifically, and without limitation, an entity licensed under chapter 62C or 62D or a preferred provider organization that is subject to chapter 72A is eligible for certification under this section. Each application for certification shall be accompanied by a ~~reasonable fee~~ prescribed by the commissioner. ~~A plan may be certified to provide services in a limited geographic area.~~ A certificate is valid for the period the commissioner prescribes unless revoked or suspended. Application for certification shall be made in the form and manner and shall set forth information regarding the proposed plan for providing services as the commissioner may prescribe. The information shall include, but not be limited to:

(1) a list of the ~~names of all health care providers who will provide services~~ under the managed care plan, together with appropriate evidence of compliance with any licensing or certification requirements for those providers to practice in this state; and

(2) a ~~description of the places and manner of providing services under the~~ plan.

Subd. 2. **CERTIFICATION.** The commissioner shall certify a managed care plan if the commissioner finds that the plan:

(1) proposes to provide quality services that meet uniform treatment standards prescribed by the commissioner and all medical and health care services that may be required by this chapter in a manner that is timely, effective, and convenient for the worker;

(2) is reasonably geographically convenient to employees it serves;

(3) provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service;

(4) provides adequate methods of peer review, utilization review, and dispute resolution to prevent inappropriate, excessive, or not medically necessary treatment, and excludes participation in the plan by those individuals who violate these treatment standards;

(5) provides a procedure for the resolution of medical disputes;

(6) provides aggressive case management for injured workers and provides a program for early return to work and cooperative efforts by the workers, the employer, and the managed care plan to promote workplace health and safety consultative and other services;

(7) provides a timely and accurate method of reporting to the commissioner necessary information regarding medical and health care service cost and utilization to enable the commissioner to determine the effectiveness of the plan;

(8) authorizes workers to receive compensable treatment from a health care provider who is not a member of the managed care plan, if that provider maintains the employee's medical records and has a documented history of treatment with the employee and agrees to refer the employee to the managed care plan for any other treatment that the employee may require and if the health care provider agrees to comply with all the rules, terms, and conditions of the managed care plan;

(9) authorizes necessary emergency medical treatment for an injury provided by a health care provider not a part of the managed care plan;

(10) does not discriminate against or exclude from participation in the plan any category of health care provider and includes an adequate number of each category of health care providers to give workers convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan;

(11) provides an employee the right to change health care providers under the plan at least once; and

(12) complies with any other requirement the commissioner determines is necessary to provide quality medical services and health care to injured workers.

The commissioner may accept findings, licenses, or certifications of other state agencies as satisfactory evidence of compliance with a particular requirement of this subdivision.

Subd. 3. **DISPUTE RESOLUTION.** An employee must exhaust the dispute resolution procedure of the certified managed care plan prior to filing a petition or otherwise seeking relief from the commissioner or a compensation judge on an issue related to managed care. If an employee has exhausted the dispute resolution procedure of the managed care plan on the issue of a rating for a disability, the employee may seek a disability rating from a health care provider outside of the managed care organization. The employer is liable for the reasonable fees of the outside provider as limited by the medical fee schedule adopted under this chapter.

Subd. 4. **ACCESS TO ALL HEALTH CARE DISCIPLINES.** The commissioner may refuse to certify or may revoke or suspend the certification of a

managed care plan that unfairly restricts direct access within the managed care plan to any health care provider profession. Direct access within the managed care plan is unfairly restricted if direct access is denied and the treatment or service sought is within the scope of practice of the profession to which direct access is sought and is appropriate under the standards of treatment adopted by the managed care plan or, in instances where the commissioner has adopted standards of treatment, the standards adopted by the commissioner.

Subd. 5. **REVOCATION, SUSPENSION, AND REFUSAL TO CERTIFY.** The commissioner shall refuse to certify or shall revoke or suspend the certification of a managed care plan if the commissioner finds that the plan for providing medical or health care services fails to meet the requirements of this section, or service under the plan is not being provided in accordance with the terms of a certified plan.

Subd. 6. **RULES.** The commissioner may adopt emergency or permanent rules necessary to implement this section.

Sec. 14. Minnesota Statutes 1990, section 176.136, subdivision 1, is amended to read:

Subdivision 1. **SCHEDULE.** (a) The commissioner shall by rule establish procedures for determining whether or not the charge for a health service is excessive. In order to accomplish this purpose, the commissioner shall consult with insurers, associations and organizations representing the medical and other providers of treatment services and other appropriate groups.

(b) The procedures established by the commissioner ~~shall~~ must limit, in accordance with subdivisions 1a, 1b, and 1c, the charges allowable for medical, chiropractic, podiatric, surgical, hospital and other health care provider treatment or services, as defined and compensable under section 176.135, ~~based upon billings for each class of health care provider during all of the calendar year preceding the year in which the determination is made of the amount to be paid the health care provider for the billing~~. The procedures established by the commissioner for determining whether or not the charge for a health service is excessive ~~shall~~ must be structured to encourage providers to develop and deliver services for rehabilitation of injured workers. The procedures ~~shall~~ must incorporate the provisions of sections 144.701, 144.702, and 144.703 to the extent that the commissioner finds that these provisions effectively accomplish the intent of this section or are otherwise necessary to insure that quality hospital care is available to injured employees.

Sec. 15. Minnesota Statutes 1990, section 176.136, is amended by adding a subdivision to read:

Subd. 1a. **RELATIVE VALUE FEE SCHEDULE.** The liability of an employer for services included in the medical fee schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee, whichever is lower. The medical fee schedule effective

Comments

(Exceeds stat. authority.)

LeroyStumpf: MCPs cant exclude/restrict direct access to any health care provider profession.

Abeler II: young doctors

Larkin H: chiropractors

5218.1000(1)(B)(3)(a)(c)

Brommer 5218.2000(4) — company plan vs. 176.1351(subd.1)
5218.1000 1(B) exer. cap - no stat. auth.
5218.2000(D), subp. 4 grandfathering provision
5218.5000 subp 2B

double check rules w/o unoff comments.

"Sal" Frederick MCPs cant discriminate
wants access to chiropractor or MD not just "company dr."

Dee Long Company Dr. can employers do MCPs?

5218.1000 (1)(B) Blue Cross say outside stat. auth.

Larkin $1500 is too high.

Group Health: 5218.1000 subp 1 D3c - no self-referrals only refs by primary Dr.

Olive (fax 10/6) change "within"
predated injuries
documented history

Hottinger - fax 10/7
No chiropractors

Gomez D(7, 10, 11) vague
2000(A B C) Conflict re choice
Oct 1, 1992

2000 2(e) liability when employer
requires treatment

2000 2(F) subst. change - 14 days

1000 1 (A) documented history

5218.1000 | D 7, 10, 11

vague. peer + utilization review.

.2000(3)(A-C)

.2000 2 E

F claims 14 day +/- = subst. change

1000 | A vague 2/4 provision.

OK. 5218.1000 (1)(B) report annual wage 10x > 176.011(20).
~~not exceed~~

(C) Reasonableness of $1500.

(D) Documentation

(1) same as stat (1)

(2) same as stat (2)

(a) uniq tmt stds 176.83 = subd 2(1)

(b) can't discriminate

(3) procedures to ensure employee will

(a) receive tmt w/i 24 hours of request following injury

(b) " " " 5 work days of change of dr. request where emp rec'd tmt hcp/n/MCP.

seems to give MCP + prov auth over choice (c) choose from 3 const. w/ subd. 4

(d)

~~5218.1000, subp 1 (c) $1,500~~ Reasonable? appvd by Finance

~~5218.1000, subp 1 (D)(5) contracts~~ contracts prob ok under 1

~~5218.2000, subp 2 (c) change of doctor~~ retroactive? No.

suppose that when a change of doctor is requested, there is no longer the "documented history" required by subd 2 (8).

~~5218.9000 2 (D) false info~~

STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

GOVERNMENT SERVICES SECTION
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FACSIMILE TRANSMISSION

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7-1329

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STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

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ATTORNEY GENERAL

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October 7, 1992

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OCT 01 1992

Office of the Attorney General
Government Services Section
Capitol Office Bldg., Suite 500
525 Park Street
St. Paul, MN 55103

Bernard L. Brommer
525 Park Street Suite 110
St. Paul, MN 55103

Re: Your letter of August 28, 1992

Dear Bernie:

Thank you for your letter to me on the subject of the workers' compensation managed care rules.

My staff attorney assigned to these rules has verified that the enclosed comments of the Minnesota AFL-CIO to the Department of Labor and Industry were timely received and considered by the Department. Those comments, along with the others submitted, were sent with the managed care emergency rulemaking file to the Public Finance Division of my office on September 28, 1992 for its required review.

Under the Attorney General's administrative rules for review of rules promulgated by state agencies, there is an opportunity for interested parties to comment on the limited subject of the legality of the emergency rules. Such comments must be submitted within the first seven days after the agency sends the file to Public Finance Division.

Accordingly, I am forwarding your letter and its attachment to the Public Finance Division. My lawyers there are the appropriate people to consider them.

Best regards,

HUBERT H. HUMPHREY III
Attorney General

cc: Public Finance Division

525 PARK STREET • SUITE 110 ST. PAUL, MINNESOTA 55103 • PHONE: (612) 227-7647

August 28, 1992

Hubert H. Humphrey III
Attorney General
102 State Capitol
St. Paul, MN 55155

Dear Attorney General Humphrey:

Enclosed you will find a copy of the Minnesota AFL-CIO's comments to the Department of Labor and Industry regarding the proposed emergency rules for the Workers' Compensation Managed Care. While we understand the Department has great latitude in promulgating the emergency rules, there are two areas we think conflict with the law.

One is Paragraph 5218.2000 Subp. D and the other in the same paragraph is Subp. 4.

Since we are uncertain as to what the Department will transmit to your office for approval, the Minnesota AFL-CIO thought it best to call attention to our concerns.

Additionally, unless there is a clarification along the lines we suggested to the Department, there could be a conflict with the statute concerning the proposed rule that requires the workers' compensation claiment's family doctor to refer all diagnostic testing to a managed care facility, if the employer/ insurer has designated one for treatment: Paragraph 5218.5000: Subp. 2B.

We appreciate your scruitiny of these items.

Sincerely,

Bernard L. Brommer

Bernard L. Brommer
President

BLB:lw
opeiu#12
afl-cio

Enc.

OPEIU 12
UNION LABEL

525 PARK STREET • SUITE 110 ST. PAUL, MINNESOTA 55103 • PHONE: (612) 227-7647

August 20, 1992

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

The Minnesota AFL-CIO has a number of questions, concerns and suggested modifications with regard to the proposed emergency rules related to Workers' Compensation Managed Care. We offer the following comments on the Department of Labor and Industry's proposed rules.

Sincerely,

Bernard L. Brommer

Bernard L. Brommer, President

cc: John Lennes
Leo Eide

bcc: Jack Engberg
Bob Rootes
Jim Ellenberger, AFL-CIO
Tim McCoy
Ron Cohen
Bernard Brommer

5218.0100 (Emergency) Definitions

Subp. 3.: "Emergency care" should mean more than professional health services necessary to preserve life or limb. It is not difficult to imagine instances where emergency care is essential but not necessary to preserve life or limb. For example--scrapes, burns, cuts, and even broken bones may not be life or limb threatening but may necessitate "emergency care."

Subp. 4.: This subpart defines an employee as an employee entitled to treatment of a "work injury". Minnesota Statutes define an injury subject to the act as a "personal injury". We suggest that to avoid possible confusion that the statutory terminology of personal injury be used, rather than a work injury or a "compensable injury" which is a phrase used later in the proposed rules.

Paragraph 5218.1000:

Subp. 1D(2): Particularly in the Metropolitan area it may be difficult for the Managed Care Plan to provide services for an entire county. For the possible convenience of the Plan, the

OPEIU 12

providers, and the employees, we suggest that consideration be given to permit service areas of less than a full county.

Subp. 1D(2)(a): Is it appropriate for the Commissioner of Labor and Industry to prescribe uniform medical treatment? Is the Department suggesting treatment protocols? What happens if quality services are provided that exceed "uniform treatment standards?".

Subp. D3(a): Under subp. 1D(2)(b), the Plan shall not discriminate among health care providers. Under that standard, we believe this subpart should require the Managed Care Plan to permit evaluation by the participating chiropractor if that should be the employee's choice. This comment would also apply to the following subp. (b).

(Subp. 1D(3)(b): The employee, who has received treatment by a provider outside the Managed Care Plan, must be evaluated by a participating physician of the Managed Care Plan within five days "of a request for a change of doctor." At whose request for a change?

Subp. 1D (3)(c): Does this mean that treatment by other disciplines in the medical profession for the injured workers is in the sole discretion of the evaluating managed care provider of the insurer?

Subp. D3 (f): We question whether the 30-mile standard will be reasonable in all cases, particularly in the Metropolitan area. We suggest that paragraph be modified to provide that the employee shall have reasonable geographical access to providers, but shall not be required to travel more than 30 miles from the place of employment or residence.

Subp. D3 (4): We interpret this to imply that the plan designates the criteria for employees to go outside the Managed Care Plan. The Commissioner, the most neutral body, should develop this type of criteria.

Subp. D7: We believe this subpart should provide a description of the type of dispute that may be subject to the internal dispute resolution procedure. The paragraph should require that the procedure for resolution of disputes for injury compensation be fair, reasonable and practical.

Subp. D8: To permit the Department to evaluate the effect on employee health care, we would suggest that the "commencement or termination of participating health care providers" be preceded by a 30-day notice to the commissioner.

Subp. D10: The plan should include in the description of case management, the provision for cooperative efforts with a QRC where such a person has been assigned to the employee's case.

Paragraph 5218.2000:

Subp. 3B: This provision provides that the employee must select a Managed Care Plan at the time of injury. Such a choice may be difficult to make at the time of injury. We suggest that the injured employee be given 30 days after an injury to make such a selection.

Subp. D: We are not aware of statutory authority to make the Managed Care Plan retroactive to injuries prior to this act. Accordingly, the application of the Managed Care Plan to an employee with a previous injury who requests a change of doctor, should be deleted.

Subp. E: We think the phrase in the second sentence "may continue to treat with the employee's original health care provider" is unclear. Does this refer to the employee's personal health care provider or the provider under the terminated plan?

Subp. F: We think that the third sentence of the second paragraph of this subpart, which permits the employer to invoke the Managed Care Plan after liability is determined, disregards the importance of the continuity of treatment. A change in medical provider at that point could be highly unproductive. Accordingly, this provision should be deleted.

Subp. 4: We believe the provision that would permit an employer or insurer to form, operate or administer its own Managed Care Plan that treats workers' compensation claimants is contrary to the legislation enacted in 1992. We know about the pressure and coercion that employers and insurance companies can exert on injured workers and this language leaves the door wide open.

Paragraph 5218.3000:

Subp. 3: The plan must submit to the insurer any information which they request which includes individual patient medical records not related to the workers' compensation injury. It is essential that such information not pertinent to the worker's compensation claim be kept confidential.

Paragraph 5218.4000:

Subp. 2: We believe that if a participating provider is terminated, the employee should have the option of continuing treatment by that provider to assure continuity of care.

Paragraph 5218.5000:

Subp. 2A: This should clarify that the commissioner is the party issuing the various requirements.

Subp. 2B: We believe that the referring out of diagnostic testing should not be limited to referral to the Managed Care Plan. We believe this to be an undue restriction upon the medical discretion of a care provider who has a documented history of treatment. At the very least, the emergency rules should make it clear that the results of diagnostic testing done by a Managed Care Provider are to be sent to the care provider who has a documented history of treatment.

BLB:pkd
opeiu12
afl-cio

LeROY STUMPF
Senator 1st District
428 Riverside Ave.
Thief River Falls, Minnesota 56701
and
G-24 State Capitol Building
St. Paul, Minnesota 55155
Phone (612) 296-8660

Senate

State of Minnesota

September 30, 1992

The Honorable Hubert H. Humphrey III
Attorney General of Minnesota
State Capitol Room 102
St. Paul, Minnesota 55155

Dear Attorney General Humphrey:

After reviewing the proposed rules regarding workers' compensation which recently appeared in the State Register and have been submitted to your office, I am concerned that the rules may not follow the intent of the legislation passed during the 1992 session.

The Legislature made its intent clear by stating that managed care plans cannot "discriminate against or exclude from participation in the plan of any category of health care provider..." Under the new law, managed care plans can have certification revoked if it "unfairly restricts direct access within the managed care plan to any health care provider profession."

I understand that the Commissioner recently amended the proposed rules to more accurately reflect the intent of the legislature. However, on behalf of my constituents who have expressed concern for injured workers, I urge you to give these rules great scrutiny.

Thank you for your consideration.

Sincerely,

LeRoy Stumpf

LS:lh

Printed on Recycled Paper

Dee Long
Speaker of the House

463 State Office Building
St. Paul, MN 55155

(612) 296-0171

Minnesota House of Representatives

October 6, 1992

The Office of the Attorney General
Public Finance Division
525 Park Street, Suite 400
St. Paul, MN 55103

RE: Proposed Emergency Rules for Workers' Compensation

To The Office of the Attorney General:

I have had the opportunity to review the proposed rules regarding workers' compensation that have appeared in the July 27, 1992 edition of the MN State Register, as well as a subsequent draft dated September 3, 1992. It is my opinion that these rules do not follow the intent or letter of the law passed by the House during the 1992 legislative session.

As you are aware, the workers' compensation enabling legislation passed earlier this year utilizes a managed care mechanism to help contain costs, but is not intended to eliminate the injured workers' access to the care provided for by statute.

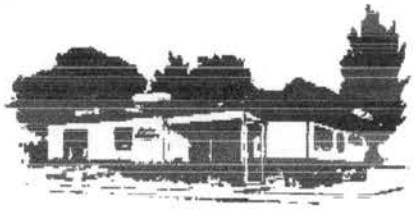
The legislation states in more than one area that discrimination against one category of health care provider is not permissible. Minn. Stat. 176.135 subdivision 1 (a) states that "The employer shall furnish any medical, psychological, chiropractic, podiatric, surgical and hospital treatment... as may reasonably be required at the time of the injury and any time thereafter to cure and relieve from the effects of the injury."

Minn. Stat. 176.1351 Subd. 2 (10) states that the managed care organizations cannot "discriminate against or exclude from participation in the plan any category of health care provided..."

Additionally, Minn. Stat. 176.1351 Subd. 4 states that a managed care organization can have its certification revoked if it "unfairly restricts direct access within the managed care plan to any health care provider profession."

The draft of the rules dated September 3, 1992 does not allow the injured worker the right to visit any category of health care provider that can, by law, provide care that is reimbursable at the time of the injury. Instead, it provides the managed care

DR. JAMES J. ABELER
DR. J. JOSEPH ABELER
DR. STEPHEN R. ABELER



Abeler CHIROPRACTIC CLINIC, 600 E. MAIN ST., ANOKA, MINN. 55303 421-3722

September 30, 1992

Dear Mr. Humphrey:

You are most certainly aware of the recent changes made in the Workman's Compensation system in Minnesota. I believe you have on your desk a copy of the proposed rules for the handling of the Managed Care Organizations and other matters pertinent to the implementation of the changes mandated by the legislature. One issue which is seeming to escape the process is one which I believe you will find very close to your heart. That has to do with the status of non-included doctors in a Managed Care Organization of an out-coming graduating young doctor who was not eligible for placement in an MCO because he was not in practice at the time of its formation.

For your information, I recently contacted some 30 insurance companies which were potentials to set up MCO's with regard to Workman's Compensation system. The majority already had in place a Preferred Provider network which they were going to be using in servicing their proposed MCO, which at this point was not yet approved by the Industry department. They generally indicated that should they have a need for more doctors they would be keeping my letter on file ("don't call us, we'll call you".) As a chiropractor in practice for some 13 years this is not so serious for me as I am currently a member of a small number of these organizations already and will be availed some number of patients should the MCO system take over in a large way. However, a young doctor who recently graduated would have had no access to belong to such a group or groups would find themselves unable to serve any patients in his locale covered by such an MCO. This to me seems to be a terrible wrong which needs to be dealt with in some fair way.

There are perhaps many options as to ways to handle this, but an idea that may work would be that the state mandate that any certified practitioner would become a part of any MCO were they willing to sign the agreement binding the current providers to that MCO. They could have some strict rules for termination, etc. or the state could offer their own rules. Upon graduation a doctor would review the criteria for participation as a state MCO doctor, would agree to abide by the rules, and would then be included from his graduation as part of all the state MCO's. This would offer many positives including giving extreme coverage to all areas of the state and a broad representation of provider types, even in areas that are under-served, but would also give the young practitioners equal footing as they attempt to find their niche in the market place.

Thank you for thinking about this. I would be very happy to talk to you personally about this matter further if it would be appropriate, but please do not let this matter die. Without someone as strong as yourself looking after these young doctors, they will find themselves graduating with a tremendous amount of debt and unable to compete in the market because they are not allowed into it.

Thank you for your fairness and openness and your concern for the people who are little.

Yours truly,

J. Joseph Abeler II, D.C.

plan with the power to select a "company doctor" which all employees will be required to visit at the onset of injury.

This scheme of managed care is not within the letter of the law or was what the members intended when this bill was discussed in committee or on the House floor.

I would strongly suggest that the rules conform to the legislation passed by allowing injured workers an initial evaluation by either a doctor of medicine or a doctor of chiropractic who are participating in the managed care plan. This language will more substantially reflect the letter of the law and the intent of legislative members.

Sincerely,

Dee Long

Dee Long, Speaker
Minnesota House of Representatives

cc: Attorney General Skip Humphrey
Representative Peter Rodosovich
Penny Johnson, Department of Labor and Industry

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OCT 06 1992

Office of the Attorney General
Government Services Section
Capitol Office Bldg., Suite 500
525 Park Street
St. Paul, MN 55103

Dee Long
Speaker of the House

463 State Office Building
St. Paul, MN 55155

(612) 296-0171

Minnesota House of Representatives

October 6, 1992

The Office of the Attorney General
Public Finance Division
525 Park Street, Suite 400
St. Paul, MN 55103

RE: Proposed Emergency Rules for Workers' Compensation

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As you are aware, the workers' compensation enabling legislation passed earlier this year utilizes a managed care mechanism to help contain costs, but is not intended to eliminate the injured workers' access to the care provided for by statute.

The legislation states in more than one area that discrimination against one category of health care provider is not permissible. Minn. Stat. 176.135 subdivision 1 (a) states that "The employer shall furnish any medical, psychological, chiropractic, podiatric, surgical and hospital treatment... as may reasonably be required at the time of the injury and any time thereafter to cure and relieve from the effects of the injury."

Minn. Stat. 176.1351 Subd. 2 (10) states that the managed care organizations cannot "discriminate against or exclude from participation in the plan any category of health care provided..."

Additionally, Minn. Stat. 176.1351 Subd. 4 states that a managed care organization can have its certification revoked if it "unfairly restricts direct access within the managed care plan to any health care provider profession."

The draft of the rules dated September 3, 1992 does not allow the injured worker the right to visit any category of health care provider that can, by law, provide care that is reimbursable at the time of the injury. Instead, it provides the managed care

plan with the power to select a "company doctor" which all employees will be required to visit at the onset of injury.

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Sincerely,

Dee Long, Speaker
Minnesota House of Representatives

cc: Attorney General Skip Humphrey
Representative Peter Rodosovich
Penny Johnson, Department of Labor and Industry



Minnesota State Senate

Facsimile Transmittal From FAX Number (612) 296-6511

Room G-1 Capitol · St. Paul, MN 55155

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ORGANIZATION: TELEPHONE: (612) 296-6153

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Of Counsel
Miles W. Lord

October 7, 1992

The Office of the Attorney General
Public Finance Division
525 Park Street - Suite 400
St. Paul, MN 55103

VIA FACSIMILE AND U.S. MAIL

In The Matter of the Proposed Adoption of Emergency Rules of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

Dear Sir/Madam:

The following is intended to represent this firm's comments regarding the above-referenced proposed emergency rules.

First, proposed Rule 5218.1000, Subpart 1D.(3)(c), provides in part that a managed care plan must include a procedure to allow the employee to change health care providers within a managed care plan at least once. Minn. Stat. § 176.1351, Subd. 3(11), states that a managed care plan must provide an employee the right to change health care providers under the plan at least once. The proposed rule should reflect the statutory language, rather than attempt to either limit or expand the statutory definition in the absence of any express statutory authority.

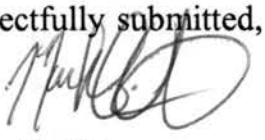
Second, Rule 5218.2000, Subpart 3D, correctly applies statutory and case law by providing, in part, that employees with compensable injuries prior to the effective date of the managed care plan contract are not subject to the managed care provisions of Minn. Stat. § 176.1351 and proposed Rules 5218.0100 to 5218.9000. However, this proposed rule carves out an exception for those employees who have compensable injuries which pre-date the managed care plan contract if they request a change of doctors. This part of the rule lacks any statutory authority and contravenes clear case law precedent with respect to attempts to retroactively limit rights to workers' compensation benefits which vest and are defined by the law in effect on the date of injury. Further, targeting employees with vested rights under prior statutes who seek

to change treating physicians raises a serious constitutional question. Rule 5218.2000, Subpart 3D, should be deleted after the word "contract" on line 25.

Finally, Rule 5218.5000, Subpart 1A, provides, in part, that an employee may treat with a health care provider not covered by a managed care plan if the health care provider has a documented history of treatment of that employee at least twice in the four years before the date of injury. Minn. Stat. 176.1351, Subd. 2(8) states only that an employee have a documented history of treatment with a health care provider in order to treat with that health care provider who is not covered by the managed care plan. This proposed rule adds additional restrictive language neither expressly authorized or intended by statute. This proposed rule represents an inappropriate attempt to legislate by rulemaking.

In closing, we would urge disapproval of those rules identified herein based on the aforementioned objections as to legality.

Respectfully submitted,



Mark G. Olive

FOR THE FIRM

MGO/nkp

cc: Kathryn Berger

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Of Counsel
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TELECOPY COVER SHEET

612/333-5970

DATE: October 7, 1992

TO: Betsy McAfee

ATTN:

FAX NO: 297-2576

FROM: Mark Olive

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Of Counsel
Miles W. Lord

October 7, 1992

The Office of the Attorney General
Public Finance Division
525 Park Street - Suite 400
St. Paul, MN 55103

VIA FACSIMILE AND U.S. MAIL

In The Matter of the Proposed Adoption of Emergency Rules of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

Dear Sir/Madam:

The following is intended to represent this firm's comments regarding the above-referenced proposed emergency rules.

First, proposed Rule 5218.1000, Subpart 1D.(3)(c), provides in part that a managed care plan must include a procedure to allow the employee to change health care providers within a managed care plan at least once. Minn. Stat. § 176.1351, Subd. 3(11), states that a managed care plan must provide an employee the right to change health care providers under the plan at least once. The proposed rule should reflect the statutory language, rather than attempt to either limit or expand the statutory definition in the absence of any express statutory authority.

Second, Rule 5218.2000, Subpart 3D correctly applies statutory and case law by providing, in part, that employees with compensable injuries prior to the effective date of the managed care plan contract are not subject to the managed care provisions of Minn. Stat. § 176.1351 and proposed Rules 5218.0100 to 5218.9000. However, this proposed rule carves out an exception for those employees who have compensable injuries which pre-date the managed care plan contract if they request a change of doctors. This part of the rule lacks any statutory authority and contravenes clear case law precedent with respect to attempts to retroactively limit rights to workers' compensation benefits which vest and are defined by the law in effect on the date of injury. Further, targeting employees with vested rights under prior statutes who seek

to change treating physicians raises a serious constitutional question. Rule 5218.2000, Subpart 3D, should be deleted after the word "contract" on line 25.

Finally, Rule 5218.5000, Subpart 1A, provides, in part, that an employee may treat with a health care provider not covered by a managed care plan if the health care provider has a documented history of treatment of that employee at least twice in the four years before the date of injury. Minn. Stat. 176.1351, Subd. 2(8) states only that an employee have a documented history of treatment with a health care provider in order to treat with that health care provider who is not covered by the managed care plan. This proposed rule adds additional restrictive language neither expressly authorized or intended by statute. This proposed rule represents an inappropriate attempt to legislate by rulemaking.

In closing, we would urge disapproval of those rules identified herein based on the aforementioned objections as to legality.

Respectfully submitted,

Mark G. Olive

FOR THE FIRM

MGO/nkp

cc: Kathryn Berger

15344_1

JOHN C. HOTTINGER
Senator 24th District
Room G-29
State Capitol Building
St. Paul, MN 55155
(612) 296-6153

Senate
State of Minnesota

October 7, 1992

The Office of the Attorney General
Public Finance Division
525 Park Street
Suite 400
St. Paul, MN 55103

To the Attorney General's Office:

I have some concerns relating to the proposed rules regarding workers' compensation managed care and access to health care providers. In participating in the various and numerous discussions about managed care, it was clear to me that the intent was that the employee's choice of the type of medical care provider within the managed care system was to be open -- that is, not directed solely to a medical provider, but also equal access to a chiropractic provider if consistent with a chiropractor's scope of practice.

The statutory language was, I believe, directed to ensuring that participation in the plan would be equally open to any category of health care provider. The law provides that a managed care plan can have its certification revoked if it "unfairly restricts direct access within the managed care plan to any health care provider profession".

These provisions were added in order to provide equal access for the employee.

It is my understanding that the rules that have been submitted to your office allow the employer and/or insurance company to utilize only medical professionals (as opposed to chiropractors) to initially treat the injured worker. This would severely restrict the worker's choice of initial provider, which is not what the Legislature intended.

Printed on Recycled Paper

I urge you to revise the rules to allow injured workers the ability to access either a chiropractor or a medical doctor within a managed care plan at the initial referral following the injury.

Thank you for your consideration.

Sincerely,

John

JOHN C. HOTTINGER
State Senator - District 24

JCH:kn

cc: Kathryn Berger
Scott Mayer

SF-00006-05 (4/86)

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT : EMPLOYEE RELATIONS - 2ND FLOOR
CENTENNIAL BUILDING, 658 CEDAR STREET

DATE : October 7, 1992

TO : Office of the Attorney General
Public Finance Division

FROM : Maria Gomez, Manager
Employee Insurance Division

PHONE : 296-6287

SUBJECT : Comments on the Proposed Adoption of the Rule of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plan

Pursuant to the Notice of Submission of Emergency Rule to the Attorney General, enclosed please find the Division's comments to the Department of Labor and Industry's proposed emergency rules governing workers' compensation managed care plans.

If you wish to discuss these comments further, please contact me.

MG:dc/4447

Enclosure

cc: Kathryn Berger, Legal Services, Dept. of Labor and Industry

COMMENTS IN THE MATTER OF THE PROPOSED ADOPTION OF THE RULE OF THE STATE DEPARTMENT OF LABOR AND INDUSTRY, GOVERNING WORKERS' COMPENSATION MANAGED CARE PLAN

The following are specific comments regarding the rule:

5218.1000, Subp. 1,D,(7),(10) and (11)

Each of these provisions of the rule are vague or ambiguous and should not be adopted as written. Specifically, section (7) requires a managed care plan to have procedures for peer review, utilization review and internal dispute resolution. However, the rule does not specify the criteria for an acceptable procedure for certification of a managed care plan. As written, the provision is vague and provides no guidance to the managed care plan seeking certification. Furthermore, the procedures used in the review and dispute resolution processes should be uniform amongst all managed care plans so that all parties utilizing these processes will be treated the same or provided the same due process regardless of which managed care plan is involved.

Section (10) requires that managed care plans describe how they will provide aggressive case management for injured employees in a program for early return to work and cooperative efforts by the employee, etc. This provision is vague in that it fails to provide the criteria for approval. A managed care plan seeking certification is not provided with the criteria it must satisfy to meet the requirements of this provision.

Finally, section (11) requires the managed care plan to submit any treatment standard it has developed for medical services that have not already been prescribed by the commissioner and that are reasonably likely to be used in the treatment of workers' compensation injuries. The provision goes on to state that all managed care plan health care providers and those providing services under part 5218.5000 [Emergency] shall be governed by these standards. This provision seems to indicate that all managed care plans and those providing services under part 5218.5000 will be governed by treatment standards submitted by other managed care plans. This provision does not provide for the commissioner adopting or prescribing the submitted treatment standards, or method to accomplish such. This provision does not provide for notice to the providers of these treatment standards or for an opportunity to be heard regarding these treatment standards. Furthermore, this provision, as written, is ambiguous as to which treatment standards a managed care plan will be governed by - the treatment standards it has developed and submitted or the treatment standards developed and submitted by another managed care plan.

5218.2000, Subp. 3,A, B, and C

This provision conflicts with Minnesota Statute 176.135, Subd. 1(f) and cannot be adopted. Section 176.135, Subd. 1(f) gives the employer authority to require that treatment and supplies for injuries compensable under the workers' compensation law be provided by and received from a managed care plan. Pursuant to this statutory provision, the employer has a right to designate the managed care plan to be utilized by employees

irregardless the of number of contracts it may have with managed care plans. Rule 5218.2000, Subp. 3,A gives the employee the choice of a managed care plan where an insurer contracts with multiple managed care plans. This rule thereby conflicts with statute and cannot be adopted.

Sections B and C of this provision, which limits application of the managed care plan provisions to injury dates occurring after the effective date of a managed care plan contract, conflicts with Minnesota Statute 176.135, Subd. 1(f) as well. Section 176.135, Subd. 1(f), which authorizes employers to require that treatment and supplies for injuries compensable under the Minnesota workers' compensation law be provided by and received from a managed care plan, is effective October 1, 1992. Pursuant to that provision, employers should be able to require that employees injured on or after October 1, 1992 utilize a managed care plan, regardless of whether a managed care plan contract existed at the time of injury and without regard to the employee requesting a change of doctors. Sections B and C of the rule conflict with this statute and, therefore, cannot be adopted.

5218.2000, Subp. 2,(E)

This provision which makes the employer liable for the cost of any treatment related to a claimed personal injury that is given by a participating health care provider before notice is given to the employee of a denial of liability or even if the employer is later determined to be not liable for the claimed injury, exceeds the statutory authority conferred on the Department of Labor and Industry, conflicts with the workers' compensation law, and has no reasonable relationship to the statutory purpose of the rule. This provision provides an unreasonable financial burden on insurers by making them liable for treatment expenses for non-work related injuries. It conflicts with Minnesota workers' compensation law which places liability on employers only in cases of a compensable workers' compensation injury. Furthermore, under Minnesota Workers' Compensation Law, employers are liable only for reasonable and necessary treatment related to a compensable personal injury. Making insurers financially responsible for injuries that are not compensable under the workers' compensation law has no reasonable relationship to the statutory purpose of the rules, which is to implement the managed care plan provisions.

5218.2000, Subp. 2,(F)

This rule provision must be disapproved by the Attorney General because it contains a substantial change in the rule as adopted from the proposed rule as noticed. The proposed rule provided that once the employer admitted liability for a claimed injury or the employer was determined to be liable for the claim, the employer could require that further medical treatment be received through the managed care plan, with the exception set out in rule 5218.5000. The rule as adopted, however, limits the employer to requiring that further medical treatment be received through the managed care plan where it has admitted liability for the claimed injury within 14 days after receiving notice of the injury. If the liability is admitted or determined later than 14 days after notice of the injury, the employer cannot require that the employee receive further treatment under the managed care plan, if the health care provider agrees to comply with part 5218.5000, Subp. 2 of the rules. This is a major

substantive change that was not raised by the proposed rule as originally noticed and as such, did not invite reaction or comment. It severely limits the application of the managed care plan provisions of the new workers' compensation law. This change from the proposed rule is such a substantial change in the rule it must be disapproved by the Attorney General pursuant to Minnesota Rules 2010.1000, Subp. D.

5218.1000, Subp. 1,(A)

This provision of the rule is vague and ambiguous. It allows for an injured employee to receive care outside of the managed care plan if a health care provider maintains the employee's medical records, has a documented history of treatment of the employee at least twice in the four years before the date of injury, and complies with the Minnesota statute 176.135, Subd. 2A. This provision is unclear whether the documented history of treatment of the employee has to be related to the same or a similar type of condition that employee sustained as a result of his work injury or if it can be treatment for any type of condition. It is unclear whether a one time examination is sufficient to qualify as a documented history of treatment. The provision is also unclear as to when the employee can implement this provision. Must the employee elect to implement this provision before receiving services under a managed care plan or can the employee, once within the managed care plan, opt out by virtue of this provision. As drafted, this provision of the rule is vague and ambiguous and, therefore, should be disapproved.

SUMMARY

As indicated above, there are a number of the provisions of the rules proposal for adoption which do not pass the Standards of Review set out in Minn. Rules 2010.1000. These provisions need to be rectified before the Attorney General can adopt the proposed rules.

4447/dmc

Marcel "Sal" Frederick
State Representative

District 24B
Nicollet, Blue Earth,
and Waseca Counties

Minnesota House of Representatives

COMMITTEES: AGRICULTURE, RURAL FINANCE AND SOIL & WATER RESOURCES; APPROPRIATIONS, ECONOMIC DEVELOPMENT, INFRASTRUCTURE & REGULATIONS; GENERAL LEGISLATION, VETERANS AFFAIRS & GAMING;
COMMISSIONS: LEGISLATIVE AUDIT COMMISSION

October 1, 1992

Office of the Attorney General
Public Finance Division
525 Park Street, Suite 400
St. Paul, MN 55103

To Whom It May Concern:

I have reviewed the proposed rules regarding workers' compensation that appeared in the State Register, as well as subsequent drafts, and believe that these rules do not follow the intent of the legislation that was passed by the House during the 1992 legislative session.

The statutory language is quite clear in stating that the managed care plans created under the legislation cannot "discriminate against or exclude from participation in the plan any category of health care provider ...". The legislation also states that a managed care plan can have its certification revoked if it "unfairly restricts direct access within the managed care plan to any health care provider profession."

This language was specifically added to the workers' compensation legislation to ensure that injured workers would have the ability to see the health care provider group of their choice, whether it be a medical doctor or a chiropractor.

It is my understanding that the rules that have been submitted to the Attorney General's office allow the employer and/or insurance company to utilize what amounts to a "company doctor" to initially treat the injured worker. If my understanding is correct, this severely restricts the worker's choice of provider, which is not what the legislature either passed or intended.

I urge you to review and amend the rules to allow injured workers the ability to access either a chiropractor or medical doctor at the time of injury.

Thank you for your consideration.

Sincerely,

Sal

Marcel "Sal" Frederick
State Representative
District 24B

cc: Kathryn Berger, Legal Services Division, MN Department of Labor & Industry
John Lennes, Commissioner, Minnesota Department of Labor & Industry

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*ALSO ADMITTED IN WISCONSIN

October 6, 1992

Office of the Attorney General
Public Finance Division
525 Park Street, Suite 400
St. Paul, Minnesota 55103

Re: Adopted Emergency Rules of the Department of Labor and Industry, Parts 5218.0100 to .9000 [Emergency], Relating to Workers' Compensation and Managed Care

TO THE ATTORNEY GENERAL, PUBLIC FINANCE DIVISION:

This firm has been retained by the Minnesota Chiropractic Association (MCA) to represent it with respect to emergency rules adopted by the Department of Labor and Industry (the Department) governing workers' compensation managed care plans. We urge the Attorney General to disapprove two provisions of the adopted emergency rules because the provisions do not meet the standards of review that the Attorney General is bound to apply under Minn. Rules Pt. 2010.1000, subpt. C., G., and J.

Specifically, the MCA takes issue with Pt. 5218.1000 [Emergency], subp. 1, D.(3)(a) and (c). Subparagraph (a) unfairly restricts direct access to any health care provider professional at the time of the injury, in direct contravention of several provisions of the workers' compensation enabling legislation. Subparagraph (c) purports to track a requirement stated in the workers' compensation enabling legislation, but omits a very important criterion that is included within the enabling legislation.

1. <u>The Enabling Legislation Contains Specific Provisions Prohibiting Discrimination and Ensuring Direct Access By Injured Workers to Health Care Providers of Their Choice</u>.

The enabling legislation requires the employer to furnish "any medical, psychological, chiropractic, podiatric, surgical and hospital treatment . . . as may reasonably be required at the time of the injury and any time thereafter to cure and relieve from the effects of

the injury." Minn. Stat. § 176.135, subd. 1(a). Thus, the legislation acknowledges freedom of choice and prohibits discrimination against any category of health care provider at the time of the injury.

The new legislation allowing the existence of managed care plans certified by the Commissioner of Labor and Industry (the Commissioner) ensures that if the employer adopts a managed care plan, that plan must not discriminate against any category of health care provider or restrict access by the injured employee to categories of health care providers. Specifically, the criteria set out by the legislature that the Commissioner must consider and find present in order to certify an employer's managed care plan include the following:

> (10) [That the managed care plan] does not discriminate against or exclude from participation in the plan any category of health care provider and includes an adequate number of each category of health care providers to give workers convenient geographical accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan.

Minn. Stat. § 176.1351, subd. 2(10). Furthermore, the enabling legislation gives the Commissioner authority to refuse to certify a managed care plan, or to revoke or suspend certification of a managed care plan "that unfairly restricts direct access within the managed care plan to any health care provider profession." Minn. Stat. § 176.1351, subd. 4. Subdivision 4 thus creates a prohibition against a managed care plan unfairly restricting access to any health care provider profession. The sanction for unfairly restricting access is either withholding certification or decertification.

The enabling legislation defines what constitutes unfair restriction of access. A managed care plan unfairly restricts access to a health care provider profession when it (1) denies direct access, and (2) the treatment or service sought is within the scope of practice of the profession to which direct access is sought, and (3) the treatment or service is appropriate under (a) standards of treatment adopted by the managed care plan, or (b) standards of treatment adopted by the Commissioner.

Accordingly, the enabling legislation prohibits discrimination or exclusion from participation in managed care plans of any category of health care provider. The enabling legislation further requires that there be choices given to the injured worker within each category of health care provider. The enabling legislation further recognizes that the existence of categories of health care providers and choices within each category is meaningless unless <u>access</u> to the health care provider of the injured worker's choice is also given. Accordingly, the enabling legislation prohibits unfair restriction of access to any health care provider profession. It is within this legislative

framework that the emergency rules adopted by the Department must be examined.

2. The Emergency Rules Fail to Provide for Direct Access and Unfairly Restrict Access to Any Category of Health Care Provider at the Time of the Injury.

The emergency rule establishes procedures and requirements for certification of managed care plans. Pt. 5218.0220 [Emergency]. Part 5218.1000 [Emergency] states the procedures for application to the Department for certification, and sets out the criteria for a proposed managed care plan in order to obtain certification. One of these criteria does not ensure direct access at the time of the injury, and states a criterion which can, and most likely will, result in the unfair restriction of access. The offending criterion in the emergency rules states as follows:

> (3) The managed care plan must include procedures to ensure that the employee will: (a) receive initial evaluation or treatment by a participating health care provider licensed in Minnesota within 24 hours of the employee's request for treatment, following a work injury. . . .

Pt. 5218.1000, subpt. 1, D.(3)(a). Conspicuously absent from this provision of the emergency rules is any language which ensures that the initial evaluation or treatment will be given by a health care provider within a category of the injured worker's choosing. The rule as written would permit a managed care plan that dictated to the injured worker what category of health care provider, and indeed what specific provider within that category, must be consulted at the time of injury for initial evaluation or treatment. This constitutes denial of direct access and unfair restriction of access in contravention of the enabling legislation.

The only cure for the existing language which would make this rule provision legal under the enabling legislation would be to adopt, at minimum, that portion of the modification previously proposed by the MCA which inserts the following language into the rule provision:

> Receive initial evaluation or treatment by a participating health care provider licensed in Minnesota and of the employee's own choosing within 24 hours of the employee's request for treatment, following a work injury; the managed care plan must include as participating providers all categories of health care providers licensed to provide care as specified in Minn. Stat. § 176.135, subd. 1(a).

Only by expressly stating that the initial evaluation or treatment is made by a health care provider of the employee's own choosing can the rule provision conform to the enabling legislation.

In addition, Pt. 5218.1000 [Emergency], subpt. 1, D.(3)(c) omits language which must be included in order to be legal under the enabling legislation. Subparagraph (c) appears to set out in rule the enabling legislation's prohibition against unfair restriction of access. The provision applies only to treatment following initial evaluation and treatment. As discussed above, this is an important and fatal omission since the enabling legislation seeks to ensure direct access at the time of the injury, as well as at later times of treatment. Minn. Stat. § 176.135, subd. 1(a).

Furthermore, if this rule provision is to be legal, it must be consistent with the enabling legislation which defines direct access in a manner different from that contained in the rule. The rule adopted by the Department states in part:

> The procedure to allow the employee to select from three health care providers must allow direct access to all health care profession disciplines if the treatment is determined to be appropriate for the condition under the managed care plan standards and the provider's scope of practice, or if the insurer approves the treatment. . . .

Pt. 5218.1000, subpt. 1, D.(3)(c). This language is not consistent with what the enabling legislation defines as constituting unfair restriction of access. Under the enabling legislation, unfair restriction of access is defined as follows:

> Direct access within the managed care plan is unfairly restricted if direct access is denied and the treatment or service sought is within the scope of practice of the profession to which direct access is sought and is appropriate under the standards of treatment adopted by the managed care plan <u>or, in instances where the Commissioner has adopted standards of treatment, the standards by the Commissioner</u>.

Minn. Stat. § 176.1351, subd. 4 (emphasis added). Missing from the rule and included in the enabling legislation is the language that the treatment or service is appropriate under either the standards of treatment adopted by the managed care plan, or the standards of treatment adopted by the Commissioner. The rule excludes the standards of treatment adopted by the Commissioner.

CONCLUSION

For the above reasons, the MCA requests the Attorney General to disapprove Pt. 5218.1000 [Emergency], subpt. 1, D.(3)(a) and (c),

because these rule provisions conflict with the enabling legislation, the rules improperly delegate the agency's power to another person or body, and the rules are unreasonable. Minn. Rules Pt. 2010.1000, C., G., and J. The rules run counter to clear mandates and prohibitions in the enabling legislation which prohibit discrimination and require direct access to all categories of health care providers. The rules improperly delegate the agency's power to the managed care plan by giving the plan the authority to dictate who will provide initial evaluation or treatment to an injured worker (Pt. 5218.1000, subpt. 1, D.(3)(a)). The rules also improperly delegate the agency's power to the managed care plan by omitting from the rule purporting to state what constitutes unfair restriction of access, the alternative criterion that treatment may be determined to be appropriate not only under the managed care plan standards, but also under standards of treatment adopted by the Commissioner. The Commissioner cannot and should not relinquish the authority to determine unfair restriction of access in accordance with the Commissioner's own standards of treatment, which is precisely the problem with Pt. 5218.1000, subpt. 1, D.(3)(c). Approval of the emergency rules with the offending provisions will make the rules vulnerable to attack on judicial review. Accordingly, the rules should be disapproved.

Thank you for your attention to these comments.

Very truly yours,

Gary A. Van Cleve

Gary A. Van Cleve, for
LARKIN, HOFFMAN, DALY & LINDGREN, Ltd.
Counsel for the Minnesota Chiropractic Association

cc: Kathryn Berger, Legal Services, Department of Labor and Industry
Scott L. Mayer, Executive Director, Minnesota Chiropractic Association

GVC:LY6s

LARKIN, HOFFMAN, DALY & LINDGREN, LTD.
ATTORNEYS AT LAW

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LARRY D. MARTIN

OF COUNSEL
WENDELL H. ANDERSON
JOSEPH QITIS
RICHARD A. NORDBYE

*ALSO ADMITTED IN WISCONSIN

October 6, 1992

Office of the Attorney General
Public Finance Division
525 Park Street, Suite 400
St. Paul, Minnesota 55103

Re: Adopted Emergency Rules of the Department of Labor and Industry, Parts 5218.0100 to .9000 [Emergency], Relating to Workers' Compensation and Managed Care

TO THE ATTORNEY GENERAL, PUBLIC FINANCE DIVISION:

This firm has been retained by the Minnesota Chiropractic Association (MCA) to represent it with respect to emergency rules adopted by the Department of Labor and Industry (the Department) governing workers' compensation managed care plans. We urge the Attorney General to disapprove two provisions of the adopted emergency rules because the provisions do not meet the standards of review that the Attorney General is bound to apply under Minn. Rules Pt. 2010.1000, subpt. C., G., and J.

Specifically, the MCA takes issue with Pt. 5218.1000 [Emergency], subp. 1, D.(3)(a) and (c). Subparagraph (a) unfairly restricts direct access to any health care provider professional at the time of the injury, in direct contravention of several provisions of the workers' compensation enabling legislation. Subparagraph (c) purports to track a requirement stated in the workers' compensation enabling legislation, but omits a very important criterion that is included within the enabling legislation.

1. <u>The Enabling Legislation Contains Specific Provisions Prohibiting Discrimination and Ensuring Direct Access By Injured Workers to Health Care Providers of Their Choice</u>.

The enabling legislation requires the employer to furnish "any medical, psychological, chiropractic, podiatric, surgical and hospital treatment . . . as may reasonably be required at the time of the injury and any time thereafter to cure and relieve from the effects of

the injury." Minn. Stat. § 176.135, subd. 1(a). Thus, the legislation acknowledges freedom of choice and prohibits discrimination against any category of health care provider at the time of the injury.

The new legislation allowing the existence of managed care plans certified by the Commissioner of Labor and Industry (the Commissioner) ensures that if the employer adopts a managed care plan, that plan must not discriminate against any category of health care provider or restrict access by the injured employee to categories of health care providers. Specifically, the criteria set out by the legislature that the Commissioner must consider and find present in order to certify an employer's managed care plan include the following:

> (10) [That the managed care plan] does not discriminate against or exclude from participation in the plan any category of health care provider and includes an adequate number of each category of health care providers to give workers convenient geographical accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan.

Minn. Stat. § 176.1351, subd. 2(10). Furthermore, the enabling legislation gives the Commissioner authority to refuse to certify a managed care plan, or to revoke or suspend certification of a managed care plan "that unfairly restricts direct access within the managed care plan to any health care provider profession." Minn. Stat. § 176.1351, subd. 4. Subdivision 4 thus creates a prohibition against a managed care plan unfairly restricting access to any health care provider profession. The sanction for unfairly restricting access is either withholding certification or decertification.

The enabling legislation defines what constitutes unfair restriction of access. A managed care plan unfairly restricts access to a health care provider profession when it (1) denies direct access, and (2) the treatment or service sought is within the scope of practice of the profession to which direct access is sought, and (3) the treatment or service is appropriate under (a) standards of treatment adopted by the managed care plan, or (b) standards of treatment adopted by the Commissioner.

Accordingly, the enabling legislation prohibits discrimination or exclusion from participation in managed care plans of any category of health care provider. The enabling legislation further requires that there be choices given to the injured worker within each category of health care provider. The enabling legislation further recognizes that the existence of categories of health care providers and choices within each category is meaningless unless <u>access</u> to the health care provider of the injured worker's choice is also given. Accordingly, the enabling legislation prohibits unfair restriction of access to any health care provider profession. It is within this legislative

framework that the emergency rules adopted by the Department must be examined.

2. The Emergency Rules Fail to Provide for Direct Access and Unfairly Restrict Access to Any Category of Health Care Provider at the Time of the Injury.

The emergency rule establishes procedures and requirements for certification of managed care plans. Pt. 5218.0220 [Emergency]. Part 5218.1000 [Emergency] states the procedures for application to the Department for certification, and sets out the criteria for a proposed managed care plan in order to obtain certification. One of these criteria does not ensure direct access at the time of the injury, and states a criterion which can, and most likely will, result in the unfair restriction of access. The offending criterion in the emergency rules states as follows:

> (3) The managed care plan must include procedures to ensure that the employee will: (a) receive initial evaluation or treatment by a participating health care provider licensed in Minnesota within 24 hours of the employee's request for treatment, following a work injury. . . .

Pt. 5218.1000, subpt. 1, D.(3)(a). Conspicuously absent from this provision of the emergency rules is any language which ensures that the initial evaluation or treatment will be given by a health care provider within a category of the injured worker's choosing. The rule as written would permit a managed care plan that dictated to the injured worker what category of health care provider, and indeed what specific provider within that category, must be consulted at the time of injury for initial evaluation or treatment. This constitutes denial of direct access and unfair restriction of access in contravention of the enabling legislation.

The only cure for the existing language which would make this rule provision legal under the enabling legislation would be to adopt, at minimum, that portion of the modification previously proposed by the MCA which inserts the following language into the rule provision:

> Receive initial evaluation or treatment by a participating health care provider licensed in Minnesota and of the employee's own choosing within 24 hours of the employee's request for treatment, following a work injury; the managed care plan must include as participating providers all categories of health care providers licensed to provide care as specified in Minn. Stat. § 176.135, subd. 1(a).

Only by expressly stating that the initial evaluation or treatment is made by a health care provider of the employee's own choosing can the rule provision conform to the enabling legislation.

In addition, Pt. 5218.1000 [Emergency], subpt. 1, D.(3)(c) omits language which must be included in order to be legal under the enabling legislation. Subparagraph (c) appears to set out in rule the enabling legislation's prohibition against unfair restriction of access. The provision applies only to treatment following initial evaluation and treatment. As discussed above, this is an important and fatal omission since the enabling legislation seeks to ensure direct access at the time of the injury, as well as at later times of treatment. Minn. Stat. § 176.135, subd. 1(a).

Furthermore, if this rule provision is to be legal, it must be consistent with the enabling legislation which defines direct access in a manner different from that contained in the rule. The rule adopted by the Department states in part:

> The procedure to allow the employee to select from three health care providers must allow direct access to all health care profession disciplines if the treatment is determined to be appropriate for the condition under the managed care plan standards and the provider's scope of practice, or if the insurer approves the treatment. . . .

Pt. 5218.1000, subpt. 1, D.(3)(c). This language is not consistent with what the enabling legislation defines as constituting unfair restriction of access. Under the enabling legislation, unfair restriction of access is defined as follows:

> Direct access within the managed care plan is unfairly restricted if direct access is denied and the treatment or service sought is within the scope of practice of the profession to which direct access is sought and is appropriate under the standards of treatment adopted by the managed care plan <u>or, in instances where the Commissioner has adopted standards of treatment, the standards by the Commissioner</u>.

Minn. Stat. § 176.1351, subd. 4 (emphasis added). Missing from the rule and included in the enabling legislation is the language that the treatment or service is appropriate under either the standards of treatment adopted by the managed care plan, or the standards of treatment adopted by the Commissioner. The rule excludes the standards of treatment adopted by the Commissioner.

CONCLUSION

For the above reasons, the MCA requests the Attorney General to disapprove Pt. 5218.1000 [Emergency], subpt. 1, D.(3)(a) and (c),

because these rule provisions conflict with the enabling legislation, the rules improperly delegate the agency's power to another person or body, and the rules are unreasonable. Minn. Rules Pt. 2010.1000, C., G., and J. The rules run counter to clear mandates and prohibitions in the enabling legislation which prohibit discrimination and require direct access to all categories of health care providers. The rules improperly delegate the agency's power to the managed care plan by giving the plan the authority to dictate who will provide initial evaluation or treatment to an injured worker (Pt. 5218.1000, subpt. 1, D.(3)(a)). The rules also improperly delegate the agency's power to the managed care plan by omitting from the rule purporting to state what constitutes unfair restriction of access, the alternative criterion that treatment may be determined to be appropriate not only under the managed care plan standards, but also under standards of treatment adopted by the Commissioner. The Commissioner cannot and should not relinquish the authority to determine unfair restriction of access in accordance with the Commissioner's own standards of treatment, which is precisely the problem with Pt. 5218.1000, subpt. 1, D.(3)(c). Approval of the emergency rules with the offending provisions will make the rules vulnerable to attack on judicial review. Accordingly, the rules should be disapproved.

Thank you for your attention to these comments.

Very truly yours,

Gary A. Van Cleve

Gary A. Van Cleve, for
LARKIN, HOFFMAN, DALY & LINDGREN, Ltd.
Counsel for the Minnesota Chiropractic Association

cc: Kathryn Berger, Legal Services, Department of Labor and Industry
Scott L. Mayer, Executive Director, Minnesota Chiropractic Association

GVC:LY6s

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RICHARD A. HORDBYE

* ALSO ADMITTED IN WISCONSIN

FACSIMILE COVER SHEET

TO: Office of the Attorney General
Attn: Patricia Nolte

FAX NUMBER: 297-2576

FROM: Gary A. Van Cleve

TELEPHONE NO. 896-3277

DATE: 10/6/92

FILE: 15,501-02

Number of pages sent including cover sheet: 6

********** M E S S A G E **********

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IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE AND RETURN THE ORIGINAL MESSAGE TO US AT THE ABOVE ADDRESS VIA THE U.S. POSTAL SERVICE. THANK YOU.

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In The Matter of the Proposed Adoption of the Rule of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

DECLARATION OF COUNSEL

I, Gilbert S. Buffington, Special Assistant Attorney General, do hereby declare that I have examined the above-captioned rule, and the supporting rulemaking record, and that, based on my examination, the Administrative Procedure Act and Minnesota Rules, chapter 2010 have been followed. Any exceptions are listed below. For Attorney General billing purposes, the four-digit docket client code is .0600

Gilbert S. Buffington
Special Assistant
Attorney General

Dated: Sept 28, 1992

Minnesota
Department of Labor and Industry

443 Lafayette Road
St. Paul, Minnesota 55155
(612) 296-6107

Telecommunication Device
for the Deaf (612) 297-4198

FAX (612) 297-1329

July 17, 1992

The Honorable Wayne Simoneau
Chair-House Appropriations Committee
365 State Office Building
St. Paul, Minnesota 55155

Re: Fee for Workers' Compensation Managed Care

Dear Representative Simoneau:

Enclosed please find pursuant to Minn. Stat. § 16A.128, subd. 2a, a copy of the proposed workers' compensation managed care emergency rules. The rules set a fee of $1,500 for Department certification of managed care plans.

Sincerely,

Kathryn Berger

Kathryn Berger
Compensation Attorney

KB/cb

Enclosure

An Equal Opportunity Employer

Minnesota
Department of Labor and Industry

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St. Paul, Minnesota 55155
(612) 296-6107

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FAX (612) 297-1329

July 17, 1992

The Honorable Gene Merriam
Chair-Senate Finance Committee
Room 122 State Capitol
St. Paul, Minnesota 55155

Re: Fee for Workers' Compensation Managed Care

Dear Senator Merriam:

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Sincerely,

Kathryn Berger

Kathryn Berger
Compensation Attorney

KB/cb

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July 23, 1992

The Honorable Gene Merriam
Chair-Senate Finance Committee
Room 122 State Capitol
St. Paul, Minnesota 55155

Re: Fee for Workers' Compensation Managed Care

Dear Senator Merriam:

Enclosed please find pursuant to Minn. Stat. § 16A.128, subd. 2a, a copy of the proposed workers' compensation managed care emergency rules as submitted to the State Register for publication. A copy of the rules was provided to you on July 17, 1992 but some minor clarifying changes were made on July 20, just prior to submission to the State Register. The changes do not change the fee for certification, which remains at $1,500.

Sincerely,

Kathryn Berger

Kathryn Berger
Compensation Attorney

KB/cb

Enclosure

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Department of Labor and Industry

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July 23, 1992

The Honorable Wayne Simoneau
Chair-House Appropriations Committee
365 State Office Building
St. Paul, Minnesota 55155

Re: Fee for Workers' Compensation Managed Care

Dear Representative Simoneau:

Enclosed please find pursuant to Minn. Stat. § 16A.128, subd. 2a, a copy of the proposed workers' compensation managed care emergency rules as submitted to the State Register for publication. A copy of the rules was provided to you on July 17, 1992 but some minor clarifying changes were made on July 20, just prior to submission to the State Register. The changes do not change the fee for certification, which remains at $1,500.

Sincerely,

Kathryn Berger

Kathryn Berger
Compensation Attorney

KB/cb

Enclosure

An Equal Opportunity Employer

STATE OF MINNESOTA

Office Memorandum

Department: of Finance

Date: July 23, 1992

To: Kathryn Berger, Compensation Attorney
Department of Labor and Industry

From: Bruce J. Reddemann, Director BJR
Budget Operations

Phone: 296-5188

Subject: Proposed Fee - Managed Care Certification

The proposed fee as submitted on a memorandum dated July 17, 1992, has been reviewed and is hereby approved for the commissioner to establish a new application fee under M.S. 176.1351, Subd. 1 (1992 Laws, Chapter 510):

1. Application Fee for Managed Care Certification $1500.00

It is my understanding that this approved fee will be charged for fiscal year 1993.

cc: Jim King
Glenn Olson
Charlie Bieleck
John Heintz

Minnesota
Department of Labor and Industry

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July 17, 1992

Post-it™ brand fax transmittal memo 7671	# of pages ▸
To Dale Nelson	From Kate Berger
Co.	Co. L + I
Dept. Finance	Phone # 7-4791
Fax # 6-8685	Fax #

Dale Nelson (for Jim King)
Department of Finance
400 Centennial Building
658 Cedar Street
St. Paul, Minnesota 55155

Dear Mr. Nelson:

I am submitting for your review, pursuant to M. S. § 16A.128, a copy of the proposed workers' compensation managed care emergency rules, which set a fee for $1,500.00 for Department certification. Also enclosed is the fee review analysis by Anina Bearrood of our Accounting Unit.

Please contact me at 297-4791 with questions.

Sincerely,

1992 LAWS
Chapter 510

Kathryn Berger

Kathryn Berger
Compensation Attorney

KB/cb

Enclosure

Department of Finance
FEE REVIEW

Date Prepared: July 17, 1992

Department/Agency: LABOR AND INDUSTRY

Budget Activity: Workers' Comp. Rehab. and Medical Affairs

Fee Name: Managed Care Certification

Legal Citation: M.S. 176.1351, Subd. 1

Fee Set By: ☐ Law ☒ Agency

Purpose of Fee: To cover the costs incurred in processing applications for certification.

☐ Dedicated ☒ Non-Dedicated

Revenue Code: 310

APID: 21400:99

Fund: 10

Accumulated Difference Thru 1988: N/A

Dollars NOT in Thousands

Fiscal Year	Actual F.Y. 89	Actual F.Y. 90	Estimated F.Y. 91	Requested F.Y. 92	Requested F.Y. 93
Actual/Anticipated Receipts	N/A	N/A	N/A	N/A	7,500
Less Actual/Anticipated Costs					7,200
Current Difference					300
Accumulated Difference					300
Number Paying Fee					5
Present Fee					1,500
Date Fee Last Changed					N/A

Remarks:
Because we have never performed this activity, we have no really good basis for our estimates of either the number of organizations applying or the time involved in processing the applications. Our best guess is that, for these emergency rules, we will have about five organizations applying for certification. We estimate that it will require approximately 50 hours of professional time and 24 hours of clerical time to process each certification. Therefore, we would like to set our fee at $1,500 per certification application. This is the same amount that is presently charged by the Minn. Dept. of Health and by the State of Oregon for similar activities. This fee is expected to be effective for approximately one year.

Department Authorized Signature: Cenina Bearrood

Finance Department Recommendation:

Executive Budget Officer Signature:

FI-00194-07 (3/90)

The Minnesota

State Register

Department of Administration—Print Communications Division



Rules edition
Published every Monday
(Tuesday if Monday is a holiday)

Monday 27 July 1992

Volume 17, Number 4

Pages 129-172

Emergency Rules

Proposed Emergency Rules

According to Minn. Stat. of 1984, §§14.29-14.30, state agencies may propose adoption of emergency rules if: 1) expressly required; 2) authorized by statute; or 3) if the manner permitted by a directive (given by statute, federal law or court order) does not allow for compliance with sections 14.14-14.28. The agency must, however, publish a notice of intent to adopt emergency rules, along with the rules themselves, in the *State Register*. The notice must advise the public:

1) that a free copy of the proposed emergency rule is available upon request from the agency;
2) that notice of the date that the rule is submitted to the attorney general will be mailed to persons requesting notification;
3) that the public has at least 25 days after publication of the proposed emergency rule to submit data and views in writing; and
4) that the emergency rule may be modified if the data and views submitted support such modification.

Adopted Emergency Rules

Emergency rules take effect five working days after approval by the attorney general, and after compliance with Minn. Stat. §§14.29-14.365. As soon as possible, emergency rules are published in the *State Register* in the manner provided for in section 14.18.

Emergency rules are effective for the period stated in the notice of intent to adopt emergency rules. This may not exceed 180 days.

Continued/Extended Emergency Rules

Adopted emergency rules may be continued in effect (extended) for an additional 180 days. To do this, the agency must give notice by: 1) publishing notice in the *State Register*: and 2) mailing the same notice to all persons who requested notification on rulemaking. No emergency rule may remain in effect 361 days after its original effective date. At that point, permanent rules adopted according to Minn. Stat. 14.14-14.28 supercede emergency rules.

Department of Labor and Industry

Proposed Emergency Rules Relating to Workers' Compensation; Managed Care

Notice of Intent to Adopt an Emergency Rule

NOTICE IS HEREBY GIVEN that the State Department of Labor and Industry intends to adopt the above-entitled emergency rules. The statutory authority to adopt the emergency rules is contained in *Minnesota Statutes*, section 176.1351, subd. 6 (*1992 Laws of Minnesota*, Chapter 510, Article 4, § 13). The agency, in adopting the rules, is following the procedures set forth in the Administrative Procedure Act for adopting emergency rules in *Minnesota Statutes*, sections 14.29 to 14.36.

All persons have 25 days after publication to submit data and views on the proposed emergency rules or any part or subpart of the rules in writing. Comments must be received by 4:30 p.m. on August 21, 1992. Comments must be submitted to:

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesoa 55155-4316
Telephone: (612) 297-5213

A copy of the proposed rules is attached to this notice.

A free copy of the proposed emergency rules is available by contacting Janice Keesling, Rehabilitation and Medical Affairs at (612) 296-8213.

The proposed emergency rules may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed emergency rules as noticed.

Upon adoption of the emergency rules by the agency, the emergency rules as adopted and its supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rules, must submit the written request to Pam Zembal at the above address.

The emergency rules will take affect five working days after approval by the Attorney General and be effective for 180 days. The

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

emergency rules will be continued in effect for an additional 180 days if the agency gives notice of continuation in accordance with *Minnesota Statutes*, section 14.35.

A fiscal note is not required by *Minnesota Statutes* § 14.11 because the rules do not require the expenditure of public money by local public bodies.

Dated 20 July 1992

John B. Lennes, Jr.
Commissioner

Rules as Proposed (all new material)

5218.0100 [Emergency] DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 5218.0100 to 5218.9000 [Emergency] have the meanings given them in this part.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Labor and Industry or a designee.

Subp. 3. **Emergency care.** "Emergency care" means professional health services necessary to preserve life or limb.

Subp. 4. **Employee.** "Employee" means an employee entitled to treatment of a work injury under *Minnesota Statutes*, section 176.135.

Subp. 5. **Geographical service area.** "Geographical service area" means those counties in which a managed care plan has been certified to provide comprehensive health care services to injured employees.

Subp. 6. **Health care provider.** "Health care provider" has the meaning given in *Minnesota Statutes*, section 176.011, subdivision 24.

Subp. 7. **Insurer.** "Insurer" means the insurer providing workers' compensation insurance required by *Minnesota Statutes*, chapter 176, and includes a self-insured employer.

Subp. 8. **Managed care plan.** "Managed care plan" means a plan certified by the commissioner that provides for the management of treatment to injured employees under *Minnesota Statutes*, sections 176.135 and 176.1351.

Subp. 9. **Participating health care provider.** "Participating health care provider" means any person, provider, company, professional corporation, organization, or business entity with which the managed care plan has contracts or other agreements.

Subp. 10. **Physician.** "Physician" has the meaning given in *Minnesota Statutes*, section 176.135, subdivision 2a.

Subp. 11. **Revocation.** "Revocation" means a permanent revocation of a managed care plan's certification to provide services under parts 5218.0100 to 5218.9000 [Emergency].

Subp. 12. **Suspension.** "Suspension" means a stopping by the commissioner of the managed care plan's authority to enter into new contracts with insurers for a specified period of time.

5218.0210 [Emergency] AUTHORITY.

Parts 5218.0100 to 5218.9000 [Emergency] are adopted under the commissioner's emergency rulemaking authority under *Minnesota Statutes*, section 176.1351, subdivision 6.

5218.0220 [Emergency] PURPOSE AND SCOPE.

The purpose of parts 5218.0100 to 5218.9000 [Emergency] is to establish procedures and requirements relating to the delivery of medical services to injured employees within the workers' compensation system under a managed care plan certified by the commissioner under *Minnesota Statutes*, sections 176.135, subdivision 1, paragraph (f), and 176.1351.

5218.0230 [Emergency] EFFECTIVE DATE.

A managed care plan certified under the emergency rulemaking authority will receive provisional certification that will expire 60 days after adoption of the permanent rules unless otherwise provided for in the permanent rules.

5218.1000 [Emergency] APPLICATION FOR CERTIFICATION.

Subpart 1. **Provisional certification.** Any person or entity may make written application to the commissioner to provide managed care to injured employees for injuries and diseases compensable under *Minnesota Statutes*, chapter 176, under a plan certified by the commissioner. To obtain provisional certification of a plan, the requirements in items A to D must be complied with and documented.

A. The plan must identify any directors and officers of the managed care plan; the title and name of the person to be the day-to-day administrator of the managed care plan; the title and name of the person to be the administrator of the financial affairs of the managed care plan; and the name, address, and telephone number of a contact person.

B. The total annual compensation paid to an administrator, director, or executive officer of the managed care plan shall not exceed ten times the average annual wage as calculated in *Minnesota Statutes*, section 176.011, subdivision 20. The limit on compen-

sation under this subpart does not include payment received by a health care provider for actual medical services rendered to an employee under *Minnesota Statutes*, chapter 176.

C. Each application for certification must be accompanied by a nonrefundable fee of $1,500.

D. Additional documentation must be submitted as specified in subitems (1) to (11).

(1) The managed care plan must provide a list of the names, addresses, and specialties of the participating health care providers who will provide services under the managed care plan, together with a statement that all licensing, registration, or certification requirements have been met for the health care provider to practice in Minnesota.

(2) The managed care plan must provide a description of the times, places, and manner of providing services under the plan, including a description of the initial geographical service area, designated by county. The plan must comply with units (a) and (b).

(a) The managed care plan must provide quality services that meet uniform treatment standards prescribed by the commissioner and all medical and health care services that may be required by *Minnesota Statutes*, chapter 176, in a manner that is timely, effective, and convenient for the employee.

(b) The managed care plan may not discriminate against or exclude from participation in the plan any category of health care providers and must include an adequate number of each category of health care providers to give employees convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan, provided that the treatment is medically appropriate.

(3) The managed care plan must include a procedure to ensure that the employee will:

(a) receive initial evaluation by a participating physician within 24 hours of a request for treatment, following a work injury; the managed care plan may permit initial evaluations by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or a chiropractor;

(b) receive initial evaluation by a participating physician within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan under part 5218.5000 [Emergency], subpart 1, item A. The managed care plan may permit an initial evaluation by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or chiropractor;

(c) initially choose from at least three health care providers to whom the employee has been referred by the evaluating provider under unit (a) or (b) for treatment, and allow the employee to change providers within the managed care plan at least once. The procedure to allow the employee to select a health care provider must provide direct access to all health care profession disciplines if the treatment is determined to be appropriate for the condition by the evaluating health care provider under unit (a) or (b) or if the insurer approves the treatment;

(d) receive treatment or consultation by a managed care plan physician in cases requiring emergency in-patient hospitalization;

(e) receive information or advice on a 24-hour basis regarding medical services available within the managed care plan; and

(f) have access to health care providers within 30 miles of the employee's place of employment or residence, or the distance the employee normally travels to work, considering the normal patterns of travel, whichever is furthest.

(4) The managed care plan must designate the procedures and criteria for approval of services from a health care provider outside the managed care plan according to part 5218.5000 [Emergency].

(5) The application must include copies of contract agreements or other documents signed by each participating health care provider. Contractual provisions must be consistent with *Minnesota Statutes*, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency]. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts submitted must include a list of signatories to the contract.

(6) The managed care plan must designate the name, address, and phone number of a communication liaison for the department and the insurer.

(7) The managed care plan must include a procedure for peer review, utilization review, and internal dispute resolution in accordance with *Minnesota Statutes*, section 176.1351, subdivision 2, paragraph (4), including a method to resolve complaints by injured employees, medical providers, and insurers.

(8) The managed care plan must include a procedure to notify the commissioner of the commencement or termination of participating health care providers.

(9) The managed care plan must describe how employers and insurers will be provided with information that will inform employees of all choices of medical service providers within the plan and how employees can gain access to those providers.

(10) The managed care plan must describe how it will provide aggressive case management for injured employees, and a program for early return to work and cooperative efforts by the employees, the employer, and the managed care plan to promote workplace health and safety consultative and other services.

(11) The managed care plan must submit treatment standards for medical services not already prescribed by the commissioner. All managed care plan health care providers and health care providers described in part 5218.5000 [Emergency] will be governed by these standards.

Subp. 2. **Notification; approval or denial.** The commissioner shall notify the applicant in writing of the approval or denial of certification. If certification is granted, the commissioner shall notify the managed care plan applicant of the effective date of the certification and the initial geographical service area approved. If the certification is denied, the applicant will be provided with the reason for the denial. The commissioner must require an in-person meeting if necessary to determine compliance with parts 5218.0100 to 5218.9000 [Emergency]. Modification of the plan as certified shall require approval before it may be implemented.

5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN.

Subpart 1. **Scope.** A managed care plan shall provide comprehensive medical services according to its certification and *Minnesota Statutes*, chapter 176, and all other applicable statutes and rules.

Subp. 2. **Geographical service area; expansion.** The commissioner shall designate a managed care plan's initial geographical service area and approve any expansions to the managed care plan's service area. Injured employees shall not be covered by a managed care plan until the commissioner has approved the proposed expansion of the geographical service area.

Subp. 3. **Contracts.** When a managed care plan contracts with an insurer to provide services, the contract shall specify those employers covered by the contract and the estimated number of covered employees. The managed care plan contract must include the terms and conditions in items A to F.

A. The employer's place of employment must be within the authorized geographical service area.

B. Insurers may contract with multiple managed care plans to provide coverage for employers. When insurers contract with multiple managed care plans to cover the same employer, each employee shall have initial choice at time of injury to select the managed care plan that will manage the employee's care.

C. An employee with a compensable injury under *Minnesota Statutes*, chapter 176, occurring on or after the effective date of the managed care plan contract shall receive medical services in the manner prescribed by the terms and conditions of the managed care plan contract.

D. The requirements established in parts 5218.0100 to 5218.9000 [Emergency] do not apply to an employee with a compensable injury under *Minnesota Statutes*, chapter 176, that occurred before the effective date of the managed care plan contract, until the employee requests a change of doctor. At that time, further services shall be provided by the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by health care providers who are not participating providers must be delivered according to part 5218.5000 [Emergency].

E. To ensure continuity of care, the managed care plan contract shall specify the manner in which an injured employee with a compensable injury will receive medical services when a managed care plan contract terminates. When managed care plan coverage for an injured employee is being transferred from one managed care plan to another, the employee may continue to treat with the employee's original health care provider until the employee requests a change of doctor. At that time further services shall be provided under the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by providers who are not participating providers must be performed according to part 5218.5000 [Emergency].

F. Except as provided in part 5218.5000 [Emergency], an employer may require an employee who is claiming a workers' compensation injury to receive treatment from a managed care plan before the employer accepts or denies liability for the injury. In such cases the employer is liable for the cost of any treatment given before notice is given to the employee of a denial of liability, even if the employer is later determined to be not liable for the claimed injury.

The employee may receive treatment from any health care provider chosen by the employee after a notice of denial of liability has been given to the employee, or if the employer does not require the employee to receive treatment from a managed care plan prior to accepting liability for a claimed injury. If the employer later accepts liability or is determined by the commissioner, a compensation judge, or an appellate court to be liable for the claimed injury, the employer is responsible for the cost of all reasonable and necessary medical treatment received by the employee. Once the employer has admitted liability for the claimed injury or once the employer has been determined to be liable for the claimed injury, the employer may require that further medical treatment be received through the managed care plan unless the employee had a documented history of treatment with the health care provider as described in part 5218.5000 [Emergency], before the injury.

Subp. 4. **Restrictions.** When an insurer contracts with a single managed care plan for coverage for an employer, the plan may not

be formed, operated, or administered by the same employer or insurer. When an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, formed, or administered by the employer or insurer. No employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under *Minnesota Statutes*, chapter 176.

5218.3000 [Emergency] REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN.

Subpart 1. **Contracts; modifications.** A managed care plan shall provide the commissioner with a copy of a managed care plan insurer contract and managed care plan participating provider contract agreements, signed by the parties, within 30 days of execution of the contracts. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts shall include a list of signatories. Amendments and addendums to the contracts shall also be submitted to the commissioner within 30 days of execution. Contract provisions shall be consistent with *Minnesota Statutes*, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency].

Subp. 2. **Requirements.** Within six months of provisional certification, each managed care plan shall provide the following information in a form and format prescribed by the commissioner:

A. a current listing of participating health care providers, including provider names, specialty, business address, and phone number, and for any new health care provider the information required by part 5218.1000 [Emergency], subpart 1, item D, subitem (1);

B. a listing of all health care providers outside of the managed care plan who provided services to employees under part 5218.5000 [Emergency];

C. a listing of all employers covered by each contract including the employer's names, unemployment insurer's identification number, and estimated number of employees governed by the managed care plan contract;

D. a summary of any sanctions or punitive actions taken by the managed care plan against its members;

E. a report that summarizes peer review and utilization review performed showing cases reviewed, issues involved, and action taken. The review must include, but is not limited to, evaluation of compliance with treatment standards adopted by the commissioner; and

F. any proposed changes to the managed care plan as certified by the commissioner.

Subp. 3. **Insurers; data.** The managed care plan must report to the insurer any data regarding medical services and supplies required by the insurer to determine compensability, and any other data required by rule.

Subp. 4. **Monitoring.** The commissioner shall require additional information from the managed care plan as necessary to monitor the managed care plan's compliance with parts 5218.0100 to 5218.9000 [Emergency] and *Minnesota Statutes*, section 176.1351.

5218.4000 [Emergency] COMMENCEMENT AND TERMINATION OF PARTICIPATING PROVIDERS.

Subpart 1. **Commencement.** Prospective new participating health care providers under a managed care plan shall submit an application to the managed care plan. A director, executive director, or administrator may approve the application under the requirements of the managed care plan. The managed care plan shall verify that each new participating health care provider meets all licensing, registration, and certification requirements necessary to practice in Minnesota.

Subp. 2. **Termination.** A participating provider may elect to terminate participation in the managed care plan or be subject to cancellation by the managed care plan under the requirements of the managed care plan. Upon termination of a provider, the managed care plan shall make alternate arrangements to provide continuing medical services for an affected injured employee under the plan.

5218.5000 [Emergency] HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subpart 1. **Authorized services.** The managed care plan shall authorize a health care provider who is not a participating health care provider to provide medical services to an employee in the following circumstances:

A. if the health care provider maintains the employee's medical records and has a documented history of treatment of that employee before the date of injury. If the employee requests a change of doctor, further services shall be provided by the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c);

B. for emergency treatment; or

C. when referred outside the managed care plan for medical services by the managed care plan.

Subp. 2. **Requirements.** A health care provider who is not a participating health care provider must:

A. agree to comply with the managed care plan treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures; and

B. agree to refer the covered employee to the managed care plan for specialized care, which includes, but is not limited to, physical therapy and diagnostic testing.

Subp. 3. **Disputes.** Any dispute under subpart 1 or 2 relating to the employee's selection of a health care provider who is not a managed care plan participating health care provider shall be resolved according to part 5218.7000 [Emergency]. Any dispute relating to a health care provider's compliance with the managed care plan standards and procedures or treatment standards adopted by the commissioner shall be resolved according to part 5218.7000 [Emergency] or *Minnesota Statutes*, section 176.103.

5218.6000 [Emergency] CHARGES AND FEES.

Billings for medical services under a managed care plan shall be submitted in the form and format as prescribed in part 5221.0700, subpart 2. The payment by the insurer or the managed care plan to participating and nonparticipating health care providers for medical services shall be according to the timeframes and procedures in part 5221.0600, subpart 3, and *Minnesota Statutes*, section 176.135, subdivision 6, and shall be the maximum amount allowed under *Minnesota Statutes*, section 176.136.

5218.7000 [Emergency] DISPUTE RESOLUTION.

Disputes that arise between the employee and the managed care plan related to delivery of health services shall first be processed through the dispute resolution process of the managed care plan. The managed care plan dispute resolution process must be completed within 30 days of receipt of a request. If the dispute cannot be resolved, the commissioner may issue an order to resolve the dispute under *Minnesota Statutes*, sections 176.106 and 176.305 or 176.2615.

5218.8000 [Emergency] MONITORING.

Subpart 1. **Audits.** The commissioner shall monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements.

Subp. 2. **Records.** All records of the managed care plan and its participating health care providers shall be disclosed on request of the commissioner when necessary to ensure compliance with *Minnesota Statutes*, section 176.1351. These records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes.

5218.9000 [Emergency] SUSPENSION; REVOCATION.

Subpart 1. **Complaints; investigation.** Complaints pertaining to violations of parts 5218.0100 to 5218.9000 [Emergency] by the managed care plan shall be directed in writing to the commissioner. On receipt of a written complaint, or after monitoring the managed care plan operations, the department shall investigate the alleged rule violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the department determines on completion of the investigation that there has been a rule violation warranting suspension or revocation of provisional certification, the commissioner shall initiate a contested case proceeding under *Minnesota Statutes*, chapter 14.

Subp. 2. **Criteria.** Under *Minnesota Statutes*, section 176.1351, subdivision 5, the provisional certification of a managed care plan issued by the commissioner shall be suspended or revoked by the commissioner if:

A. service under the plan is not being provided according to the terms of the certified plan;

B. the plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of parts 5218.0100 to 5218.9000 [Emergency] or *Minnesota Statutes*, section 176.1351;

C. the managed care plan fails to comply with *Minnesota Statutes*, section 176.1351, parts 5218.0100 to 5218.9000 [Emergency], and requirements of utilization and treatment standards adopted under *Minnesota Statutes*, section 176.83;

D. any false or misleading information is submitted by the managed care plan or a member of the plan; or

E. the managed care plan continues to use the services of a health care provider whose license has been suspended or revoked by the licensing board, or under *Minnesota Statutes*, section 176.103, or who is ineligible to provide treatment to an injured employee under *Minnesota Statutes*, section 256B.0644.

Subp. 3. **Effects.** All contracts with insurers are void if a managed care plan's provisional certification is revoked. Upon suspension of certification, the managed care plan may continue to provide services under contracts in effect if the commissioner determines injured employees will continue to receive necessary medical services under *Minnesota Statutes*, section 176.135.

Minnesota
Department of Labor and Industry

443 Lafayette Road
St. Paul, Minnesota 55155
(612) 296-6107

Telecommunication Device
for the Deaf (612) 297-4198

FAX (612) 297-1329

September 28, 1992

Office of the Attorney General
Public Financial Division
525 Park Street - Suite 400
St. Paul, MN 55103

Re: Department of Labor and Industry, Workers' Compensation, Managed Care, Emergency Rules

To The Office of the Attorney General:

Pursuant to Minnesota Rules, Part 5020.0400, enclosed please find the following documents regarding the above emergency rules:

1. A photocopy of the Notice of Solicitation of Outside Information, as published in the State Register;

2. A copy of the proposed emergency rules with the Revisor's certificate of approval as to form;

3. The Notice of Intent to Adopt the Emergency Rules as mailed;

4. The Affidavit of Mailing the Notice of Intent to Adopt the Emergency Rules, to those on the Department's Workers' Compensation Mailing List, a separate Certificate of Mailing list, and also an Affidavit of Discretionary Mailing.

5. A photocopy of the Notice of Intent to Adopt Emergency Rules as published in the State Register.

6. Four copies of the emergency rules as adopted, with the Revisor's Certificate of Approval as to form;

7. The Findings of Fact, Conclusions and Order adopting the emergency rules;

8. All timely received submissions and comments on the rule, and a copy of the record of a public meeting held on Medical Rules on July 17, 1992. Also included are untimely comments, received after August 21, 1992.

An Equal Opportunity Employer

9. Notice of the proposed fee to the Chair of the House Appropriations and Senate Finance Committees and approval of the fee by the Commissioner of Finance. It is unclear whether the requirements of M.S. 16A.128 apply to emergency rules, because they are not referenced in M.R. 2010.0400. However, the agency provided the notices and obtained the approval in the event the requirements do apply.

10. The Declaration of Counsel.

11. The Notice of Submission of the Emergency Rules to the Attorney General.

12. The Affidavit of Mailing the Notice of Submission to the Attorney General.

Please contact me at 297-4791 if you need further information.

Sincerely,

Kathryn Berger

Kathryn Berger, Attorney
Department of Labor and Industry

KB/kmpy

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed
Adoption of Emergency Rules of the State
Department of Labor and Industry,
Governing Workers' Compensation
Managed Care Plans

NOTICE OF INTENT TO ADOPT AN EMERGENCY RULE

(1) Notice is hereby given that the State Department of Labor and Industry intends to adopt the above-entitled emergency rules. The statutory authority to adopt the emergency rules is contained in Minnesota Statutes, section 176.1351, subd. 6 (1992 Laws of Minnesota, Chapter 510, Article 4, § 13). The agency, in adopting the rules, is following the procedures set forth in the Administrative Procedure Act for adopting emergency rules in Minnesota Statutes, sections 14.29 to 14.36.

(2) All persons have 25 days after publication to submit data and views on the proposed emergency rules or any part or subpart of the rules in writing. (3) Comments must be received by 4:30 p.m. on August 21, 1992. Comments must be submitted to:

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316
Telephone: (612) 297-5213

(4) A copy of the proposed rules is attached to this notice.

(5) A free copy of the proposed emergency rules is available by contacting Janice Keesling, Rehabilitation and Medical Affairs at (612) 296-8213.

(6) The proposed emergency rules may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed emergency rules as noticed.

(7) Upon adoption of the emergency rules by the agency, the emergency rules as adopted and its supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rules, must submit the written request to Pam Zembal at the above address.

(8) The emergency rules will take effect five working days after approval by the Attorney General and be effective for 180 days. The emergency rules will be continued in effect for an additional 180 days if the agency gives notice of continuation in accordance with Minnesota Statutes, section 14.35.

(9) A fiscal note is not required by Minnesota Statutes § 14.11 because the rules do not require the expenditure of public money by local public bodies.

7/20/92
Date

FOR
JOHN B. LENNES, JR.
Commissioner

KB/cj (190-1)

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Adoption of the Rule of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

NOTICE OF SUBMISSION OF EMERGENCY RULE TO THE ATTORNEY GENERAL

Pursuant to your request and in accordance with Minnesota Statutes, section 14.32:

PLEASE TAKE NOTICE that the above-captioned emergency rule as adopted has been submitted to the Office of the Attorney General on the date of this notice, September 28, 1992, for review as to legality and form to the extent form relates to legality. The proposed emergency rule, the rule as adopted, all the notices, all written comments received and other required documents also have been submitted to the attorney general.

The proposed emergency rule which was published in the State Register and made available to the public on July 27, 1992, has been modified. A copy of the rule as modified is enclosed with this notice.

The rule must be approved or disapproved by the Attorney General on the tenth working day following date of receipt of the rule. You may submit written comments to the Attorney General. Any written comments must be submitted within seven working days of the date of this notice. Your comments must address only the issue of legality of the rule or the legality of the specific parts or subparts of the rule. The attorney general standards for review are set forth in Minnesota Rules, part 2010.1000. You may receive a copy of the attorney general decision upon written request to the attorney general. Your comments or requests for the decision must be directed to:

The Office of the Attorney General
Public Finance Division
525 Park Street - Suite 400
Saint Paul, Minnesota 55103
Telephone: (612) 297-2040

Any written comments submitted to the attorney general must be submitted simultaneously to:

Kathryn Berger
Legal Services
Department of Labor and Industry
443 Lafayette Road North
Saint Paul, Minnesota 55155-4301

September 28, 1992

John B. Lennes, Jr., Commissioner

Department of Labor and Industry

Adopted Emergency Rules Relating to Workers' Compensation; Managed Care

Rules as Adopted

5218.0100 [Emergency] DEFINITIONS.

Subpart 1. Scope. The terms used in parts 5218.0100 to 5218.9000 [Emergency] have the meanings given them in this part.

Subp. 2. Commissioner. "Commissioner" means the commissioner of the Department of Labor and Industry or a designee.

Subp. 3. Emergency care. "Emergency care" means ~~professional-health-services-necessary-to-preserve-life-or-limb~~ those medical services that are required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain.

Subp. 4. Employee. "Employee" means an employee entitled to treatment of a ~~work~~ personal injury under Minnesota Statutes, section 176.135.

~~Subp. 5. Geographical service area. "Geographical service area" means those counties in which a managed care plan has been certified to provide comprehensive health care services to injured employees.~~

Subp. ~~6~~ 5. Health care provider. "Health care provider" has the meaning given in Minnesota Statutes, section 176.011, subdivision 24.

Subp. ~~7~~ 6. Insurer. "Insurer" means the insurer providing workers' compensation insurance required by Minnesota Statutes, chapter 176, and includes a self-insured employer.

Subp. ~~8~~ 7. Managed care plan. "Managed care plan" means a plan certified by the commissioner that provides for the management of treatment to injured employees under Minnesota

Approved by Revisor MEO

Statutes, sections 176.135 and 176.1351.

Subp. ~~9.~~ 8. Participating health care provider. "Participating health care provider" means any person, provider, company, professional corporation, organization, or business entity with which the managed care plan has contracts or other agreements for the delivery of medical services or supplies to injured employees.

Subp. ~~10.~~ 9. Physician. "Physician" has the meaning given in Minnesota Statutes, section 176.135, subdivision 2a.

Subp. ~~11.~~ 10. Revocation. "Revocation" means ~~a permanent revocation~~ the termination of a managed care plan's certification to provide services under parts 5218.0100 to 5218.9000 [Emergency].

Subp. ~~12.~~ 11. Suspension. "Suspension" means ~~a stopping by the commissioner of~~ the managed care plan's authority to enter into new or amended contracts with insurers has been suspended by the commissioner for a specified period of time.

5218.0210 [Emergency] AUTHORITY.

Parts 5218.0100 to 5218.9000 [Emergency] are adopted under the commissioner's emergency rulemaking authority under Minnesota Statutes, section 176.1351, subdivision 6.

5218.0220 [Emergency] PURPOSE AND SCOPE.

The purpose of parts 5218.0100 to 5218.9000 [Emergency] is to establish procedures and requirements for certification as a managed care plan relating to the delivery of medical services to injured employees within the workers' compensation system ~~under a managed care plan certified by the commissioner~~ under Minnesota Statutes, sections 176.135, subdivision 1, paragraph (f), and 176.1351.

5218.0230 [Emergency] ~~EFFECTIVE DATE~~ PROVISIONAL CERTIFICATION.

A managed care plan certified under the emergency rulemaking authority will receive provisional certification that will expire 60 days after adoption of the permanent rules unless otherwise provided for in the permanent rules.

Approved by Revisor _____

5218.1000 [Emergency] APPLICATION FOR CERTIFICATION.

Subpart 1. Provisional certification. Except as provided in part 5218.2000 [Emergency], subpart 3, any person or entity may make written application to the commissioner to provide managed care to injured employees for injuries and diseases compensable under Minnesota Statutes, chapter 176, under a plan certified by the commissioner. To obtain provisional certification of a plan, the requirements in items A to D must be complied with and documented.

A. The plan must identify any directors and officers of the managed care plan; the title and name of the person to be the day-to-day administrator of the managed care plan; the title and name of the person to be the administrator of the financial affairs of the managed care plan; and the name, address, and telephone number of a contact person.

B. The plan must report the total annual compensation paid to an administrator, director, or executive officer of the managed care plan ~~shall not exceed~~ if it exceeds ten times the average annual wage as calculated in Minnesota Statutes, section 176.011, subdivision 20. The ~~limit on~~ total annual compensation under this subpart does not include payment received by a health care provider for actual medical services rendered to an employee under Minnesota Statutes, chapter 176. When a managed care plan is certified, the commissioner shall report any annual compensation that exceeds ten times the average annual wage to the Legislative Reference Library in accordance with Minnesota Statutes, section 3.302.

C. Each application for certification must be accompanied by a nonrefundable fee of $1,500.

D. Additional documentation must be submitted as specified in subitems (1) to (11).

(1) The managed care plan must provide a list of the names, addresses, and specialties of the participating health care providers who will provide services under the managed care plan~~, together with~~; the type of license,

Approved by Revisor _____

registration, or certification held by each participating provider; and a statement that all licensing, registration, or certification requirements have been met and are current for the health care provider to practice in Minnesota.

(2) The managed care plan must provide a description of the times, places, and manner of providing services under the plan~~, including a description of the initial geographical service area, designated by county~~. The plan must comply with units (a) and (b).

(a) The managed care plan must ~~provide~~ ensure provision of quality services that meet all uniform treatment standards ~~prescribed~~ adopted by the commissioner under Minnesota Statutes, section 176.83, subdivision 5, and all medical and health care services that may be required by Minnesota Statutes, chapter 176, in a manner that is timely, effective, and convenient for the employee.

(b) The managed care plan may not discriminate against or exclude from participation in the plan any category of health care providers and must include an adequate number of each category of health care providers to give employees convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan, consistent with subitem (3), provided that the treatment is medically appropriate.

(3) The managed care plan must include ~~a procedure~~ procedures to ensure that the employee will:

(a) receive initial evaluation or treatment by a participating ~~physician~~ health care provider licensed in Minnesota within 24 hours of ~~a~~ the employee's request for treatment, following a work injury; ~~the managed care plan may permit initial evaluations by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or a chiropractor;~~

(b) receive initial evaluation or treatment by a participating ~~physician~~ health care provider licensed in

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Minnesota within five working days of ~~a~~ the employee's request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan under part 5218.5000 [Emergency], subpart 1, item A.~~--The managed care plan may permit an initial evaluation by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or chiropractor~~;

(c) be initially allowed to choose from at least three health care providers to whom the employee has been referred by the evaluating provider under unit (a) or (b) for treatment, and allow the employee to change providers within the managed care plan at least once. The evaluating provider may be one of the three providers. The procedure to allow the employee to select ~~a~~ from three health care ~~provider~~ providers must ~~provide~~ allow direct access to all health care profession disciplines if the treatment is determined to be appropriate for the condition ~~by the evaluating health care provider under unit (a) or (b)~~ under the managed care plan's standards and the provider's scope of practice, or if the insurer approves the treatment;

(d) receive ~~treatment or~~ consultation by a managed care plan physician in cases requiring emergency in-patient hospitalization at a hospital that is not a participating provider;

(e) receive information ~~or advice~~ on a 24-hour basis regarding the availability of necessary medical services available within the managed care plan. The information may be provided through recorded telephone messages. However, the message must include information on how the employee can obtain emergency services or other urgently needed care and how the employee can access an evaluation within 24 hours of the injury as required under unit (a); and

(f) have access to treatment from health care providers within 30 miles of either the employee's place of employment or residence~~, or the distance the employee normally~~

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~~travels-to-work,-considering-the-normal-patterns-of-travel,~~ ~~whichever-is-furthest~~ if the residence or place of employment is within the seven-county metropolitan area. The seven-county metropolitan area includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. If the employee's residence and place of employment are outside the seven-county metropolitan area the allowable distance is 50 miles. If the employee requires specialized care that is not available within the stated mileage restriction, the managed care plan may refer the employee to a provider outside of the stated mileage restriction.

(4) The managed care plan must designate the procedures and criteria for approval of services from a health care provider outside the managed care plan according to part 5218.5000 [Emergency].

(5) The application must include copies of contract agreements or other documents signed by each participating health care provider. Contractual provisions must be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency]. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts submitted must include a list of signatories to the contract.

(6) The managed care plan must designate the name, address, and phone number of a communication liaison for the department ~~and~~, the insurer, the employer, and the employee.

(7) The managed care plan must include a procedure for peer review, utilization review, and internal dispute resolution in accordance with Minnesota Statutes, section 176.1351, subdivision 2, paragraph (4), including a method to resolve complaints by injured employees, medical providers, and insurers.

(8) The managed care plan must include a procedure to notify the commissioner of the commencement or termination of participating health care providers.

(9) The managed care plan must describe how

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employers and insurers will be provided with information that will inform employees of all choices of medical service providers within the plan and how employees can gain access to those providers.

(10) The managed care plan must describe how it will provide aggressive case management for injured employees, and a program for early return to work and cooperative efforts by the employees, the employer, and the managed care plan to promote workplace health and safety consultative and other services. The program for early return to work must provide for cooperation with an employee's qualified rehabilitation consultant.

(11) The managed care plan must submit any treatment standards it has developed for medical services that have not already been prescribed by the commissioner and that are reasonably likely to be used in the treatment of workers' compensation injuries. All managed care plan health care providers and ~~health-care-providers-described-in~~ those providing services under part 5218.5000 [Emergency] ~~will~~ shall be governed by these standards and by the standards prescribed by the commissioner under Minnesota Statutes, section 176.83, subdivision 5.

Subp. 2. **Notification; approval or denial.** The commissioner shall notify the applicant in writing of the approval or denial of certification. If certification is granted, the commissioner shall notify the managed care plan applicant of the effective date of the certification ~~and-the initial-geographical-service-area-approved~~. If the certification is denied, the applicant will be provided in writing with the reason for the denial. If the commissioner ~~must-require~~ is unable to determine whether the proposed plan complies with all statutory and rule requirements from the documents submitted, an in-person meeting ~~an-if-necessary-to determine-compliance-with-parts-5218.0100-to-5218.9000~~ ~~[Emergency]~~ with the managed care plan applicant shall be held. Modification of the plan as certified shall require approval

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before it may be implemented.

Subp. 3. Review of decision. Any person aggrieved by a denial of certification by the commissioner may request in writing, within 30 days of the date the denial is served and filed, the initiation of a contested case proceeding under Minnesota Statutes, chapter 14. Following receipt of the administrative law judge's findings and recommendations, the commissioner shall issue a final decision in accordance with Minnesota Statutes, section 14.62. An appeal from the commissioner's final decision and order may be taken to the workers' compensation court of appeals pursuant to Minnesota Statutes, sections 176.421 and 176.442.

5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN.

Subpart 1. Scope. A managed care plan shall provide comprehensive medical services according to its certification and Minnesota Statutes, chapter 176, and all other applicable statutes and rules.

Subp. 2. ~~Geographical service area; expansion. The commissioner shall designate a managed care plan's initial geographical service area and approve any expansions to the managed care plan's service area. Injured employees shall not be covered by a managed care plan until the commissioner has approved the proposed expansion of the geographical service area.~~

~~Subp. 3.~~ Contracts and coverage. ~~When~~ A managed care plan ~~contracts~~ must contract with ~~an~~ the insurer liable under Minnesota Statutes, chapter 176, to provide services, to employees with a personal injury. The contract shall specify those employers covered by the contract and the estimated number of covered employees. The managed care plan contract must include the terms and conditions in items A to F.

A. ~~The employer's place of employment must be within the authorized geographical service area.~~

B. Insurers may contract with multiple managed care plans to provide coverage for employers. ~~When insurers contract~~

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an insurer contracts with multiple managed care plans to cover the same employer, each employee shall have the initial choice at time of injury to select the managed care plan that will manage the employee's care. The employee shall select a managed care plan from those that have a contract with the insurer liable for the personal injury under Minnesota Statutes, chapter 176, and that provide services within the mileage restrictions under part 5218.1000 [Emergency], subpart 1, item D, subitem (3), unit (f).

~~C.~~ B. An employee with a compensable personal injury under Minnesota Statutes, chapter 176, occurring on or after the effective date of the managed care plan contract with the insurer liable for the injury under Minnesota Statutes, chapter 176, shall receive medical services in the manner prescribed by the terms and conditions of the managed care plan contract.

~~B.~~ C. The requirements established in parts 5218.0100 to 5218.9000 [Emergency] do not apply to an employee with a compensable injury under Minnesota Statutes, chapter 176, that occurred before the effective date of the managed care plan contract, until the employee requests a change of doctor. At that time, further services shall be provided by the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by health care providers who are not participating providers must be delivered according to part 5218.5000 [Emergency].

~~E.~~ D. To ensure continuity of care, the managed care plan contract shall specify the manner in which an injured employee with a compensable injury will receive medical services when a managed care plan contract or a contract with a health care provider terminates. When a contract with a health care provider terminates, or when managed care plan coverage for an injured employee is being transferred from one managed care plan to another, the employee may continue to treat with the ~~employee's original~~ health care provider under the terminated contract until the employee requests a change of doctor. At

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that time further services shall be provided under the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by providers who are not participating providers must be performed according to part 5218.5000 [Emergency].

~~F.~~ E. Except as provided in part 5218.5000 [Emergency], an employer may require an employee who is claiming a workers' compensation injury to receive treatment from a managed care plan before the employer accepts or denies liability for the injury. In such cases the employer is liable for the cost of any treatment related to the claimed personal injury that is given by a participating health care provider before notice is given to the employee of a denial of liability, even if the employer is later determined to be not liable for the claimed injury. If liability is denied, the employer cannot pursue reimbursement from the employee. This item does not limit the employer's right to pursue any other applicable subrogation or reimbursement rights it may have against parties.

F. The employee may receive treatment from any health care provider chosen by the employee after a notice of denial of liability has been given to the employee, or if the employer does not require the employee to receive treatment from a managed care plan prior to accepting liability for a claimed injury. If the employer later accepts liability or is determined by the commissioner, a compensation judge, or an appellate court to be liable for the claimed injury, the employer is responsible for the cost of all reasonable and necessary medical treatment received by the employee. ~~Once~~ If the employer ~~has admitted~~ admits liability for the claimed injury ~~or once the employer has been determined to be liable for the claimed~~ within 14 days after receiving notice of the injury, the employer may require that further medical treatment be received through the managed care plan unless the employee had a documented history of treatment with the health care provider as described in part 5218.5000 [Emergency], before the injury. If

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liability is admitted or determined later than 14 days after notice of the injury and the employee has been receiving treatment from a nonparticipating provider under this item, the employee is not required to receive further treatment under the managed care plan, if the health care provider agrees to comply with part 5218.5000 [Emergency], subpart 2.

Subp. ~~4.~~ 3. Restrictions. When an insurer contracts with a single managed care plan for coverage for an employer, the plan may not be formed, operated, or administered by the same employer or insurer. When an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, formed, or administered by the employer or insurer. No employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota Statutes, chapter 176. At the time such a plan is offered, the employer shall give written notice of the affiliation and that no employee is required to obtain services under a managed care plan operated, formed, or administered by the employer or insurer.

5218.3000 [Emergency] REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN.

Subpart 1. Contracts; modifications. A managed care plan shall provide the commissioner with a copy of a managed care plan insurer contract and managed care plan participating provider contract agreements, signed by the parties, within 30 days of execution of the contracts. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts shall include a list of signatories. Amendments and addendums to the contracts shall also be submitted to the commissioner within 30 days of execution. Contract provisions shall be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency].

Subp. 2. Requirements. Within six months of provisional

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certification, each managed care plan shall provide the following information ~~in a form and format prescribed by the commissioner~~:

A. a current listing of participating health care providers, including provider names, specialty, business address, and phone number, and for any new health care provider the information required by part 5218.1000 [Emergency], subpart 1, item D, subitem (1);

B. a listing of all health care providers outside of the managed care plan who provided services to employees under part 5218.5000 [Emergency], subpart 1, item C;

C. a listing of all employers covered by each contract including the employer's names, unemployment insurer's identification number, and estimated number of employees governed by the managed care plan contract;

D. a summary of any sanctions or punitive actions taken by the managed care plan against its ~~members~~ participating providers;

E. a report that summarizes peer review ~~and~~, utilization review ~~performed~~, and dispute resolution proceedings showing cases reviewed, issues involved, and any action taken. The peer and utilization review must include~~, but is not limited to~~, evaluation of compliance with applicable treatment standards adopted by the commissioner; and

F. any proposed changes to the certified managed care plan ~~as certified by the commissioner~~.

Subp. 3. **Insurers; data.** The managed care plan must report to the insurer any data regarding medical services and supplies related to the workers' compensation claim required by the insurer to determine compensability, in accordance with Minnesota Statutes, sections 176.135, subdivision 7 and 176.138, and any other data required by rule.

Subp. 4. **Monitoring.** The commissioner shall require additional information from the managed care plan ~~as necessary to monitor~~ if the information is relevant to determining the managed care plan's compliance with parts 5218.0100 to 5218.9000

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[Emergency] and Minnesota Statutes, section 176.1351.

5218.4000 [Emergency] COMMENCEMENT AND TERMINATION OF CONTRACT WITH PARTICIPATING PROVIDERS.

Subpart 1. Commencement. Prospective new participating health care providers under a managed care plan shall submit an application to the managed care plan. A director, executive director, or administrator may approve the application under the requirements of the managed care plan. The managed care plan shall verify that each new participating health care provider meets all licensing, registration, and certification requirements necessary to practice in Minnesota.

Subp. 2. Termination. A participating provider may elect to terminate participation in the managed care plan or be subject to cancellation by the managed care plan under the requirements of the managed care plan. Upon termination of a provider contract, the managed care plan shall make alternate arrangements to provide continuing medical services for an affected injured employee under the plan in accordance with part 5218.2000 [Emergency], subpart 2, item D.

5218.5000 [Emergency] HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subpart 1. Authorized services. ~~The managed care plan shall authorize~~ A health care provider who is not a participating health care provider ~~to~~ may provide medical services to an employee covered by a managed care plan in any of the following circumstances:

A. if the health care provider maintains the employee's medical records ~~and~~, has a documented history of treatment of that employee at least twice in the four years before the date of injury, and complies with Minnesota Statutes, section 176.1351, subdivision 2, clause (8). The employee must provide the insurer with copies of medical records documenting the previous treatment. The insurer must treat the medical records as private data. If the employee requests a change of doctor, further services shall be provided by the managed care

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plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c);

B. for emergency treatment; ~~or~~

C. when the employee is referred outside the managed care plan for medical services by the managed care plan; or

D. when the employee has received treatment for a claimed injury from a nonparticipating provider under part 5218.2000 [Emergency], subpart 2, item F, and liability for the injury is admitted or established later than 14 days after the employer received notice of the injury.

Subp. 2. **Requirements.** A health care provider who is not a participating health care provider must:

A. agree to comply with the managed care plan treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures; and

B. agree to refer the covered employee to the managed care plan for specialized care, ~~which includes, but is not limited to,~~ physical therapy, and diagnostic testing, except for minor diagnostic testing that may be done in the provider's office. The provider referring the employee may continue to provide direct treatment.

Subp. 3. **Disputes.** Any dispute under subpart 1 or 2 relating to the employee's selection of a health care provider who is not a managed care plan participating health care provider shall be resolved according to part 5218.7000 [Emergency]. Any dispute relating to a health care provider's compliance with the managed care plan standards and procedures or treatment standards adopted by the commissioner shall be resolved according to part 5218.7000 [Emergency] ~~or~~. A health care provider who does not comply with the requirements in subpart 2 is subject to denial of payment for the services in accordance with the procedures in part 5218.7000 [Emergency] and sanctions under Minnesota Statutes, section 176.103.

5218.6000 [Emergency] CHARGES AND FEES.

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Billings for medical services under a managed care plan shall be submitted in the form and format as prescribed in part 5221.0700, subpart 2. The payment by the insurer or the managed care plan to participating and nonparticipating health care providers for medical services shall be according to the timeframes and procedures in part 5221.0600, subpart 3, and Minnesota Statutes, section 176.135, subdivision 6, and shall be equal to the maximum amount allowed under Minnesota Statutes, section 176.136, subdivisions 1a and 1b. A managed care plan may not require a health care provider to accept a lesser payment or pay a fee as a condition of receiving referrals from or becoming a participating provider in the plan.

5218.7000 [Emergency] DISPUTE RESOLUTION.

Disputes that arise between the employee and the managed care plan related to the delivery of health services under this chapter shall first be processed through the dispute resolution process of the managed care plan. The managed care plan dispute resolution process must be completed within 30 days of receipt of a request. If the dispute cannot be resolved, the commissioner ~~may issue an order to resolve the dispute~~ shall proceed under Minnesota Statutes, sections 176.106 and 176.305 or 176.2615.

5218.8000 [Emergency] MONITORING.

Subpart 1. **Audits.** The commissioner shall monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements.

Subp. 2. **Records.** All records of the managed care plan and its participating health care providers ~~shall be disclosed on request of the commissioner when necessary to ensure~~ relevant to determining compliance with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency] shall be disclosed upon request of the commissioner. ~~These~~ Records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes. The release of

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records filed with the commissioner is subject to Minnesota Statutes, sections 13.37, 145.61 to 145.67, 176.231, subdivisions 8 and 9, 176.234, and 176.138.

5218.9000 [Emergency] SUSPENSION; REVOCATION.

Subpart 1. Complaints; investigation. Complaints pertaining to violations of parts 5218.0100 to 5218.9000 [Emergency] or Minnesota Statutes, section 176.1351, by the managed care plan shall be directed in writing to the commissioner. On receipt of a written complaint, or after monitoring the managed care plan operations, the department shall investigate the alleged ~~rule~~ violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the ~~department determines on completion of the~~ investigation ~~that~~ reveals reasonable cause to believe that there has been a ~~rule~~ violation warranting suspension or revocation of provisional certification, the commissioner shall initiate a contested case proceeding under Minnesota Statutes, chapter 14.

Subp. 2. Criteria. Under Minnesota Statutes, section 176.1351, subdivision 5, the provisional certification of a managed care plan issued by the commissioner shall be suspended or revoked by the commissioner if:

A. service under the plan is not being provided according to the terms of the certified plan;

B. the plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of parts 5218.0100 to 5218.9000 [Emergency] or Minnesota Statutes, section 176.1351;

C. the managed care plan fails to comply with Minnesota Statutes, section 176.1351, parts 5218.0100 to 5218.9000 [Emergency], ~~and~~ or requirements of utilization and treatment standards adopted under Minnesota Statutes, section 176.83;

D. any false or misleading information is submitted by the managed care plan or ~~a member of the plan~~ participating

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provider; or

E. the managed care plan continues to use the services of a health care provider whose license, registration, or certification has been suspended or revoked ~~by the licensing~~ board, or under Minnesota Statutes, section 176.103, or who is ineligible to provide treatment to an injured employee under Minnesota Statutes, section 256B.0644.

Subp. 3. Effects. ~~All contracts with insurers are void~~ No employee is covered by a contract between a managed care plan and insurer if ~~a~~ the managed care plan's provisional certification is revoked. The managed care plan may reapply for certification as specified in the order of revocation. Upon suspension of certification, the managed care plan may continue to provide services under contracts in effect if the commissioner determines injured employees will continue to receive necessary medical services under Minnesota Statutes, section 176.135.

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STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In The Matter of the Proposed Adoption of the Rule of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

AFFIDAVIT OF MAILING THE NOTICE OF SUBMISSION OF EMERGENCY RULES TO THE ATTORNEY GENERAL

STATE OF MINNESOTA)
) SS.
COUNTY OF RAMSEY)

Kathryn Berger, being sworn says:

That on the 28th day of September, 1992, in the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice of Submission to the Attorney General by depositing in the State of Minnesota Central Mail System for United States mailing, a copy thereof, with postage prepaid, to all persons and associations who requested notice that the rule in the above-entitled matter has been submitted to the Attorney General.

Kathryn Berger
Name

Attorney
Title

Cheryl A Bauer

Subscribed and sworn to before me
this 28 day of September, 1992.

CHERYL A. BAUER
NOTARY PUBLIC—MINNESOTA
RAMSEY COUNTY
MY COMMISSION EXPIRES 11-03-97

DEPARTMENT OF LABOR AND INDUSTRY
WORKERS' COMPENSATION, MANAGED CARE EMERGENCY RULES

NOTICE OF SUBMISSION TO ATTORNEY GENERAL

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Minnesota Chiropractic Association
1700 West Highway 36 - Suite 130
Roseville, MN 55113-4057

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STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Adoption of the Rule of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

NOTICE OF SUBMISSION OF EMERGENCY RULE TO THE ATTORNEY GENERAL

Pursuant to your request and in accordance with Minnesota Statutes, section 14.32:

PLEASE TAKE NOTICE that the above-captioned emergency rule as adopted has been submitted to the Office of the Attorney General on the date of this notice, September 28, 1992, for review as to legality and form to the extent form relates to legality. The proposed emergency rule, the rule as adopted, all the notices, all written comments received and other required documents also have been submitted to the attorney general.

The proposed emergency rule which was published in the State Register and made available to the public on July 27, 1992, has been modified. A copy of the rule as modified is enclosed with this notice.

The rule must be approved or disapproved by the Attorney General on the tenth working day following date of receipt of the rule. You may submit written comments to the Attorney General. Any written comments must be submitted within seven working days of the date of this notice. Your comments must address only the issue of legality of the rule or the legality of the specific parts or subparts of the rule. The attorney general standards for review are set forth in Minnesota Rules, part 2010.1000. You may receive a copy of the attorney general decision upon written request to the attorney general. Your comments or requests for the decision must be directed to:

The Office of the Attorney General
Public Finance Division
525 Park Street - Suite 400
Saint Paul, Minnesota 55103
Telephone: (612) 297-2040

Any written comments submitted to the attorney general must be submitted simultaneously to:

Kathryn Berger
Legal Services
Department of Labor and Industry
443 Lafayette Road North
Saint Paul, Minnesota 55155-4301

September 28, 1992

John B. Lennes, Jr., Commissioner

Department of Labor and Industry

Adopted Emergency Rules Relating to Workers' Compensation; Managed Care

Rules as Adopted

5218.0100 [Emergency] DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 5218.0100 to 5218.9000 [Emergency] have the meanings given them in this part.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Labor and Industry or a designee.

Subp. 3. **Emergency care.** "Emergency care" means ~~professional health services necessary to preserve life or limb~~ those medical services that are required for the immediate diagnosis and treatment of medical conditions that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or that are immediately necessary to alleviate severe pain.

Subp. 4. **Employee.** "Employee" means an employee entitled to treatment of a ~~work~~ personal injury under Minnesota Statutes, section 176.135.

~~Subp. 5. Geographical service area. "Geographical service area" means those counties in which a managed care plan has been certified to provide comprehensive health care services to injured employees.~~

Subp. ~~6~~ 5. **Health care provider.** "Health care provider" has the meaning given in Minnesota Statutes, section 176.011, subdivision 24.

Subp. ~~7~~ 6. **Insurer.** "Insurer" means the insurer providing workers' compensation insurance required by Minnesota Statutes, chapter 176, and includes a self-insured employer.

Subp. ~~8~~ 7. **Managed care plan.** "Managed care plan" means a plan certified by the commissioner that provides for the management of treatment to injured employees under Minnesota

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Statutes, sections 176.135 and 176.1351.

Subp. ~~9.~~ 8. **Participating health care provider.** "Participating health care provider" means any person, provider, company, professional corporation, organization, or business entity with which the managed care plan has contracts or other agreements for the delivery of medical services or supplies to injured employees.

Subp. ~~10.~~ 9. **Physician.** "Physician" has the meaning given in Minnesota Statutes, section 176.135, subdivision 2a.

Subp. ~~11.~~ 10. **Revocation.** "Revocation" means ~~a permanent revocation~~ the termination of a managed care plan's certification to provide services under parts 5218.0100 to 5218.9000 [Emergency].

Subp. ~~12.~~ 11. **Suspension.** "Suspension" means ~~a stopping by the commissioner of~~ the managed care plan's authority to enter into new or amended contracts with insurers has been suspended by the commissioner for a specified period of time.

5218.0210 [Emergency] AUTHORITY.

Parts 5218.0100 to 5218.9000 [Emergency] are adopted under the commissioner's emergency rulemaking authority under Minnesota Statutes, section 176.1351, subdivision 6.

5218.0220 [Emergency] PURPOSE AND SCOPE.

The purpose of parts 5218.0100 to 5218.9000 [Emergency] is to establish procedures and requirements for certification as a managed care plan relating to the delivery of medical services to injured employees within the workers' compensation system ~~under a managed care plan certified by the commissioner~~ under Minnesota Statutes, sections 176.135, subdivision 1, paragraph (f), and 176.1351.

5218.0230 [Emergency] ~~EFFECTIVE DATE~~ PROVISIONAL CERTIFICATION.

A managed care plan certified under the emergency rulemaking authority will receive provisional certification that will expire 60 days after adoption of the permanent rules unless otherwise provided for in the permanent rules.

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5218.1000 [Emergency] APPLICATION FOR CERTIFICATION.

Subpart 1. **Provisional certification.** Except as provided in part 5218.2000 [Emergency], subpart 3, any person or entity may make written application to the commissioner to provide managed care to injured employees for injuries and diseases compensable under Minnesota Statutes, chapter 176, under a plan certified by the commissioner. To obtain provisional certification of a plan, the requirements in items A to D must be complied with and documented.

A. The plan must identify any directors and officers of the managed care plan; the title and name of the person to be the day-to-day administrator of the managed care plan; the title and name of the person to be the administrator of the financial affairs of the managed care plan; and the name, address, and telephone number of a contact person.

B. The plan must report the total annual compensation paid to an administrator, director, or executive officer of the managed care plan ~~shall not exceed~~ if it exceeds ten times the average annual wage as calculated in Minnesota Statutes, section 176.011, subdivision 20. The ~~limit on~~ total annual compensation under this subpart does not include payment received by a health care provider for actual medical services rendered to an employee under Minnesota Statutes, chapter 176. When a managed care plan is certified, the commissioner shall report any annual compensation that exceeds ten times the average annual wage to the Legislative Reference Library in accordance with Minnesota Statutes, section 3.302.

C. Each application for certification must be accompanied by a nonrefundable fee of $1,500.

D. Additional documentation must be submitted as specified in subitems (1) to (11).

(1) The managed care plan must provide a list of the names, addresses, and specialties of the participating health care providers who will provide services under the managed care plan~~, together with~~; the type of license,

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registration, or certification held by each participating provider; and a statement that all licensing, registration, or certification requirements have been met and are current for the health care provider to practice in Minnesota.

(2) The managed care plan must provide a description of the times, places, and manner of providing services under the plan~~,-including-a-description-of-the-initial-geographical-service-area,-designated-by-county~~. The plan must comply with units (a) and (b).

(a) The managed care plan must ~~provide~~ ensure provision of quality services that meet all uniform treatment standards ~~prescribed~~ adopted by the commissioner under Minnesota Statutes, section 176.83, subdivision 5, and all medical and health care services that may be required by Minnesota Statutes, chapter 176, in a manner that is timely, effective, and convenient for the employee.

(b) The managed care plan may not discriminate against or exclude from participation in the plan any category of health care providers and must include an adequate number of each category of health care providers to give employees convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan, consistent with subitem (3), provided that the treatment is medically appropriate.

(3) The managed care plan must include ~~a procedure~~ procedures to ensure that the employee will:

(a) receive initial evaluation or treatment by a participating ~~physician~~ health care provider licensed in Minnesota within 24 hours of ~~a~~ the employee's request for treatment, following a work injury; ~~the-managed-care-plan-may-permit-initial-evaluations-by-a-participating-chiropractor,-in-which-case-the-employee-may-decide-whether-the-evaluation-will-be-by-a-physician-or-a-chiropractor;~~

(b) receive initial evaluation or treatment by a participating ~~physician~~ health care provider licensed in

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Minnesota within five working days of ~~a~~ the employee's request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan under part 5218.5000 [Emergency], subpart 1, item A~~.--The managed care plan may permit an initial evaluation by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or chiropractor~~;

(c) be initially allowed to choose from at least three health care providers to whom the employee has been referred by the evaluating provider under unit (a) or (b) for treatment, and allow the employee to change providers within the managed care plan at least once. The evaluating provider may be one of the three providers. The procedure to allow the employee to select ~~a~~ from three health care ~~provider~~ providers must ~~provide~~ allow direct access to all health care profession disciplines if the treatment is determined to be appropriate for the condition ~~by the evaluating health care provider under unit (a) or (b)~~ under the managed care plan's standards and the provider's scope of practice, or if the insurer approves the treatment;

(d) receive ~~treatment or~~ consultation by a managed care plan physician in cases requiring emergency in-patient hospitalization at a hospital that is not a participating provider;

(e) receive information ~~or advice~~ on a 24-hour basis regarding the availability of necessary medical services available within the managed care plan. The information may be provided through recorded telephone messages. However, the message must include information on how the employee can obtain emergency services or other urgently needed care and how the employee can access an evaluation within 24 hours of the injury as required under unit (a); and

(f) have access to treatment from health care providers within 30 miles of either the employee's place of employment or residence~~, or the distance the employee normally~~

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~~travels-to-work,-considering-the-normal-patterns-of-travel,~~ ~~whichever-is-furthest~~ if the residence or place of employment is within the seven-county metropolitan area. The seven-county metropolitan area includes Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties. If the employee's residence and place of employment are outside the seven-county metropolitan area the allowable distance is 50 miles. If the employee requires specialized care that is not available within the stated mileage restriction, the managed care plan may refer the employee to a provider outside of the stated mileage restriction.

(4) The managed care plan must designate the procedures and criteria for approval of services from a health care provider outside the managed care plan according to part 5218.5000 [Emergency].

(5) The application must include copies of contract agreements or other documents signed by each participating health care provider. Contractual provisions must be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency]. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts submitted must include a list of signatories to the contract.

(6) The managed care plan must designate the name, address, and phone number of a communication liaison for the department ~~and~~, the insurer, the employer, and the employee.

(7) The managed care plan must include a procedure for peer review, utilization review, and internal dispute resolution in accordance with Minnesota Statutes, section 176.1351, subdivision 2, paragraph (4), including a method to resolve complaints by injured employees, medical providers, and insurers.

(8) The managed care plan must include a procedure to notify the commissioner of the commencement or termination of participating health care providers.

(9) The managed care plan must describe how

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employers and insurers will be provided with information that will inform employees of all choices of medical service providers within the plan and how employees can gain access to those providers.

(10) The managed care plan must describe how it will provide aggressive case management for injured employees, and a program for early return to work and cooperative efforts by the employees, the employer, and the managed care plan to promote workplace health and safety consultative and other services. The program for early return to work must provide for cooperation with an employee's qualified rehabilitation consultant.

(11) The managed care plan must submit any treatment standards it has developed for medical services that have not already been prescribed by the commissioner and that are reasonably likely to be used in the treatment of workers' compensation injuries. All managed care plan health care providers and ~~health-care-providers-described-in~~ those providing services under part 5218.5000 [Emergency] ~~will~~ shall be governed by these standards and by the standards prescribed by the commissioner under Minnesota Statutes, section 176.83, subdivision 5.

Subp. 2. **Notification; approval or denial.** The commissioner shall notify the applicant in writing of the approval or denial of certification. If certification is granted, the commissioner shall notify the managed care plan applicant of the effective date of the certification ~~and-the initial-geographical-service-area-approved~~. If the certification is denied, the applicant will be provided in writing with the reason for the denial. If the commissioner ~~must-require~~ is unable to determine whether the proposed plan complies with all statutory and rule requirements from the documents submitted, an in-person meeting ~~an-if-necessary-to determine-compliance-with-parts-5218.0100-to-5218.9000~~ ~~[Emergency]~~ with the managed care plan applicant shall be held. Modification of the plan as certified shall require approval

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before it may be implemented.

Subp. 3. **Review of decision.** Any person aggrieved by a denial of certification by the commissioner may request in writing, within 30 days of the date the denial is served and filed, the initiation of a contested case proceeding under Minnesota Statutes, chapter 14. Following receipt of the administrative law judge's findings and recommendations, the commissioner shall issue a final decision in accordance with Minnesota Statutes, section 14.62. An appeal from the commissioner's final decision and order may be taken to the workers' compensation court of appeals pursuant to Minnesota Statutes, sections 176.421 and 176.442.

5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN.

Subpart 1. **Scope.** A managed care plan shall provide comprehensive medical services according to its certification and Minnesota Statutes, chapter 176, and all other applicable statutes and rules.

Subp. 2. ~~**Geographical service area; expansion.** The commissioner shall designate a managed care plan's initial geographical service area and approve any expansions to the managed care plan's service area. Injured employees shall not be covered by a managed care plan until the commissioner has approved the proposed expansion of the geographical service area.~~

~~Subp. 3.~~ **Contracts and coverage.** ~~When~~ A managed care plan ~~contracts~~ must contract with ~~an~~ the insurer liable under Minnesota Statutes, chapter 176, to provide services~~,~~ to employees with a personal injury. The contract shall specify those employers covered by the contract and the estimated number of covered employees. The managed care plan contract must include the terms and conditions in items A to F.

A. ~~The employer's place of employment must be within the authorized geographical service area.~~

B~~.~~ Insurers may contract with multiple managed care plans to provide coverage for employers. When ~~insurers contract~~

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an insurer contracts with multiple managed care plans to cover the same employer, each employee shall have the initial choice at time of injury to select the managed care plan that will manage the employee's care. The employee shall select a managed care plan from those that have a contract with the insurer liable for the personal injury under Minnesota Statutes, chapter 176, and that provide services within the mileage restrictions under part 5218.1000 [Emergency], subpart 1, item D, subitem (3), unit (f).

~~C.~~ B. An employee with a compensable personal injury under Minnesota Statutes, chapter 176, occurring on or after the effective date of the managed care plan contract with the insurer liable for the injury under Minnesota Statutes, chapter 176, shall receive medical services in the manner prescribed by the terms and conditions of the managed care plan contract.

~~B.~~ C. The requirements established in parts 5218.0100 to 5218.9000 [Emergency] do not apply to an employee with a compensable injury under Minnesota Statutes, chapter 176, that occurred before the effective date of the managed care plan contract, until the employee requests a change of doctor. At that time, further services shall be provided by the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by health care providers who are not participating providers must be delivered according to part 5218.5000 [Emergency].

~~E.~~ D. To ensure continuity of care, the managed care plan contract shall specify the manner in which an injured employee with a compensable injury will receive medical services when a managed care plan contract or a contract with a health care provider terminates. When a contract with a health care provider terminates, or when managed care plan coverage for an injured employee is being transferred from one managed care plan to another, the employee may continue to treat with the ~~employee's original~~ health care provider under the terminated contract until the employee requests a change of doctor. At

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that time further services shall be provided under the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by providers who are not participating providers must be performed according to part 5218.5000 [Emergency].

~~F.~~ E. Except as provided in part 5218.5000 [Emergency], an employer may require an employee who is claiming a workers' compensation injury to receive treatment from a managed care plan before the employer accepts or denies liability for the injury. In such cases the employer is liable for the cost of any treatment related to the claimed personal injury that is given by a participating health care provider before notice is given to the employee of a denial of liability, even if the employer is later determined to be not liable for the claimed injury. If liability is denied, the employer cannot pursue reimbursement from the employee. This item does not limit the employer's right to pursue any other applicable subrogation or reimbursement rights it may have against parties.

F. The employee may receive treatment from any health care provider chosen by the employee after a notice of denial of liability has been given to the employee, or if the employer does not require the employee to receive treatment from a managed care plan prior to accepting liability for a claimed injury. If the employer later accepts liability or is determined by the commissioner, a compensation judge, or an appellate court to be liable for the claimed injury, the employer is responsible for the cost of all reasonable and necessary medical treatment received by the employee. ~~Once~~ If the employer ~~has admitted~~ admits liability for the claimed injury ~~or once the employer has been determined to be liable for the claimed~~ within 14 days after receiving notice of the injury, the employer may require that further medical treatment be received through the managed care plan unless the employee had a documented history of treatment with the health care provider as described in part 5218.5000 [Emergency], before the injury. If

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liability is admitted or determined later than 14 days after notice of the injury and the employee has been receiving treatment from a nonparticipating provider under this item, the employee is not required to receive further treatment under the managed care plan, if the health care provider agrees to comply with part 5218.5000 [Emergency], subpart 2.

Subp. ~~4.~~ 3. **Restrictions.** When an insurer contracts with a single managed care plan for coverage for an employer, the plan may not be formed, operated, or administered by the same employer or insurer. When an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, formed, or administered by the employer or insurer. No employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota Statutes, chapter 176. At the time such a plan is offered, the employer shall give written notice of the affiliation and that no employee is required to obtain services under a managed care plan operated, formed, or administered by the employer or insurer.

5218.3000 [Emergency] REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN.

Subpart 1. **Contracts; modifications.** A managed care plan shall provide the commissioner with a copy of a managed care plan insurer contract and managed care plan participating provider contract agreements, signed by the parties, within 30 days of execution of the contracts. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts shall include a list of signatories. Amendments and addendums to the contracts shall also be submitted to the commissioner within 30 days of execution. Contract provisions shall be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency].

Subp. 2. **Requirements.** Within six months of provisional

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certification, each managed care plan shall provide the following information ~~in a form and format prescribed by the commissioner~~:

A. a current listing of participating health care providers, including provider names, specialty, business address, and phone number, and for any new health care provider the information required by part 5218.1000 [Emergency], subpart 1, item D, subitem (1);

B. a listing of all health care providers outside of the managed care plan who provided services to employees under part 5218.5000 [Emergency], subpart 1, item C;

C. a listing of all employers covered by each contract including the employer's names, unemployment insurer's identification number, and estimated number of employees governed by the managed care plan contract;

D. a summary of any sanctions or punitive actions taken by the managed care plan against its ~~members~~ participating providers;

E. a report that summarizes peer review ~~and~~, utilization review ~~performed~~, and dispute resolution proceedings showing cases reviewed, issues involved, and any action taken. The peer and utilization review must include~~, but is not limited to~~, evaluation of compliance with applicable treatment standards adopted by the commissioner; and

F. any proposed changes to the certified managed care plan ~~as certified by the commissioner~~.

Subp. 3. **Insurers; data.** The managed care plan must report to the insurer any data regarding medical services and supplies related to the workers' compensation claim required by the insurer to determine compensability, in accordance with Minnesota Statutes, sections 176.135, subdivision 7 and 176.138, and any other data required by rule.

Subp. 4. **Monitoring.** The commissioner shall require additional information from the managed care plan ~~as necessary to monitor~~ if the information is relevant to determining the managed care plan's compliance with parts 5218.0100 to 5218.9000

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[Emergency] and Minnesota Statutes, section 176.1351.

5218.4000 [Emergency] COMMENCEMENT AND TERMINATION OF CONTRACT WITH PARTICIPATING PROVIDERS.

Subpart 1. **Commencement.** Prospective new participating health care providers under a managed care plan shall submit an application to the managed care plan. A director, executive director, or administrator may approve the application under the requirements of the managed care plan. The managed care plan shall verify that each new participating health care provider meets all licensing, registration, and certification requirements necessary to practice in Minnesota.

Subp. 2. **Termination.** A participating provider may elect to terminate participation in the managed care plan or be subject to cancellation by the managed care plan under the requirements of the managed care plan. Upon termination of a provider contract, the managed care plan shall make alternate arrangements to provide continuing medical services for an affected injured employee under the plan in accordance with part 5218.2000 [Emergency], subpart 2, item D.

5218.5000 [Emergency] HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subpart 1. **Authorized services.** ~~The managed care plan shall authorize~~ A health care provider who is not a participating health care provider ~~to~~ may provide medical services to an employee covered by a managed care plan in any of the following circumstances:

A. if the health care provider maintains the employee's medical records ~~and~~, has a documented history of treatment of that employee at least twice in the four years before the date of injury, and complies with Minnesota Statutes, section 176.1351, subdivision 2, clause (8). The employee must provide the insurer with copies of medical records documenting the previous treatment. The insurer must treat the medical records as private data. If the employee requests a change of doctor, further services shall be provided by the managed care

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plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c);

B. for emergency treatment; ~~or~~

C. when the employee is referred outside the managed care plan for medical services by the managed care plan; or

D. when the employee has received treatment for a claimed injury from a nonparticipating provider under part 5218.2000 [Emergency], subpart 2, item F, and liability for the injury is admitted or established later than 14 days after the employer received notice of the injury.

Subp. 2. **Requirements.** A health care provider who is not a participating health care provider must:

A. agree to comply with the managed care plan treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures; and

B. agree to refer the covered employee to the managed care plan for specialized care, ~~which includes, but is not limited to,~~ physical therapy, and diagnostic testing, except for minor diagnostic testing that may be done in the provider's office. The provider referring the employee may continue to provide direct treatment.

Subp. 3. **Disputes.** Any dispute under subpart 1 or 2 relating to the employee's selection of a health care provider who is not a managed care plan participating health care provider shall be resolved according to part 5218.7000 [Emergency]. Any dispute relating to a health care provider's compliance with the managed care plan standards and procedures or treatment standards adopted by the commissioner shall be resolved according to part 5218.7000 [Emergency] ~~or~~. A health care provider who does not comply with the requirements in subpart 2 is subject to denial of payment for the services in accordance with the procedures in part 5218.7000 [Emergency] and sanctions under Minnesota Statutes, section 176.103.

5218.6000 [Emergency] CHARGES AND FEES.

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Billings for medical services under a managed care plan shall be submitted in the form and format as prescribed in part 5221.0700, subpart 2. The payment by the insurer or the managed care plan to participating and nonparticipating health care providers for medical services shall be according to the timeframes and procedures in part 5221.0600, subpart 3, and Minnesota Statutes, section 176.135, subdivision 6, and shall be equal to the maximum amount allowed under Minnesota Statutes, section 176.136, subdivisions 1a and 1b. A managed care plan may not require a health care provider to accept a lesser payment or pay a fee as a condition of receiving referrals from or becoming a participating provider in the plan.

5218.7000 [Emergency] DISPUTE RESOLUTION.

Disputes that arise between the employee and the managed care plan related to the delivery of health services under this chapter shall first be processed through the dispute resolution process of the managed care plan. The managed care plan dispute resolution process must be completed within 30 days of receipt of a request. If the dispute cannot be resolved, the commissioner ~~may issue an order to resolve the dispute~~ shall proceed under Minnesota Statutes, sections 176.106 and 176.305 or 176.2615.

5218.8000 [Emergency] MONITORING.

Subpart 1. **Audits.** The commissioner shall monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements.

Subp. 2. **Records.** All records of the managed care plan and its participating health care providers ~~shall be disclosed on request of the commissioner when necessary to ensure~~ relevant to determining compliance with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency] shall be disclosed upon request of the commissioner. ~~These~~ Records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes. The release of

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records filed with the commissioner is subject to Minnesota Statutes, sections 13.37, 145.61 to 145.67, 176.231, subdivisions 8 and 9, 176.234, and 176.138.

5218.9000 [Emergency] SUSPENSION; REVOCATION.

Subpart 1. **Complaints; investigation.** Complaints pertaining to violations of parts 5218.0100 to 5218.9000 [Emergency] or Minnesota Statutes, section 176.1351, by the managed care plan shall be directed in writing to the commissioner. On receipt of a written complaint, or after monitoring the managed care plan operations, the department shall investigate the alleged ~~rule~~ violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the ~~department determines on completion of the~~ investigation ~~that~~ reveals reasonable cause to believe that there has been a ~~rule~~ violation warranting suspension or revocation of provisional certification, the commissioner shall initiate a contested case proceeding under Minnesota Statutes, chapter 14.

Subp. 2. **Criteria.** Under Minnesota Statutes, section 176.1351, subdivision 5, the provisional certification of a managed care plan issued by the commissioner shall be suspended or revoked by the commissioner if:

A. service under the plan is not being provided according to the terms of the certified plan;

B. the plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of parts 5218.0100 to 5218.9000 [Emergency] or Minnesota Statutes, section 176.1351;

C. the managed care plan fails to comply with Minnesota Statutes, section 176.1351, parts 5218.0100 to 5218.9000 [Emergency], ~~and~~ or requirements of utilization and treatment standards adopted under Minnesota Statutes, section 176.83;

D. any false or misleading information is submitted by the managed care plan or ~~a member of the plan~~ participating

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provider; or

E. the managed care plan continues to use the services of a health care provider whose license, registration, or certification has been suspended or revoked ~~by the licensing board~~, or under Minnesota Statutes, section 176.103, or who is ineligible to provide treatment to an injured employee under Minnesota Statutes, section 256B.0644.

Subp. 3. **Effects.** ~~All contracts with insurers are void~~ No employee is covered by a contract between a managed care plan and insurer if ~~a~~ the managed care plan's provisional certification is revoked. The managed care plan may reapply for certification as specified in the order of revocation. Upon suspension of certification, the managed care plan may continue to provide services under contracts in effect if the commissioner determines injured employees will continue to receive necessary medical services under Minnesota Statutes, section 176.135.

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STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Adoption of the Rule of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

AFFIDAVIT OF DISCRETIONARY NOTICE OF RULEMAKING

STATE OF MINNESOTA)
) ss.
COUNTY OF RAMSEY)

Janis Kressling, being sworn says:

I hereby certify that on the 24th day of July, 1992, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice of Intent to Adopt An Emergency Rule by depositing in the State of Minnesota Central Mail System for United States mailing a copy thereof, with postage prepaid, to all persons and associations on the attached list who requested notice of the Managed Care Emergency Rules.

(Name) Janis Kressly

(Title) Exec 1

Subscribed and sworn to before me
this 27th day of July, 1992.

Julie A. Kress

KB/cb

JULIE A. KRESS
NOTARY PUBLIC—MINNESOTA
DAKOTA COUNTY
MY COMMISSION EXPIRES 10-30-97

DEB WELLS
Benefits Administrator

Hoffman® ENGINEERING

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ELECTRICAL/ELECTRONIC ENCLOSURES & ACCESSORIES

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TOM SPICZKA
Chief Administrative Officer

Kurt K MANUFACTURING COMPANY

KERN G. WALKER
Vice President,
Human Resources
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Office: (612) 572-1500

DEB KNUTSON
Vice President - Human Resources

Hoffman ENGINEERING COMPANY

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Anoka, Minnesota 55303-7504
612-422-2564
Fax: 612-421-1070

ELECTRICAL/ELECTRONIC ENCLOSURES & ACCESSORIES

Physicians
Main
East

Debra Wagner
Clinic Administrator
612/421-4217

East Main Clinic 612/421-7070 FAX 612/421-6836 • 550 East Main Street • Anoka, MN 55303
Northway Clinic 612/755-8182 • 13200 Central Avenue NE • Blaine, MN 55434
After Hours Urgent Care at Northway location only 755-8263

S

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Lake Calhoun Executive Center
3033 Excelsior Blvd., Suite 490
Minneapolis, MN 55416-4686

(612) 929-4685
FAX (612) 929-7016

WORKERS' COMPENSATION PROPOSED RULE MAILING LIST

Please check (√) the proposed rules you would like copies of when they become available. "Other" workers' compensation rules may include but are not limited to other medical, rehabilitation, benefit, procedural and practice rules implementing 1992 legislation and chapter 176.

Names and Addresses	Managed Care (Emergency Rules)	Health Care Provider Standards of Practice (Emergency Rules)	Other Workers' Compensation (Non-Emergency)
Amy Levy 1660 South Highway 100 Suite 356 Mpls, MN 55416			X
Elizabeth Melbye Health Root 557 Capitol Blvd - St Paul 55106	X	X	X
Kurt Schwarzkopf Blue Cross P.O Box 64560 St. Paul, MN 55164	X	X	
Holly Olsen 7500 Flying Cloud Drive CompCost, LLC. #875 Eden Prairie, MN 55344	✓	✓	✓
Bard Barker 600 Marquette St 56480 Preferred Work Care Mpls 55414	✓	✓	✓
Gary Westman MN DEPT OF EMPLOYEE RELATIONS P.O. Box 64081 ST PAUL MN 55164-0081	—	—	
Bob Murphy Diversified Medical 430 Oak Grove St. Minneapolis 55403	✓	—	✓
Diana Friede State Fund Mutual 7500 Flying Cloud Dr., #900 Eden Prairie, MN 55344	✓	✓	✓
Cindy Widman 812d Penn Ave. So. #252 Bloomington, MN	X		X
[illegible] 9021 Highpoint Eden Prairie, MN 55347	X	X	X
Dr. Kathy Bloom D.C. ATTN: 12107 12th Ave S Burnsville, MN 55337 Jeff	X	X	X
Andrew Aho ACN 5620 Smetana Drive Suite 225 Minnetonka MN 55[illegible]	X	X	X
Linda Kelley Sister Kenny Institute 800 E. 28th St. Mpls., MN 55407	X	X	X
JACKIE ROSS 7501 W 101ST ST #309 BLOOMINGTON MN 55438	X	X	X

WORKERS' COMPENSATION PROPOSED RULE MAILING LIST

Please check (√) the proposed rules you would like copies of when they become available. "Other" workers' compensation rules may include but are not limited to other medical, rehabilitation, benefit, procedural and practice rules implementing 1992 legislation and chapter 176.

Names and Addresses	Managed Care (Emergency Rules)	Health Care Provider Standards of Practice (Emergency Rules)	Other Workers' Compensation (Non-Emergency)
STEVEN H. OSTERKAMP Ethix midwest - 8500 Normandale Lake Blvd. Bloomington MN 55437	✓	✓	✓
M.F. Spallino, D.C. 1986 Hwy 96 White Bear Lake, MN. 55110	✓	✓	✓
David C Giliuson 14050 Pilot Knob Rd. #120 Apple Valley, MN. 55124	✓	✓	✓
Ed Spitler, Mgr., Staff Services VanWagner & Associates, Inc. 2626 East 82nd St., Suite 220 Bloomington, MN 55425	✓	✓	✓
Linda Davis 9916 Dunham Dr. Edina MN 55435	✓	✓	
Karen Gordon North Memorial Medical Center 3300 N Oakdale, Robbinsdale, MN 55422	✓	✓	
~~Bob~~ Fitzgerald, D.C. 133 W. Lake St Mpls 55408	✓	✓	✓
Michael R. Lamppa, D.C. 8746 Lyndale Ave S Bloomington, MN 55420	✓	✓	✓
Mary K Hahn Hazelden 3033 Chicago Ave S, Mpls 55414	✓	✓	✓
ROBERT J. STRUPP FAIRVIEW (1 FCO) 2312 S. SIXTH ST. MINNEAPOLIS, MN 55454	✓	✓	✓
Barb Dunbar Medcheck 1-380 Energy Lane St 111 St Paul MN 55108	✓	✓	✓
SHirley J. Friberg 2130 Fairways Lane Roseville, MN 55113	✓	✓	✓
Karen Baker Intracorp 10260 Viking Dr. Eden Prairie MN 55344	✓	✓	✓

WORKERS' COMPENSATION PROPOSED RULE MAILING LIST

Please check (√) the proposed rules you would like copies of when they become available. "Other" workers' compensation rules may include but are not limited to other medical, rehabilitation, benefit, procedural and practice rules implementing 1992 legislation and chapter 176.

Names and Addresses	Managed Care (Emergency Rules)	Health Care Provider Standards of Practice (Emergency Rules)	Other Workers' Compensation (Non-Emergency)
Lynne Meckstroth ERL 14031 Pennock Ave Apple Valley 55124	✓	✓	✓
Paula Heppelmann / Liberty Mutual 5402 Parkdale Dr Mpls Mn 55416	✓	✓	✓
Shelly Anderson 1301 Coon Rapids Blvd. Coon Rapids, Mn. 55433	✓	✓	✓
Andy Lynn 7506 Flying Cloud Dr Eden Prairie 55344	✓	✓	✓
Vic's Welding & Engrg Rosemount B. Wenzel 2829 & 185.5506	✓		✓
Patty Strait / Intercap 11045 Viking Dr Suite 502 Eden Prairie MN	✓	✓	✓
Jon Busse 3900 Cedarvale Dr. Ellingson & Assoc. Eagan, MN 55122	✓	✓	✓
Cliff Goede Liberty Mutual 5402 Pardale Mpls 55416	✓	✓	✓
Donald Boyd Liberty Mutual 5402 Parkdale Mpls 55416			
Mark Anderle, NRC 1700 W. Hwy 36, #400 St. Paul 55113	✓	✓	✓
Diana Friede State Fund Mutual 7500 Flying Cloud Dr., #900 Eden Prairie, MN 55343	✓	✓	✓
Ed Spitler 2600 E. 82nd #200 Bloomington, MN 55425	✓	✓	✓
Gary Livingston Lakes Rehabilitation 1633 NE Hwy 10 Spring Lake Park 55432	✓	✓	✓

WORKERS' COMPENSATION PROPOSED RULE MAILING LIST

Please check (√) the proposed rules you would like copies of when they become available. "Other" workers' compensation rules may include but are not limited to other medical, rehabilitation, benefit, procedural and practice rules implementing 1992 legislation and chapter 176.

Names and Addresses	Managed Care (Emergency Rules)	Health Care Provider Standards of Practice (Emergency Rules)	Other Workers' Compensation (Non-Emergency)
ODELL WILSON 302 E LAFAYETTE ST PAUL 55107			✓
(See next page)			

WORKERS' COMPENSATION PROPOSED RULE MAILING LIST

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Names and Addresses	Managed Care (Emergency Rules)	Health Care Provider Standards of Practice (Emergency Rules)	Other Workers' Compensation (Non-Emergency)
GLENDA KEY 1010 PARK AVE, MPLS 55404	✓	✓	✓
JOHN E. DIEHL 1600 NORWEST FIN. CNTR 7900 XERXES AVE. So., BLMGTN 55431	X	X	X
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BRIAN PELTO 16344 Milford Dr Eden Prairie MN 55347	✓	✓	✓
Wm Borden 4700 IDS, MPLS 55402	✓	✓	✓
Barbara LARSON THE CLARK Center River Heights Place 1410 Frontage Rd W. Stillwater MN 55082	✓	✓	✓
JUDY FABIG RNC - PO BOX 27243 MPLS 55427	✓	✓	✓
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all

all

all

WORKERS' COMPENSATION PROPOSED RULE MAILING LIST

Please check (√) the proposed rules you would like copies of when they become available. "Other" workers' compensation rules may include but are not limited to other medical, rehabilitation, benefit, procedural and practice rules implementing 1992 legislation and chapter 176.

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PAUL TAUTGES 2231 MCKINLEY ST NE MPLS MN 55418	✓	✓	✓
Iennon Rowen, Aetna Health Plans 7760 France Ave So. Suite 504 Mpls mn 55435	✓	✓	✓
Julie Haben 4867 Thielen Ave Mpls., MN 55436	✓	✓	✓
JOHN Brandt Jean 8500 Normandale Lk. Blvd Suite 1430 mpls 55437	✓	✓	✓
Thomas Bergquist 55343 and Associates 3000 Plymouth Rd. Mtka	✓	✓	✓
Don Wick 55441 12730 Fourty Fifth Plymouth	✓	✓	✓
Dennis Isernhagen 2202 water str Duluth, MN 55812	✓	✓	✓
David Thoreson 1870 Alta Vista Drive Roseville MN 55113	✓	✓	✓
Betty TEAL / J. BROOKS Assoc 8609 Lyndale Ave So, Blmgt 55420	✓	✓	✓
Patti Magnus Plymouth, Mn. 2025 Black Oaks Ln. 55447	✓	✓	✓
LARRY Hoverstem Airport Medical Clinic 7775 26th Ave. S. Mpls MN 55459	✓	✓	✓
Pamela Coubere Airport Medical Clinic 7775 26th Ave S Mpls. MN 55459	✓	✓	✓
R. D. Hall, MD CPMG suite 200 6401 University Ave NE. Fridley, MN 55432	✓	✓	✓

WORKERS' COMPENSATION PROPOSED RULE MAILING LIST

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Margaret Kasting State Fund Mutual 900 Wilson Ridge 7500 Flying Cloud Dr. Eden Prairie, MN 55344			✓
Bill HoKness & assoc. 133 Blue Earth St. MANKATO, MN. 56001			✓
RTW, Inc. / American Compensation Ins. P.O. Box 39327 Mpls 55423	✓	✓	✓
Brent Wilde F00-1 Fairview Hospitals 2312 S. 6th St. MPLS, MN 55454	✓	✓	✓
TIJERINA REHAB. SERVICE 4207 ALDRICH AV N MPLS MN 55412	✓	✓	✓
GARY J. MLYNEK A&H INTERNATIONAL 55113 2665 LONG LAKE RD. #220 ROSEVILLE, MN	✓		✓
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John Ramm - Ramm Placemnt 2205 Robert #208 St Paul 55107			
Connie Bloodgood ARC 16483 ELLER Dale MN EDEN PRAIRIE, MN. 55346	✓	✓	✓
Jan Christopherson 5148 park ave. So Mpls, MN 55408	✓	✓	✓
Jim Stein 4700 IDS, Mpls, MN 55402	✓	✓	✓

WORKERS' COMPENSATION PROPOSED RULE MAILING LIST

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Received these names late on Friday
so they were mailed on Monday, July 23, 198
Janis Keese

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

In the matter of the Proposed Adoption of the Rule of the State Department of Labor and Industry Governing Workers' Compensation Managed Care Plans

CERTIFICATE OF RULE NOTICE LIST

STATE OF MINNESOTA)
)ss.
COUNTY OF RAMSEY)

Charlotte K. Chilson, being sworn says:

I hereby certify that the list of persons and associations who have requested, pursuant to Minnesota Statutes, sections 14.14, subdivision 1a and 14.22 or 14.30, that their names be placed on the state Department of Labor and Industry, Workers' Compensation rulemaking mailing list is accurate, complete, and current as of this 24th day of July, 1992.

Charlotte K. Chilson
[Name]

Word Processing Operator
[Title]

Subscribed and sworn to before me this 24 day of July, 1992.

Cheryl A Bauer

KB/cj (190-1)

CHERYL A. BAUER
NOTARY PUBLIC—MINNESOTA
RAMSEY COUNTY
MY COMMISSION EXPIRES 11-06-97

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

In the matter of the Proposed Adoption of the Rule of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

AFFIDAVIT OF MAILING NOTICE OF RULEMAKING

STATE OF MINNESOTA)
)ss.
COUNTY OF RAMSEY)

Janis Keesling, being sworn says:

I hereby certify that on the 24th day of July, 1992, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notice of Intent to Adopt An Emergency Rule by depositing in the State of Minnesota Central Mail System for United States mailing a copy thereof, with postage prepaid, to all persons and associations on the Workers Compensation rule mailing list.

Janis Keesling
[Name]

Exec I
[Title]

Subscribed and sworn to before me this 27th day of July, 1992.

Julie A. Kress

KB/cj (190-1)

JULIE A. KRESS
NOTARY PUBLIC—MINNESOTA
DAKOTA COUNTY
MY COMMISSION EXPIRES 10-30-97

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STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed
Adoption of Emergency Rules of the State
Department of Labor and Industry,
Governing Workers' Compensation
Managed Care Plans

NOTICE OF INTENT
TO ADOPT AN
EMERGENCY RULE

Notice is hereby given that the State Department of Labor and Industry intends to adopt the above-entitled emergency rules. The statutory authority to adopt the emergency rules is contained in Minnesota Statutes, section 176.1351, subd. 6 (1992 Laws of Minnesota, Chapter 510, Article 4, § 13). The agency, in adopting the rules, is following the procedures set forth in the Administrative Procedure Act for adopting emergency rules in Minnesota Statutes, sections 14.29 to 14.36.

All persons have 25 days after publication to submit data and views on the proposed emergency rules or any part or subpart of the rules in writing. Comments must be received by 4:30 p.m. on August 21, 1992. Comments must be submitted to:

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316
Telephone: (612) 297-5213

A copy of the proposed rules is attached to this notice.

A free copy of the proposed emergency rules is available by contacting Janice Keesling, Rehabilitation and Medical Affairs at (612) 296-8213.

The proposed emergency rules may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed emergency rules as noticed.

Upon adoption of the emergency rules by the agency, the emergency rules as adopted and its supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rules, must submit the written request to Pam Zembal at the above address.

The emergency rules will take effect five working days after approval by the Attorney General and be effective for 180 days. The emergency rules will be continued in effect for an additional 180 days if the agency gives notice of continuation in accordance with Minnesota Statutes, section 14.35.

A fiscal note is not required by Minnesota Statutes § 14.11 because the rules do not require the expenditure of public money by local public bodies.

7/20/92
Date

John Gartman FOR
JOHN B. LENNES, JR.
Commissioner

KB/cj (190-1)

Energy Assistance Program
Community Based Services Division
670 American Center Building
150 East Kellogg Boulevard
St. Paul, MN 55101

NOTICE IS HEREBY GIVEN that the public hearings for the 1993 Energy Assistance State Plan will be held at:

CITY	HEARING SITE AND ADDRESS	TIME	DATE
St. Paul	MN Senior Federation 1885 University Avenue Iris Park Place lower level conference room St. Paul, MN 55101	1:00-3:00 p.m.	7/14
Duluth	Damiano Center 206 West 4th Street Duluth, MN 55805	3:00-5:00 p.m.	7/16

Oral and written testimony may be submitted at the hearings. Written testimony will also be accepted at the Community Based Services Division address until 5:00 p.m., Friday, July 31, 1992. All comments will be considered by the Department of Jobs and Training, Community Based Services Division.

Department of Labor and Industry

Workers' Compensation Division

Notice of Solicitation of Outside Information or Opinions Regarding Proposed Workers' Compensation Rules

NOTICE IS HEREBY GIVEN that the State Department of Labor and Industry is seeking information or opinions from sources outside the agency in preparing to propose the adoption and amendment of workers' compensation rules. The proposed rules will clarify and implement the statutory changes contained in 1992 *Minnesota Laws*, chapter 510; change existing workers' compensation rules of the Department of Labor and Industry; and adopt new workers' compensation rules. The scope of subjects addressed by new rules is expected to be broad. Therefore, the Department is seeking information or opinions on any of its existing rules or concerning subject matters for which the Department is authorized to adopt rules relating to workers' compensation. This may include, but is not limited to, policies, procedures, forms, and interpretations of the law.

The adoption of rules is authorized by the following *Minnesota Statutes:*

Sections 79.253, subd. 5, 175.17, 175.171, 176.021, subd. 5, 176.081, subd. 6, 176.101, subd. 3e, 176.102, subd. 2 and 9, 176.105, 176.129, subd. 4a, 176.132, subd. 4, 176.135, subd. 2 and 7, 176.1351, 176.136, 176.15, subd. 2, 176.185, subd. 1, 176.191, subd. 3, 176.194, subd. 3(3) and 5, 176.221, subd. 6a, 176.231, subd. 5, 176.232, 176.238, subd. 8, 176.239, subd. 2 and 3, 176.245, 176.285, 176.291, 176.361, subd. 1, 176.669, subd. 2, 176.83, and 176.84, subd. 3.

The State Department of Labor and Industry requests information and opinions concerning the subject matter of the rules. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally. Written statements should be addressed to:

Leo Eide, Assistant Commissioner
Department of Labor and Industry
443 Lafayette Road
St. Paul, Minnesota 55155-4319

Oral statements will be received during regular business hours over the telephone at 612-297-3537 and in person at the above address.

Oral and written statements will also be taken at public meetings scheduled as follows:

MEDICAL ISSUES ONLY:

July 16, 1992, from 8:30 a.m. to 12:30 p.m. in the Richfield Senior High School Lunchroom, 7001 Harriet Avenue South, Richfield, Minnesota;

-and-

NON-MEDICAL WORKERS' COMPENSATION ISSUES:

July 17, 1992 from 8:30 a.m. to 12:30 p.m. in the Richfield Senior High School Lunchroom, 7001 Harriet Avenue South, Richfield, Minnesota.

The purpose of these meetings will be to solicit input to assist in rule drafting, and not to review proposed rules. Therefore, a copy of proposed rules will not be available for review at the time of the July meetings. Further opportunities for public comments concerning published proposed rules will be available as provided in *Minnesota Statutes*, Chapter 14.

All statements of information and opinions will be accepted until rules are proposed and thereafter as provided by *Minnesota Statutes*, Chapter 14 or until further notice closing the comment period is published. Any written material received by the Department of Labor and Industry shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that rules are adopted.

Dated: 22 June 1992

John B. Lennes, Jr., Commissioner

Department of Natural Resources

Division of Fish and Wildlife, Section of Fisheries

Notice of Intent to Solicit Outside Information or Comments Regarding a Proposed Rule Governing the Construction and Operation of a Quarantine Facility for Fish Eggs

NOTICE IS HEREBY GIVEN that the Minnesota Department of Natural Resources is seeking information or comments from outside the agency in preparing to propose the adoption of a rule governing the construction and operation of a quarantine facility for fish eggs. Adoption of the rule is authorized by *Minnesota Statutes*, section 17.496, which requires the agency to adopt rules in consultation with the commissioner of agriculture and the aquaculture advisory committee.

The Minnesota Department of Natural Resources requests information and comments concerning the subject matter of the draft rule. Interested or affected persons or groups may submit statements of information or comment in writing or orally. Written statements should be addressed to:

Steve Hirsch
Department of Natural Resources
Division of Fish and Wildlife
Fisheries Section
500 Lafayette Road
St. Paul, Minnesota 55155-4012

Oral statements will be received during regular business hours over the telephone at 612-296-0791 and in person at the above address.

All statements of information and comments **will be accepted until July 22, 1992.** Any written material received by the Minnesota Department of Natural Resources will become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that the rule is adopted.

Dated: 22 June 1992

Roger Holmes, Director
Division of Fish and Wildlife

Department of Revenue

Appeals, Legal Services, and Criminal Investigation Division

Notice of Solicitation of Outside Information or Opinions Regarding Proposed Rule Governing Sales and Use Taxation Relating to Isolated or Occasional Sales

NOTICE IS HEREBY GIVEN that the Minnesota Department of Revenue is seeking information or opinions from sources outside the agency in preparing to propose the adoption of a rule governing sales and use taxation relating to isolated or occasional sales. The adoption of this rule is authorized by *Minnesota Statutes*, section 270.06 which requires the commissioner of revenue to make, publish, and distribute rules for the administration and enforcement of state tax laws.

COPY

MINNESOTA DEPARTMENT OF LABOR AND INDUSTRY
WORKERS' COMPENSATION DIVISION
PUBLIC HEARINGS

DATE: July 16, 1992

TIME: 8:30 a.m. to 12:30 p.m.

LOCATION: Richfield High School
Richfield, Minnesota

REPORTED BY: Debbie L. Olson
Southwest Reporters, Inc.

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MR. EIDE: Good morning Ladies and Gentlemen. My name is Leo Eide, Assistant Commissioner for the Workers' Compensation. I'd like very much to thank you for coming out this morning for this first informational meeting on implementation of the new portions of the Workers' Compensation laws, which today will be specifically dealing with medical issues.

As most or all of you are well aware, the legislature passed a number of measures during a closed session amending the Workers' Compensation law. Included in that was creation of authorization for managed care organizations for treatment of Workers' Compensation injuries and authorization for creation of standards of care among other features, also, provision for establishment of fee schedules for independent medical examinations and a number of other related medical issues.

The purpose of these meetings is to receive information, advice, counsel from the public. We're not here today to present proposed rules or critique. We will have those rules out as soon as we can. And today we're in the process of getting more information to make sure that we don't leave out areas of interest and overlook matters that appropriately should be included in any rules of the implement to facilitate the new law.

It should be noted; however, that the Commissioner has

made it very clear to us that he wants us to examine the entire Workers' Compensation law and the entire Workers' Compensation system. So we are not confining ourselves to the creation of administrative rules only related to the new amendment, but are rather reviewing the entire system to try to make it all sufficient as possible.

We have a beginning list of people who want to speak to the issues today. And it's not too long at this point. And I'm sure that we'll have an opportunity for anyone who wants to speak on the record. If at some point during the morning it begins to become apparent that we won't be able to get everyone in this room, we do have two side rooms set up down the hallway with court reporters who would be able to take statements there. At this point it doesn't appear that we need to open those rooms. And we will do that later if it becomes necessary.

It's my intention to -- it's about 8:38 now -- it's my intention to take a five or ten minute break in approximately one hour. And we will review whether we want to open up the side rooms for additional statements at that point. And the staff will be watching if it becomes apparent we need to, we might even do it sooner.

For the purposes of maintaining an appropriate record, when the speakers come to the microphone, we would like them to identify themselves by name and spell their name so

that the court reporter makes sure that she has it correct. And identify any organization that you may be speaking on behalf.

And that's just about the extent of the rules of the game for today because we're trying to do this in a very informal matter. Unless we get to have so many people speaking that it becomes necessary, I don't think we need to go to a formal time limit just now. If it begins to become apparent, we're going to have so many speakers that we can't get through it, I would propose that we would then go to an eight minute speaking limit. And we have that set up to the microphone with the red light that will come on if we begin to use that system.

We would also be very happy to accept any written material that you want to present to us today in support of your statements or in lieu of your statements if you should choose to do it that way. We'll get right to it. I apologize in advance if I mispronounced anyone's name. They're written for -- many of them as signatures and so I'm not entirely sure, but I believe the first person requesting to speak is Bob Fitzgerald; is that correct. Approach one of the microphones and identify yourself and spell your name and any organization you're with, please.

* * *

MR. FITZGERALD: Bob Fitzgerald is my name. I'm a chiropractor. And I represent the International Chiropractors Association. And my address is 133 West Lake Street, Minneapolis, Minnesota. 55408. And I appreciate the opportunity to speak this morning on the issues of the Workers' Compensation law and past law that has just enacted for this last session. Chiropractors --

MR. LEONARD: Can we have a little amplifier there.

MR. EIDE: Okay. Is that better.

MR. FITZGERALD: I'm Bob Fitzgerald. I represent the International Chiropractors Association. Can you hear me?

MR. EIDE: Is that better. More. Why don't you move it up more. Move the mike just a little more towards you.

MR. FITZGERALD: Short people have short voices. Bob Fitzgerald is my name. I represent the International Chiropractors Association. And have for several years in the State of Minnesota. I've practiced over 40 years in Minneapolis. And I'm certified in spinal evaluation and disabilities.

Chiropractors can fit into the newly enacted Workers' Compensation law and under the present state statutes,

Minnesota Statutes 148.01 to 148.15. I have here the present statutes that I would like to read in the present scope of practice to clarify our position. For the purposes of this, this is in 148.01, Subdivision 1. For the purpose of Sections 148.01 to 148.15 chiropractors is defined as a science of adjusting any abnormal articulations of the human body, especially those of the spinal column, for the purposes of giving freedom of action to a pinched nerve that may cause pain or deranged function.

In Subdivision 2, which I think is very important, the practice of chiropractors is not the practice of medicine, surgery or ophthalmology so we are separate and distinct.

The present end updated policy handbook of the International Chiropractors Association covers that and will fall within the State Statutes of Minnesota. It's a policy handbook and the Code of Ethics, Second Edition. And it was published in April of 1991. And I would submit that after I make my presentation to the Board, sir.

Chiropractors are primary providers. Chiropractors refer to other health care providers when necessary and accept referrals from health providers when it was in the patient's best interest. In spite of the recent anti-trust ruling of Wilt versus the American Medical Association, the medical profession has not entirely gotten used to

referring patients to chiropractors. While knowing they cannot help, they still don't do it on a percentage and ethical basis.

If free choice of health care is to continue for the sick and the injured worker, there cannot be the obvious discrimination exhibited against the patient and the chiropractic profession or by any managed health care organizations. Many of the managed health care groups are under medical pressure for their direction. There are some managed care groups that gain financially by not performing requested health services for the patient.

Doctors of chiropractic should be allowed to accept patients in need of chiropractic care on the same equal basis as medical doctors and osteopaths. This should be done without encumbrance to the patient or the chiropractor. An example of the encumbrance would be interference done by burdensome paperwork. The International Chiropractors Association advocates the Department of Labor, chiropractors, and patients follow Minnesota Statutes 148.01 to 148.15.

The Minnesota Board of Chiropractic Examiners has adopted administrative rules that extends to the scope of chiropractic without the advice and the consent of the legislature. The Minnesota Board of Chiropractic Examiners has the obligation to adopt rules that fall within their

jurisdiction, no more, no less. The Minnesota Board of Chiropractic Examiners has gone beyond their authority in adopting acupuncture, medical differential diagnosis, physical rehabilitation therapy, prescribing vitimins, homeopathy, naturopathies, medical rehabilitation and herbal medicine.

The chiropractic profession goes on the basis if it is not prohibited, then you can do it. This compass attitude is entirely opposed by the International Chiropractors Association.

The International Chiropractors Association presents a rational posture by following the present state statutes in all respects. Chiropractors should render spinal adjustments for adjustments to the joints of the body, especially subluxated vertebrae -- subluxated means partly displaced vertebrae to reduce in pinched nerves causing pain and deranged function -- the use of physical examination of the skeletal system, x-rays of the skeletal system, and other orthodox instruments that are not evasive in order to detect subluxations of the spine of the joint of the body are acceptable.

The chiropractic profession has been licensed since 1919 in Minnesota. The rational weight for chiropractors to continue to serve the public is to follow the International Chiropractors Association policy handbook, Code of Ethics,

and standard practice. This will be cost effective and quality assured.

And I appreciate the time that you gave me this morning to speak. At any time there's any questions, I'd be glad to answer them, attempt to.

MR. EIDE: Thank you very much.

MR. FITZGERALD: Just as a footnote, I purchased this from the book store at -- well, the Chiropractic Board just recently in the latest update laws and the latest in rules that are adopted by the Chiropractic Examining Board. And overnight chiropractors are just about covering A to Z, which we certainly object to. I'd like to leave this booklet if I may.

MR. EIDE: The next person signing up to speak -- Before that, I'd like to point out that there is a sign up list out in the lobby to sign up if you want to obtain a copy -- if you want to receive a copy of the proposed administrative rules as soon as we publish them.

We anticipate that the next week on the 27th the manage care proposed rules for certification of managed care will be published. And, hopefully, approximately a month after that we will publish the proposed rules for standards of care and other aspects of medical issues that are -- for which we are authorized to do emergency rule making.

And we would hope that sometime around Labor Day we would

be publishing all of the other proposed rules that are on the regular rule making process. So if you want a copy of those rules, there's a sheet out in the lobby at the table out there that you can sign up to be on the mailing list for that.

The next person requesting to speak is Steven Osterman.

MR. OSTERMAN: I'd waive that at this point.

MR. EIDE: Okay. I believe David C. Giliuson is the next person on the list to speak.

* * *

MR. GILIUSON: My name is Dr. Giliuson, G-I-L-I-U-S-O-N. I practice chiropractic in Apple Valley. I'm not representing any group other than the Giliuson family. And I'm quite concerned about the changes in the Workers' Comp.

A couple of things I would ask you to consider when looking at these rules or forming the laws -- and I'm not sure how far along these are -- is to remember that there are some of us out there that are individual practitioners. We rely on ourselves. We don't have a lot of political clout. And the workers are a very important part of your source of income. When you set these rules up, if you would try to remember several things or keep these in mind.

If you would please allow existing patients to visit their present chiropractor for job related injuries. If there's some way that you can keep that in mind or if that would be possible. Chiropractors are very territorial when it comes to their patients, at least mine are more like distant family rather than people who just parade through your office. When their health care becomes an issue, I'm very concerned with them.

Also, having to do with these managed care organizations. If you would please, when these are set up, allow anyone who wishes to get into them an opportunity. If they are anything like the HMO's, PHP Share, Ethics, Chiro care, et cetera, et cetera; they're virtually impossible to get into. I've tried for approximately four years now to get into any one of those and have always gotten a polite, we are not accepting applications at this point.

I would hope that you would consider these. I want to thank you for your time. And if I can be of any help, I would gladly discuss this with you at any time. Thank you.

MR. EIDE: Thank you. Ann Tessman.

MS. TESSMAN: No.

MR. EIDE: Pass. John Diehl.

* * *

MR. DIEHL: Thank you very much. And my name is John Diehl. I'm with the Larkin Hoffman Law Firm at 1500 Norwest Financial Center, 7900 Xerxes Avenue Bloomington. And I'm representing Diversified Medical, which is an organization that arranges for independent medical evaluations. And I want to submit a written statement for the record and; therefore, I can be quite brief in my presentation.

The long and short of our point of view. Our advice to you, I guess as you put it, is that in the development of regulations establishing fees for independent medical evaluations we would urge that the Department adopt a market oriented or market value approach.

I suppose there are two or three, maybe more, I don't know, methodologies that you might lien on in developing these regulations. And we would urge that you select this approach as specifically as we envision that approach, that it would involve identifying the purchasers of IMEs and the providers of IMEs and from them learning the variables that go into establishing IME fees, such as perhaps the nature of the specialty involved in the physicians specialty, the travel element that may be involved, and other appropriate variables, and then establishing a regulated fee that is based on current market value. We urge this approach.

And in light of our observations -- which I will try to

summarize briefly -- there are presently, as we see the state, two services, my client and one other, that provide a service of arranging for IME examinations. And this -- Their services encompass both the professional service involved and certain administrative support services.

In addition, we estimate that there are only about 30 or 40 -- and I might say that I challenge that because it doesn't seem like very many people -- but 30 or 40 physicians who are trained and experienced in providing this service state wide. This is a relatively limited supply in providing a very important service in the Workers' Compensation claim ajudication and litigation process.

And so my next natural question was, well, how come more people don't do this. And I think the answer is that there's a complex set of services that perhaps don't meet the eye. This is not the same thing as merely conducting an examination of a patient as one would in the course of therapy. It is a far more complicated process than that, and plus the physicians who are involved of necessity have to be not only well qualified medically, but they have to have a great deal of sophisticated understanding of the legal system and the Workers' Compensation legal system. And they have to be experienced in and willing to get into the fray of the litigation because almost always these

services lead to at least discovery testimony if not testimony at trial.

And this is a set of skills and services that goes beyond what one would normally think of in a physician's practice. This is forensic medicine. And we think it's a different market than just -- and I'm not by any means belittling it -- but just basic care.

And so we think the appropriate approach would be to start by determining market value and taking the regulated fees along those lines, which would then give the state a handle on these fees on an affording basis. If you would take a different approach and end up with a high fee, which I don't think is your objective, obviously the cost containment objective of this statute would be lost.

If you were to take some other approach and fix a fee that is not within current market value, then the predictable result would be that there would be even fewer people involved in this system. And with that, the statute requirements for timeliness of the exam and so on would be very difficult to achieve.

The present experience, which I think most people agree, is the case of the quality of the physicians; that is, their clinical competence and expertise. That quality of the physicians involved would naturally decline. And I think that the net result would be increased cost in the

litigation process and the Workers' Compensation in general. So we urge you at this early stage of this process to focus on a market value approach in establishing these fees.

MR. EIDE: Thank you. The next person requesting to speak is Marie Quilling.

MS. QUILLING: I'll waive that.

MR. EIDE: Pardon me.

MS. QUILLING: I'll waive that.

MR. EIDE: Stewart Leonard.

MR. LEONARD: I'll waive.

MR. EIDE: This may be a short meeting. Amy Levy.

* * *

MS. LEVY: Good morning. My name is Amy Levy. A-M-Y, L-E-V-Y. I'd like to read my statement into the record. And I'll provide you with a copy of it. I'm Director of Legal Services for Medical Evaluations --

MR. EIDE: Could you put the microphone a little closer to you. I'm not hearing you.

MS. LEVY: I'm short too. How's that. I'm Director of Legal Services for Medical Evaluations, Incorporated, a firm which provides independent medical

examinations and reports to the plaintiffs and defendants in civil actions and employees and employers in Workers' Compensation cases.

Approximately one-half of our work is in the Workers' compensation area. And most of that work is performed at the request of the employers.

At the outset, it is important to note that Section 21 of the Workers' Compensation law, as it was originally enacted in 1913, provided that the employer had a right to have the injured employee examined by the physician of the employer's own choosing. This provision has been in the law for 79 years and must be recognized as one of the basic elements of the agreement between employers and employees which result in the Workers' Compensation law.

Another critical element which affected the way that independent medical examinations are done was the change in the 1980's, which requried the filing of the independent medical examiner's report within 120 days for the commencement of the action. Prior to that time, independent medical examinations were arranged by employers with doctors at the doctor's convenience, which sometimes meant a wait of many months. The 120-day requirement made it mandatory that independent medical examinations be conducted expeditiously. Our organization is one of those which was created to meet this need.

The doctors who affiliate with our organization are committed to promptly and expeditiously conducting these examinations and complete their reports so that the interests of a speedy resolution of the case are met. These doctors are independent contractors. And the requirement that they interrupt their normal work schedules to undertake the task of an independent medical examination in a particular case, on an expedited basis; of course, is an expense which the system must bear.

Without organizations such as ours, the ability of the employer to adequately meet the requirements of the 120-day independent medical examination report filing period would be greatly impaired.

In the interest of the constitutional right to due process of law and the prohibition against impairment of contracts, the employer should be allowed to engage the physician of his choice to conduct the independent medical examination. This means those physicians must be allowed adequate compensation for the time and expertise which they use in meeting the employer's request for an independent medical examination.

Article 4, Section 17 of the new Minnesota Workers' Compensation Reform Measure requires the Commissioner to adopt rules which reasonably limit amounts charged for independent medical examinations.

There may be abusers in the system who overcharge for their services in conducting independent medical examinations. And these practices must be stopped.

Obviously, the legislative intent of Section 17 is to require the commissioner to take the necessary action and eliminate those abuses. On the other hand, it is important to note that the legislature recognize that the limitations must be reasonable.

At the present time the fees which are charged by our organization and others, which constitute a vast majority of the independent medical examinations done, are in fact reasonable.

While these fees differentiate among various disciplines and make other allowances for different circumstances, the net result is a fee which adequately compensates the doctor for his or her time and expertise and does it for a fair and reasonable cost to the employer.

If the commissioner adopts rules which unreasonably limit the amounts to be charged for independent medical examintions, doctors would be unwilling to give the required priority to Workers' Compensation independent medical examinations and, in many instances, would be unwilling to do them at all.

The employer in the State of Minnesota would thereby be deprived of one of the basic early rights under the

Workers' Compensation law to have the employee examined by the physician of the employer's own choice, even if he were willing to pay the entire cost for that physician.

We, therefore, urge the Commissioner of Labor and Industry to carefully consider the available information and the circumstances which surround the request for an independent medical examination and adopt rules which eliminate the abuses in the system and at the same time give employers the ability to contract with the physician of their choice for independent medical examinations and at the same time adequately compensate those health care providers.

We will be providing addition information to the Commisioner in the future. And we are available to answer any questions which he might have or anyone on the staff might have with respect to those issues. Thank you for listening to our concerns.

MR. EIDE: Thank you. You stated you are going to be providing additional information later.

MS. LEVY: Yeah. Within the next two weeks. Will that be enough time.

MR. EIDE: Thank you.

MS. LEVY: And if you do have any questions, I am available, anybody on the staff.

MR. EIDE: Gary Westman.

* * *

MR. WESTMAN: Thank you. My name is Gary Westman. And I'm a representative of the State of Minnesota as a self-injured employer. And my question specifically here today is in regard to the post medical --

MR. EIDE: I don't believe that the folks can hear you.

MR. WESTMAN: My question is with regards to the manage care programs. Specifically, I understand there is going to be allowances allowed for the employees to treat outside of the managed care. The issues -- Three questions that I have would be, if an employee is allowed to treat outside of the places; for instance, if they had prior treatment with the physician or a medical provider, will the Department specifically define what constitutes a treatment plan?

Will the treatment plan have to be related to the same type of injury as the subsequent work injury?

And will there be a specified time period between the prior treatment plan and the subsequent work injury, which would allow the employee to treat outside of the managed care program?

And we ask these questions as a self-insured employer in

hopes that disputes arising around the area of allowing employees to treat outside a managed care plants can be minimumized and not left open to the legal system of the Workers' Compensation policy.

MR. EIDE: Gloria Gebhard of my staff is going to respond briefly to this. It isn't our intention to go in deeply into that during questions today because we're trying to go gather information; but Gloria will tell us a little bit about what we worked on.

MS. GEBHARD: We have made some attempt to in the area that you brought up this morning. And any information that you can give us in assisting with those definitions we will certainly be looking at them.

I'm not exactly sure what the final rules are going to be, temporary rules, are going to say about that; but you will have an opportunity give information on that. So if you have any information, please leave it with us.

MR. WESTMAN: Thank you.

MR. EIDE: Therese Berquist. Perhaps I didn't even come close to pronouncing is her name. Scott Mayer. Anyone else of the folks that previously past now want to speak.

* * *

MR. MAYER: Good morning. My name is Scott Mayer.

MR. EIDE: Could you put the microphone close to you.

MR. MAYER: Good morning. Is that better.

MR. EIDE: Can you hear in the back?

MR. MAYER: My name is Scott Mayer. I'm the Director of the Minnesota Chiropractic Association. The Minnesota Chiropractic Association first of all would like to commend the Department on their hard work and in formulating rules regarding the relative value fee schedule and treatment matters for the care of low back and upper extremity injuries.

Both in the 1991 and 1992 legislative sessions this association has supported the Department's recommendations for prompt payment strategy, which included the development of the relative value fee schedule. And as you know, the chiropractic profession is the only health care profession in the state that develops a comprehensive set of standards for the conditions that diagnose and treats.

We believe that proper administration, both the relative value fee schedule and the adoption of the treatment perimeters, can do much to control the health care cost component of the over all compensation system.

A greater challenge for the Department; however, is the

implementation of a mechanism to certified managed care organizations that can help detain costs without depriving workers to the care in which they're entitled.

If the only concern of the legislature was to save money, that goal would not be difficult, simply deprive the injured worker needed care. However, the concern of missed days of work, increased competitive injuries, not to mention the burden on the employee, quickly surpass the money saved on the front end of such a program.

Several years ago this state had a Workers' Compensation plan in place that was a failure. Now some insurance companies have resurrected this plan and are attempting to voice it upon the injured work. It's called a company doctor. Managed care insurers are attempting to follow all workers down to one narrow course of treatment by restricting their original treating doctor then hoping at this point of the injury the doctor will refer out to another health care provider.

They argue that from prohibiting an injured worker from seeing the provider group from his or her choice, and instead limiting them to one providing group, is somehow going to save the system money. This path that some insurers would like to lead the Department down is not the right path for three basic reasons:

No. 1, it does not save money. Eliminating access to a

health care provider group that utilizes more conservative techniques is not causation. Several studies indicate that utilizing chiropractic care as an alternative to surgery can be very cost effective, especially when factoring time off work. The treatment standards soon to be implemented by the Department will be a very effective mechanism to insure that the chiropractic care will be managed wisely.

No. 2, this path does not provide the employee with any self-determination. Twenty-five percent of all workers with back injuries seek chiropractic care exclusively in Minnesota. And one-third of all workers with back injuries use chiropractic care in conjunction with medical care. Prohibiting such a large percentage of workers from seeking the health care providing group of their choice creates an antagonism that presents itself throughout the treatment process, slowing recovering treatment and increasing cost.

And third, the Minnesota legislature intents that injured workers in this state have access to the health care provider of their choice.

Legislation considers several remedies for the high cost of Workers' Compensation in this state. And what they agreed on was the right of injured workers to the health care provider group of their choice. Language in the Workers' Compensation lesgislation specifically states that a managed plan cannot "discriminate against or exclude from

participation in the plan any category of any health care provider." And give the Commissioner power to assume certification of any managed care plans that "unfairly restricts direct access within the managed care plan to any health care provider or profession."

This Department has the opportunity to rule making of adopting the managed health care in the Workers' Compensation that lays new ground in creating sufficient mechanisms for containing health care cost and allowing for the better quality care. Frequent standards of the relative value fee schedule are invaded ways in accomplishing these goals. Relying on a competent doctor mechanism is converting back to an old system that did not work in the first place. Minnesota injured workers deserve better than that. Thank you.

MR. EIDE: Thank you. Therese Berquist.

* * *

MS. BERQUIST: Good morning. My name is Therese Berquist. Good morning. My name is Therese Berquist. It's spelled T-H-E-R-E-S-E, B-E-R-Q-U-I-S-T. As a wife of an independent heating and cooling contractor, I hope for the employers as reasonable Workers' Comp rates as possible. My specific purpose here is so speak out for

what is just.

It's my understanding that pretty important decisions are being made in the areas of cost containment.

I'll get to the point. I do not want to see a medical keeper when it comes to an injured worker seeking or receiving chiropractic care for a spinal problem. Until there is a greater understanding of the benefits of the chiropractic among the medical field, there will be bias that will postpone wellness and return to work.

In this country -- and particularly Minnesota being a home of the Northwestern Chiropractic College and the home of the Grove Harris Research Center -- citizens will no longer stand for such bias.

A medical gate keeper is an insult to doctors in chiropractic who have mastered studies of the spinal muscular system.

I would like to present how well educated the chiropractic profession. Please note the similar subject areas studied by both the chiropractor and the M.D.

Chiropractors complete more class hours in anatomy, physchology diagnoses, neurology, x-ray, and orthopedic. Down below there are subject studies then by chiropractors alone and M.D.s alone. Adjusting and manipulation are within the chiropractors' expertise. Pharmacology and general surgery are the M.D. Having an M.D. overseeing

areas of spinal correction of injured workers seems as inappropriate as having a chiropractor overseeing general surgery practices.

Please consider a better managed care method utilizing chiropractic standards of practice. All I ask is that the facts are studied. A chiropractor's care is cost effective.

The Minnesota Department of Labor and Industry study reports chiropractic costs one-half of that of medical care in records to back injuries. And chiropractic's care returns patients to work in no waste of time. Any increase in chiropractic benefits to the injured employee will have to hold up as just and justifiable.

In case you're wondering where on earth did this speaker come from, I'll tell. I've been in chiropractic assistance for 17 years, part-time that is. I'm on my own time today in an effort to protect the rights of injured workers and the rights of their children and my children who are coming of age. Please continue to allow them the courtesy to choose their -- to choose a doctor of their own choosing. Thank you very much.

MR. EIDE: Do we have other people waiting to speak at this time. If you would approach the microphone.

* * *

MS. ISERNHAGEN: My name is Susan Isernhagen. I'm the President of Isernhagen in Duluth Minnesota. That's a physical therapy --

MR. EIDE: Perhaps if you could pull the microphone. They're having trouble hearing. We've got a feedback perhaps from hearing the volume.

MS. ISERNHAGEN: Okay. I'm Susan Isernhagen, President of Isernhagen, Inc., clinic of freestanding physical therapy group in Duluth, Minnesota. I'm speaking here just as an individual, but I am a member of the Minnesota Physical Therapy Association.

I want to just mention that physical therapists have been a critical part of returning injured workers to work for many years. In this room we do have some leaders in the physical therapy process who also teach naturally concepts regarding the injured worker and getting them back to work sooner and safer.

Also, the Minnesota Physical Therapy Association has spent much time and effort in defining what we do, defining physical therapy practice, work conditioning, work hardening, and functional capacity evaluations. So we have been very tentative to the Department of Labor and Industry when it comes to trying to provide better services for the injured worker.

With advent of large costs in the Workers' Compensation system, physical therapist have tried to look at a better way to get people back to work.

One of the ways is to get out of the large systems. And we have seen a change to some private independent work hardening centers as well as hospitals developing departments that specialize in Workers' Compensation.

In our own experience we have found that by dealing directly with the employer and the QRC that we can contact employers, injured workers, cut down the communication barriers, and get injured workers back to work in a very cost effective manner.

Our clinic has only been open for four months in Duluth. And we have seen a tremendous increase in work referrals because I think it is that smaller independent ability to communicate system that we don't get very democracy. So that's kind of a past history of some of the things that have happened in Minnesota.

But some of the things that we're concerned about have to do with the new law. It seems that some of the opportunities that the new law brings also brings a shutdown of some of the systems we've tried to develop. For example, right now workers seek people who care about them, and they do seek to go back to work.

In the new system it is possible the worker will not have

a choice to go to their own medical provider, and that would include physical therapists. And we have seen workers call physical therapists to say we would like to work with your system.

We are afraid that's no longer going to be available to them. We're very concerned about the lack of workers choice. We also -- Some of the smaller groups of us have seen the larger institutions sometimes have a monopolistic attitude toward the way they manage Workers Comp care.

We are also, in our own sense, worried about the anti-trust implications of having managed care that doesn't allow for other people to be in the system.

Lastly, we have tried to market directly to the employer and the employee to try and go out to the work site and bring people in, go and help them go back to work to make sure they don't fall through the Workers' Compensation crack.

We have had employees come directly to us asking if we cannot do a certain portion of the care, even though they've tried to get in with other medical institutions. We are very afraid that the new managed care system may take that employer's ability to come directly to the smaller provider away; thus, meaning the employer will be locked into a bigger system and no longer able to make a choice to perhaps select a smaller provider.

So we would, in our own organization and I may speak for other physical therapists here, ask that the Commissioner of the Department of Labor and Industry in writing the rules find a way for the independent smaller responsive provider to be able to work in the managed care system, to allow the managed care systems to open doors to contracting with more than one physical therapist provider if, of course, we need the standards of the managed care organization.

We ask that in the rules the employer still be able to seek out providers of services and ask the managed care organizations to be responsive also.

So in summary, I would ask that we hope that this trend towards managed care is not a trend toward the monopolistic system, but rather the one that would continue the communication and availability of physical therapists who really wish to communicate with the employers and work with the injured workers in an individual way. Thank you.

MR. EIDE: Thank you. Do we have others wishing to speak at this time. Yes. Will you approach the microphone, please.

* * *

MS. GLENDA KEY: I'm Glenda G-L-E-N-D-A,

K-E-Y. I'm also a physical therapist in private practice and the President of Key Functional Assessments here in Minneapolis. And I thank you for the opportunity today. I have three points that I guess I'd like to make. Some of them are just repetition of what's already been said.

No. 1, I ask and encourage you to use all data resources available to you to make educated recommendations and decisions as it relates to the Workers' Compensation return to work guidelines here.

No. 2, I ask that the single, small private practioner primary be considered in this managed care system as you established this. The practioner can often times offer the high quality that's required without some of the higher costs involved with it.

10

And third, issues that I ask in this managed care system that the selections of the providers be made determined at least in part by societal settings and results specifically relating to the relationship to successfully return to work.

I thank you for the opportunity and thank you with respect with what you have done in this area and all the work that's ahead of you.

MR. EIDE: Thank you very much. Other speakers. Do we have others that would like to add to the record at this time.

* * *

MS. DAIKER: My name is Barbara Daiker, D-A-I-K-E-R. I'm from the firm Work Care, which is a PTO to the Workers' Comp in the Twin Cities.

A couple of points that I would like to recommend to the Department of Labor and Industry in developing the managed care rules.

The first is I would like to have a real clear data selection criteria to insure that there's consistency of information when we're trying to determine cost effectiveness of such organizations. It will also assist in making sure that the analysis is of high quality.

In other words, I want to make sure that all of the certified managed care organations are collecting similar data so that we can make more -- make better quality determinations about their effectiveness.

I also would like to have managed care organizations able to set more aggressive practice guidelines than what the state might recommend. That will make sure that they can respond to new research that's being done and also allow the managed care organizations to be more flexible.

I think that the practic guidelines will be key evaluation factors in differentiating between the different

managed care organizations.

Third, I would like the managed care organizations to be able to establish provider enrollment criteria that they will be able to use criteria perhaps that is less restricted than the state requirements so that they can build their managed care organizations to have as many providers as necessary that they feel will meet the needs of their employers that they're serving.

I would also like to have -- as was mentioned earlier -- very specific rules on when an employee may seek care outside the network. That will reduce litigation and also make it more clearer for providers who are not inside the managed care organization.

I would also like to make sure that managed care is available outside the metropolitan area. We were able to demonstrate in a private project of ours that access and quality providers reduce lost time by at least 90 percent. I do believe that that is a benefit that greater Minnesota should also be able to use.

I think that like on the group medical side, managed care in Workers' Comp will balance itself out, that employers who wish to seek care with specific providers will access managed care that have those providers or they will negotiate contracts with their carriers that will allow that kind of access. Thank you very much for this

opportunity.

MR. EIDE: Thank you. I believe we had someone back here that wanted to speak.

* * *

MS. LARSON: My name is a Barbara Larson. And I'm an Occupational Therapist working in the area of industrial rehabilitation. I am a member of the Minnesota Occupational Therapy Association. And I work for an independent physical therapist, orthopedic sports physical therapy. We have a work center in Stillwater, Minnesota, which employs both occupational therapists and physical therapist in looking at the final services regarding the injured worker.

And I would also like to reiterate physical therapy also to include that we work as a team in this area of occupational therapists and physical therapists working very closely to the employers and QRCs. We do have the opportunity to go into the work site to abide the services so that in a timely manner we can get these people back to work.

The other thing I want you to note is the outcome setting, to look at just how far this treatment is going.

So we would just like you to consider these proposals in

looking at writing rules for the injured worker in the Workers' Compensation. Thank you.

MR. EIDE: Thank you. Another speaker back there, I believe.

* * *

MR. LEONARD: My name is Stewart Leonard. I'm -- I'm just a patient. And I would just -- for me as a grandfather I would like to speak for the people that are coming up that I don't like this. When I got hurt, if I had horsed around and waited for somebody do the job for me and decide, I would -- I go to a chiropractor. And he has kept me working for 13 years. And I have nothing but the greatest respect for the man. And it's tough. I just said that my chiropractor to me is very fair to me. And I don't know. I don't like the idea of having to go to some people that would have to go to a keeper to decide where they can go and if they can go to a chiropractor or not.

I've been in the hospital and have had surgery. And they say you go home now as far as I'm concerned because there's nothing that I can do for me. My chiropractor is still treating me.

And I guess this is all I've got except I seen in the paper yesterday an article about Workmans' Comp costs went

down 16 percent because they have a surplus of a billion dollars and the interest on that money is probably what they're paying on claims. So I don't know why Workers' Comp has to be as complicated as it is. Thank you.

MR. EIDE: Thank you. Do we have other speakers at this time. Anyone else want to add to the record at this point.

* * *

MR. SHIPMAN: Good morning. My name is Donald Shipman, S-H-I-P-M-A-N. I'm speaking just as an individual that, unfortunately, was hurt in an accident a couple of years ago. And I just have a brief statement I'd like to to make.

I really feel that it's important that a person who's been injured does have the right to choose whatever health care that he feels is beneficial to him.

You know, I've heard a lot about cost effectivness and, you know, the problems that this creates for the employer. I'm been an employer myself. I understand. But in the long run, it's the patient or the person who's been injured who has to live with this program for the rest of his life. And I strongly urge the Department the Labor and Industry to consider this. Thank you very much.

MR. EIDE: Thank you. Who else would like to speak. Do we have other speakers at this point.

* * *

MR. SITLER: My name is Ed Sitler. I'm a QRC in Bloomington, Minnesota. I haven't prepared information for this meeting, but as a result of listening to others, I did want to make a few comments.

First, I believe it would be a real tragedy if independent therapists, QRCs, and medical specialty groups are eliminated from the Workers' Compensation system by virtue of the managed care system. I think we're going to loose a lot of valuable people in the process and ultimately raising the cost of Workers' Comp with regards to the managed care systems.

And I do believe that it's important that the, as I understand the case managed system, that would represent a conflict of interest and probably it could eventually result in an increase in cost rather than a decrease in cost with that system. Thank you.

MR. EIDE: Thank you very much. Who else would like to speak at this time.

* * *

MS. MATHESIS: Hi. My name is Patty Mathesis. And I'm the physical therapist at the University of Minnesota Hospital and Clinic. I'm a physical therapist by training, member of the Minnesota APTA Association.

And the point I would like to have in the report in relation to the managed care contact is for you to consider a few points as you choose your managed care providers.

We've talked about functional outcome study, which I think is critical. That's one point I would like to make.

The second point I would like to make in the area of assessment, the functional assessments, that you are sure that your managed care providers have proven assessments and retaining visually where some of them have the researched based assessments so you review that and you look at your providers.

And thirdly, which compasses the scope of passive and active treatment as well as assessments, that you consider who is providing the service, that you've got qualified physician providers.

There are a number of health care professions that provide treatment. And I'm concern that you consider who is providing the assessments as well as treatment. Thank you.

MR. EIDE: Thank you very much. Next

speaker, please. Who else would like to speak. Do we have any questions that relate to people that would want to provide us with information or advice and have questions that specifically need to be answered for them to do that? Anybody else that would like to comment on any of the medical related issues, including new amendments as well the existing features of the Workers' Compensation law and Workers' Compensation administrative system.

MR. DIEHL: I don't have a question, but earlier I think Gloria said a date when you were planning to have a rule draft available, and I missed that.

MR. EIDE: Okay. The question was when would the rule draft be available. And there is a sign up sheet to get the proposed rules mailed to you out in the lobby. We would be publishing the proposed rules, for the temporary rules, for certification of managed care organizations on or about the 27th. And we would hope to follow up with the proposed rules for other medical issues under our authority for emergency rule making process approximately a month after that so towards had end of August.

And we would hope that sometime around in September we would publish the propsoed rules for all other issues. That would be handled through the "regular" rule making process rather than their emergency ruling authority.

If you want copies of those rules, you can sign up in the lobby and you will be provided with them.

Other questions or comments at this time, any other speakers at this time. One of the purposes of holding this meeting was to make that anyone that had a desire to provide information to us or advice to us would have that opportunity.

And since the public notice provided that this meeting would be open from 8:30 to 12:30, we will have staff remaining here with a court reporter till 12:30 to be sure that anyone having a wishing and opportunity to make a statement on the medical issues can do so. A number of us will still remain in case someone wants to discuss something with us more directly.

Tomorrow at the same time as published in the public notice, the meeting will reconvene at 8:30 for consideration of all other rules related to subjects other than medical and chiropractic, all kinds of health care treatment. And so tomorrow the issues will run again for benefits that relate to anything else in the system other than that treatment. Do we have any other speakers wishing to speak on the medical issues at this time. Okay. That being the case, we're going to take a short break; but we will stay around for those who want to comment.

(WHEREUPON, a brief recess was taken, after

which the following proceedings transpired.)

MR. EIDE: I believe we have one or two more people at this time that would like to make a statement. And if we could have you come forward to this mircrophone to help out our court reporter a little bit, we'd be happy to take those down.

* * *

MS. FRIBERG: Hello. My name a Shirley Friberg. And I'm the President of Minnesota Metropolitan Chapter of the Rehabilitation Nurses. And I have worked with injured workers since 1974. And I'm a QRC.

MR. EIDE: Shirley, could you speak a little more directly into the microphone.

MS. FRIBERG: Sure. The law indicates intent certified to provide managed care is to provide case management. It's our responsibility to define these terms.

The Supreme Court has already made a decision in the Laborer versus State of Minnesota case that have been QRC cannot be the same. I believe the Supreme Court was telling us that you cannot provide services in law for them at the same time.

To reduce the cost of Workers' Compensation and prevent unnecessary litigation, an outside entity is needed to

monitor the surface.

Rehabilitation nurses are trained to coordinate the medical care. In hospitals, clinics, nursing homes, and other facilities, the nurses act as the coordinator.

As experienced QRCs, we have worked with employees improving communication and coordinating all of the recent work activities to reduce costs. In order to reduce the cost by 16 percent, you will need an outside objective monitoring system.

I would also, on my own, support the use of expert independent PTs and low-T services. I would be very sad to see the choice of these good services go also. Thank you.

MR. EIDE: Thank you very much. We have another speaker here somewhere I think, Jim. Does anyone else want to comment while we're waiting for what I believe is another speaker that asked to speak on any aspects of the medical issues of the Workers' Comp system and the rules that we're working on. Jim, if you can come around and use this microphone, that would help our court reporter a little bit.

* * *

MR. HOYME: My name a Jim Hoyme, H-O-Y-M-E. I'm a physical therapist. And I'm also an owner of a

physical therapy clinic. And I represent the American Physical Therapy Association as a Co-chair of the Government Affairs Committee and also have been involved with the low back tasks force within the Medical Services Review Board and the Department of Labor and Industry.

As an independent business owner, I'd like to reiterate some of the other comments regarding applauding your efforts. And I appreciate the fact that reform is in the works regarding the Workers' Compensation system to help control costs.

We, as an organization, the Physical Therapy Association of Minnesota want to do as much as we can to help facilitate this. The question that I have regarding managed care, that I feel needs to be addressed, would be the reimbursement schedule. And I realize the relative value fee schedule is going to take a lot of work and effort to develop in an appropriate manner. Within certain managed care systems, whether they be HMOs or PTOs, there are limitations and specific fees that are set for services provided such as physical therapists and other medical services.

I guess I would like to know what standards will be used for reimbursement. Will it be the relative value fee schedule for Workers' Compensation or would be the established fee scheduled set by the HMO.

My recommendation is that this is the reflection of our associations' standards and that the relative fee schedule for Workers' Compensation cases would take precedence over any other established fee schedule.

MS. GEBHARD: Okay. The rules have not been set yet for sure. And there's a lot of fluidness to them. However, one of the things that we have to consider is that the health care provider be reimbursed accordingly to the relative value fee schedule. But, again, as I said, this is not strong yet; but that's the way it currently is.

MR. HOYME: Okay. Thank you very much.

MR. EIDE: Do we have anyone else that would like to speak to the medical issues at this time. Yes, sir. If you could use this microphone, it would help our court reporter.

* * *

MR. THORSON: My name is David Thorson. And I'm a physical therapist. I'm here representing the Minnesota Chapter of Minnesota Physical Therapist Association, specifically, the Workers' Compensation Subcommittee of the Governmental Affairs.

I'm here in -- The area I'd like to address is the area of managed care. First of all, I'd like to inform you that

the Minnesota Chapter has been proven quality insurance and per view process, by which it's our own that we evaluate the quality of care based upon written documentation.

This care has been reviewed by peers based upon standards of practice and both the National American Physical Therapy Association and the Minnesota Chapter and the American Physical Therapy Association. This process insures high quality care. It insures that providers follow certain rules and guidelines in the treatment process, which insures the best possible physical care in terms of rehabilitation and physical therapy with excellent outcomes of treatment.

We would address the managed care by asking for strong consideration of equal access by all providers regardless of their setting.

We strongly support the treatment guidelines that are currently being established by the Medical Services Review Board. And we would encourage that these guidelines be established and that for the provider within the Workers' Compensation system, that the provider need to follow these strictly.

It's also recommended or encourage that these guidelines would be reviewed frequently and updated as the knowledge base and research would dictate changes in treatment process for the varies diseases and pathologies present.

This system of equal access by all providers would give the employee and the employer choice of providers as long as they met the qualifications as established by the Department of Labor and Industy. It would also keep in check with the concept of cost-control guidelines and insuring that the injured worker would receive the best quality rehabilitation, which they deserve and need.

The emphasizes that this would -- This mechanism would also address the issue of basing quality or basing provider certification based upon their ability to demonstrate good outcomes through established programs and eliminate the organizational provider, becoming a provider through an organization who happens to be within a managed care system that's either exiting or would be established. Thank you very much.

MR. EIDE: Thank you. Do we have anyone else that would like to comment at this time. We are going to keep the record open. And we'll be here until 12:30 as the public notice provided. And we will wait now and see if anyone else shows up who wants to talk. There will be an informal recess until then.

(WHEREUPON, a brief recess was taken, after which the following proceedings transpired.)

MR. EIDE: If you could just speak right into the microphone there and identify yourself by name and

spelling for the court reporter. And then go right ahead.

* * *

MR. MCDERMOTT: My name is Lawerence McDermott, M-C-D-E-R-M-O-T-T. I am an injured worker. I believe this hearing is on the --

MR. EIDE: Medical issues.

MR. MCDERMOTT: -- medical issues. One of the problems that I've had is my insurance company admits liability but refuses payment. I believe with the new law they're trying to correct some of this. And I think in order for the law to work, they're going to have to have some kind of a determining factor so that the insurance company does not have the option open to them to indiscriminately determine whether or not they wish to pay.

Now you have to take it to Court. In my case we had a hearing. I believe they must have determined that they were going to loose the hearing so they didn't show up and then they filed an appeal. This is probably going to take me close to another year to again show up in Court.

We have to have a system so that -- The average working man cannot afford to wait year after year. The insurance company can. I believe that if we don't do this, the system is going to continue to run downhill. And the

injured worker is going to be continuously abused to the point where what is going to happen is that the injured worker is going to end up on welfare, which the state is already burdened with.

I believe we should put the cost where it belongs and, that is on the insurance companies who guarantees that persons welfare. I don't know, is there -- I thought there was going to be kind of a general hearing. I didn't realize that at the time that I came that I would just have an opportunity to speak so I really didn't prepare.

MR. EIDE: That's okay. We were taking statements from the public today on any opinions that they wanted to express to help guide us in creation of the administrative rules, which are the rules that actually governor the administration of the law itself.

The law typically specifies the Broad guidelines, but to implement them, we have to administor rules. And the purpose here was just to get advice on that. And your information is useful to us.

MR. MCDERMOTT: Thank you. Yeah. I believe the new law, if we implement it properly, is going to assist the injured worker. Because the biggest handicap now, is the fact that the insurance companies can use the legal system to dodge their obligation. Not really not pay them, but if they can extend it out, they can destroy the

injured worker before he ever has a chance to get well. I thank you.

MR. EIDE: Thank you very much. It will be part of the report that we'll be using in working out the rules.

* * * (END OF REPORT) * * *

STATE OF MINNESOTA

CERTIFICATE

COUNTY OF SCOTT

I, Debbie L. Olson, Court Reporter, do hereby certify that the foregoing pages 1 - 52 inclusive are a true and correct transcript of my stenotype notes.

Dated at Prior Lake, Minnesota, on this 16th day of July, 1992.

_____

Court Reporter

UNTIMELY COMMENTS RECEIVED

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FAX COVER LETTER

DATE: _____

TO: Pam Lembal Rehab + Med

FIRM: _____

FAX NUMBER: 296-9634

FROM: Scott Mayer

FAX NUMBER: 612-639-1951

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LABOR & INDUSTRY
W. C. ADMINISTRATIVE OPERATIONS

MESSAGE: here is our suggested revision of the rules as apparently submitted to the A.G.'s offic
Thanks for your assistance.

TRANSMITTAL CONTAINS 2 PAGES, INCLUDING THIS COVER LETTER.

IF YOU DO NOT RECEIVE ALL THE PAGES, PLEASE CALL 612-639-0663.

(3) the managed care plan must include procedures to ensure that the employee will:

(a) receive initial evaluation or treatment by a participating health care provider licensed in Minnesota and of the employee's choosing within 24 hours of the employee's request for treatment, following a work injury; the managed care plan must include as participating providers both medical physicians and chiropractors;

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Commissioner's Office
Dept. Of Labor & Industry

September 14, 1992

Mr. John Lennes
Commissioner
Department of Labor and Industry
443 Lafayette Road
St. Paul, Minnesota 55155

Dear Commissioner Lennes: John -

As one of the business representatives who worked for passage of the workers compensation reform bill this past session, I wanted to comment on the proposed rules for implementation of the new Managed Care Program.

The managed care section is one of the most important elements of the new law for long-term cost savings in the workers compensation system. Your department has done an outstanding job in drafting the rules to provide for significant savings in this area. When implemented, these rules will provide important cost savings in the system.

We appreciate and thank you for all your efforts to make Minnesota's workers compensation system more fair and more competitive.

Sincerely,

Judy E. Cook
President

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ROLLIN F. WESY
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WASHINGTON, D. C. 20005
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September 25, 1992

330-3004
WRITER'S DIRECT LINE

Memorandum Via Fax

TO: John Ellefson
Department of Labor and Industry

FROM: Winston Borden

RE: DOL Emergency Rules on Managed Care

Please advise when the above rules are submitted to the Attorney General for approval. At that time we would appreciate receiving a copy of the revised rules.

Also advise when the Attorney General acts on the proposed rules. Thanks for all your good work.

26188-1

MINNESOTA CHAMBER OF COMMERCE

MAKING MINNESOTA'S FUTURE OUR BUSINESS

RECEIVED
SEP 11 1992
Commissioner's Office
Dept. Of Labor & Industry

September 8, 1992

John B. Lennes, Jr., Esq.
Commissioner
Minnesota Department of Labor & Industry
Workers' Compensation Division
443 Lafayette Road
St. Paul, MN 55155-4316

RE: Proposed Emergency Rules Governing Workers' Compensation Managed Care Plans

Dear Commissioner Lennes:

On behalf of the Minnesota Chamber of Commerce, we wish to express our strong support for your Proposed Emergency Rules. Although the comment period for the proposal expired on August 21, 1992, we did not want you and your department to conclude that our silence was in any way a lack of support for this proposal. On the contrary, its focus and breadth are not only consistent with the thrust of the enabling legislation (SF 2107) but offer the hope that the cost of treating injuries in the context of Minnesota's workers' compensation system will no longer be significantly greater than the cost of treating a similar injury outside Minnesota's workers' compensation system.

The Minnesota Chamber of Commerce is Minnesota's largest and most diverse business trade association. Representing more than 3,000 Minnesota businesses and 120 local chambers of commerce, the Minnesota Chamber represents businesses of all sizes, in all locales providing a broad range of services and products to Minnesotans and consumers worldwide.

When the legislature passed and the Governor signed into law SF 2107, it marked a solid "first step" in needed reform of Minnesota's workers' compensation system and the first material change in the law since 1983.

While we were disappointed that the bill did not address all of the Governor's important principles of reform, such as the elimination of (a) long-term benefits for people without serious injury and (b) "double-dipping"; i.e., coordinating supplemental benefits with social security payments, we were very pleased that this legislation did at least specifically address the Governor's call for reducing workers' compensation health care costs which now comprise over 40% of the total benefit costs.

Workers' compensation reform has been and remains a top priority of the Minnesota Chamber. Workers' compensation is one of the greatest state-imposed costs of doing business in Minnesota. It is particularly burdensome on businesses employing people at high wages (primarily manufacturing, construction, mining and trucking jobs), the very kind of employment Minnesota needs to encourage.

480 Cedar Street ▲ Suite 500 ▲ St. Paul, Minnesota 55101-2298 ▲ 612-292-4650 ▲ FAX 612-292-4656

To the extent Minnesota reforms its workers' compensation laws to both protect the truly injured worker and encourage safety in the workplace by rewarding employers with good safety records with reduced costs, Minnesota will take a giant step forward in encouraging job growth.

By way of background on this medical care issue, we offer these comments:

1. **Medical Care Charges are a Significant and Increasing Portion of Workers' Compensation Costs.**

   Under the workers' compensation system, injured workers receive all necessary medical and hospital services at no cost to themselves.

   Medical services include, but are not limited to, office visits, surgeries, x-rays, physiotherapy, psychiatry and chiropractic services. Currently, the costs of these services are regulated by the Minnesota Medical Fee schedule established by the Department of Labor and Industry; however, this schedule is of limited effectiveness.

   Hospital services include, but are not limited to, room charges, laboratory fees, medical appliances and prescription drugs. These costs are not subject to any such regulations.

   Workers' compensation health care expenditures in Minnesota have been growing at a rate faster than its entire economy. Today, workers' compensation costs comprise more than 40% of Minnesota's benefit costs. Moreover, Minnesota's average medical cost per workers' compensation case is roughly twice that of our surrounding states. See Chart I.

2. **Medical Care for Injuries Treated Under Workers' Compensation are Increasingly More Expensive Than Care For Similar Injuries Outside the Workers' Compensation System.**

   While the growth in general medical expenditures was 101.7% between 1980 and 1987, the growth in workers' compensation medical expenditures during the same period was 150.5%. See Chart II.

   Moreover, a 1990 Department of Labor and Industry study of health care costs and cost containment in the Minnesota workers' compensation system compared medical claims of the state's largest workers' compensation insurer to Blue Cross/Blue Shield claims for similar injuries. The study found that the total charges in the workers' compensation system are higher than in the Blue Cross system. The differences are greatest for back injuries and sprains/strains, and smallest for fractures. See Chart III.

   The comparative study also found that the treatment duration is generally longer for workers' compensation claims, and that workers' compensation is being billed for a more complex level of services than is Blue Cross.

While the study shows that workers' compensation charges are higher, the study could not determine whether these higher charges result in more effective treatment or improved outcomes compared to Blue Cross.

The report advanced two explanations for the differences in cost of the two programs:

a) The workers' compensation system is over-treating certain types of workplace injuries because providers are exercising discretion in treatment course, or employers or employees are demanding more tests and treatment.

b) There is something indigenous to workers' compensation systems in general that may promote, allow or require additional and more intensive treatments. It may be a response to the threat of litigation, demands on providers to provide disability assessments in addition to treatments, or increased testing to prove liability.

Regardless of which explanation is the more accurate, the salient fact remains that treatment of the same injury under the workers' compensation system is more expensive than outside the system.

3. **The Greatest Disparity in Costs Occurs in Back Disorders, the Single Greatest Injury Cost in Minnesota's System.**

The median medical charge for "Back Disorders" is nearly 2½ times its cost in the Blue Cross/Blue Shield system. See Chart III. Significantly, back disorders comprise nearly two-thirds of Minnesota's more expensive workers' compensation cases. See Chart IV. In short, controlling costs in the treatment of back disorders represents a huge potential for savings.

Quite frankly, the Chamber chose not to comment originally because on balance, the rules as written effectively address the foregoing concerns; however, we offer the following observations:

1. **Choice of Medical Care Provider Preserved and Controlled.**

Since there is no incentive to the injured employee to resist or restrict health care treatment, this freedom has in some instances encouraged injured employees to seek costly, unnecessary and frequent treatment. Since this cost is borne entirely by the employer, it is imperative that some reasonable controls be imposed on the kind and extent of treatment.

Accordingly, your requirement that each health care provider pay a certification fee, document specialties, methods of practice and treatment standards, and describe early return to work programs assures injured workers and their employers that qualified care is available at a reasonable cost with a view towards returning the injured employee to the workplace.

2. **Restriction May Unduly Hamper Rural Employers.**

While the Chamber of Commerce supports your proposal, we do have one concern with respect to its impact on employers located in rural Minnesota. Many rural communities have but one hospital or health care provider. If this facility or enterprise refuses to participate, the 30-mile limitation poses a significant limitation. Since Minnesota's roadway system is superior and long travel is a way of life for many people, we would suggest a more realistic limitation of 75 miles. See Subp. 4. Restrictions. Another suggestion is to allow rural health care providers the opportunity to align themselves with larger providers in the metro area.

Again, we express our strong support for you and your department in promulgating fair and effective regulation.

With warmest regards,

Joseph P. Goggin
Chair

David C. Olson
President

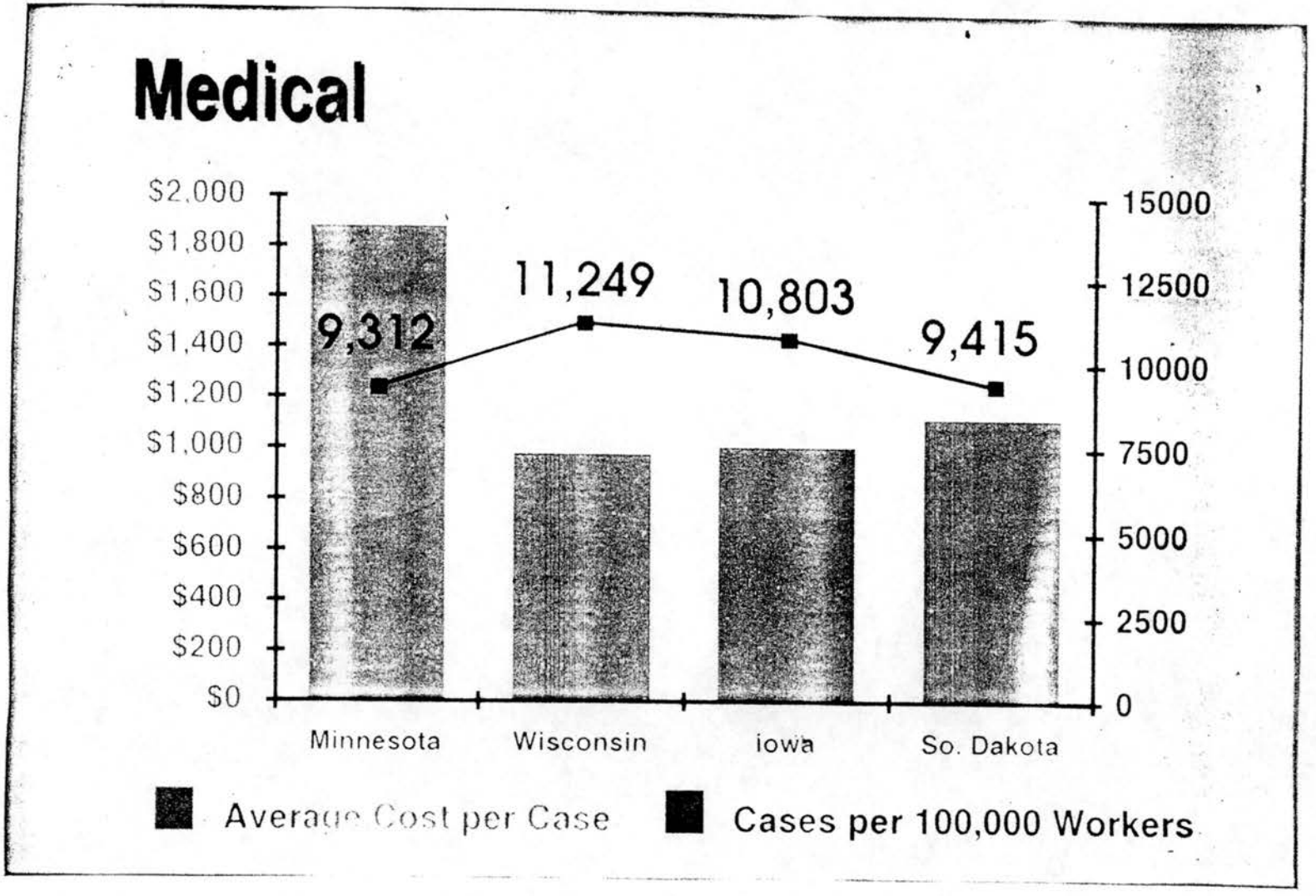

Medical
$2,000
$1,800
$1,600
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0
15000
12500
10000
7500
5000
2500
0
9,312
11,249
10,803
9,415
Minnesota
Wisconsin
Iowa
So. Dakota
Average Cost per Case
Cases per 100,000 Workers

CHART I

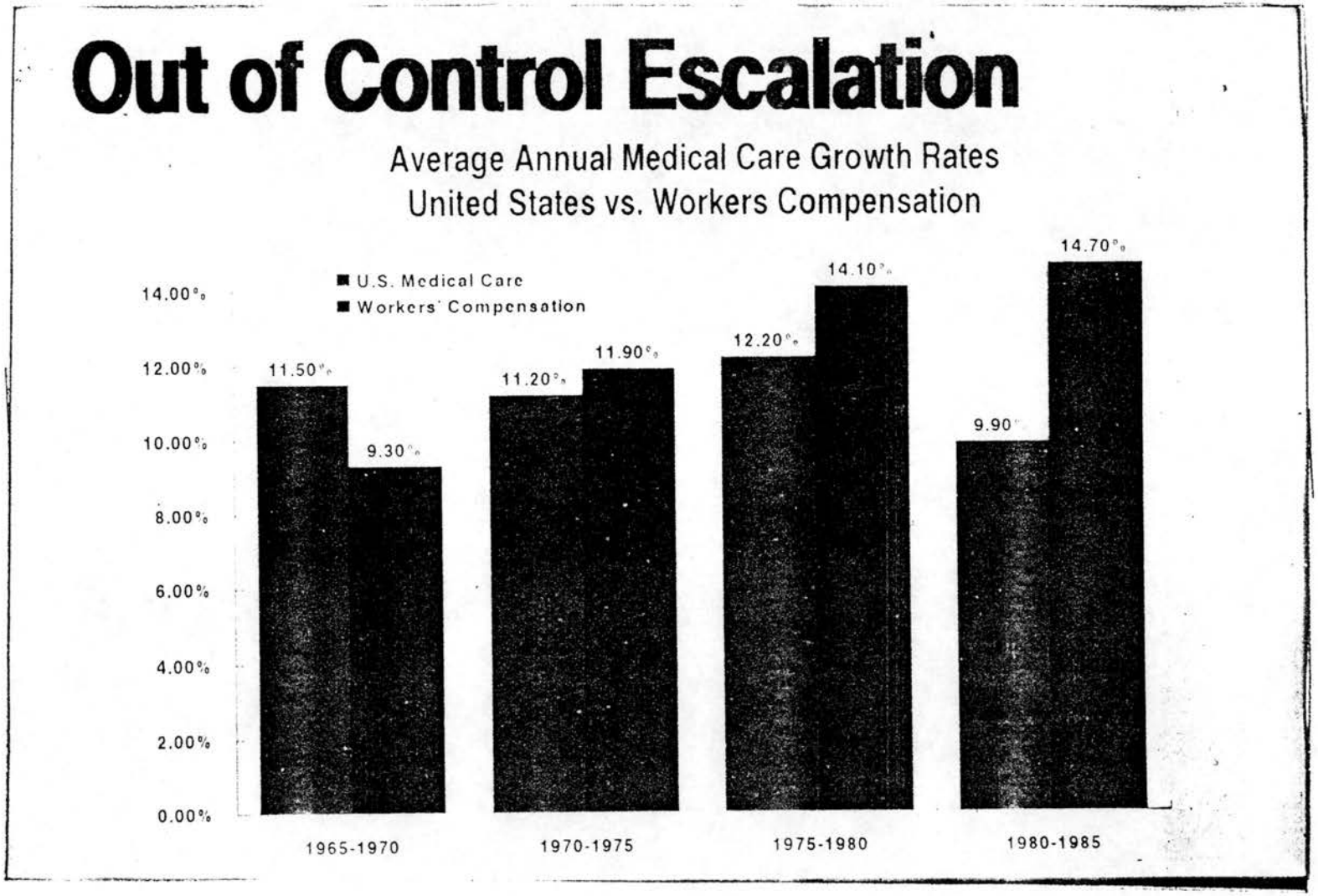

Out of Control Escalation
Average Annual Medical Care Growth Rates
United States vs. Workers Compensation
U.S. Medical Care
Workers' Compensation
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
11.50%
9.30%
11.20%
11.90%
12.20%
14.10%
9.90%
14.70%
1965-1970
1970-1975
1975-1980
1980-1985

CHART II

Out of Control Escalation

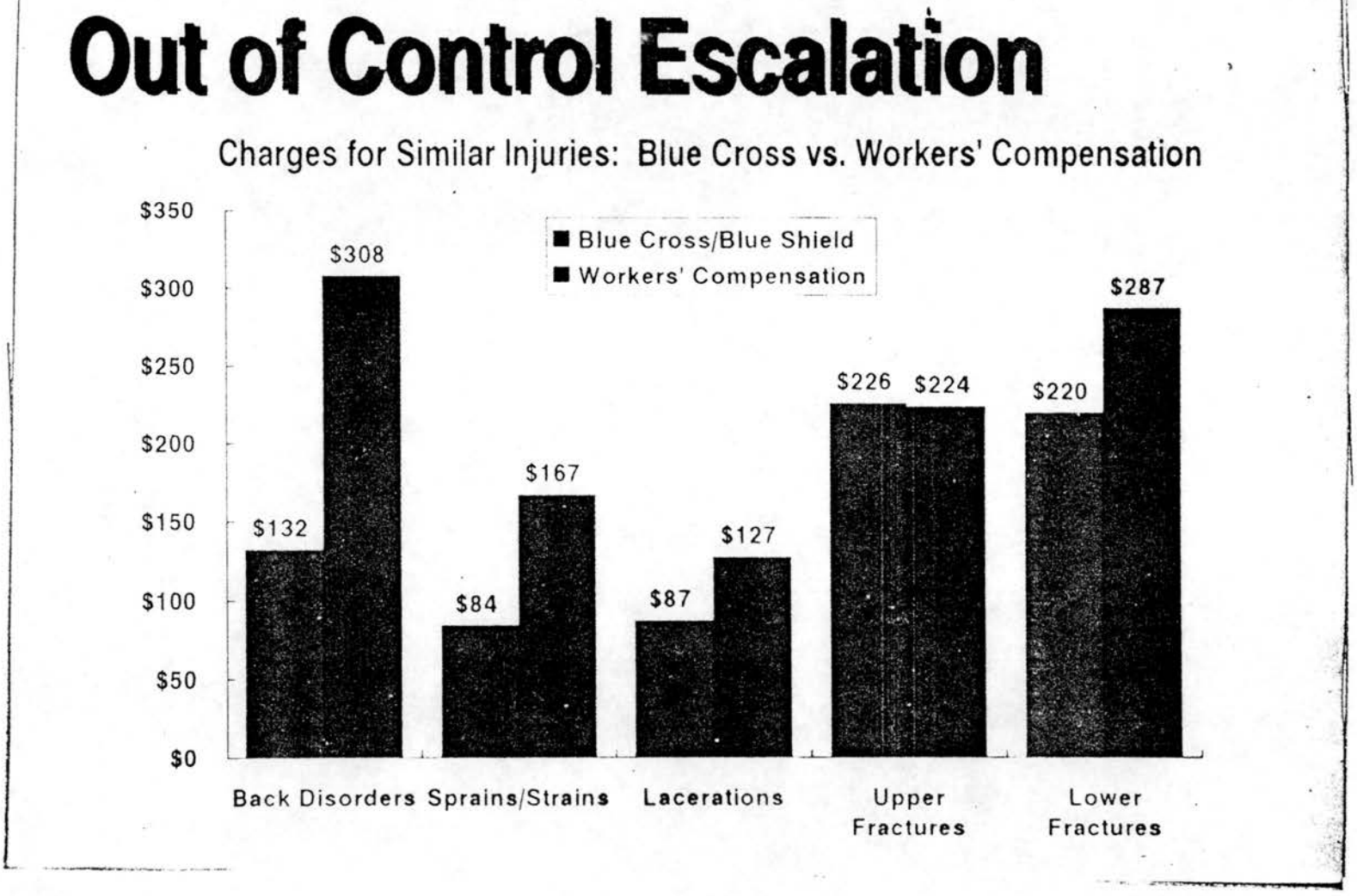
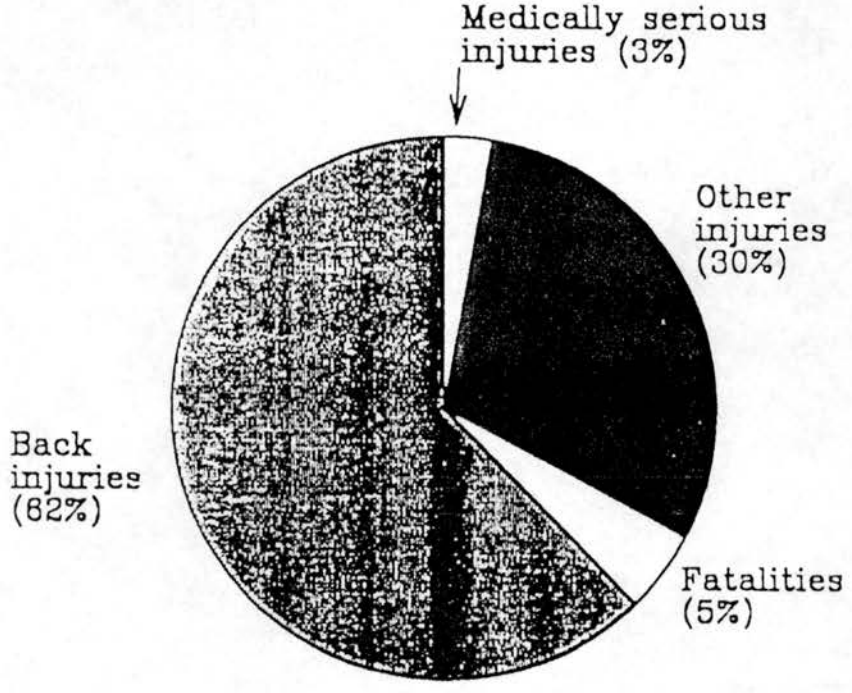


CHART III

FIGURE 3.5

TYPES OF INJURIES REPORTED
TO THE WORKERS' COMPENSATION REINSURANCE ASSOCIATION
1981-82



Source: Workers' Compensation Reinsurance Association.

CHART IV

1988 Legislative Auditor's Report

LAW OFFICES
HESSIAN, McKASY & SODERBERG
PROFESSIONAL ASSOCIATION
4700 IDS CENTER
MINNEAPOLIS, MINNESOTA 55402
(612) 330-3000
TELECOPIER: (612) 371-0653

HAROLD J. SODERBERG
WINSTON W. BORDEN
ROLLIN F. WEST
THOMAS E. HARMS
JAMES A. STEIN
DARRELL B. JOHNSON
LLOYD S. STERN
MARK R. MILLER
WILLIAM J. JOANIS
WILLIAM S. BORCHERS
THOMAS E. SCHMIDT
JEROME M. SODERBERG
LEE A. HENDERSON
SUSAN REITER MILES
STEVEN T. HETLAND

MAURICE A. HESSIAN, SR. (1888-1956)
MAURICE A. HESSIAN, JR. (1920-1971)
JOHN J. MCKASY (1906-1966)

SAINT PAUL OFFICE
700 SAINT PAUL BUILDING
SIX WEST FIFTH STREET
SAINT PAUL, MINNESOTA 55102
(612) 224-4911

WASHINGTON, D. C. OFFICE
SUITE 500, 1225 EYE STREET, N. W.
WASHINGTON, D. C. 20005
(202) 842-5000

September 10, 1992

330-3004
WRITER'S DIRECT LINE

Memorandum Via Fax

TO: John Ellefson
Department of Labor and Industry

FROM: Winston W. Borden

RE: Emergency Rules for Managed Care Plans

First let me say thanks for your thoughtful presentation to our attorneys, clients, and guests yesterday. You are the first "non political type" we have invited to address our government relations group and I received a tremendous amount of favorable comment on your remarks.

Second, after the luncheon we were retained by the Hennepin County Medical Center to represent them on issues relating to the 1992 Workers' Compensation law and subsequent rule hearings.

While I am aware that the official time for comment has passed on the Managed Care Plan rules, Hennepin County Medical Center is concerned about the definition contained in the rules relating to "emergency care" (p. 1, line 13) and they would like the definition of emergency care to incorporate the definition of the American College of Emergency Physicians (ACEP) by reference. While I have not been able to contact the person handling this issue for the Minnesota Medical Association, I understand they have previously communicated that desire to the Department.

I know that you are up against a deadline on this and are concerned about the issue of "substantial change". From my viewpoint the adoption of the ACEP definition would not be a substantial change, but rather would made the rules more easily understood by practitioners. The ACEP definition is a widely recognized standard within the medical community.

If you have time for a phone call, I would appreciate your thoughts on this matter. Thanks.

cc: Thomas Harms, Esq.

Minnesota Department of Health
717 Delaware Street Southeast
P.O. Box 9441
Minneapolis, MN 55440-9441
(612) 623-5000

August 21, 1992

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Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

Re: Workers'Compensation Managed Care Emergency Rules

Dear Ms. Zembal:

Thank you for the opportunity to comment about the proposed emergency rules governing workers' compensation managed care plans. We have identified some rule provisions that we believe could use clarification and further definition. We believe that most of the suggested changes would be non-substantive. However, if you determine that some of these changes would be substantive, please consider incorporating these changes in your permanent rules. We would like to make some general comments to be followed by comments about specific sections of these proposed rules.

There are several terms used in these rules that are not defined in these rules or cross-referenced to definitions in other rules or statutes. We suggest that terms be defined using definitions that are either identical to or at least consistent with definitions as used by HMOs or as defined in HMO rules. Terms particularly in need of definition are: uniform treatment standards; medically appropriate; timely, effective and convenient for the employee; peer review; utilization review; case management; aggressive case management; specialized care; quality services or quality treatment; category of health care provider; and direct access.

We suggest that these rules be expanded to clarify both the roles of the insurer and the managed care plans and to clarify the relationship between participating providers and managed care plans. Please refer to points #5 and #6 for more specifics about these provisions.

The following comments and suggestions are related to specific provisions of the proposed rules.

1. Definition of "Emergency care" in proposed Minn. Rule 5218.0100, Subp. 3. This is a more limited definition than that contained in our soon-to-be proposed HMO rules governing accessibility of care. Our proposed definition includes the concepts of prevention of serious injury to bodily functions, organs or parts, and preventing placing the physical or mental

health of the person in serious jeopardy. We suggest that these rules be revised to be consistent with the HMO rule definition by adding the words "or prevent placing the physical or mental health of the injured employee in serious jeopardy."

2. Definition of "Geographic service area" in proposed Minn. Rule 5218.0100, Subp. 5. This differs from the HMO rule definition which defines the geographic service area in terms of the area in which an HMO can market its products. As a practical matter, under your definition some specialists (such as the Mayo Clinic, the University of Minnesota or certain hospitals) may be participating providers with the managed care entity but not be located in the geographic service area certified for workers' comp managed care. In addition, your definition does not take into consideration the capacity of the managed care plan to accept injured employees. We suggest that you amend this definition to read as follows: "Geographical service area means those counties in which a managed care plan has been certified to market its arrangements for comprehensive health care services to injured employees and has demonstrated the capacity to provide comprehensive health care services."

3. Application for certification in proposed Minn. Rule 5218.1000, Subp. 1, D. (2)(a). "The procedure to allow the employee to select a health care provider must provide direct access to all health care profession disciplines if the treatment is determined to be appropriate for the condition." HMOs are not required to include all health care profession disciplines in their provider networks. Since more than one professional discipline can generally treat the same condition, an HMO may make arrangements with the disciplines which are needed but not necessarily with all disciplines. This rule provision is not consistent with HMO rules or practices.

4. "Continuity of care" in proposed Minn. Rule 5218.2000, Subp. 3. E. These proposed rules allow an injured employee to continue care with the original provider until the employee requests a change of provider when the managed care plan contract terminates. This is inconsistent with HMO rules and practice which would not allow for continuation with a previous provider to be dependent on the wishes of the patient. HMO rules would allow the patient to request referral back to the previous provider, based on specific and unusual medical reasons. Except for unusual cases and circumstances, we would not expect an HMO to pay a previous provider to continue caring for an HMO enrollee. This would not be medically necessary and it would not be cost effective.

5. We suggest that you add a new provision to the proposed rules requiring all participating providers to sign contracts with the managed care plan. We recognize that the definition of participating health care provider includes the requirement of a contract or other arrangement with the managed care plan, and that the proposed rule contains filing requirements that

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imply the need to have signed contracts with participating providers. However, we suggest that you clarify this requirement by specifying in the proposed rules the need to have signed written contracts. These contracts should include, at a minimum, the terms and conditions of participation, the obligations of each party, a non-recourse statement, agreement of the participating provider to cooperate with the managed care plan's programs of quality assurance, utilization review and dispute resolution, and advance notice requirements for termination of the contract.

6. We suggest that you add a new provision to the proposed rules clarifying the obligation of the insurer. The rules should specify that the insurer is ultimately responsible for fulfilling contractual obligations at the agreed upon premium rate. In case the managed care plan for any reason ceases doing business or terminates the contract during the period of the prepaid contract, the insurer shall reimburse the providers at a rate and in a manner agreed upon by the managed care plan.

Please accept these comments and suggestions with our understanding that these rules are only temporary rules and that we anticipate that permanent rules will address many more details of managed care operation. We believe that it is in the best interest of both agencies that any rules governing managed care be consistent to the greatest extent possible. We are willing to provide more specific suggestions and comments or any other assistance you need when you begin the process of drafting permanent rules.

Sincerely,

Andrea M. Walsh

Andrea M. Walsh
Assistant Commissioner

AMW:IG

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

Dear Ms. Zembal:

I have read the proposed worker's comp and object that the following emergency rules are not in the spirit of the law and will become a hardship and burden to all Minnesota taxpayors.

1. This is America and I deserve freedom of choice to choose my own doctor that I trust. I will not go to a company doctor because of his conflicting interest with the company and MCO/Insurance carrier.

2. It is not fair for me to have to see an M.D. within 24 hours of an injury. I need my own choice to see who I want to see. I see this law as an adverse attempt to control my care or for the MD to direct me to his friends not to who I need. If I want to see a chiropractor, it is unlikely an M.D. will refer me to one because M.D.'s have not attended chiropractic courses and don't understand which cases chiropractic can help, hence they will not refer me to someone they don't understand.

3. The review process for dispute between patients are MCO's are very unfair, they descriminate against the patient and give the MCO too much control. This will only lead to increased costs due to the increased litigation it will cause.

4. I don't think my chiropractor should be excluded from the managed care plan and according to the rules. I have no evidence that he will be chosen, The MCO should have to participate with whichever doctors want to. They should not be allowed to pick and choose whoever they want. If this is allowed, the only doctors who they will choose are the ones they want. If this is allowed, the only doctors who they will choose are the ones they can control, not doctors who care about their patient needs.

5. The treatment guidelines were set up by IME doctors and the the way they are designed is a danger to the public. They will not allow us to get the care we need which will make our generation live with more disability than we would have had to.

6. This whole bill is a bad attempt by the legislature. It will only serve to cut good doctors from the system, give patients less care than what they will need, fill the managed care organizations with excessive monies, and therefore will cause unecessary costs, pain, suffering and disabilities for the Minnesota public.

I urge you to change these rules before it is too late. This is America, a country founded by freedom of choice. This law will take that away from us, will give the MCO insurance control over our health, which leads to our longevity and ultimately our life.

Rhonda L Maanum

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

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LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

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Thomas W. Starks

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

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AUG 24 1995
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

Dear Ms. Zembal:

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Michele L Pellatier

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

RECEIVED
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

Dear Ms. Zembal:

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Robert T. Potts

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

RECEIVED
AUG 24
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

Dear Ms. Zembal:

I have read the proposed worker's comp and object that the following emergency rules are not in the spirit of the law and will become a hardship and burden to all Minnesota taxpayors.

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Dani N. Rae-Leslie

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

Dear Ms. Zembal:

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8/19/92

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

Dear Ms. Zembal:

I am an employer and object that the following emergency rules are not in the spirit of the law and will become a hardship and burden to all Minnesota taxpayors.

1. It is not fair for me or my employees to have to see an M.D. within 24 hours of an injury. I need my own choice to see who I want to see. I see this law as an adverse attempt to control my care or for the MD to direct me to his friends not to who I need. If I want to see a chiropractor, it is unlikely an M.D. will refer me to one because M.D.'s have not attended chiropractic courses and don't understand which cases chiropractic can help, hence they will not refer me to someone they don't understand.

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I urge you to change these rules before it is too late. This is America, a country founded by freedom of choice. This law will take that away from us, will give the MCO insurance control over our health, which leads to our longevity and ultimately our life.

Kay Adams

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REHABILITATION & MEDICAL AFFAIRS

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

Dear Ms. Zembal:

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6. This whole bill is a bad attempt by the legislature. It will only serve to cut good doctors from the system, give patients less care than what they will need, fill the managed care organizations with excessive monies, and therefore will cause unecessary costs, pain, suffering and disabilities for the Minnesota public.

I urge you to change these rules before it is too late. This is America, a country founded by freedom of choice. This law will take that away from us, will give the MCO insurance control over our health, which leads to our longevity and ultimately our life.

Micah Wheeler

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

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AUG 24
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

Dear Ms. Zembal:

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

RECEIVED
AUG 2
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

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Jennie Morris

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AUG 24 1992
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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

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Julie Debbeck

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

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AUG 14
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

Dear Ms. Zembal:

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Michael Tibbetts

Fairview
Hospital and Healthcare Services

2312 South Sixth Street
Minneapolis, MN 55454-1395
612-371-6300
Fax 612-371-6303

August 18, 1992

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

Dear Ms. Zembal:

I am writing on behalf of Fairview Hospital and Health Care Services to provide our perspective and comment on the proposed emergency rules to implement the new worker's compensation legislation. Our comments are limited to two:

First, Fairview is generally supportive of the concepts of managed care and recognizes the potential that managed care can bring. Our comment is a general one in this regard. We encourage you to work to draft the rules to allow the managed care plans to be truly effective in the clinical management of care and the cost of care. The worst case scenario, in our minds, would be the establishment of an administrative and reporting layer on the health care system that did not result in a more effective delivery system in terms of clinical and financial outcomes.

Our second comment is more specific. It is our interpretation that the proposed rule goes beyond the scope and intent of the law in one regard. Section 13 (176.1351), Subdivision 1 (page 64, lines 17-22) of the law reads "Any person or entity, **other than a workers' compensation insurer or an employer for its own employees,** may make written application to the commissioner to have a plan certified that provides management of quality treatment to injured workers for injuries and diseases compensable under this chapter". The proposed rule, section 5218.2000, Subpart 4 (page 9, line 1-4) reads "when an insurer contracts with multiple managed care plans, **one or more of the plans, but not all, may be operated, formed or administered by the employer or insurer.**" It is our reading that the proposed rule goes beyond the scope of the law and does not reflect the attempt written into the law to avoid the inherent conflict of interest that exists when an employer/insurer owns the managed care plan.

If you have any questions about our comments or would like to discuss them further, please contact me at your convenience at 371-6050. Thank you.

Sincerely,

Jeanne M. Lally

Jeanne M. Lally
Director, Continuum Operations

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August 19, 1992

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Ms. Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor & Industry
State of Minnesota
443 Lafayette Road
St. Paul, MN 55155

Dear Ms. Zembal:

Please consider the following comments regarding the proposed adoption of emergency rules of the State Department of Labor and Industry governing Workers' Compensation Managed Care Plans.

- **5218.100 (Emergency APPLICATION FOR CERTIFICATION)** Regarding Part III, the Managed Care Plan must include a procedure to insure that the employee will... Subpart C - initially choose from at least three health care providers to whom the employee has been referred by the evaluating provider under A or B for treatment and allow the employee to change providers under the managed care plan at least once.

- The concern is that in rural Minnesota, the number of eligible providers by specialty may not equate to the total number of the three required. The geographical requirement of 30 miles within the employer or in the same distance the employee travel to work each day would have to be lifted in such instances.

- **Subpart 3, Part F - Regarding Compensability.** Accept as provided in part 5218.5000, an employer may require an employee who is claiming a Workers' Compensation injury to receive treatment from a Managed Care Plan before the employer accepts or denies liability for the injury. In such cases, the employer is liable for the cost of any treatment before notice is given to the employee of a denial of liability even if the employer is later determined to be not liable for the claimed injury.

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- Clarification is requested regarding this rule. It is our previous understanding, that once an insurer accepts liability for a pre-existing condition, such as diabetes, they become responsible for all future costs regarding the diabetic claim. What are the liabilities with the new law?

- **Subpart 4 Restrictions.**
When an insurer contracts with a single managed care plan coverage for an employer, the plan may not be formed, operated, or administered by the same employer of insurer. When an insurer contracts with multiple managed care plans, one or more of the plans but not all may be operated, formed, or administered by the employer or insurer. No employee shall be required to obtain services under the managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota statutes, Chapter 176.

- Clarification is requested regarding this particular subpart in reference to the managed care plan created by an employer. In the instance that an employer does create its own managed care plan, does an alternate plan <u>always</u> need to be offered?

- **5218.6000 Emergency Charges and Fees.**
The payment by the insurer or the managed care plan to participating and non-participating health care providers for medical services shall be according to the timeframes and procedures in part 5221.0600, subpart III and Minnesota statues section 176.135, subdivision 6 and shall be the <u>maximum amount allowed under Minnesota statutes 176.136,</u> which is the Minnesota state fee schedule.

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- Traditionally, preferred provider organizations and managed care organizations have allowed for reimbursement at a discounted rate. It is apparent that the proposed rules in the workers compensation system in Minnesota are driving for reduced costs. Thus, a managed care organization should have the ability to negotiate a discounted fee with a health care provider and yet maintain

quality appropriate and cost effective medical care to the injured worker. Reducing costs throughout the system appears to be win-win situation for all parties involved.

Thank you for your consideration of these issues. Please do not hesitate to call with any questions you may have regarding these comments.

Sincerely,

Steven H. Osterkamp

Steven H. Osterkamp
Vice President, Sales and Marketing

SHO/nks

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

Date: August 21, 1992

Subject: Proposed Emergency Rules/Workers' Compensation
Managed Care

Dear Ms. Zembal:

This letter contains MedCenters Health Plan's comments regarding the proposed Emergency Rule of the Department of Labor and Industry setting forth the procedures and conditions for certification of a Managed Care Plan to deliver medical services to an employer for Workers Compensation coverage.

We were particularly pleased this past legislative session, that the legislature had the foresight to introduce into the workers compensation system, the ability of HMOs and other organizations to manage the care of injured employees. We look forward to the opportunity to participate in the delivery of high quality health care to this population. As demonstrated in the A. Foster Higgins Report of 1991, Minnesota HMOs have demonstrated their ability to contain the cost of health care by excluding unnecessary services, and providing higher quality of care delivery to our enrollees.

As you proceed to the final adoption of these rules, we ask that you keep in mind a couple of thoughts. First, Minnesota HMOs are highly regulated by the Minnesota Department of Health. Many of the reporting requirements contained in the proposed emergency rules can be satisfied through inter-agency cooperation with the Department of Health. Such coordination will save administrative costs.

Second, we appreciate the difficulty you may have in drafting rules that recognize all types of managed care organizations in the State of Minnesota. Historically, HMOs, and Non-profit Health Service Plan Corporations(BCBS), are heavily regulated. PPOs are relatively un-regulated in the State of Minnesota. Given the imbalance of current regulatory burdens, we ask that in your attempts to be equitable, you not make it overly burdensome for HMOs to participate in this program by promulgating regulations that duplicate or are inconsistent with oversight activities already being performed by other state agencies.

The legislature's intent in allowing HMOs to deliver care in the workers compensation system, in our opinion, was to utilize the already regulated managed care systems, as is witnessed in the legislation's specific mention of 62D and 62C corporations. We therefore strongly encourage you to coordinate with the regulatory systems at the Department of Health in those areas where HMOs have already met the criteria set forth in the rule. This could result in tremendous administrative cost savings, a goal which we all supported in the HealthRight legislation.

Finally, we understand that the emergency rule making process is an abbreviated one, with constraints on your ability to make substantive changes at this point. We ask that to the extent you are not able to incorporate all our suggestions at this time that you consider them when permanent rules are developed.

With regard to the proposed emergency rules, our comments are as follows:

5218.0100 DEFINITIONS

Subpart 3. Emergency Care. Recognizing that the definition is provided for purposes of worker's compensation coverage, we would recommend that a more traditional definition of Emergency Care be used, which is consistent with current laws and rules regarding the delivery of services by managed care organizations. Specifically, we recommend the following definition for the Department to consider:

"Professional health services provided to treat a medical condition resulting from an injury and necessary to preserve life, limb, or stabilize the health of the individual"

Subpart 5. Geographical service area. The proposed rules define the service area in which a managed care plan has been certified to provide "comprehensive" health care services to injured employees. The use of the word "comprehensive" may be interpreted to include the provision of care which is not "medically necessary" or "appropriate" in order to preserve the life, health or limb resulting from a work place injury. We recommend deletion of the word "comprehensive", to be replaced by "medically necessary". "Medically necessary" services, as provided in the managed care industry, by definition anticipate that services provided could not have been omitted without having an adverse affect upon the employee's condition, or the quality of care delivered. We believe this change would Provide a more precise definition of what care is to be delivered, and avoids the potential of otherwise unnecessary care.

HMOs have their service areas approved by the commissioner of Health to ensure that there is an adequate number of providers to deliver all services to members within the service area. We ask that the Department of Labor and Industry attempt to coordinate this provision with the Department of Health. Although we may have a designated county within our service areas, that does not necessarily mean that the entire county is part of our service area. We therefore request language clarifying that a service area need not cover an entire county. We could still meet the access requirements for employees near their place of employment as otherwise provided in the rules.

Subpart 9. Participating Health Care Provider. We recommend expanding the definition to clarify that the "contracts or other agreements" are specifically for the purpose of providing health care services to employees of an employer insured under Chapter 176. To provide clarity and consistency with other statutes regulating HMOs, we recommend that this definition incorporate by reference the language contained in Minnesota Statutes 62D.02, Subd. 9 and 12.

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5218.1000 APPLICATION FOR CERTIFICATION.

Subpart 1, Paragraph B. This paragraph limits the total annual compensation to be paid to an administrator of the managed care plan to not exceed 10 times the average annual wage as calculated in Minnesota Statutes, section 176.011, subdivision 20. Although we do not anticipate this will present any problems for our organization, it is unclear to us what the authority for such a limitation is, what the purpose is, and how it will be calculated.

Does the average annual wage include any bonuses, benefits, or other incentives that may be provided for in an administrator's contract? Does this provision allow for the separation of reimbursement by lines of responsibility defined in the administrator's contract? For example, if the administrator for the managed care plan also provides administrative services for other lines of a plan's business, is the reimbursement for other lines of business included within the calculation of reimbursement for the administrator responsible for the workers compensation managed care business? What is the Department's authority for limiting administrator's reimbursement? We are unaware of any statute which grants such authority to the commissioner.

Subpart 1, Paragraph D.,(2),(a). This subparagraph requires a managed care plan to provide services that meet uniform treatment standards to be prescribed by the commissioner.

We recognize that the statute provides for the adoption, or development of "standards". It is important to recognize that HMOs have adopted, or are in the process of adopting "guidelines" for treatment. The use of the term "standards" implies an absolute procedure for practice as compared to "practice guidelines" which provide a framework within which physicians exercise professional judgment. Utilization of the "practice guideline" terminology would be more consistent with the current "state of the art" in medical community efforts to enhance consistency and quality among provider groups. Perhaps it would be possible to define standards to be consistent with this concept.

We further suggest that these "guidelines" be consistent with the philosophy, intent, etc. of those referenced in the Health Right/Minnesota Care legislation.

In the event that treatment standards, or practice parameters and protocols are developed by the commissioner of Health under the new HealthRight legislation, how will the Department of Labor and Industry reconcile any differences which may exist? We encourage the coordination of any practice standards between the two agencies.

Further, Minnesota Statutes 176.1351, Subdivision 2, Paragraph 12, provides that the commissioner may accept findings, licenses, or certifications of other state agencies as satisfactory evidence of compliance with a particular requirement of the "managed care" requirements of this law.

One of the unique, and valuable, features of HMOs in the State of Minnesota, is that we are required by law to have a Quality Assurance plan in place and operational. This plan is audited and regulated by the Commissioner of Health to assure quality and appropriateness of treatment standards. We are also required by the Minnesota Department of Health to maintain "practice guidelines" on file for review. We

recommend that you change the requirement for submitting these guidelines to the commissioner, to a requirement that we have these guidelines available to the commissioner for review. Submitting them to the commissioner would be administratively burdensome, as there will be ongoing evaluations and updates.

With regard to the "quality" of services provided by an HMO, and treatment standards, we encourage the commissioner to consider those requirements already placed on HMOs by section 62D.03, subdivision 4, paragraph (n), and the Commissioner of Health.

Subpart 1.,D., paragraph (2),(b). For consistency, and clarification, we recommend that wherever the word "provider" is used, the definition be expanded to incorporate the reference to Chapter 176.011, Subd. 24.

Paragraph (3),(a) requires a managed care plan to have procedures to ensure that an employee will "receive an initial evaluation by a participating physician within 24 hours of a request for treatment following an injury..."

There are two issues which we would like to discuss here: the timing for initial evaluation, and entrance into the managed care system.

We agree that access to a provider for evaluation needs to be expedited, particularly where there is an urgent need for care. In such an instance, we find that the 24 hour requirement is reasonable.

Due to the nature of injuries occurring in the work place, it is important that managed care organizations have an opportunity to get the employee into their care delivery system as quickly as possible. In the situation where an employee is injured, and requires immediate attention, we want to make sure the employee enters the managed care plan's case management system as quickly as possible so that intensive case management can be commenced.

Paragraph (3), (c) requires that a managed care plan include a procedure to ensure that an employee can choose from at least three health care providers to whom the employee has been referred by the evaluating provider for treatment.
We recommend that such a requirement be placed upon the managed care plan upon "request" by the employee to ensure that this provision does not become overly burdensome. It is our understanding, from a meeting with Department staff, that this provision would be revised to clarify the Department's intent that more that one provider be <u>available</u>, but that a list of these providers not be required. Also, we believe it is important that the rules recognize that the evaluating provider can also be the treating provider.

On page 4, line 26, we recommend a technical correction. The language currently reads: "...health care providers to whom the employee has been referred by..." We believe the intent is to address a current or future situation, not a past situation. There we recommend changing "has been" to " may be".

It is also not clear to us if this provision includes specialty care in a referral situation. This provision raises a number of questions: Is a managed care plan required to have 3 referral providers within the geographic area for all services, including specialty

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services? There may be some specialty areas where there may be only a handful of providers in the state. It may not be necessary, nor would it be advisable, for a managed care plan to have 3 of each provider specialty available for treatment, and delivery of care. Such a provision would negate the advantages achieved through managed care. Depending on the care needs of the population, having three providers may not be necessary, or possible.

Subpart 1.D.(3)(c) requires that the managed care plan's procedure to allow the employee to select a health care provider must provide "direct access" to all health care profession disciplines if the treatment is determined to be appropriate for the condition by the evaluating health care provider. The use of the words "direct access" in this context seems to imply that an employee is not required to use the primary care provider for referrals on specialty services. Clarification needs to be made that although the employee may have the ability to choose their own primary care provider, that primary care provider will need to make referrals to specialty care services within the plan. Again, the Department has told us that they plan to revise the language in this provision to eliminate the apparent internal inconsistencies.

Subpart 1., D., (11) requires a managed care plan to submit treatment standards for medical services not already prescribed by the commissioner.

Treatment guidelines measured by outcomes of patient treatment are a relatively new method of developing care protocols for specific treatments and procedures. Debate is ongoing as to whether such standards should be established at the federal level, at the state level(as prescribed in HealthRight), or at the community level.

HMOs do develop their own treatment guidelines for care to be delivered by their providers, however, such guidelines to date have focused on primary/preventive care. It is our intent to go beyond this point, however, we are not yet there.

We further recommend that the requirement on page 6, paragraph (11) be clarified to provide that managed care plans be required to submit treatment guidelines for medical services not already prescribed by the commissioner, to the extent they are developed by the plan.

Managed Care Organizations conduct literature reviews on a regular basis for the most appropriate and up to date protocols for delivery of health care services. Requiring that managed care organizations deliver to the commissioner treatment standards for all medical services, not already prescribed by the commissioner, appears to require that such standards be developed. There are many reasons for which this simply would not be possible to deliver. Assuming standards are attainable, it is very possible that there will be more than one possible treatment methodology for any given medical condition resulting from an injury. Development of standards do not ensure that the appropriateness of care to be delivered will be up to date with the current state of technology, or medical knowledge.

As the technology or knowledge continues to evolve, the adoption of treatment standards would require continuous up-dating with the department, which will not be practical.

Again, HMOs do develop guidelines for the delivery of preventive care. The circumstances under which preventive care is delivered is quite different than for the treatment of injuries.

Under Health Department regulations, we are required to make available to the commissioner, upon the commissioner's request, access to standards for treatment if they are developed and adopted by the plan. We encourage you to consider this approach for certification of managed care plans for workers compensation; it is our understanding that the Department is open to this suggestion.

Subpart 2 should include a time-frame for notification of approval or denial of the application. This is necessary for the organization's internal planning process. We would also appreciate if you added the words "in writing" to the sentence stating that the applicant will be provided with the reasons for the denial."

Subpart 3. Contracts. This subpart establishes the terms and conditions for contracting with an insurer to cover an employer under Chapter 176. The proposed rules do not anticipate the possibility that a managed care plan, such as an HMO, a Non-Profit Health Service Plan Corporation, or a PPO, may directly contract with an employer. We view such a contractual relationship to be much more beneficial to both the employer and the employee.

By allowing a direct contractual relationship with the employer, the employer and their employees have a much more direct relationship with the providers of that managed care plan. By interjecting the insurer directly between the employer and the managed care plan, another level of communication and negotiation is created which could add to the cost of care to be delivered.

It is possible that managed care plans will contract directly with the insurer, however, the alternative method of contracting should not be discounted as a possibility.

Subpart 1 of 5218.2000(Coverage Responsibility of Managed Care Plan) states that "a managed care plan shall provide comprehensive medical services according to its certification and Minnesota Statutes, chapter 176, and all other applicable statutes and rules. This provision could be problematic since in instances an HMO's scope of covered services could be broader than those required in the workers compensation context. We suggest inserting, "to the extent applicable" after "certification" on line 29, page 6.

5218.3000 REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN.

Subpart 2 of that same provision requires the commissioner to designate and approve a managed care plan's service area. Since HMO's already have service areas approved by the Department of Health, we suggest that an HMO's service area be automatically approved by the Commissioner of Labor and Industry.

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Subpart 2., D. requires a summary of any sanctions or punitive actions taken by the managed care plan against its members.

It is unclear as to whom this provision applies. It would be helpful if clarification was provided as to who "members" are within the context of this paragraph. Are they participating providers? Are they employees? Are they employers?

We do not object to submitting a summary of actions taken, however, we do believe that this language should be clarified to provide that the summaries not contain individually identifiable information. We would recommend the same clarifiers for paragraph E. relating to Peer Review and Utilization Review.

Subpart 3. Again, we encourage the Department to consider language which would permit a direct contractual relationship for coverage of medical services with the employer.

5218.5000 HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subpart 1., A. this paragraph provides that if a previous health care provider maintains the employee's medical records and has a documented history of treatment of that employee before the date of injury, then the employee may receive services from that provider for any subsequent injury which may occur.

It is our understanding that the intent of the law was to permit an employee to see a previous provider who was treating that employee. An employee could totally avoid the managed care contract which an employer has to deliver medical services to an injured employee. The rules should be clarified and tightened to ensure this intent is clear.

We can accept such a condition, under Workers Compensation for treatment of a previous injury. However, it would be contrary to the intent of the law, which was to allow employers to use restricted, managed care networks, to provide quality, cost efficient care to their employees. This rule would not permit the managed care organization to aggressively case manage an injury. Subsequently, any benefits which might be derived from using a managed care system are lost.

Further, when an employee seeks care from a previous provider, we would ask that some allowance be made in the managed care plan procedures to allow for a pre-certification requirement.

5218.6000 CHARGES AND FEES.

This rule provides that payment by the insurer or managed care plan to participating of nonparticipating health care providers for medical services shall be the maximum amount allowed under Minnesota Statutes, section 176.136. This amount is either the amount established by the Relative Value Fee Schedule to be adopted, or the provider's actual fee, whichever is lower.

One of the values of using a managed care plan is that of negotiating a fee for services to be delivered. Should the negotiated rate between a managed care plan and a participating provider, for the treatment of an injury, whether it be at work, or at home, be lower than the maximum permitted in law, it would not make sense to require a managed care plan to pay a higher rate.

We recommend that the Department amend this language to provide that "The managed care plan shall reimburse the participating and nonparticipating health care providers for medical services according to the maximum amount allowed under Minnesota Statutes, section 176.136, or the amount provided for in the managed care plan's provider contract, whichever is lower."

5218.9000 SUSPENSION/REVOCATION OF CERTIFICATION

The rules as proposed provide for the revocation or suspension of a managed care plan's certification. The criteria for such actions are delineated under Subpart 2.

The proposed rules only provide, for revocation or suspension of a managed care plan's certification, the criteria for which ranges from actions causing minimal harm to actions being more serious in nature.

For minimal violations, revocation or suspension are severe forms of disciplinary action. Either the Department will be forced to use overly dramatic enforcements, or, due to the extremely punitive nature provided or a violation of rules no action will be taken. We recommend the following: that the rules provide for a provision which allows for an intermediate disciplinary action short of revocation or suspension of certification. We recommend you look to the Department of Health authorities, under Chapter 62D for disciplinary action of an HMO, and the criteria established for taking those actions.

For more serious violations of the proposed rules relating to issues of quality of care delivered, findings of the Commissioner should be turned over to the appropriate licensure agency for appropriate review and action. This would avoid duplicative and overlapping regulatory activities.

Thank you for this opportunity to comment. We look forward to working with you to ensure that the permanent rules to be adopted will make it possible for managed care organizations to play an integral part in the delivery of health care within the context of workers compensation.

Sincerely,

Mark Skubic

Mark Skubic VCR

BlueCross BlueShield of Minnesota

P.O. Box 64560 • St. Paul, Minnesota 55164-0560

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AUG 24 1992
COMMISSIONER'S OFFICE
DEPT. OF LABOR & INDUSTRY

August 19, 1992

John D. Lennes, Jr.
Commissioner
State of Minnesota
Department of Labor and Industry
443 Lafayette Road
St. Paul, Minnesota 55155

RE: Proposed Emergency Rules Governing Workers' Compensation Managed Care Plans

Dear Commissioner Lennes:

Thank you for meeting with Doug Franzen, Kurt Schwarzkopf and myself to discuss the concerns of Blue Cross regarding the Department's proposed emergency rules governing workers' compensation managed care plan certification. The comments and thoughts you shared with us reflected an understanding of Blue Cross' concerns and with certain revisions the rules should allow for the creation of managed care plans that will benefit employees, employers, providers and managed care plans.

As a follow-up to our meeting, Blue Cross is pleased to provide you with the following suggested revisions to the emergency rules which address the concerns we discussed.

As you recall, Blue Cross is concerned that the rules as drafted would require managed care plans to micro manage the delivery of health care to injured workers to assure appropriate quality care and avoid the abuses of fee-for-service reimbursement required by strict adherence to the

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statutory fee schedule. Through its years of managed care experience, Blue Cross has found that a reimbursement system built upon economic principles of financial incentives and penalties provides a more efficient and effective means of assuring appropriate delivery of quality health care services. Economic incentives such as risk sharing and payments based at least in part on outcomes are accepted methods by which providers negotiate their actual fee with health carriers. Such negotiations result in rewarding quality providers and allowing providers to correct problems of over utilization, ineffective and inappropriate services, without having the manage care plan reviewing each service rendered by the provider. Blue Cross believes the Department has the statutory authority to revise this rule stated below.

RECOMMENDATION: Modify Rule 5218.6000 (page 12, line 1- 10) as follows:

5218.6000 [Emergency] CHARGES AND FEES.

Billings for medical services under a managed care plan shall be submitted in the form and format as prescribed by the managed care plan and consistent with ~~in~~ part 5221.0700, subpart 2. The payment by the insurer or the managed care plan to participating providers and nonparticipating health care providers authorized under Rule 5218.5000 for medical services shall be according to the timeframes and procedures in part 5221.0500, subpart 3, Minnesota Statutes, section 176.136, subdivision 1a, and Minnesota Statutes, section 176.135, subdivision 6, ~~and shall be the maximum amount allowed under Minnesota Statutes, section 176.136~~. The managed care plan and participating providers may enter into negotiated payment arrangements which shall establish the providers actual fee and are consistent with Minnesota Statutes, section 176.1351, subdivision 2.

The other concern of Blue Cross, which we discussed was in regard to the problems created by allowing employees to select at the time of injury a managed care plan where multiple plans are available, Blue Cross suggests the following revisions:

RECOMMENDATION: Modify Rule 5218.2000 Subp. 3.B. such that page 7, lines 12-15 read as follows: "with multiple managed care plans to cover the same employer, each employee shall have initial choice ~~at the time of injury~~ to select the managed care plan that will manage the employee's care from any managed care plan authorized to cover the employee at the time the employee commences employment or at the time the insurer contracts with a managed care plan.

As you recall, Blue Cross is concerned that allowing the employee to choose a managed care plan at the time of injury creates real and administrative problems for the employer and managed care plans. For example, what happens with an employee who is incapacitated by an injury and rendered incapable of making a choice at or after the time of injury; which managed care plan is responsible for overseeing and monitoring the care of an employee who at the time of injury chooses to use a nonparticipating provider; how can managed care plans report on the number of covered employees. By changing only the timing of this election, the suggested revision maintains the employees right to choose among multiple plans while allowing the employee to make a more informed choice and helping the managed care plan determine their servicing and reporting accountability.

Thank you again for taking the time to meet with Blue Cross to discuss our concerns. We hope that the revisions contained herein are helpful and will be adopted by the Department prior to finalizing the emergency rules.

Sincerely,

Michael Morrow
Assistant Vice President
Provider Contracts and Payment

MR:fc
cc: Gloria Gephart

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Proposed Emergency Rules on Work Comp Managed Care Plans

Dear Ms. Zembal:

I am an employer and object that the following emergency rules are not in the spirit of the law and will become a hardship and burden to all Minnesota taxpayors.

1. It is not fair for me or my employees to have to see an M.D. within 24 hours of an injury. I need my own choice to see who I want to see. I see this law as an adverse attempt to control my care or for the MD to direct me to his friends not to who I need. If I want to see a chiropractor, it is unlikely an M.D. will refer me to one because M.D.'s have not attended chiropractic courses and don't understand which cases chiropractic can help, hence they will not refer me to someone they don't understand.

2. The review process for dispute between patients are MCO's are very unfair, they descriminate against the patient and give the MCO too much control. This will only lead to increased costs due to the increased litigation it will cause.

3. I don't think my chiropractor should be excluded from the managed care plan and according to the rules. I have no evidence that he will be chosen, The MCO should have to participate with whichever doctors want to. They should not be allowed to pick and choose whoever they want. If this is allowed, the only doctors who they will choose are the ones they want. If this is allowed, the only doctors who they will choose are the ones they can control, not doctors who care about their patient needs.

4. The treatment guidelines were set up by IME doctors and the the way they are designed is a danger to the public. They will not allow us to get the care we need which will make our generation live with more disability than we would have had to.

5. This whole bill is a bad attempt by the legislature. It will only serve to cut good doctors from the system, give patients less care than what they will need, fill the managed care organizations with excessive monies, and therefore will cause unecessary costs, pain, suffering and disabilities for the Minnesota public.

I urge you to change these rules before it is too late. This is America, a country founded by freedom of choice. This law will take that away from us, will give the MCO insurance control over our health, which leads to our longevity and ultimately our life.

2712 IDAHO AV S.
MPLS MN 55426

BRIST CHIROPRACTIC
FAMILY HEALTH CENTER

August 19, 1992

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Rd. N.
St. Paul, MN 55155

RE: Comment on Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

As a licensed doctor of chiropractic who has been practicing in Minnesota for four years, I would like to express my deep concern regarding the emergency rules that have been proposed for the new worker's compensation program.

I--and most of my fellow chiropractors--have been stunned and appalled at some of the provisions contained in the proposed rules because they so blatantly defy the letter and the intent of the 1992 worker's compensation legislation. Specifically, the rules discriminate against doctors of chiropractic, despite the statutory prohibition against MCPs discriminating against any category of health care provider. This discrimination prohibition--which is also consistent with our state's insurance equity laws--was included in part, I believe, because of the hundreds of letters legislators received from their constituents who insist that their freedom of choice in health care systems be maintained. Should the voices of these--and the thousands of other satisfied chiropractic patients--be swept out the door in the rush to implement "emergency rules?"

The rules are inherently or potentially discriminatory in the following ways:

1. They provide that initial evaluations are to be made by a "physician," which is defined as an M.D. or D.O. I am a licensed physician in this state. Why should my medical and osteopathic counterparts be given a privilege I am denied?

2. They allow MCPs to select and later exclude specific doctors to participate. There is no equity in such a system. All doctors who are licensed and who are willing to abide by the rules and limitations of the MCP should be allowed to participate.

3. They allow the "evaluating provider," who by definition is not a doctor of chiropractic, to determine which health

care profession should provide treatment. This is ludicrous, given the medical profession's long-standing and criminal attempts to unfairly restrict the chiropractic profession (as was verified by a U.S. District Court). The medical gatekeeper was by no means within the intent of the legislation; on the contrary, the discrimination prohibition was meant to prevent such an unwise and unfair system.

Other concerns I have with the proposed rules are:

1. MCPs should not be allowed to devise their own treatment standards. This is confusing and will result in inconsistent benefits being provided to citizens who are hurt at work. The Minnesota Chiropractic Association standards, which are already formulated, should be adopted across the board.

2. The rules should not be made retroactive. That is, if a person injured before 10/1/92 desires to change his treating physician, he should not be bound by the managed care plans that have since gone into effect. My understanding is that state law does not allow retroactive application of legislation unless specifically provided for by the legislature, which is not the case here.

The 1992 work comp legislation was designed to reduce or eliminate inappropriate or unnecessary treatment. This can be accomplished without discriminating against an entire category of health care providers--and without depriving Minnesota citizens of their fundamental right to choose their own treating physicians.

In our haste to implement this legislation by the deadline, we must not accept rules that violate the provisions of the legislation itself. That would indeed be a travesty.

Sincerely,

Jeff Brist D.C.

Jeff Brist, D.C.

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LAMPPA CHIROPRACTIC

DR. MICHAEL R. LAMPPA, D.C.

8746 Lyndale Ave. S.
Bloomington, Minnesota 55420

612-888-6000

August 20, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comment to Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

I am writing in regard to the letter dated August 7, 1992 that Mr. David C. Wulff wrote to you. I agree strongly with all of the comments that Mr. Wulff wrote. If these rules are put into effect, there will be discrimination on certain doctors as well as discrimination on behalf of the injured person to have his/her choice of physician that they want to see. For your convenience I had included a copy of Mr. Wulff's letter.

If you have any questions, please feel free to contact me at 888-6000.

Sincerely,

Michael R. Lamppa, D.C.

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August 19, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 LaFayette Road No.
St. Paul, MN 55155-4316

Dear Ms. Zembal,

I am writing to you as a physical therapist who is concerned about the proposed rules for the State Department of Labor and Industry regarding workman's compensation managed care plans. I am employed in a private physical therapy clinic owned by physical therapists and am concerned that these rules inhibit participation in a small business. A significant amount of our revenue is based in the workmen's compensation system and this will be a significant determent for our survival. I also feel a lack of good competition among the field will inhibit quality of care and also limit access of workers to physical therapy.

While I respect the need for cost control in the health care field I do feel that further evaluation and consideration of effects of these proposed rules should be considered. We do have active peer review within our profession for monitoring of quality of care and ~~these~~ fee schedules have already been altered. I appreciate your review of this matter.

Sincerely yours,

Alana J Hinrich PT

Alana J. Hinrich, PT

AJH/czu

ORTHOPAEDIC SPORTS, INC.
specialized physical therapy

STILLWATER OFFICE
1700 Tower Dr. W.
Stillwater, MN 55082
(612) 439-8540

MAPLEWOOD OFFICE
Maplewood Professional Bldg.
1655 Beam Ave., Suite 308
Maplewood, MN 55109
(612) 779-6543

WOODBURY OFFICE
2025 Woodlane Dr., Suite 100
Woodbury, MN 55125
(612) 738-8270

FOREST LAKE OFFICE
146 North Lake Street
Forest Lake, MN 55025
(612) 464-8502

THE WORK CENTER
River Heights Plaza
1410 Frontage Rd. W.
Stillwater, MN 55082
(612) 439-9509

August 24, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs Department
of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

My purpose for contacting you is regarding the proposed rules of the State Department of Labor and Industry governing workers' compensation managed care plans. As an owner of Orthopaedic Sports Inc. a private practice physical therapy clinic in Stillwater, Maplewood, Woodbury and Forest Lake I am concerned regarding the above mentioned issue. One of our offices, The Work Center, deals exclusively with work related injuries re-utilizing functional rehabilitation including FCE's work hardening along with various other services such as ergonomic evaluation of industrial sities.

As you can well imagine I am quite concerned about the proposed regarding managed care plans and our workers' compensation system. The fact that managed care plans will be structured such that they must include at least three physicians would make it difficult for the small business owners/physical therapists to complete with the larger, more powerful corporations such as HealthEast, Fairview and HealthOne. Since approximately 35-40% of our business is workers' compensation we would lose a great deal of our business if we did not see the injured worker. I have further concerns that by limiting the number of providers in the managed care plan that injured workers would have limited access to physical therapy, this would certainly delay rehabilitation recooperation thus to delay their return to work. This would in essence add cost to this system instead of lessen cost.

The managed care plan seems to me to be (accompanied doctor) system which limits the injured worker's choice in choosing a health care provider.

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Because of my concerns I do feel that these rules should be closely scrutinized and altered. I would recommend that cost controls be attained through the fee schedule, pay review of various professions by the respective peers, and treatment guidelines developed by the Medical Services Review Board of the Department of Labor and Industry.

(Continued)

Lastly I would think that since the injured worker is considered as having a disability following his injury that restricting his ability to receive care within the managed care system may lead to a conflict with the Americans with Disabilities Act. This may also open the door to potential litigation. Thank you for your consideration of this issue. At our clinic we sincerely desire to provide high quality care for the injured worker and faciliate optimal return to work at appropriate time frames. All of us in health care strive to reduce our health care costs and provide high quality care. I do not feel that restricting access would be a reasonable approach to managing this problem. This issue could also potentially cause health care providers to go out of business adding further to the burden of this state.

Sincerely,

Mike Ripley RPT, ATC
Vice-President
Orthopaedic Sports, Inc.

MR:kam

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ADVANCED CHIROPRACTIC CLINIC

Dr. Tim Mieczkowski
Dr. Lovette Mieczkowski

857 South Main Street
Sauk Centre, MN 56378
Telephone: (612) 352-5227

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08/21/92

MS. PAM ZEMBAL
REHABILITATION AND MEDICAL AFFAIRS
DEPARTMENT OF LABOR AND INDUSTRY
443 LAFAYETTE ROAD NORTH
ST. PAUL, MN 55155-4316

RE: COMMENT TO PROPSED EMERGENCY RULES
ON MANAGED CARE PLANS

Dear Ms. Zembal:

I am writing in regards to the emergency rules governing managed care plans as it pertains to Workman's Compensation. Many of the rules are contrary or violate legislative changes made in 1992 session. A letter sent by the law firm Wilson and Wulff to your office sufficiently outline my concerns on the emergency rulings. These matters must be addressed to comply with legislative intent.

Sincerely,

DR. LOVETTE MIECZKOWSKI

LM:sjd

ADVANCED CHIROPRACTIC CLINIC

Dr. Tim Mieczkowski
Dr. Lovette Mieczkowski

857 South Main Street
Sauk Centre, MN 56378
Telephone: (612) 352-5227

08/21/92

MS. PAM ZEMBAL
REHABILITATION AND MEDICAL AFFAIRS
DEPARTMENT OF LABOR AND INDUSTRY
443 LAFAYETTE ROAD NORTH
ST. PAUL, MN 55155-4316

RE: COMMENT TO PROPOSED EMERGENCY RULES
ON MANAGED CARE PLANS

Dear Ms. Zembal:

I am writing in regards to the emergency rules governing managed care plans as it pertains to Workman's Compensation. Many of the rules are contrary or violate legislative changes made in 1992 session. A letter sent by the law firm Wilson and Wulff to your office sufficiently outline my concerns on the emergency rulings. These matters must be addressed to comply with legislative intent.

Sincerely,

D.C.

DR. TIM MIECZKOWSKI

TEM:sjd

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REHABILITATION & MEDICAL AFFAIRS

Law Offices

GORMAN & GORMAN, LTD.

THOMAS E. GORMAN*
RICHARD D. GORMAN
BARBARA M. McLAUGHLIN*
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PHONE (612) 388-1511
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August 19, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

RE: Proposed Emergency Rules/Managed Care Plans

Dear Ms. Zembal:

Please accept this letter as my comments and position with respect to the proposed emergency rules. I am an attorney working in the field of workers' compensation and feel that some of these rules are inconsistent with the callings of the 1992 legislative changes.

My understanding that the basic intent of the legislature in adopting the amendments to the rules was that they were concerned over the skyrocketing costs and wanted to reduce the number of unnecessary treatments with respect to health care. It is also my understanding of the law that individual medical care providers were not to be discriminated against.

I feel that proposed rules do unfairly and unjustly signal out the chiropractic profession and is directly contrary to what the legislature intended and wrote.

By adopting these emergency rules, I feel that the commissioner is using a small window of opportunity in the law to adopt these emergency rules eventhough he knows them to be contrary to the law. By getting these rules temporarily into effect, it will be much easier for the permanent rules to be adopted. As we all know once the amendment is in place, it will be more difficult to override in the future.

Specifically, I feel that the initial evaluations under the proposed Rule 5218.1000(d)3, is in direct contradiction with the law. I believe that these initial evaluations are quite clearly against the calling of the law and require that a licensed medical doctor make the decision whether or not chiropractic care is appropriate. I believe that the physicians that make the decisions will no doubt be discriminatory as this has been in the past

towards chiropractors and will leave the chiropractic trade out, as if to line their own pockets.

I have also had a chance to review a letter which I have enclosed from the law firm Wilson & Wulff, P.A. which summarizes some of the programs and after discussing some of these items with Mr. Wulff, I will wholeheartedly agree with his suggestions and his interpretations of these various rules.

Lastly, and most importantly what really concerns me is the attitude which the department has taken with respect to these matters. It is my opinion that they are trying to use a small window in the law to rewrite the way we provide health care to Minnesotans. We recently enacted a Minnesota Health Right Act and the Act in itself was monumental. Now the department seems to be taking their own approach with respect to these matters and disregarding legislature entirely. What the legislature gave the Department of Labor and Industry seems to be taking away. Under the proposed emergency rules, health care will not be a right but a luxury. I note that at various conferences and CLE's, some officers from the Department for the Department have been particularly boisterous with concerns with respect to these matters and they have said they are going to dictate how things will be. These cannot be just oversight and errors on the part of the department, but I feel are conscious efforts on the part of a few to diminish the rights of working people. I believe that the department is trying to put these changes into effect and I am sure that litigation will come about if these changes, which are directly in contrast to the law. I would hope that you would make some changes prior to their enactment so that all parties are treated equally, and the rules are consistent with the law.

Thank you for this opportunity to comment on these rules.

Very truly yours,

GORMAN & GORMAN, LTD.

By: Richard D. Gorman

RDG:slb
cc: Jay Greenberg

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REHABILITATION & MEDICAL AFFAIRS

MJOEN CHIROPRACTIC OFFICE, P.A.

DR. DAVID L. MJOEN

300 West Oakland Avenue

437-7781

Austin, Minnesota 55912

437-7782

8-19-92

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LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comments about the proposed Emergency Rules on Managed Care Plans.

Dear Ms. Zembal,

I am very concerned about the direction workers compensation is going in the state of Minnesota. I am especially concerned about the proposed emergency rules on managed care plans published on July 27, 1992. The following are of major importance as I see it and need to be changed or deleted entirely.

1. The exclusion of Health Care Providers from MCPs.
2. Initial evaluation under 5218.1000 D(3).
3. Entities which may be certified as MCPs.
4. Peer Review, Utilization Review and Internal Dispute Resolution
5. Aggressive Case Management and Early Return to Work Programs.
6. Treatment Standards Not Prescribed by the Commissioner.
7. Retroactive Application of MCPs.
8. Termination of Participating Providers.
9. Treatment Provided by Non-Participating Health Care Providers.

Generally speaking I do not think that this particular proposal is what the intent of the legislature wanted. I believe that this will further increase the cost of comp in the state of Minnesota. The managing agencies will be the ones who will now get their hand in the pie and send costs soaring and decrease the quality of care.

This work comp bill and the proposed emergency changes are un-American. It takes away the freedom of choice. It is not fair to all involved. There are better ways to solve this problem than the direction it is going now.

I ask that you seriously consider what this bill will do in the long run. It is very obvious to those who work within the system that this proposed program will not work the way in which it was envisioned.

Sincerely,

David L. Mjoen, D.C.

DR. KEITH R. KAMRATH, P.A., *CHIROPRACTOR*

35 Second Avenue SW • Hutchinson, Minnesota 55350 • (612) 587-3888

August 19, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comment on Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

I'm writing to you to comment on the proposed emergency rules on managed care plans published on 07-27-92.

1. It is my understanding that under the proposed rules some health care providers may be totally excluded from treating injured workers. Rather then selecting some providers and excluding others, I would recommend that MCPs accept all health care providers who apply for admission so long as their license is in good standing and they agree to abide by the rules and limitations of the MCP.

2. The "inital evaluations" should be allowed to be performed not only by M.D.'s and D.O's, but by Doctors of Chiropractic as well.

3. The proposed rule which requires individual MCPs to submit treatment standards for medical services not previously described by the commissioner, should be eliminated.

4. The proposed rule which allows managed health care plans to cancel participating health care providers under the requirements of the managed care plan should be eliminated. Providers who provide excessive or unnecesary treatment are already handled under the authority of the Medical Services Review Board.

Thank you for your careful consideration of this matter. Please feel free to contact me if you have any questions.

Sincerely,

Keith R. Kamrath, D.C.

KRK/kmk

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LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

DR. JAMES H. NELSON
DR. MARYBETH NELSON

NELSON CHIROPRACTIC CLINIC
306 WEST BECKER AVENUE
WILLMAR, MN 56201
Telephone (612) 235-2720

August 19, 1992

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LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Ms Pam Zembal
Rehabilitation of Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

RE: Comment to proposed emergency rules on managed care plans'

Dear Ms Zembal:

Just a short note to you regarding all of the proposed changes on those already in force and those that will be made in the coming months regarding workman's compensation health care delivery.

While it is common knowledge that we have a health care crisis in Minnesota and throughout the country we also do have a workman's compensation crisis at this time although the degree of that is truly not known at this time. I felt I wanted to interject a couple of my thoughts regarding some of the changes that are being looked at to go into effect as of October 1, 1992.

As chiropractors, we treat a great number of work related injuries every year in this state. Currently there is some talk of initial evaluation to be preformed by a physician which is defined as a medical doctor or doctor of osteopathy within 24 hours of the employees request for treatment of a work injury. Since we as chiropractors are a primary portal of entry into the health care field I feel it would naturally follow to allow patients to also be able to be seen by a chiropractor for their initial evaluation. We must remember that as chiropractors, we are the experts on injuries to the lower back, neck and middle back and also do treat throughout the day injuries to the other portions of the body. Both the medical doctor and osteopath have either nothing or very little time spent on diagnosis and treatment of these types of injuries and as you are aware they are very busy diagnosing and treating the other systems of the body throughout the day. Thus, I feel it would be very important to have an expert such as a chiropractor involved in the initial evaluations.

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With regard to the preferred providers (the MCP's) I feel that this is not good for different reasons:

1. It may cut out a number of excellent health care providers, both chiropractic, medical and osteopathic from treating these work related injuries simply because of numbers or because of quota's an insurance company feels the need to fall within.

2. There could also come into play some bias in the choosing of preferred providers. By going ahead of the preferred providers we are: a) disrupting the doctor/patient relationship which is very important as the trust and the bond that forms between the doctor and the patient is necessary and important in the healing process and the return back to work. Currently in Chiropractic we have a standards of practice that we feel Doctors of Chiropractic should try to fall within when treating any kind of injury. Granted, this is what most patients will fall within as far as types of treatment or amount of treatment goes. However, there will always be exceptions to that rule whether it is a work injury or any other type of health care problem.

3. Any abuse that is currently going on in the health care field especially with regards to workman's compensation is typically being done by a very small minority of providers regardless of there field of practice and to cut.a number of good qualified health care providers/chiropractors out of a group of providers while in the process of trying to get rid of those who may be excessive in their delivery of health care does not truly address the problem. It is my feeling that if a doctor, regardless of what field he or she practices in, is in good standing with the state association, their peer review board and their method of practice is within reason, they should be allowed to continue to treat injured workers. As time goes on and a provider falls outside of the norm for their utilization of health care for work related injuries they can then be put under a utilization review and possible put on some type of probation for a time. If, at that time, they still do not fall into the delivery and utilization standards, they could be suspended.

4. If we continue to go with these different groups of preferred providers, soon a patient will go to one chiropractor for there health insurance, another chiropractor for their automobile accident insurance and another for their workman's compensation insurance. This does not serve the patient well and it makes it much more difficult for the treating doctor to follow through with care as this person has been seen by a number of different providers, depending on what type of injury they had and how they had it.

Thus, I feel that if we are going to go with preferred providers than all should be allowed to begin in the program. We should get a standard of practice that is what most injuries will fall within with the realization that there

will always be exceptions to the rule. You can always decrease providerships based on aberration of different providers as time goes, on but everyone should be allowed to at least begin in the program of treating work related injuries.

I hope this information was of value to you. I look forward to seeing your recommendation in the near future.

Sincerely,

James H Nelson D.C.

James H. Nelson D.C.

JHN/lmm

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Natural Health Care For The Entire Family

Dr. Steven Z. Johnson
P.O. Box 577
26673 Fallbrook Ave.
WYOMING, MN 55092
(612) 462-1038

August 20, 1992

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Ms. Pam Zembal
Dept. of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

To Whom It May Concern:

I am writing to express my concern in regards to the proposed emergency rules on managed care published July 27, 1992. I am concerned that the rules could exclude some health care providers from treating Workers' Compensation Patients. I am also concerned that these proposals may take away the right of the injured worker from seeking care from the Doctor of his choice. It is my opinion that any licensed health care provider who meets the State's requirements should be included in this plan.

Exclusion from being able to treat injured workers could have very grave consequences for any health care provider who is excluded and could unfairly benefit the provider who is picked by the MCP.

Also the provision that requires the initial evaluation to be performed by a Medical Doctor or Doctor of Osteopathy could lead to unfair discrimination against any catagory of Health Care Provider. It is my opinion that the injured worker should have the right to choose from all the MCP'S participating Health Care Providers, including Chiropractors.

The rule that gives the evaluating provider the power to determine what treatment is appropriate and what type of health care and professional discipline should provide the treatment could be used to discriminate against categories of health care providers.

These are some of my major concerns with the new rules. As you look at the new program please consider these concerns.

Sincerely,

Dr. Steven Z. Johnson
SZJ/ar

Park Nicollet Medical Center

2001 Blaisdell Avenue South
Minneapolis, Minnesota 55404

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REHABILITATION & MEDICAL AFFAIRS

August 19, 1992

Molly Siegel
Minnesota Medical Association
Suite 400
2221 University Avenue Southeast
Minneapolis, MN 55414

Comments on treatment standards found on following page.

Dear Molly:

This is regarding comments on the Managed Care Emergency Rules. In general, I believe the rules to be generally vague and clearly lacking in definition. They are not very specific. Specifically, the rules refer to an insurer in several situations within the rules. Our practice has been to contract for services formally or informally with employers and not with insurance companies, and we need a clear definition as to whether a Managed Care organization has the ability to contract with employers or if they have to contract with insurers (i.e. insurance companies) or both.

The definition of insurer on page 1 states the insurer providing Worker's Compensation insurance required by Minnesota statutes, including self-insured employer. Does it also include other employer groups who purchase their insurance from insurance companies?

On page 6, the aggressive case management and the program for early return to work are poorly described. We would ask for more specific rules regarding the aggressive case management. Our concept of aggressive case management is to look at the assignment of the case manager for at least the more difficult cases, if not all cases, for tracking of the injured employee through the Work Comp system. The case manager would follow-up on appointments that are failed and with subspecialists and specialty providers, consolidating the return to work information so that a cooperative plan could be developed with regard to early return to work and restricted work activities for that individual. It is our belief that this might require the hiring of additional personnel.

It is our belief that the aggressive case management may necessitate, in some clinics with sufficient volume, the hiring of additional personnel, i.e. case managers. There is no clear definition of reimbursement mechanisms for operation of a Managed Care organization. The intention, of course, is to reduce costs by eliminating unnecessary procedures and tests and by returning individuals to work at an earlier date. This is a direct cost savings to the employer, but the reimbursement for the Managed Care portion of the Work Comp system is clearly lacking.

There is a reference in the Managed Care plan procedure on page 8, subpart 4., restrictions with reference to self-insured organizations that have developed their own Managed Care plan. Are they going to be permitted to treat their own injured employers, or must they refer all these cases to an outside agency even though they are, in fact, their own health agency with specialty departments in occupational medicine? Do they merely need to provide a second option for the employee should they decide to switch to a different Managed Care program? Does the employee have an ability to switch from one Managed Care plan to another Managed Care plan if the company contracts only with a single Managed Care plan?

On page 12 under charges and fees, my assumption here is that the wording has already been changed, indicating that insurance plans or Managed Care organizations cannot charge a participating physician a percentage fee of the Worker's Comp fee schedule or other charge or in order to provide the service or receive patients. (You have already sent this to me.)

In addition, with regard to the standards of care, I will send you some information from Dr. Scott McPherson, one of our hand surgeons, who has reviewed the cumulative trauma disorder policies. I also have some reports from Dr. George Kramer, Director of Physiatry of the Rehabilitation section of Park Nicollet and Dr. Robert Gorman from our Department of Low Back Pain. I also have comments on some of the standards of care from the chief of Orthopedic Surgery, Dr. Renner Johnston, which we will include for your perusal. Dr. Korbuly from Radiology will also respond to the imaging guidelines.

My own basic comment, in addition to theirs, with regard to the standard treatment for low back pain if no improvement in 45 days, refer: The question would be, "To whom would you refer to?" What physician group would you refer to if you were primary care doctor or if, in fact, you already were an orthopedic surgeon having treated this.

On page 4, passive treatments not to be extended in excess of three months or 90 days: There are many patients who need ongoing medication for a much longer period of time than that and who require reconditioning programs that are not addressed, such as health club memberships, for definitive periods of time, i.e. six months to a year. I have treated many patients in the 3-6 month range with resolution of their back pain and return to unrestricted work, and some patients require ongoing medication well beyond 90 days.

On the active treatment, subpart d. on the low back care, I would include relaxation training as a third component. In subpart 4., first line, duplication of treatments, I would change treatments to read modalities, and I think, in general, the time frames are fairly short for treatment of people with degenerative back conditions aggravated by postural and/or mechanical problems. In regard to the cumulative trauma disorder, the electroneurometry, in my experience, has been a useful screening test and is an appropriate (and much more cost effective) precursor to determine whether or not the EMG or nerve conduction velocities would even be needed for diagnostic purposes, and it should be regarded as a screening test and not a diagnostic test.

With regard to the treatment guidelines, the bottom line on page 3 refers once again to consultation or second opinion. The questions here would be as follows: (1) referred by whom, (2) referred for consultation to whom, or (3) a second opinion from whom. Another question I have is, "How are they going to be implemented and to whom are they going to be effective?" Specifically, how would they be implemented with regard to patients that are currently within the Work Comp system who have been receiving treatment for months/years for their low back and chronic neck pain in the form of medications or other passive treatments (i.e., health club memberships going beyond one year). There needs to be much more clear definition as regards specialties.

On the surgical treatment, page 4, I think the percentages are off with regard to the 95% or more patients with carpal tunnel having the abnormal EMG. I think that number is high, and the true number is closer to 90% or 92%. Please refer to page 5, b.1., the second opinion under repeat surgical treatment. Again, the question would be whom and what would be the reason for that. If, in fact, they are already seeing a hand surgeon, it sounds like duplication of cost. Another indication, of course, would be the failed

Park Nicollet Medical Center

OFFICE MEMORANDUM

Date: August 20, 1992

To: J. N. Dunne, M.D.

Subject: Comments for the Proposed Emergency Rules Relating to Workers' Compensation; Managed Care and MSRB Subcommittee on Low Back Treatment Guidelines

From: R.J. Gorman, M.D.

On page 2, I have a question of who is the administrative director for the managed care plan. On page 4, I have questions whether it is acceptable to have chiropractors within the physical therapy department who could be used on the same basis as physical therapists who are currently being used on a referral indication type of procedure if we outlined the referral indications for chiropractic therapy in advance for our managed care institution. It appears that we may be able to determine whether chiropractic initial evaluations would be performed at our institution and we may not choose to have this option, but rather have a referral for chiropractic evaluation if indicated.

Comments Regarding the Proposed Emergency Rules Relating to Workers' Compensation Managed Care

Page 6, Section 10: I would enclose attachment of our Occupational Medicine Department brochure which outlines information regarding early return-to-work and cooperative efforts by employees and the employer. Also, I would include a copy of our Low Back Pain Continuous Quality Improvement patient education brochure which, again, outlines the importance of early return-to-work.

According to section 11 on page 6, I would include our current Best Process for the Management of Mechanical Low Back Pain at Park Nicollet as a treatment standard, and would ask that this standard be accepted in lieu of the standard developed by the MSRB Board. This standard is based on necessary, appropriate care from well-designed studies done in the medical literature. This was previously submitted to Dr. Joseph Wegner of the MSRB who developed the patient educational brochure.

Page 7: It is unclear to me how the employee will be made aware of the choice for care he has since it is directed by the employer and sometimes the employee will present at an Urgent Care or a primary care physician, etc.

Page 9 line 26: Subpart 2 A. Will the entire Park Nicollet roster list be submitted or just departments such as Urgent Care, Family Practice, Orthopedic Surgery, Physical Medicine, Rehab, Internal Medicine that form the bulk of the Workers' Comp care.

B. Does Park Nicollet determine whether we will contract for an outside relationship with chiropractors or would it make more sense to have chiropractors within the Park Nicollet system who would be part of our managed care organization complying with the treatmnet guidelines developed by the clinic and part of our peer review professional education process.

Page 10 line 5 E: We need to discuss further how the peer review utilization mechanism will be performed at Park Nicollet, and who will be responsible for this, and how this mechanism will be funded. As I see it, there are a number of options we could have trigger such as an employee not returning to unrestricted duty within 30 days or an employee being totally off work for a period of two weeks would trigger some sort of review process. Ideally, I think it would be helpful to have a representative from the employer such as a case manager or Work Comp contact person be present at a meeting with the treating physician at which time a return-to-work program could be structured.

Page 11 line 24: It is unclear to me what is included in physical therapy and diagnostic testing. Does this include lumbar spine x-rays. A chiropractor uses modalities; is that considered physical therapy.

MINNESOTA
CHIROPRACTIC
ASSOCIATION

1700 W. Highway 36, Suite 130 ■ Roseville, Minnesota 55113-4057 ■ 612/639-0663 ■ MN WATS 1-800-279-1627 ■ Fax: 612/639-1951

September 15, 1992

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Layfayette Road
St. Paul, MN 55155-4316

RE: PROPOSED EMERGENCY RULES FOR WORKERS" COMPENSATION

Dear Ms. Zembal:

Thank you for the opportunity to respond further to suggested changes regarding workers compensation reform. We have reviewed changes faxed to us on 10 September 1992. The Minnesota Chiropractic Association recognizes the importance of carefully crafting rules which address the important issues of cost containment in the workers compensation area.

The most recent version of the proposed rule changes go further in providing adequate protection for injured workers, but it is the extreme concern of this association that they do not go far enough in guaranteeing the direct access that the Minnesota Legislature mandated in their original law. The MCA stands ready to support efforts which are aimed at curbing excessive costs in workers compensation benefits. The application of solutions to problems of high costs must obviously be weighed carefully, inasmuch as solutions applied must themselves not create further problems which must then be solved. Managed care programs are currently being applied to these types of programs, and clearly are a part of the near future regarding Minnesota workers compensation benefits. The Department has obviously worked hard to provide a substantial framework for these managed care efforts to operate successfully within, while being mindful of the needs of the injured workers.

As currently constructed, the emergency rules require a managed care plan to establish procedures providing for "initial evaluation or treatment by a participating health care provider licensed in Minnesota within 24 hours of the employee's request for treatment". While this provision elimates the effective two-tiered approach that existed in earlier language, current language does not require the MCP to have a chiropractic physician available for the initial evaluation. Leaving the provision, management, or referral for chiropractic care up to a medical evaluator is <u>not</u> direct access. The same defects exist in language regarding injured workers seeking care after requesting a change of doctor where initial care has been provided outside the plan.

There is no successful model of medical management of chiropractic care.

Our second concern lies with language regarding treatment standards. As currently written, "The procedure to allow the employee to select from three health care providers must allow direct access to all health care profession diciplines if the treatment is determined to be appropriate for the condition under the managed care plan's standards and the provider's scope of practice." This linkage of the managed care plan's standards with the profession's scope of practice constitutes a potentially dangerous effective rewriting of a profession's scope of practice. The rules language permits, then, the managed care plan to write standards more restrictive than a professions scope of practice, effectively potentially restricting further the direct access requirement. Where substantive work exists regarding treatment standards, such as the MCAs Standards of Practice, application of these seems an effective tool in providing a framework for evaluation of treatment duration and objective justification for care. Certainly any profession being required to operate within standards of practice should enjoy the protection of having those standards created by a member of the same profession.

This association would like to emphasize again that managed care is not the central issue in our concerns. The MCA is willing to support reasonable efforts at cost containment based on practice parameters which realistically mirror the needs of the patient, based on costs which realistically reflect the requirements of delivering that care.

The MCA continues to take the position that language provided in our letter of 13 August 1992 more substantially reflects the letter of the law and spirit of legislative intent. We are again grateful for the opportunity to continue discussing these matters. Under the managed care model, language requiring a managed care plan to have a dual gatekeeper system of chiropractic and medical physicians would, we feel, be an extremely cost-effective approach to a provision of health care to injured workers. Anything less simply is not direct access.

Sincerely,

Stephen T. Bolles, D.C.

Stephen T. Bolles, D.C.
Chairperson, Legislative Committee
Minnesota Chiropractic Association

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MEMO

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TO: Dr. Steve Bolles

FROM: Cort C. Holton

DATE: September 11, 1992

RE: Proposed Modification of Workers' Compensation Managed Care Rules (September 10, 1992)

I have reviewed the two pages of the proposed emergency workers' compensation rules, which you faxed to me. These two pages propose changes in the proposal by marking up the original document. They relate to the operational aspects of the proposed managed care plan.

There are numerous changes suggested in the markup. Unfortunately, these are changes of form and not of substance. The proposed rules, as originally drafted, created the situation wherein a competing health care profession (medical doctors) would be in a position to effectively prevent injured workers from receiving chiropractic treatment. In other words, they could fence chiropractors out of the system. This situation remains true even if the indicated changes are made.

On the first page under what is subparagraph (b) of paragraph 2, there is a statement that the managed care plan may not discriminate against or exclude from participation in the plan any category of health care providers, etc. However, there is a proviso to this guarantee, and that proviso is that "the treatment is medically appropriate." As you know, the term "medical" distinguishes certain health care services, such as treatment by a medical doctor from other health care services, such as chiropractic. Therefore, the non-discrimination proviso only applies to medical services and, furthermore, there would always be the question of who makes the determination of what is appropriate.

The intake procedure has been changed, but here again the result remains the same. The original intake procedure under paragraph 3 required that the initial evaluation be by a participating physician and allowed the plan, if it so desired, to let a chiropractor perform this evaluation. Under the new intake procedure, any health care provider licensed in Minnesota can serve as the initial evaluator; however, it is still the plan, and not the injured worker that designates this initial

evaluator. The initial evaluator in all plans will be a medical doctor, because medical doctors have the most broad scope of practice, and also because this mechanism will effectively fence chiropractors out of the system. The flaw with this intake procedure is not the fact that a medical doctor would perform the initial evaluation. The flaw is that the injured worker does not get to select what category of provider will perform this function and, more importantly, the power that is handed to the initial evaluator under the proposed plan. Under the proposed plan, the initial evaluator has the power to fence out competing health care providers, and they will do so.

The mechanism by which the injured worker would receive further care is set forth in subparagraph (c) of section 3. Under this section, the injured employee would be allowed to choose from at least three health care providers. However, the injured employee would have to have a referral to such provider from the original evaluating provider. At this point, the language gets rather tricky. It states that the procedure to allow the employee to make the selection must allow direct access to all health care profession disciplines. However, first there is no requirement that the three providers be anything other than three members of the same profession as the evaluating provider. In fact, it could be the evaluating provider and two other persons from the evaluating provider's profession. Secondly, the direct access requirement only applies if the treatment is deemed appropriate under (1) the managed care plan's standards and (2) the provider's scope of practice. The "and" in this statement is conjunctive; therefore, even if the treatment was appropriate to the provider's scope of practice, it would not be allowed unless it was provided for under the managed care plan's standards, if any. Lastly, there can be direct access if the insurer approves of same. This, of course, is a rather cynical addition.

Subparagraph (e) of section 3 requires that the injured party be able to receive information on the availability of services on a 24-hour basis. However, as in the case of the non-discrimination provision, this provision is limited to "medical" services.

The cure for these defects is as follows:

1. The injured workers must be allowed to select his or her own evaluator from the participants in the plan. The participants in the plan must be assembled in a manner that is consistent with the principles of direct access and non-discrimination. The selection of the initial evaluator must be deemed appropriate if treatment for the injury falls within that provider's scope of practice.

2. The injured worker must be allowed to seek additional or other treatment, after the initial evaluation or treatment,

from any provider who is participating in the plan as long as that treatment is within the provider's scope of practice.

3. With regard to treatment that is within the scope of practice of the provider, determinations as to justification and duration of the treatment must be made by an unbiased member of the same profession.

4. Other mechanisms of management of health care should be in the form of substantive standards of care, such as those developed by the chiropractic profession. Substantive criteria must be used instead of individual authority and discretion. If this is not the case, then the legislative mandates regarding non-discrimination and direct access will either be inconsistent with a mechanism developed, or the mechanism that is developed will operate to defeat these legislative mandates. In the plan before you, the mechanisms developed will operate to defeat the legislative mandates.

/nls

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HAPKA CHIROPRACTIC CENTER
2599 WHITE BEAR AVENUE
MAPLEWOOD, MN 55109
(612)779-8961
FAX: (612)227-1940

I WOULD LIKE TO RECEIVE A COPY OF THE PROVIDERS THAT HAVE PLACED BIDS FOR THE MANAGED CARE PLAN.

PLEASE FAX TO THE ABOVE NUMBER.

THANKYOU.

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TeamWork
Industrial Rehabilitation, Inc.

TeamWork

Industrial Rehabilitation, Inc.

August 18, 1992

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Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor & Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal,

As an Occupational Therapist in private practice I have serious concerns regarding the proposed emergency rules of the State Department of Labor & Industry, governing Worker's Compensation Managed Care Plans.

My company, TeamWork Industrial Rehabilitation, is a new small business which provides specialty services solely related to injured workers. We do not provide acute care therapy. Since our services are specialized, reimbursement has been 97% from work comp carriers, no-fault auto insurance and attorneys. Only one case has been through HMO providers since we began in January, 1992. Therefore we have not pursued provider relationships with the HMO's, PPO's and other traditional health care insurers.

I feel the way the rules are written and especially section 5218.5000, subpart 2B, facilitates big business, clinics and physician owned practices who currently have those arrangements and discriminates against small business and free enterprise. I foresee managed care providers not seeking or desiring to sign on new providers due to the complexities of the regulations.

I see the agreements/contracts for participating providers as a means to increase self-referral patterns within the managed care providers and ultimately raise the costs of work comp.

An additional concern I have is in regards to section 5128.1000, subpart 1, division 7. This seems to imply the managed care providers would need to develop review procedures for the specialty services. Both the Physical Therapist and Occupational Therapist have peer review programs in place and again I see potential duplication of services or increased costs.

Finally, I am concerned that Occupational Therapy is not represented on the Medical Services Review Board and that their committee to develop standards for care as identified in section 5218.100 subpart 1 division 11 is closed to public input.

8960 Springbrook Drive, Suite 140, Coon Rapids, Minnesota, 55433 • 612-785-7966 FAX 612-785-9018

Traditionally Occupational Therapy services are overlooked or lumped under Physical Therapy. Potentially services that Occupational Therapists provide, with proven effectiveness and cost savings could be omitted.

I respectfully request these concerns be addressed and an additional public hearing be called for further input on these issues.

If you have questions you may reach me at (612) 785-7966.

Sincerely,

Louise Montague

Louise Montague, OTR, CVE, CWCE
Certified Work Capacity Evaluator
President

LM:pm

cc: File

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ANOKA
CHIROPRACTIC,
P.A.

August 19, 1992

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Ms. Pam Zembal
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Proposed rules on Managed Care Plans

Dear Ms. Zembal:

I would like to take a moment of your time to briefly discuss the proposed rules concerning Managed Care Plans. My first concern is with the potential that some providers will be excluded from participation in a Managed Care Plan solely on the discretion of the Managed Care Plan. It is very important that the injured worker have the ability to choose whichever physician they feel will best suite their needs, be it chiropractic, medical or osteopathic. The focus of workers compensation must continue to be what is best for the injured worker with an emphasis on cost control. The worker as a health care consumer must have the ability to choose their primary physician based on a number of factors. A comfortable, caring and trusting doctor/patient relationship, effectiveness of care, cost effectiveness, readily accessible office hours and geographic convenience are from our experience factors of importance to our patients. Inclusion in Managed Care Plans should therefore be open to all duly licensed physicians (D.C., M.D., or D.O.) who are willing to participate.

Managed Care Plans must also be required to include chiropractors in the initial evaluation process. No primary care physicians (chiropractors, medical doctors or osteopaths) should be excluded form this process. It should not be left up to the discretion of the individual Managed Care Plan. It must be mandated to prevent discrimination. Additionally, the requirement for the injured worker to submit to an "initial evaluation" within 5 working days after changing to a provider outside the Managed Care Plan is

900 E. Main St., Anoka, MN 55303-1748 (612) 421-1410

nothing more than a mandatory adverse examination performed by a doctor of the Managed Care Plan's choosing and does not even come close to treating the injured worker fairly. This provision must be eliminated. Also not acceptable is the principle of subpart (c) that allows the evaluating provider unlimited powers to discriminate against certain providers as well as entire categories of providers based entirely on that doctors professional as well as personal opinions. No one should have this kind of power to wield against a worker or another provider. All providers should be made available that are within the Managed Care Plan.

It is frightening to think of the power and discretion that is proposed to be left up to the Managed Care Plans regarding peer review. The Division must come up with acceptable rules that all Managed Care Plans would be required to adhere to. Equally disturbing would be the allowance that each Managed Care Plan develop their own treatment standards based solely on criteria they feel is important. Services must be provided on a usual and customary basis for the particular provider group involved. This would insure adequate care for the injured and minimize any confusion that would surely arise in the minds of the injured as well as the provider. Confusion would be incredible if the standard would be left up to each individual Manage Care Plan.

Similarly the potential for confusion and abuse of power is great if the individual Managed Care Plans are allowed to "cancel" participating providers based entirely on the whim of the Managed Care Plan. This could easily be eliminated in favor of procedures already available under the authority of the Medical Services Review Board. Its procedures could be applied universally with accountable checks and balances.

Finally, newly injured workers must be allowed to continue to see providers with which there is an existing relationship if the worker chooses to continue the relationship. Workers compensation should not drive a wedge in the doctor/patient relationship even if the doctor is not a provider for the Managed Care Plan.

As a provider of chiropractic services and an employer as well I feel fortunate to be able to see and hopefully in some small way be able to impact the changes in workers compensation facing us. While I have concerns for the escalating costs of workers compensation insurance as well as the potential affects of changing legislation facing my employees should they be injured while at work for me. The potential loss of business as a health care provider could be catastrophic should chiropractic be discriminated against. Chiropractic care has been shown by numerous national (including Minnesota) as well as international

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studies to be much more cost effective involving spinal injuries than medical care. There is also one third the time loss from work when injured workers use chiropractic care versus medical for comparable injuries. Logic would dictate that these workers should be encouraged to seek chiropractic care and not restricted from it in any way. Chiropractic patients and those who which to be should be applauded for their judicious use of workers compensation resources and most certainly not discriminated against.

Thank you for once again for your thoughtful attention.

Sincerely,

Patrick M. Barnes, D.C.

PMB/cp

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JOHN P. SAUTER, D. C.
30495 PARK ST.
LINDSTROM, MINNESOTA 55045
257-5118

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aug 19, 1992

Ms Pam Zembal
Rehabilitation and Medical affairs
Department of Labor & Industry
443 Lafayette Road North
St Paul Mn 55155-4316

Dear Ms Zembal.

I am writing this note to inform you that I am in complete agreement of the comments of David C. Wolff, Attorney at Law on the proposed emergency rules on managed care plans published on July 27, 1992.

His letter to your department was dated 8-7-92.

In all fairness I trust you will give it deep consideration.

Sincerely,

John P. Sauter D.C.



RUSOFF
CHIROPRACTIC CENTER

8-19-92

Ms. Pam Zembal
Rehab. & Med. Affairs
Dept. of Labor and Industry
443 Lafayette Rd. N.
St. Paul, Mn. 55155-4316

Re: Proposed rules on Managed Care Plans (MCP's)

Dear Ms. Zembal,

I wish to send this letter to you with my observations and comments on the emergency rules for proposed managed care plans published 7-27-92.

1. Exclusion of Health care providers from MCP's.

I have sent in my application to nine MCP's and have received rejections from 7 of them because they list of providers is already established and full. 2 notified me that they were not yet establishing the workers comp MCP but I should notify them again at some time in the future. This also means that providers already in MCP's will have an unfair windfall of new cases.

At present most chiropractic health care providers are being excluded from participating in MCP's because they do not presently belong to one. This means that an injured worker very likely has no access to a qualified doctor of his choice. Rule 5218.4000, Subp. 1, should require as a prerequisite to certification that ALL MCP's MUST accept any health care provider who meets all licensing, registration and certification requirements necessary to practice in Minnesota.

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2. Termination of participating providers

Proposed rule 5218.4000, Subp. 2, allows MCP's to cancel participation of providers "under the management of the MC Plan."

The legislature created a **comprehensive** procedure for the investigation and sanction of providers who chronically provide inappropriate or unnecessary treatment to injured workers. (Mn Stat. 176.103). The proposed rule 5218.4000 subp. 2 gives MCP's unrestricted power over the canceling of

David S. Rusoff D.C.
7707 149 Street West • Apple Valley, MN 55124
612-431-7000

providers, and for what circumstances and reasons. This allow MCP's to sidestep the specific checks and balances

that was specifically established by the legislature.

3. Initial Evaluations under 5218.1000 D (3)

The proposed rules allows MCP's to required employees to submit to initial evaluation by a physical which is defined as a medical or osteopathic doctor. Chiropractors are entirely excluded! This violate the statutory prohibition against MCP's from discriminating against any category of health provider.

5218.1000 Subp. 1 D (3) (b) states that an employee must submit to an "initial evaluation" within 24 hrs. of a request for treatment following a work injury. Also the same within 5 working days after a request for a change of doctor. This is essentially a **mandatory "ADVERSE EXAMINATION"** performed by a provider of the employers choice. A small group of "select" providers who benefit greatly from their "select position" can certainly not be considered impartial. This leaves the worker at great risk of becoming victimized by a system that can refuse to provide care to a person that is hurt on the job. If an initial evaluation must be performed it should be the patient's right to choose a doctor from the entire list of providers of the MCP.

Subp. (c) in the same rule states that the evaluating provider conducting the initial evaluation must provide the employee with a list of **at least 3 providers** with whom the patient may treat. The evaluating provider, who is certainly not a chiropractor at this point, is given the power to determine what type of treatment is appropriate for the patient. This gives that provider the power to show favoritism to some and certainly to discriminate against others.

4. PEER AND UTILIZATION REVIEWS AND INTERNAL DISPUTES

MCP's are allowed to determine, with great individual discretion, procedures for peer and utilization reviews. See #2 above. This invites a hodge-podge of many different procedures for the same health problem. It is the workers comp division that should come up with specific rules concerning these procedures.

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5. Referrals back to MCP

Minn. Statute 176.1351 subd. 2 (8) requires a non-participating provider to refer the employee back to the MCP for "any **other** treatment that the employee may require".

Proposed Rule **5218.5000 subp. 2B** requires a nonparticipating provider to refer the employee back to the MCP for "specialized care and diagnostic testing". This rule appears to go beyond the statute and should be changed.

Sincerely,
David S. Rusoff D.C.

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MASSOGLIA CHIROPRACTIC
DR. CHRISTOPHER MASSOGLIA
1600 UNIVERSITY AVE., SUITE 5
SPRUCE TREE CENTER
ST. PAUL, MINNESOTA 55104
(612) 644-7207

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August 20, 1992

Ms. Pam Zembal
Rehab & Medical Affairs Division
Department of Labor
443 Lafayette Road
St. Paul, MN 55155

Re: Emergency Rules

Dear Ms. Zembal:

In reviewing the new emergency rules, governing implimentation of the workers' compensation managed health care system, I find in general they mirror the statute. I would like to suggest consideration of the following changes.

1). On line 4 page 12 change last work "may" to "shall" or "must", the statute makes it clear that this is the employees right and not at the discretion of the managed care plan. The word "may" leaves open the ability of the managed care plan to limit the employees' right.

2). On page 8 paragraph F. It seems that if the managed care plan does not accept liablity, then the employee should be able to treat with any provider he chooses and should not be restricted on the grounds that the managed care can't determine liability.

Thank you for consideration of these views.

Respectfully,

C Massoglia D.C.

Christopher P. Massoglia D.C.

CPM:rlb

COUNTRYSIDE CHIROPRACTIC CENTER
7700 W. OLD SHAKOPEE ROAD
BLOOMINGTON, MN 55438
(612) 829-0262

August 20, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

RE: Comment to proposed Emergency Rules
on Managed Care Plans

Dear Ms. Zembal:

I am greatly concerned by the proposed emergency rules on Managed Care Plans. The main concern I have is that the injured worker will be denied necessary care in the quest for cost savings. Also, the injured worker will be limited in his or her access to the physician of their choice. A medical gatekeeper doing the intake evaluation will limit and possibly intimidate the worker in receiving less or inappropriate care that is required.

My other concern is that the emergency rules openly discriminate against chiropractic care. The work comp law is specific in allowing an injured worker to select chiropractic care if they are injured. The emergency rules would seriously limit this choice.

Please consider some of these very important issues concerning an injured workers rights before the current proposed rules are implemented.

Sincerely,

Dr. Gerald W. Seliski

GWS:kv

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PLYMOUTH BACK & NECK CLINIC

FREDRICK P. PACOVSKY D.C.

Xenium Office Bldg. • 13550 26th Ave. N. • Plymouth, MN 55441 • (612) 557-0101

August 19, 1992

Ms. Pam Zembal
Rehab and Medical Affairs
Dept. of Labor and Industry
443 Lafayette Rd. North
St. Paul, MN 55155-4316

Re: Comments on proposed rules on managed care.

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Dear Ms. Zembal:

I would like to respectfully comment on proposed rules regarding recent work-comp legislation.

My main concern is for my patients that have been injured on the job and their ability to choose the health care provider of their choice. I would like to ensure that the intention of the new rules be followed in such a way as to not infringe on the rights of the individual to choose their practitioner.

Also, with the advent of managed care into the work-comp arena of health care, I am concerned that certain organizations which already have adopted a discriminatory policy toward certain health care groups (namely chiropractic) will follow these polices into the work-comp system, by not allowing all providers the opportunity to be in their network.

I don't believe the legislation was enacted to discriminate against any particular health care group, but rather to provide proper health care for the injured worker at a reasonable expense to the employer. Therefore I trust the Department of Labor and Industry will keep the above concerns in mind while adopting the recent rules.

PLYMOUTH BACK & NECK CLINIC

FREDRICK P. PACOVSKY D.C.

Xenium Office Bldg. • 13550 26th Ave. N. • Plymouth, MN 55441 • (612) 557-0101

If I can be of service in adopting these rules, please consider this my offical request to be included on any board which may oversee these rules.

Respectfully Submitted,

Fredrick P. Pacovsky D.C.

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Crystal New Hope Chiropractic Clinic, P.A.
DR. MARTIN VON IDERSTINE
DIPLOMATE: AMERICAN BOARD OF CHIROPRACTIC ORTHOPEDISTS

19 August 1992

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Pam Zembal

Re-Hab and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul MN 55155-4316

Re: Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

Be advised that I am extremely concerned with the rules and regulations that you are setting up as to Managed Care Plans for worker's compensation.

It appears to me that the idea of setting up a "medical gate keeper" is a deliberate attempt to eliminate the participation of chiropractic in worker's compensation.

This obviously was not the intent of the state legislature and I wonder if these rules were designed more to eliminate our profession in its participation rather than to save costs.

It is silly to think that someone would be required to see a medical doctor or an osteopath after the initial claim of injury, and then be allowed to seek chiropractic care; when there is an inherent bias against our profession by the medical community. I think the insurance industry has know this all along and the proposal of these rules violates legislative intent. I would kindly and respectfully ask you to please remove that because this will inhibit the participation from chiropractors in worker's compensation when the Department of Labor and Industry has already indicated in previous studies that we are " 5 times more cost containing".

Sincerely,

M Von Iderstine

Martin Von Iderstine, D.C.

MVI:db

4600 LAKE ROAD ROBBINSDALE, MINNESOTA 55422 TELEPHONE 533-6775

ROSEMOUNT CHIROPRACTIC CLINIC

14450 So. Robert Trail
Rosemount, MN 55068
612-423-2251

DR. ALBERT C. HOFF, JR., D.C.

AUGUST 19, 1992

REHABILITATION AND MEDICAL AFFAIRS
DEPARTMENT OF LABOR AND INDUSTRY
443 LAFAYETTE ROAD
ST. PAUL, 55155-4316

TO: PAM ZEMBAL
RE: PROPOSED EMERGENCY RULES ON MANAGED CARE

DEAR MISS ZEMBAL,

The purpose of this letter is to express my concern of the emergency rules of managed care plans as a provider and spokesperson for our patients in this clinic I am deeply concerned of the 24 hour request for treatment following a work injury, and use of the "Gatekeeper" which would essentially eliminate the patients right to free choice. Particulary, free choice for Chiropractic care. In my opinion this is unreasonable restriction.

I also oppose the rule 5218.4000 subpart 2 which allows Managed Care Plans to cancel any health care provider under the requirements of the manage care plan. This would unduly discriminate against all providers particulary Chiropractic providers who may be overruled by medical providers in a Managed Care Plan.

Sincerely,

ALBERT C. HOFF JR. D.C.

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TeamWork
Industrial Rehabilitation, Inc.

August 18, 1992

Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor & Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal,

As an Occupational Therapist in private practice, I have several concerns regarding the Adaption of Emergency Rules Governing Work Comp Managed Care Plans. The services we provide are strictly limited to industrial rehabilitation and consultation. Injured workers are referred for functional capacity evaluations, work hardening and conditioning programs. We decided not to provide acute care physical therapy to avoid the potential problem of excessive care through referral to other in house services.

The rules, as they now stand, favor the large clinics/providers who provide acute care as well as industrial rehab services since they already have provider status due to the acute care component. My fear is that the managed care providers will decide they already have a sufficient number of specialty providers. With 97% of our reimbursement is related to work injuries, this type of situation would put us out of business despite years of experience and training in this field. In short I believe section 5218.5000, subpart 2B promotes big business, clinics and physician owned practices and discriminates against our small, women owned business.

It seems unfortunate that the state had a managed care system in place through the QRC's and rather than tighten the controls decided to reinvent the wheel.

Section 5218.1000, subpart 1, division 7 suggests the managed care plan must develop peer review procedures for the specialty areas. This does not take into account the peer review programs in place with both the Occupational Therapy and Physical Therapy organizations and would be a duplication of services.

Also, I am concerned that the Medical Review Board has no Occupational Therapy representation. Their task is to develop standards for care (section 5218.100, subpart 1 division 11).

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8960 Springbrook Drive, Suite 140, Coon Rapids, Minnesota, 55433 • 612-785-7966 FAX 612-785-9018

Without representation and without public access standards for Occupational Therapists may be poorly developed or ignored completely.

I hope you will consider these issues and that a public hearing for additional input be arranged.

Sincerely,

Mary Ann Caesar OTR, CWCE

Mary Ann Caesar, OTR, CWCE
Certified Work Capacity Evaluator
Vice President

MAC:pm

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GREGORY T. SMOCK, D.C.
Doctor of Chiropractic

August 7, 1992

BIG LAKE CHIROPRACTIC CLINIC, P.A.
171 N. LAKE STREET
BIG LAKE, MN 55309
TELEPHONE (612) 263-3470

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comment to Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

Please accept this letter as my comments to the proposed emergency rules on managed care plans published on July 27, 1992.

1. **Exclusion of Health Care Providers from MCPs.**

Two major concerns which should be addressed by the rules on MCPs are (1) the threat that some health care providers may be effectively excluded from treating workers' compensation patients because they are not accepted members of any MCP; and (2) the threat that an injured employee will be forced to treat with a health care provider he or she does not trust rather than a doctor of his or her choice. The proposed emergency rules, and specifically Rule 5218.4000, subp. 1, should require as a prerequisite to certification that all MCPs must accept any health care provider who meets all licensing, registration and certification requirements necessary to practice in Minnesota, and who agrees to abide by the rules and limitations of the MCP. MCPs should not be given unrestricted discretion to pick and choose the doctors who will constitute participating health care providers.

If the MCPs are allowed to choose the health care providers who will participate in their plans, there will be health care providers who are not accepted into any managed care plan. Those providers will be effectively excluded from treating injured employees in this state. Such exclusion will have a devastating impact on those health care providers. Conversely, these practitioners who are accepted into MCPs could receive an unfair windfall of new cases. This was clearly not intended by the legislature.

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Giving such discretion to MCPs will also significantly limit the right of injured employees to choose the health care provider from whom they will receive treatment. The right to choose ones treating doctor has always been jealously protected by both the legislature and the courts of this state. It is significant to note that of the nineteen persons who spoke at the public hearing on the proposed medical rules on 7/16/92, all but two (the two attorneys who spoke on behalf of the IME firms) urged the Division not to limit the right of injured employees of this state to choose their own treating physician. The legislature clearly did not intend to abrogate the fundamental right of the citizens of this state to choose their own treating physicians.

The basic goal of the legislature in adopting the 1992 amendments was to provide a mechanism for reducing or eliminating inappropriate, excessive or unnecessary treatment. The accomplishment of this goal does not require the exclusion of innocent and qualified health care providers from the system. It also does not require the complete abrogation of a citizen's right to choose their own treating physician. The new treatment standards coupled with the MCP peer review utilization review and dispute resolution process, the MSRB investigation/sanction process, and the traditional medical request/claim petition process are adequate to guard against abuses.

Requiring MCPs to accept all health care providers who apply for admission, so long as their license is in good standing and they agree to abide by the rules and limitations of the MCP, would avoid the dual threats of provider exclusion and limitation of choice without endangering the goal of controlling utilization costs. It is a win/win proposal that should be adopted. The authority for such a rule can be found in Minn. Stat. §176.1351, subd. 2(12).

2. Initial Evaluations Under 5218.1000 D(3).

The proposed rule as drafted allows MCPs to require employees to submit to "initial evaluations" by a "physician" (defined to be a medical doctor or a doctor of osteopathy but not a chiropractor) within 24 hours after an employee requests treatment following a work injury. The rule allows MCPs to permit initial evaluations by chiropractors but does not require this. This rule violates the statutory prohibition against MCPs discriminating against any category of health care provider.

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The same argument applies to 5218.1000, subp. 1D (3)(b) dealing with initial evaluations within five working days of a request for change of doctor.

The requirement that an employee must submit to an "initial evaluation" within 24 hours of a request for treatment following the work injury, or within five working days after a request for a change of doctor in cases where the employee has received treatment for the work injury by health care provider outside of the MCP, is nothing less than a mandatory adverse examination by a health care provider of the employer's choice. As such, it violates the provisions of M.S. 176.155 and should be eliminated from the proposed rules all together.

Alternatively, if an initial evaluation is to be required, then the employee should be given the right to choose from among all of the MCPs participating health care providers, including the chiropractors. Otherwise, the chiropractic profession will be unlawfully discriminated against, and the injured employee's right to choose his or her own treating physician will be unreasonably and unnecessarily restricted.

Subp. (c) in the same rule provides that the "evaluating provider" who conducts the "initial evaluation" must provide the employee with a list of at least three health care providers with whom the employee may treat. The "evaluating provider" is given the power to determine what treatment is appropriate for the condition and what type of health care profession discipline should provide that treatment. This process effectively gives the "evaluating provider" the power to discriminate against categories of health care providers. Allowing MCPs to simply delegate the authority to discriminate against categories of health care providers would obviously violate the prohibition against such discrimination clearly set forth in the 1992 amendments.

The problems inherent in the initial evaluation process set forth by the Rule as drafted could be minimized if not eliminated by simply requiring MCPs to provide injured employees with a list of the names, addresses and telephone numbers of all participating health care providers within 24 hours of a request for treatment following a work injury or within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the MCP. The employee's initial choice of health care provider could then be required to perform an initial evaluation to determine the treatment which is appropriate for the condition. If the

employee's initial choice of health care provider is not the appropriate health care discipline to provide the treatment, that health care provider could simply provide the employee with a list of the participating providers under the MCP within the proper health care discipline.

3. **Entities Which May be Certified as MCPs.**

Minn. Stat. §176.1351, subd. 1 provides, "any person or entity, other than a workers' compensation insurer or an employer for its own employees, may" be certified as an MCP (emphasis added). The statute specifically prohibits workers' compensation insurers and self-insured employers from becoming certified as MCPs.

Proposed Rules 5218.1000, subp. 1 and 5218.2000, subp. 4, as drafted, would appear to violate this specific statutory prohibition. Therefore, these proposed rules should be redrafted.

4. **Peer Review, Utilization Review and Internal Dispute Resolution.**

Proposed rules 5218.1000, subp. 1D (7) and 5218.7000 provide MCPs with too much discretion over devising procedures for peer review, utilization review and internal dispute resolution. The Division should attempt to come up with specific rules concerning these procedures. Otherwise, the citizens of this state will be confronted by a myriad of different procedures giving rise to inconsistent treatment of similar injuries.

5. **Aggressive Case Management and Early Return To Work Programs.**

Proposed Rule 5218.1000, subp. 1D (10) requires MCPs to describe how they will provide aggressive case management, programs for early return to work, and cooperative efforts to promote work place health and safety services without specifying what those terms mean or what, if any, limitations should apply. The Department of Labor and Industry should develop more specific definitions and requirements in order to avoid the development of myriad different rules and limitations resulting in inconsistent treatment of like cases.

6. Treatment Standards Not Prescribed by the Commissioner.

Proposed Rule 5218.1000, subp. 1D (11) requires individual MCPs to submit treatment standards for medical services not previously prescribed by the Commissioner. This proposed rule should be eliminated.

It will be completely unworkable and unjust for MCPs to be allowed to develop individualized and differing treatment standards applicable to their member employees. All MCPs should be required to comply with the same treatment standards promulgated by the Commissioner. Prior to the time that the Commissioner has promulgated treatment standards covering all types of medical services, the MCPs should simply be required to provide services which are usual and customary for the provider's health care profession, and which are reasonably required to cure or relieve the effects of the employee's work related injury. Allowing MCPs to develop their own unique treatment standards, even if limited to the period of time prior to the development of uniform standards by the Commissioner will only result in confusion and inconsistent treatment of the injured employees of this state.

7. Retroactive Application of MCPs.

Proposed Rule 5218.2000, subp. 3D provides that the MCP rules will apply to employees injured prior to the effective date of the 1992 amendments if the employee requests a change of doctor. The proposed rule provides that an employee who requests a change of doctor must receive further treatment provided by the employer's MCP.

This provision violates the statutory and constitutional prohibition against substantive rights being taken away or affected by the retroactive application of statutory amendments. The law of this State is clear that statutory amendments shall be applied prospectively only, whether or not the amendments are substantive or procedural in nature, unless the legislature specifically provides for retroactive application. The legislature has not provided for the retroactive application of managed care plans. Therefore, any employee injured prior to 10/1/92 cannot be required to receive treatment through a managed care plan even if the employee requests a change of treating physician.

8. Termination of Participating Providers.

Proposed Rule 5218.4000, subp. 2 allows managed care plans to "cancel" participating health care providers "under the requirements of the managed care plan." This rule effectively provides MCPs with totally unrestricted discretion over when and under what circumstances they may cancel or terminate participating health care providers. This proposed rule should be eliminated.

The legislature specifically created an exhaustive and comprehensive procedure for the investigation and sanction of health care providers who chronically provide inappropriate, excessive or unnecessary treatment to injured employees. This process is set forth in Minn. Stat. §176.103 under the authority of the Medical Services Review Board. This process requires the MSRB to investigate suspected cases of inappropriate, excessive or unnecessary treatment. It authorizes the Department to sanction providers found to be abusing the system. Said sanctions can include a total exclusion from treating injured employees.

The process established by the legislature sets forth specific checks and balances to protect wrongly accused providers from being unjustifiably sanctioned, while enabling the Division to identify and sanction actual abusers.

Obviously, the legislature did not intend to allow MCPs to side step this established process and effectively sanction health care providers without the checks and balances of appropriate due process.

The rules should be changed to allow MCPs to terminate participating health care providers only if the providers are found to have been abusing the system and the provider is sanctioned with exclusion from the workers' compensation system by the Department of Labor and Industry following the MSRB investigation. To provide MCPs with unfettered discretion to terminate health care providers would create a significant risk of abuse in direct contravention of legislative intent.

9. Treatment Provided by Non-Participating Health Care Providers.

Proposed Rule 5218.5000, subp. 1A proposes to limit the ability of an employee to treat with a health care provider who is not a participating health care provider to providers which have

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a documented history of treatment with the employee before the date of injury. Minn. Stat. §176.1351, subp. 2(8) does not require that the history of treatment be prior to the date of injury. There is nothing in the statute to suggest that if the employee develops a history of treatment with a health care provider after the date of injury and thereafter wishes to switch the care of their work related injury to that health care provider, that the employee should not be able to do so. The legislature obviously intended to allow employees to treat with doctors in whom they have developed a certain level of confidence. Whether that treatment history and level of confidence is developed before or after the date of injury should not matter.

Proposed Rule 5218.5000, subp. 2B requires health care providers who are not participating health care providers to agree to refer the covered employee back to the managed care plan for "specialized care, which includes, but is not limited to, physical therapy and diagnostic testing". Minn. Stat. §176.1351, subd 2(8) only requires the non-participating health care provider to agree to refer the employee back to the managed care plan for "any other treatment that the employee may require". This would appear to allow the non-participating health care provider to provide any type of treatment he or she is licensed to provide, specifically including physical therapy and diagnostic testing. Therefore, it would appear that this proposed rule goes beyond the statute and is therefore unenforceable.

Respectfully submitted,

Gregory T. Smock, D.C.

Timothy D. Hubbard, D.C.

WESTONKA CHIROPRACTIC OFFICE

4000 Shoreline Drive, P.O. Box 305
Spring Park, MN 55384
Telephone: (612) 471-8404

August 20, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comment to proposed emergency rules on managed care plans.

Dear Ms. Zembal:

This letter is sent from an office that has treated Worker's Compensation patients since 1980. The goals of returning a patient to their workplace as soon as medically possible, while utilizing the apporpriate care for the particular health related spinal condition, has always been our goal.

Now we find that under the new law governing Worker's Compensation health care, a major component in continuing to be able to treat these patients is being part of a Mangaged Care Program (MCP). To be part of this program there must be access to such MCPs. This access we find to be extremely limited or non-existent.

Our concern is not of the managed care concept as far as the patient/doctor is concerned. It is of great concern when the availability and access to such programs to be able to continue to treat these patients, who desire chiropractic care, is limited or denied.

We felt it necessary to voice our opinion, not only for ourselves as Doctors of Chiropractic, but for our current patients who send their family and friends to this office for care. It would be a shame in this state, this country, if this particular freedom of choice is in any way curtailed.

Sincerely,

Geraldine Y. Holland, B.S., D.C.
Dr. Geraldine Y. Holland

Jon J. Blish, D.C.
Dr. Jon J. Blish

GYH/sh

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Wenger

PHYSICAL THERAPY • SPORTS MEDICINE • WELLNESS PLANS

Ronald J. Wenger, P.T.
Linda D. Wenger, P.T.
Matt Mehegan, P.T.
Rhonda Kimler, P.T.
Paul Bruning, A.T.C.
Randy Palmer, M. Ed., A.T.C.
Jeri Baker, M.P.T., P.T.

August 20, 1992

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REHABILITATION & MEDICAL AFFAIRS

Pam Zembel
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Pam:

I am writing to you regarding Proposed Rules of the State Department of Labor and Industry governing workers compensation managed care plans. I am a partner in Wenger Physical Therapy, Inc., a private physical therapy clinic located in Mankato and another office located in North Mankato, Minnesota. We provide approximately 35 percent of our care to people with work related injuries, utilizing Functional Capacity Assessments, Work Hardening, and various other programs provided to businesses and industries.

I am concerned about the rules that require at least three physicians to be part of a managed care plan. As a private business, I am not aligned with any physician group. In fact, many physician groups own their own physical therapy clinics in an effort to increase their income levels. I feel that the small business owner and physical therapist would have an extreme amount of difficulty competing with the hospital in our area and large powerful corporations in the Twin Cities area. I think by limiting the number of providers in a managed care plan would possibly limit access to physical therapy care, and possibly delay rehabilitation and return to work. This philosophy of quick return to work very often saves money in the workers compensation system.

I do consult with business and industry regarding the Americans With Disabilities Act, and I am aware that in the new Federal Law that an injured worker certainly has the freedom of choice in the professional they choose to work with for medical care. The new Minnsota law could possibly conflict with the ADA.

I feel that the intent of the managed care plan is to save money, and I think that most of the cost control can be attained through the decreased fee schedule, the increasing use of peer review of all professionals by their respective professions, and treatment guidelines developed by the Medical Services Review Board of the Department of Labor and Industry.

Thank you very much for taking the time to consider by views. I believe our business has always provided a high quality of care for the injured worker, and feel that all health care providers must strive to reduce health care costs, and provide prompt, curtious, high quality care. I feel strongly that the business that my wife and I have put our sweat and time into in the last twelve years be allowed to continue to operate within the workers compensation system, and offer the best quality service in the Mankato area to injured workers without restriction.

Sincerely,

Ronald J. Wenger, P.T.
President
Wenger Physical Therapy, Inc.

RJW:srk
cc: John Hottinger

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REHABILITATION & MEDICAL AFFAIRS

CHIROPRACTIC

August 20, 1992

Mrs. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

RE: Comment to Propose Medical Emergency Rules to Manage Care Plans

Dear Ms. Zembal:

As a treating chiropractor, I am greatly dismayed regarding the proposed emergency rules on managed care plans published on July 27, 1992.

First, there was an obvious threat that many health care providers will be effectively excluded from treating workers compensation patients due to not being accepted members of any MCP.

Second and most importantly, you have drafted that initial evaluations by a physician is defined as a medical doctor within 24 hours after the employee request treatment following a work injury. This is blatant discrimination toward the chiropractic profession and violates the statutory prohibition against MCP discriminating against any health care provider.

The emergency rules greatly discriminate against the chiropractic profession and will be used zealously by managed care plans to exclude chiropractic care from injured workers. Statistics have shown for years that chiropractors are much more effective and cost productive in terms of treating workers compensation injuries and that chiropractic renders a service not available effectively and competently provided by other health care providers.

Many injured workers find themselves in the position of seeing a chiropractor after most conventional medical treatment has failed them and have been able to get relief and care and successful return to work as the result of chiropractic care.

To limit the ability of chiropractors to treat patients is not the intent of the legislature, and we ask you to please reconsider these provisions. Physicians are independent individuals whose treatment of the patient is based solely and entirely on the needs of the patient. Managed care plans will put the physician treating the patient in the position of

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Maple Grove • MN 55369 • 612 420-2226

compromise as the result of trying to stay within guidelines rather than tending to the needs of the injured worker.

The Minnesota Chiropractic Association has a minimum level of standard care. Guidelines less than that would not be reasonable for treatment.

Respectfully submitted,

Dr. Curtis L. Cich

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Robert J. Vornbrock, D.C.
P.O. Box 237
St. Joseph, MN 56374
August 20, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comment to Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

Please accept this letter as my comments to the proposed emergency rules on managed care plans published on July 27, 1992.

1. Exclusion of Health Care Providers from MCPs.

Two major concerns which should be addressed by the rules on MCPs are (1) the threat that some health care providers may be effectively excluded from treating workers' compensation patients because they are not accepted members of any MCP; and (2) the threat that an injured employee will be forced to treat with a health care provider he or she does not trust rather than a doctor of his or her choice. The proposed emergency rules, and specifically Rule 5218.4000, subp. 1, should require as a prerequisite to certification that all MCPs must accept any health care provider who meets all licensing, registration and certification requirements necessary to practice in Minnesota, and who agrees to abide by the rules and limitations of the MCP. MCPs should not be given unrestricted discretion to pick and choose the doctors who will constitute participating health care providers.

If the MCPs are allowed to choose the health care providers who will participate in their plans, there will be health care providers who are not accepted into any managed care plan. Those providers will be effectively excluded from treating injured employees in this state. Such exclusion will have a devastating impact on those health care providers. Conversely, these practitioners who are accepted into MCPs could receive an unfair windfall of new cases. This was clearly not intended by the legislature.

Giving such discretion to MCPs will also significantly limit the right of injured employees to choose the health care provider from whom they will receive treatment. The right to choose ones treating doctor has always been jealously protected by both the legislature and the courts of this state. It is significant to note that of the nineteen persons who spoke at the public hearing on the proposed medical rules on 7/16/92, all but two (the two attorneys who spoke on behalf of the IME firms) urged the Division not to limit the right of injured employees of this state to choose their own treating physician. The legislature clearly did not intend to abrogate the fundamental right of the citizens of this state to choose their own treating physicians.

The basic goal of the legislature in adopting the 1992 amendments was to provide a mechanism for reducing or eliminating inappropriate, excessive or unnecessary treatment. The accomplishment of this goal does not require the exclusion of innocent and qualified health care providers from the system. It also does not require the complete abrogation of a citizen's right to choose their own treating physician. The new treatment standards coupled with the MCP peer review utilization review and dispute resolution process, the MSRB investigation/sanction process, and the traditional medical request/claim petition process are adequate to guard against abuses.

Requiring MCPs to accept all health care providers who apply for admission, so long as their license is in good standing and they agree to abide by the rules and limitations of the MCP, would avoid the dual threats of provider exclusion and limitation of choice without endangering the goal of controlling utilization costs. It is a win/win proposal that should be adopted. The authority for such a rule can be found in Minn. Stat. §176.1351, subd. 2(12).

2. Initial Evaluations Under 5218.1000 D(3).

The proposed rule as drafted allows MCPs to require employees to submit to "initial evaluations" by a "physician" (defined to be a medical doctor or a doctor of osteopathy but not a chiropractor) within 24 hours after an employee requests treatment following a work injury. The rule allows MCPs to permit initial evaluations by chiropractors but does not require this. This rule violates the statutory prohibition against MCPs discriminating against any category of health care provider.

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The same argument applies to 5218.1000, subp. 1D (3)(b) dealing with initial evaluations within five working days of a request for change of doctor.

The requirement that an employee must submit to an "initial evaluation" within 24 hours of a request for treatment following the work injury, or within five working days after a request for a change of doctor in cases where the employee has received treatment for the work injury by health care provider outside of the MCP, is nothing less than a mandatory adverse examination by a health care provider of the employer's choice. As such, it violates the provisions of M.S. 176.155 and should be eliminated from the proposed rules all together.

Alternatively, if an initial evaluation is to be required, then the employee should be given the right to choose from among all of the MCPs participating health care providers, including the chiropractors. Otherwise, the chiropractic profession will be unlawfully discriminated against, and the injured employee's right to choose his or her own treating physician will be unreasonably and unnecessarily restricted.

Subp. (c) in the same rule provides that the "evaluating provider" who conducts the "initial evaluation" must provide the employee with a list of at least three health care providers with whom the employee may treat. The "evaluating provider" is given the power to determine what treatment is appropriate for the condition and what type of health care profession discipline should provide that treatment. This process effectively gives the "evaluating provider" the power to discriminate against categories of health care providers. Allowing MCPs to simply delegate the authority to discriminate against categories of health care providers would obviously violate the prohibition against such discrimination clearly set forth in the 1992 amendments.

The problems inherent in the initial evaluation process set forth by the Rule as drafted could be minimized if not eliminated by simply requiring MCPs to provide injured employees with a list of the names, addresses and telephone numbers of all participating health care providers within 24 hours of a request for treatment following a work injury or within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the MCP. The employee's initial choice of health care provider could then be required to perform an initial evaluation to determine the treatment which is appropriate for the condition. If the

employee's initial choice of health care provider is not the appropriate health care discipline to provide the treatment, that health care provider could simply provide the employee with a list of the participating providers under the MCP within the proper health care discipline.

3. Entities Which May be Certified as MCPs.

Minn. Stat. §176.1351, subd. 1 provides, "any person or entity, other than a workers' compensation insurer or an employer for its own employees, may" be certified as an MCP (emphasis added). The statute specifically prohibits workers' compensation insurers and self-insured employers from becoming certified as MCPs.

Proposed Rules 5218.1000, subp. 1 and 5218.2000, subp. 4, as drafted, would appear to violate this specific statutory prohibition. Therefore, these proposed rules should be redrafted.

4. Peer Review, Utilization Review and Internal Dispute Resolution.

Proposed rules 5218.1000, subp. 1D (7) and 5218.7000 provide MCPs with too much discretion over devising procedures for peer review, utilization review and internal dispute resolution. The Division should attempt to come up with specific rules concerning these procedures. Otherwise, the citizens of this state will be confronted by a myriad of different procedures giving rise to inconsistent treatment of similar injuries.

5. Aggressive Case Management and Early Return To Work Programs.

Proposed Rule 5218.1000, subp. 1D (10) requires MCPs to describe how they will provide aggressive case management, programs for early return to work, and cooperative efforts to promote work place health and safety services without specifying what those terms mean or what, if any, limitations should apply. The Department of Labor and Industry should develop more specific definitions and requirements in order to avoid the development of myriad different rules and limitations resulting in inconsistent treatment of like cases.

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6. Treatment Standards Not Prescribed by the Commissioner.

Proposed Rule 5218.1000, subp. 1D (11) requires individual MCPs to submit treatment standards for medical services not previously prescribed by the Commissioner. This proposed rule should be eliminated.

It will be completely unworkable and unjust for MCPs to be allowed to develop individualized and differing treatment standards applicable to their member employees. All MCPs should be required to comply with the same treatment standards promulgated by the Commissioner. Prior to the time that the Commissioner has promulgated treatment standards covering all types of medical services, the MCPs should simply be required to provide services which are usual and customary for the provider's health care profession, and which are reasonably required to cure or relieve the effects of the employee's work related injury. Allowing MCPs to develop their own unique treatment standards, even if limited to the period of time prior to the development of uniform standards by the Commissioner will only result in confusion and inconsistent treatment of the injured employees of this state.

7. Retroactive Application of MCPs.

Proposed Rule 5218.2000, subp. 3D provides that the MCP rules will apply to employees injured prior to the effective date of the 1992 amendments if the employee requests a change of doctor. The proposed rule provides that an employee who requests a change of doctor must receive further treatment provided by the employer's MCP.

This provision violates the statutory and constitutional prohibition against substantive rights being taken away or affected by the retroactive application of statutory amendments. The law of this State is clear that statutory amendments shall be applied prospectively only, whether or not the amendments are substantive or procedural in nature, unless the legislature specifically provides for retroactive application. The legislature has not provided for the retroactive application of managed care plans. Therefore, any employee injured prior to 10/1/92 cannot be required to receive treatment through a managed care plan even if the employee requests a change of treating physician.

8. Termination of Participating Providers.

Proposed Rule 5218.4000, subp. 2 allows managed care plans to "cancel" participating health care providers "under the requirements of the managed care plan." This rule effectively provides MCPs with totally unrestricted discretion over when and under what circumstances they may cancel or terminate participating health care providers. This proposed rule should be eliminated.

The legislature specifically created an exhaustive and comprehensive procedure for the investigation and sanction of health care providers who chronically provide inappropriate, excessive or unnecessary treatment to injured employees. This process is set forth in Minn. Stat. §176.103 under the authority of the Medical Services Review Board. This process requires the MSRB to investigate suspected cases of inappropriate, excessive or unnecessary treatment. It authorizes the Department to sanction providers found to be abusing the system. Said sanctions can include a total exclusion from treating injured employees.

The process established by the legislature sets forth specific checks and balances to protect wrongly accused providers from being unjustifiably sanctioned, while enabling the Division to identify and sanction actual abusers.

Obviously, the legislature did not intend to allow MCPs to side step this established process and effectively sanction health care providers without the checks and balances of appropriate due process.

The rules should be changed to allow MCPs to terminate participating health care providers only if the providers are found to have been abusing the system and the provider is sanctioned with exclusion from the workers' compensation system by the Department of Labor and Industry following the MSRB investigation. To provide MCPs with unfettered discretion to terminate health care providers would create a significant risk of abuse in direct contravention of legislative intent.

9. Treatment Provided by Non-Participating Health Care Providers.

Proposed Rule 5218.5000, subp. 1A proposes to limit the ability of an employee to treat with a health care provider who is not a participating health care provider to providers which have

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a documented history of treatment with the employee before the date of injury. Minn. Stat. §176.1351, subp. 2(8) does not require that the history of treatment be prior to the date of injury. There is nothing in the statute to suggest that if the employee develops a history of treatment with a health care provider after the date of injury and thereafter wishes to switch the care of their work related injury to that health care provider, that the employee should not be able to do so. The legislature obviously intended to allow employees to treat with doctors in whom they have developed a certain level of confidence. Whether that treatment history and level of confidence is developed before or after the date of injury should not matter.

Proposed Rule 5218.5000, subp. 2B requires health care providers who are not participating health care providers to agree to refer the covered employee back to the managed care plan for "specialized care, which includes, but is not limited to, physical therapy and diagnostic testing". Minn. Stat. §176.1351, subd 2(8) only requires the non-participating health care provider to agree to refer the employee back to the managed care plan for "any other treatment that the employee may require". This would appear to allow the non-participating health care provider to provide any type of treatment he or she is licensed to provide, specifically including physical therapy and diagnostic testing. Therefore, it would appear that this proposed rule goes beyond the statute and is therefore unenforceable.

Respectfully submitted,

Robert J. Vornbrock D.C.

Robert J. Vornbrock, D.C.

VIRGA CHIROPRACTIC CLINIC, P.A.
12760 Lake Blvd.
P.O. Box 482
Lindstrom, Minnesota 55045

Telephone: (612) 257-1000

August 20, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
442 Lafayette Road North
St. Paul, Mn 55155-4316

Dear Ms. Zembal,

I ask that you please accept this letter and the enclosed material as my comments to the proposed emergency rules on managed care plans published on July 27, 1992.

Sometimes I feel that one person writing a letter can't make a difference, but this issue is important enough that I write anyway.

It is my understanding that the intent of the workers comp reform is to reduce the cost on the system. This will not be done by limiting chiropractors and limiting patient choices through the managed care program. Chiropractic care by it's nature is a lower cost care. We do not use extremely costly tools or techniques in treating our patients. Our hands are our tools. This is proven by simply looking at the work comp fee schedule. When comparing fees of similar services that are provided by different health care providers you will see that many times chiropractic fees are lower.

I have listened to several attorneys opinions on the work comp changes. They all seem to feel that the proposed changes make it ripe for litigation. This litigation will come both from the injured workers for restricting their freedom of choices and by health care providers who are unfairly denied access to managed care systems. This can raise the costs to staggering levels as litigation blossoms.

I beg you to keep freedom of choice a high priority. Do not be overwhelmed by the powerful lobbying groups. We have the power to make a model that the rest of the country can follow. Please take time to study the information enclosed. This is an opinion of a local attorney named David C. Wulff. Thank you!

Sincerely,

Dr. Joseph Virga

Dr. Joseph Virga

Dr. Kathleen Virga

Dr. Kathleen M. Virga

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employee's initial choice of health care provider is not the appropriate health care discipline to provide the treatment, that health care provider could simply provide the employee with a list of the participating providers under the MCP within the proper health care discipline.

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6. Treatment Standards Not Prescribed by the Commissioner.

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It will be completely unworkable and unjust for MCPs to be allowed to develop individualized and differing treatment standards applicable to their member employees. All MCPs should be required to comply with the same treatment standards promulgated by the Commissioner. Prior to the time that the Commissioner has promulgated treatment standards covering all types of medical services, the MCPs should simply be required to provide services which are usual and customary for the provider's health care profession, and which are reasonably required to cure or relieve the effects of the employee's work related injury. Allowing MCPs to develop their own unique treatment standards, even if limited to the period of time prior to the development of uniform standards by the Commissioner will only result in confusion and inconsistent treatment of the injured employees of this state.

7. Retroactive Application of MCPs.

Proposed Rule 5218.2000, subp. 3D provides that the MCP rules will apply to employees injured prior to the effective date of the 1992 amendments if the employee requests a change of doctor. The proposed rule provides that an employee who requests a change of doctor must receive further treatment provided by the employer's MCP.

This provision violates the statutory and constitutional prohibition against substantive rights being taken away or affected by the retroactive application of statutory amendments. The law of this State is clear that statutory amendments shall be applied prospectively only, whether or not the amendments are substantive or procedural in nature, unless the legislature specifically provides for retroactive application. The legislature has not provided for the retroactive application of managed care plans. Therefore, any employee injured prior to 10/1/92 cannot be required to receive treatment through a managed care plan even if the employee requests a change of treating physician.

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8. Termination of Participating Providers.

Proposed Rule 5218.4000, subp. 2 allows managed care plans to "cancel" participating health care providers "under the requirements of the managed care plan." This rule effectively provides MCPs with totally unrestricted discretion over when and under what circumstances they may cancel or terminate participating health care providers. This proposed rule should be eliminated.

The legislature specifically created an exhaustive and comprehensive procedure for the investigation and sanction of health care providers who chronically provide inappropriate, excessive or unnecessary treatment to injured employees. This process is set forth in Minn. Stat. §176.103 under the authority of the Medical Services Review Board. This process requires the MSRB to investigate suspected cases of inappropriate, excessive or unnecessary treatment. It authorizes the Department to sanction providers found to be abusing the system. Said sanctions can include a total exclusion from treating injured employees.

The process established by the legislature sets forth specific checks and balances to protect wrongly accused providers from being unjustifiably sanctioned, while enabling the Division to identify and sanction actual abusers.

Obviously, the legislature did not intend to allow MCPs to side step this established process and effectively sanction health care providers without the checks and balances of appropriate due process.

The rules should be changed to allow MCPs to terminate participating health care providers only if the providers are found to have been abusing the system and the provider is sanctioned with exclusion from the workers' compensation system by the Department of Labor and Industry following the MSRB investigation. To provide MCPs with unfettered discretion to terminate health care providers would create a significant risk of abuse in direct contravention of legislative intent.

9. Treatment Provided by Non-Participating Health Care Providers.

Proposed Rule 5218.5000, subp. 1A proposes to limit the ability of an employee to treat with a health care provider who is not a participating health care provider to providers which have

a documented history of treatment with the employee before the date of injury. Minn. Stat. §176.1351, subp. 2(8) does not require that the history of treatment be prior to the date of injury. There is nothing in the statute to suggest that if the employee develops a history of treatment with a health care provider after the date of injury and thereafter wishes to switch the care of their work related injury to that health care provider, that the employee should not be able to do so. The legislature obviously intended to allow employees to treat with doctors in whom they have developed a certain level of confidence. Whether that treatment history and level of confidence is developed before or after the date of injury should not matter.

Proposed Rule 5218.5000, subp. 2B requires health care providers who are not participating health care providers to agree to refer the covered employee back to the managed care plan for "specialized care, which includes, but is not limited to, physical therapy and diagnostic testing". Minn. Stat. §176.1351, subd 2(8) only requires the non-participating health care provider to agree to refer the employee back to the managed care plan for "any other treatment that the employee may require". This would appear to allow the non-participating health care provider to provide any type of treatment he or she is licensed to provide, specifically including physical therapy and diagnostic testing. Therefore, it would appear that this proposed rule goes beyond the statute and is therefore unenforceable.

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Polar FAMILY CHIROPRACTIC

Dr. Richard A. Hastings

August 19, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Mn 55155-4316

Re: Comment to Proposed Emergency Rules
on Managed Care Plans

Dear Ms. Zembal,

Please find enclosed my comments to the proposed emergency rules on Managed Care Plans published on July 27, 1992.

I refer to a letter to you from the Law Firm of Wilson & Wulff dated August 7, 1992, copy enclosed.

It would be redundant to repeat what has so meticulously and succinctly identified the inequities of the proposed emergency rules.

I would like to comment however that these rules are profoundly discriminatory and anti-Chiropractic with obvious intentional CHIROCIDE.

It is maddening that once again politics has smothered what is right, fair, honest and a benifit to the citizens of Minnesota.

Most Sincerely,

Richard A. Hastings, D.C.

RAH/sjl

ENCLOSURER

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Polar Plaza 2231 Eleventh Avenue East, North St. Paul, MN 55109 (612) 777-3877

CHISAGO LAKES CHIROPRACTIC
DR. RANDY R. JOHNSON
HIGHWAY 8, P.O. BOX 426
CHISAGO CITY, MN 55013

TELEPHONE: (612) 257-1559

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August 20, 1992

Ms. Pam Zembal
Rehabiliation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

I wish to express my concerns over the emergency rules being considered for our Workers' Compensation Managed Care Plan System. Specifically; rule 5218.4000 subp. 1, which will ultimately limit the choice of an injured worker as to her/his health care provider.

Rule 5218.1000 D(3) - this rule, by eliminating chiropractic from initial evaluations, openly discriminates against us and subpart (C), most certainly has the potential of discrimination in a workers ongoing care.

Rule 5218.1000 Subp. 1D(7), 5218.7000 provides managed care plan's with too much discretion over peer and utilization review. This must be changed.

Rule 5218.1000 Subp. 1D(11), should be eliminated since it will result in inconsistent treatment of injured workers in this state.

Rule 5218.4000 Subp. 2 - This rule gives the managed care plan's unrestricted power as to who they wish to have as providers. Our state already has laws to deal with providers who abuse the system.

I appreciate your consideration on these issues.

Sincerely,

Randy R. Johnson, D.C.

August 18, 1992

Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor
443 Lafayette Road
St. Paul, MN. 55155

Re: Emergency Worker Compensation Rules Published July 27, 1992

Dear Ms. Zembal:

I am writing in opposition to the proposed emergency rules. The rules effectively take away the right of the working citizens of this state to see the doctor of their choice when injured at work. Under these rules referral to chiropractors by a medical physician is for the most part mandated. This will effectively result in few, if any, referrals based on my 15 years of practice here in the state of Minnesota.

Research shows that overall chiropractic treatment saves money in back injury cases. How can these proposed rules benefit the citizens of Minnesota? The added administration costs and bureaucratic tangle is likely to be expensive and this type of added cost doesn't treat a single patient. It will frustrate doctors of any type, medical or chiropractic as well as the injured. Health care is increasingly, under the rhetoric of reducing costs, added "middlemen" that take their cut and lengthen the distance between the doctor and patient by cutting down the time the doctor has to spend with the patient to attend instead to paper work.

I ask that the proposed rules be entirely redone. They do not meet the intent of the legislature, nor do they meet the needs of the injured workers.

Sincerely,

Marya Greenberg, D.C.

Marya Greenberg, D.C.
Rt. 3, Box 104
Red Wing, MN. 55066

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LINDSTROM CHIROPRACTIC CENTER, P.A.

Dr. Robert D. Waddell
12153 Lake Blvd.
Lindstrom, MN 55045
(612) 257-1103

August 19, 1992

Ms. Pam Zembal
Rehabiliation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN. 55155-4316

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RE: Proposed Emergency Rules On
Managed Care Plans

Dear Ms. Zembal:

I recently had the opportunity to review the proposed emergency rules on managed care plans published on July 27, 1992 and have two major concerns. The possibility of some health care providers maybe being excluded from treating worker's compensation patients because they are not accepted members of the MCP; and the possibility that an injured employee will be forced to treat with a health care provider he or she does not trust rather than a doctor of his or her choice. The proposed emergency rules should require as a prerequisite to certification that all MCP's must accept any health care provider who meets all licensing, registration and certification requirements necessary to practise in Minnesota, and who agrees to abide by the rules and limitations of the MCP. MCP's should not be given unrestricted discretion to pick and choose the doctors who will constitute participating health care providers.

Requiring MCP's to accept all health care providers who apply for admission, so long as their license is in good standing and they agree to abide by the rules and limitations of the MCP, would prevent provider exclusion and limitations of choice without endangering the goal of controlling utilization costs.

Please take into account my concerns as you implement the new rules on managed care.

Sincerely,

Dr. Robert D. Waddell
RDW/dal

PHYSICIANS HEALTHCARE CENTERS INC.

Furthermore, by not allowing providers to work on a negotiated fee basis, the rules as proposed would effectually bar preferred provider organizations from forming, operating or administering a certified managed care plan or plans. The intent of the legislature was clear in allowing preferred provider organizations eligibility for certification under Section 13, subdivision 1. The State Department of Labor and Industry's proposed rules do not comply with legislative intent, and may also open the door to antitrust litigation.

Physicians HealthCare Centers, Inc. requests that the State Department of Labor and Industry modify the proposed rules as follows:

> From section- 5218.2000 [Emergency] Coverage Responsibility of Managed Care Plan
> Subpart 4. Restrictions.
> Delete entirely and insert in its place rules which are consistent with Section 13, subdivision 1 of the legislation.
> The Department should specifically adhere to the ineligibility of insurers and employers to form, operate or administer their own certified managed care plans.
>
> From section 5218.6000 [Emergency] Charges and Fees.
> Delete entirely the line which begins on line 8 and wherein it states "and shall be the maximum amount allowed under Minnesota Statutes, section 176.136.

We also request the State Department of Labor and Industry send us notification of the date the adopted emergency rules governing managed care plans are submitted to the Attorney General's office.

We thank the State Department of Labor and Industry for addressing our concerns and look forward to a response.

Sincerely,

Scott A. Sexton
Area Manager

Cynthia L. Ballard
Regional Manager

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MINNESOTA
HOSPITAL
ASSOCIATION

August 21, 1992

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Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St Paul MN 55155-4316

Dear Ms. Zembal:

On behalf of the Minnesota Hospital Association, we appreciate the opportunity to comment on the proposed emergency rules governing Workers' Compensation managed care plan. During the legislative session, MHA supported the use of case management as a way to control medical costs by ensuring appropriate utilization of health care services.

In general, the new rule does not appear to break with present practices. Providers will continue to be reimbursed for performing procedures as opposed to being rewarded for providing effective case management. A new system should address expenses associated with case management and reward providers for effective case management.

Without addressing these issues, it is possible that case management will just add another administrative layer that adds costs to the system and does not improve the quality of care.

More specifically, we would like to comment on certain sections of the rule.

5218.1000 Application for Certification D(2b) & D(3b)

This section requires that a managed care plan may not discriminate against or exclude from participation any category of health care providers and workers must be able to choose health care providers from the plan, provided the treatment is medically appropriate. The rules, however, do not address who decides what is medically appropriate.

This section also allows the initial evaluation by a participating chiropractor. How will the issue be dealt with if the injury to be evaluated is outside the scope of chiropractic practice?

5218.200 Coverage Responsibility of Managed Care Plan (Subp 4 - Restrictions)

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This section prohibits, in cases where there is a single managed care plan, the plan from being administered by the employer. While this restriction was part of the Workers' Compensation law, MHA believes that it should not apply to hospitals. Obviously, hospitals are in a unique position to provide services and many already coordinate services for their own employees. This section, however, does allow employers to administer plans when an insurer contracts with multiple managed-care plans. This is a step in the right direction.

5218.6000 Charges and Fees

This section requires that providers will be reimbursed according to the fee schedule. As the rule perpetuates the current system (i.e. no rewards for providers providing effective case management) MHA supports this section.

It is important that managed care organizations do not produce cost savings by simply "gauging" medical providers. The additional administrative costs added to the system because of managed care should not be borne by health care providers. The fee schedule already significantly discounts providers charges.

We appreciate the opportunity for responding to these proposed rules and look forward to working with the Department in assuring quality cost-effective health care services to injured workers.

Sincerely,

Linda Sandvig

Linda Sandvig
Legislative Consultant

LS:jf

MMA
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VIA FACSIMILE

August 21, 1992

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Pam Zembal, MSN
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Proposed Emergency Rules Relating to Workers' Compensation; Managed Care

Dear Ms. Zembal:

Pursuant to the Notice of Intent to Adopt an Emergency Rule published in the State Register, Monday July 27, 1992, the Minnesota Medical Association (MMA) has the following comments:

1. Proposed Minnesota Rule 5218.0100, subpt. 3., [Emergency], (hereinafter "Proposed Minn. R.") defines emergency care as "professional health services necessary to preserve life or limb". This definition is somewhat restrictive. The MMA recommends adoption of the following definition of emergency care. This definition was adopted by the Health Care Financing Administration and has been endorsed by the American College of Emergency Physicians:

> [a] medical condition that is manifested by symptoms of sufficient severity (including severe pain) that, in the absence of immediate medical attention, could reasonably be expected to result in placing health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of a bodily organ or part.

2. Proposed Minn. R. 5218.1000, subpt. 1., states that "Any person or entity may make written application to the commissioner to provide managed care..." The MMA understands that this is interpreted to include independent groups of physicians who may wish to seek application.

3. Proposed Minn. R. 5218.1000, subpt. 1.C., establishes that each application for certification must be accompanied by a nonrefundable fee of $1500. A fee of $50 per physician with a **limit of $1500** would be less burdensome for small managed care groups.

4. Proposed Minn. R. 5218.1000, subpt. 2., sets forth that "If a certification is denied, the applicant will be provided with the reason for the denial. The commissioner must require an in-person meeting if necessary to determine compliance with parts 5218.0100 to 5218.9000 [Emergency]". This provision does not provide adequate due process review of denied certifications. Rather, the MMA recommends implementation of a contested case proceeding.

5. Proposed Minn. R. 5218.2000, subpt. 4., states as follows:

> When an insurer contracts with a single managed care plan for coverage for an employer, the plan may not be formed, operated, or administered by the same employer or insurer. When an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, **formed**, or administered by the employer or **insurer**. No employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota Statutes, chapter 176 (emphasis added).

Minn. Stat. 176.1351, subd. 1 states:

> Any person or entity, **other than a workers' compensation insurer** or an employer for its own employees, may make written application to the commissioner to have a plan certified...(emphasis added).

A review of the above provisions indicates that Proposed Minn. R. 5218.2000, subpt. 4., is inconsistent with Minn. Stat. 176.1351. Proposed Minn. R. 5218.2000, subpt. 4., implies that workers' compensation insurers will be allowed to obtain certification. The plain meaning of the law prohibits workers' compensation insurers from forming managed care plans.

The MMA is concerned that this interpretation of the law will not serve the legislative intent of reducing health care costs. This interpretation presents the old paradigm of the insurance carrier holding information and establishing a barrier between employer and providers who together can determine what is the best care and how it can be provided in the most cost effective manner. The MMA believes that this interpretation presents an inappropriate profit motivation for carriers to keep all services in a closed system in which they determine: compensability of a claim; level of reserve of the claim; how and when medical care is provided; limits of rehabilitation and retraining and ultimately, determine employer insurance premiums based on all of these factors which they control.

6. Proposed Minn. R. 5218.6000, establishes that the payment by the insurer or the managed care plan to participating and nonparticipating health care provider for medical services shall be the maximum amount allowed under Minn. Stat. section 176.136. The MMA understands that this provision means that no discounting will be allowed. The MMA requests that language be added to this provision to clarify this intent of the Department.

7. General Comments

The MMA has received comments from physicians concerning clarification of various rules. There is concern that it will be difficult to comply with the rules if they are vague. The following examples illustrate this concern:

> 1. Proposed Minn. R. 5218.1000, subpt. 1.D.(2)(a).
> The definition of "all medical and health care services that may be required by Minnesota statutes" is vague. Standards do not exist for all services.
>
> 2. Proposed Minn. R. 5218.1000, subpt. 1.D.(7).

Requirements for peer review, utilization review, and internal dispute resolution need to be clarified.

3. Proposed Minn. R. 5218.3000 subpt. 2. E.
Reporting requirements need to be clarified.

4. Proposed Minn. R. 5218.8000 subpt. 1.
Periodic audits and special examinations needs to be clarified. Specifically, what is included in the periodic audits and special examinations - is it the records review mentioned in the following subpt. 2.?

The MMA appreciates the opportunity to comment on the Proposed Emergency Rules Relating to Workers' Compensation; Managed Care. Please do not hesitate to contact the undersigned if you should have any questions regarding the above comments. In addition, if necessary, we could meet to further discuss MMA comments.

Very truly yours,

S M Veenhuis

Suzanne M. Veenhuis
Associate Legal Counsel

Molly Sigel

Molly Sigel
Lobbyist

PreferredOne

August 20, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

As you requested this letter contains comments on the proposed emergency rules for managed care plans in workers' compensation. PreferredOne would like to congratulate and support you in your efforts in development of these rules. Like the Department of Labor and Industry, PreferredOne strongly believes that managed care can effectively demonstrate a system wide cost savings while improving the quality of care delivered through the system. We look forward to a continuing dialogue with you on managed care in workers' compensation.

Comments on the rules have been identified by the numbering system used in the emergency rules.

5218.01000 Definitions

Geographic Service Area:

This portion of the rules sounds like an HMO environment. As a managed care organization, there will be areas in which we do not, at this point and time, have contracted providers. However, we will be able to perform utilization management and case management services. By definition, Preferred WorkCare will not be providing comprehensive health care services as would a staff model HMO. Limiting managed care oversite to only those geographic areas in which there are participating providers will limit the potential cost savings available in these areas.

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Managed Care Plan:

The terminology Managed Care Plan suggests the financing and delivery of medical care services. More appropriately this should be named Managed Care Organization as a organized provider network that is able to coordinate the delivery of a comprehensive range of necessary and appropriate services for an injured employee.

5128.1000 Subpart 1,D (2)

Preferred WorkCare recognizes the sensitivity of providers, employers, purchasers, consumers, and regulators to the reported exorbitant salaries and compensation packages of certain publically held managed care organizations. Such a requirement as described in the emergency rules has little relevance to the performance of a managed care organization

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in generating cost savings for workers' compensation. PreferredOne would urge the deletion of this subpart.

5218.1000 Subpart 1, D (3), (e) Information or advice availability on a 24-hour basis could be in the form of a recorded message after normal working hours. This message would instruct employers and employees to use the nearest emergency facility for all urgent issues or to call back during business hours for non-urgent question.

5218.2000 Supart 2 As long as the Department of Labor and Industry has the managed care organizations provider enrollment procedure and approves of it, there is little value in regulating expansion. This would be a disservice to greater Minnesota since this is where expansion is likely to occur. The Department could retain the right to audit the managed care organizations records to ensure adherence to certified protocols. Our concern is that the approval for expansion would involve a significant delay and therefore prevent access to managed care for employers and employees in greater Minnesota.

5218.2000 Subpart 3, B Many companies have high turnover in staff (sometimes 50-60%) and keeping them up-to-date on the managed care plan will be difficult. The employer should be able to direct employees to a particular clinic for initial services and then offer a choice of managed care organizations after that initial treatment. This prevents a delay in treatment from occurring while preserving the employees' ability to choose managed care options.

5218.4000 It is imperative that the managed care organization be able to determine provider eligibility and selection as described in their own policies and procedures.

5218.5000 Subpart 1, A The non-participating provider has the right to know the treatment standards against which she or he will be held. Additionally the managed care organization needs to determine quickly if the provider maintains the employees medical records and has a documented history of treatment before the injury. In conflict with this, the medical records in question are not available to the managed care organization, employer, or workers' compensation insurer without a release of medical information

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authorization from the employee. This could easily delay notification of the provider. A solution could be to have the employees register the name of their primary providers with the employer at the time of enrollment with managed care or at the time of hire, which ever is first. If subsequently the employee seeks workers' compensation care with a non-participating provider, the managed care organization would verify if the provider is registered. If not, care would be denied until the release of medical information was signed and the history of treatment confirmed. This system places a burden on the employer to maintain the provider information but could easily be incorporated as part of the managed care enrollment.

One concern from this process is how long before the date of injury must the last documented history of treatment have occurred, one month, one year, or ten years? Another concern is if the employee views the provider as a family doctor but the provider has only seen other members of the family for medical care.

Thank you for the opportunity to comment on these emergency rules. If you need further information or comment you can reach me at 331-0268.

Sincerely Yours,

Barbara L. Daiker, RN,MS,COHN
Manager, Preferred WorkCare

BLD/kmo

cc: Dr. Ken Dedeker
Dave Olsen
Dr. Vijay Eyunni
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August 7, 1992

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Ms. Pam Zembal
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Re: Comment to Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

Thomas J. Lyons
of Counsel

Ann Moore
Legal Assistant

Please accept this letter as my comments to the proposed emergency rules on managed care plans published on July 27, 1992.

1. **Exclusion of Health Care Providers from MCPs.**

Two major concerns which should be addressed by the rules on MCPs are (1) the threat that some health care providers may be effectively excluded from treating workers' compensation patients because they are not accepted members of any MCP; and (2) the threat that an injured employee will be forced to treat with a health care provider he or she does not trust rather than a doctor of his or her choice. The proposed emergency rules, and specifically Rule 5218.4000, subp. 1, should require as a prerequisite to certification that all MCPs must accept any health care provider who meets all licensing, registration and certification requirements necessary to practice in Minnesota, and who agrees to abide by the rules and limitations of the MCP. MCPs should not be given unrestricted discretion to pick and choose the doctors who will constitute participating health care providers.

If the MCPs are allowed to choose the health care providers who will participate in their plans, there will be health care providers who are not accepted into any managed care plan. Those providers will be effectively excluded from treating injured employees in this state. Such exclusion will have a devastating impact on those health care providers. Conversely, these practitioners who are accepted into MCPs could receive an unfair windfall of new cases. This was clearly not intended by the legislature.

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Giving such discretion to MCPs will also significantly limit the right of injured employees to choose the health care provider from whom they will receive treatment. The right to choose ones treating doctor has always been jealously protected by both the legislature and the courts of this state. It is significant to note that of the nineteen persons who spoke at the public hearing on the proposed medical rules on 7/16/92, all but two (the two attorneys who spoke on behalf of the IME firms) urged the Division not to limit the right of injured employees of this state to choose their own treating physician. The legislature clearly did not intend to abrogate the fundamental right of the citizens of this state to choose their own treating physicians.

The basic goal of the legislature in adopting the 1992 amendments was to provide a mechanism for reducing or eliminating inappropriate, excessive or unnecessary treatment. The accomplishment of this goal does not require the exclusion of innocent and qualified health care providers from the system. It also does not require the complete abrogation of a citizen's right to choose their own treating physician. The new treatment standards coupled with the MCP peer review utilization review and dispute resolution process, the MSRB investigation/sanction process, and the traditional medical request/claim petition process are adequate to guard against abuses.

Requiring MCPs to accept all health care providers who apply for admission, so long as their license is in good standing and they agree to abide by the rules and limitations of the MCP, would avoid the dual threats of provider exclusion and limitation of choice without endangering the goal of controlling utilization costs. It is a win/win proposal that should be adopted. The authority for such a rule can be found in Minn. Stat. §176.1351, subd. 2(12).

2. **Initial Evaluations Under 5218.1000 D(3).**

The proposed rule as drafted allows MCPs to require employees to submit to "initial evaluations" by a "physician" (defined to be a medical doctor or a doctor of osteopathy but not a chiropractor) within 24 hours after an employee requests treatment following a work injury. The rule allows MCPs to permit initial evaluations by chiropractors but does not require this. This rule violates the statutory prohibition against MCPs discriminating against any category of health care provider.

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The same argument applies to 5218.1000, subp. 1D (3)(b) dealing with initial evaluations within five working days of a request for change of doctor.

The requirement that an employee must submit to an "initial evaluation" within 24 hours of a request for treatment following the work injury, or within five working days after a request for a change of doctor in cases where the employee has received treatment for the work injury by health care provider outside of the MCP, is nothing less than a mandatory adverse examination by a health care provider of the employer's choice. As such, it violates the provisions of M.S. 176.155 and should be eliminated from the proposed rules all together.

Alternatively, if an initial evaluation is to be required, then the employee should be given the right to choose from among all of the MCPs participating health care providers, including the chiropractors. Otherwise, the chiropractic profession will be unlawfully discriminated against, and the injured employee's right to choose his or her own treating physician will be unreasonably and unnecessarily restricted.

Subp. (c) in the same rule provides that the "evaluating provider" who conducts the "initial evaluation" must provide the employee with a list of at least three health care providers with whom the employee may treat. The "evaluating provider" is given the power to determine what treatment is appropriate for the condition and what type of health care profession discipline should provide that treatment. This process effectively gives the "evaluating provider" the power to discriminate against categories of health care providers. Allowing MCPs to simply delegate the authority to discriminate against categories of health care providers would obviously violate the prohibition against such discrimination clearly set forth in the 1992 amendments.

The problems inherent in the initial evaluation process set forth by the Rule as drafted could be minimized if not eliminated by simply requiring MCPs to provide injured employees with a list of the names, addresses and telephone numbers of all participating health care providers within 24 hours of a request for treatment following a work injury or within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the MCP. The employee's initial choice of health care provider could then be required to perform an initial evaluation to determine the treatment which is appropriate for the condition. If the

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employee's initial choice of health care provider is not the appropriate health care discipline to provide the treatment, that health care provider could simply provide the employee with a list of the participating providers under the MCP within the proper health care discipline.

3. **Entities Which May be Certified as MCPs.**

Minn. Stat. §176.1351, subd. 1 provides, "any person or entity, other than a workers' compensation insurer or an employer for its own employees, may" be certified as an MCP (emphasis added). The statute specifically prohibits workers' compensation insurers and self-insured employers from becoming certified as MCPs.

Proposed Rules 5218.1000, subp. 1 and 5218.2000, subp. 4, as drafted, would appear to violate this specific statutory prohibition. Therefore, these proposed rules should be redrafted.

4. **Peer Review, Utilization Review and Internal Dispute Resolution.**

Proposed rules 5218.1000, subp. 1D (7) and 5218.7000 provide MCPs with too much discretion over devising procedures for peer review, utilization review and internal dispute resolution. The Division should attempt to come up with specific rules concerning these procedures. Otherwise, the citizens of this state will be confronted by a myriad of different procedures giving rise to inconsistent treatment of similar injuries.

5. **Aggressive Case Management and Early Return To Work Programs.**

Proposed Rule 5218.1000, subp. 1D (10) requires MCPs to describe how they will provide aggressive case management, programs for early return to work, and cooperative efforts to promote work place health and safety services without specifying what those terms mean or what, if any, limitations should apply. The Department of Labor and Industry should develop more specific definitions and requirements in order to avoid the development of myriad different rules and limitations resulting in inconsistent treatment of like cases.

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6. Treatment Standards Not Prescribed by the Commissioner.

Proposed Rule 5218.1000, subp. 1D (11) requires individual MCPs to submit treatment standards for medical services not previously prescribed by the Commissioner. This proposed rule should be eliminated.

It will be completely unworkable and unjust for MCPs to be allowed to develop individualized and differing treatment standards applicable to their member employees. All MCPs should be required to comply with the same treatment standards promulgated by the Commissioner. Prior to the time that the Commissioner has promulgated trèatment standards covering all types of medical services, the MCPs should simply be required to provide services which are usual and customary for the provider's health care profession, and which are reasonably required to cure or relieve the effects of the employee's work related injury. Allowing MCPs to develop their own unique treatment standards, even if limited to the period of time prior to the development of uniform standards by the Commissioner will only result in confusion and inconsistent treatment of the injured employees of this state.

7. Retroactive Application of MCPs.

Proposed Rule 5218.2000, subp. 3D provides that the MCP rules will apply to employees injured prior to the effective date of the 1992 amendments if the employee requests a change of doctor. The proposed rule provides that an employee who requests a change of doctor must receive further treatment provided by the employer's MCP.

This provision violates the statutory and constitutional prohibition against substantive rights being taken away or affected by the retroactive application of statutory amendments. The law of this State is clear that statutory amendments shall be applied prospectively only, whether or not the amendments are substantive or procedural in nature, unless the legislature specifically provides for retroactive application. The legislature has not provided for the retroactive application of managed care plans. Therefore, any employee injured prior to 10/1/92 cannot be required to receive treatment through a managed care plan even if the employee requests a change of treating physician.

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8. Termination of Participating Providers.

Proposed Rule 5218.4000, subp. 2 allows managed care plans to "cancel" participating health care providers "under the requirements of the managed care plan." This rule effectively provides MCPs with totally unrestricted discretion over when and under what circumstances they may cancel or terminate participating health care providers. This proposed rule should be eliminated.

The legislature specifically created an exhaustive and comprehensive procedure for the investigation and sanction of health care providers who chronically provide inappropriate, excessive or unnecessary treatment to injured employees. This process is set forth in Minn. Stat. §176.103 under the authority of the Medical Services Review Board. This process requires the MSRB to investigate suspected cases of inappropriate, excessive or unnecessary treatment. It authorizes the Department to sanction providers found to be abusing the system. Said sanctions can include a total exclusion from treating injured employees.

The process established by the legislature sets forth specific checks and balances to protect wrongly accused providers from being unjustifiably sanctioned, while enabling the Division to identify and sanction actual abusers.

Obviously, the legislature did not intend to allow MCPs to side step this established process and effectively sanction health care providers without the checks and balances of appropriate due process.

The rules should be changed to allow MCPs to terminate participating health care providers only if the providers are found to have been abusing the system and the provider is sanctioned with exclusion from the workers' compensation system by the Department of Labor and Industry following the MSRB investigation. To provide MCPs with unfettered discretion to terminate health care providers would create a significant risk of abuse in direct contravention of legislative intent.

9. Treatment Provided by Non-Participating Health Care Providers.

Proposed Rule 5218.5000, subp. 1A proposes to limit the ability of an employee to treat with a health care provider who is not a participating health care provider to providers which have

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a documented history of treatment with the employee before the date of injury. Minn. Stat. §176.1351, subp. 2(8) does not require that the history of treatment be prior to the date of injury. There is nothing in the statute to suggest that if the employee develops a history of treatment with a health care provider after the date of injury and thereafter wishes to switch the care of their work related injury to that health care provider, that the employee should not be able to do so. The legislature obviously intended to allow employees to treat with doctors in whom they have developed a certain level of confidence. Whether that treatment history and level of confidence is developed before or after the date of injury should not matter.

Proposed Rule 5218.5000, subp. 2B requires health care providers who are not participating health care providers to agree to refer the covered employee back to the managed care plan for "specialized care, which includes, but is not limited to, physical therapy and diagnostic testing". Minn. Stat. §176.1351, subd 2(8) only requires the non-participating health care provider to agree to refer the employee back to the managed care plan for "any other treatment that the employee may require". This would appear to allow the non-participating health care provider to provide any type of treatment he or she is licensed to provide, specifically including physical therapy and diagnostic testing. Therefore, it would appear that this proposed rule goes beyond the statute and is therefore unenforceable.

Respectfully submitted,

WILSON & WULFF, P.A.

David C. Wulff
Attorney at Law

DCW/cmg

Wilson & Wulff, P.A.

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Scott Wilson

David C. Wulff

Thomas J. Lyons
of Counsel

Ann Moore
Legal Assistant

August 7, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comment to Proposed Emergency Rules
on Managed Care Plans

Dear Ms. Zembal:

Please accept this letter as my comments to the proposed emergency rules on managed care plans published on July 27, 1992.

1. Exclusion of Health Care Providers from MCPs.

Two major concerns which should be addressed by the rules on MCPs are (1) the threat that some health care providers may be effectively excluded from treating workers' compensation patients because they are not accepted members of any MCP; and (2) the threat that an injured employee will be forced to treat with a health care provider he or she does not trust rather than a doctor of his or her choice. The proposed emergency rules, and specifically Rule 5218.4000, subp. 1, should require as a prerequisite to certification that all MCPs must accept any health care provider who meets all licensing, registration and certification requirements necessary to practice in Minnesota, and who agrees to abide by the rules and limitations of the MCP. MCPs should not be given unrestricted discretion to pick and choose the doctors who will constitute participating health care providers.

If the MCPs are allowed to choose the health care providers who will participate in their plans, there will be health care providers who are not accepted into any managed care plan. Those providers will be effectively excluded from treating injured employees in this state. Such exclusion will have a devastating impact on those health care providers. Conversely, these practitioners who are accepted into MCPs could receive an unfair windfall of new cases. This was clearly not intended by the legislature.

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Giving such discretion to MCPs will also significantly limit the right of injured employees to choose the health care provider from whom they will receive treatment. The right to choose ones treating doctor has always been jealously protected by both the legislature and the courts of this state. It is significant to note that of the nineteen persons who spoke at the public hearing on the proposed medical rules on 7/16/92, all but two (the two attorneys who spoke on behalf of the IME firms) urged the Division not to limit the right of injured employees of this state to choose their own treating physician. The legislature clearly did not intend to abrogate the fundamental right of the citizens of this state to choose their own treating physicians.

The basic goal of the legislature in adopting the 1992 amendments was to provide a mechanism for reducing or eliminating inappropriate, excessive or unnecessary treatment. The accomplishment of this goal does not require the exclusion of innocent and qualified health care providers from the system. It also does not require the complete abrogation of a citizen's right to choose their own treating physician. The new treatment standards coupled with the MCP peer review utilization review and dispute resolution process, the MSRB investigation/sanction process, and the traditional medical request/claim petition process are adequate to guard against abuses.

Requiring MCPs to accept all health care providers who apply for admission, so long as their license is in good standing and they agree to abide by the rules and limitations of the MCP, would avoid the dual threats of provider exclusion and limitation of choice without endangering the goal of controlling utilization costs. It is a win/win proposal that should be adopted. The authority for such a rule can be found in Minn. Stat. §176.1351, subd. 2(12).

2. Initial Evaluations Under 5218.1000 D(3).

The proposed rule as drafted allows MCPs to require employees to submit to "initial evaluations" by a "physician" (defined to be a medical doctor or a doctor of osteopathy but not a chiropractor) within 24 hours after an employee requests treatment following a work injury. The rule allows MCPs to permit initial evaluations by chiropractors but does not require this. This rule violates the statutory prohibition against MCPs discriminating against any category of health care provider.

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The same argument applies to 5218.1000, subp. 1D (3)(b) dealing with initial evaluations within five working days of a request for change of doctor.

The requirement that an employee must submit to an "initial evaluation" within 24 hours of a request for treatment following the work injury, or within five working days after a request for a change of doctor in cases where the employee has received treatment for the work injury by health care provider outside of the MCP, is nothing less than a mandatory adverse examination by a health care provider of the employer's choice. As such, it violates the provisions of M.S. 176.155 and should be eliminated from the proposed rules all together.

Alternatively, if an initial evaluation is to be required, then the employee should be given the right to choose from among all of the MCPs participating health care providers, including the chiropractors. Otherwise, the chiropractic profession will be unlawfully discriminated against, and the injured employee's right to choose his or her own treating physician will be unreasonably and unnecessarily restricted.

Subp. (c) in the same rule provides that the "evaluating provider" who conducts the "initial evaluation" must provide the employee with a list of at least three health care providers with whom the employee may treat. The "evaluating provider" is given the power to determine what treatment is appropriate for the condition and what type of health care profession discipline should provide that treatment. This process effectively gives the "evaluating provider" the power to discriminate against categories of health care providers. Allowing MCPs to simply delegate the authority to discriminate against categories of health care providers would obviously violate the prohibition against such discrimination clearly set forth in the 1992 amendments.

The problems inherent in the initial evaluation process set forth by the Rule as drafted could be minimized if not eliminated by simply requiring MCPs to provide injured employees with a list of the names, addresses and telephone numbers of all participating health care providers within 24 hours of a request for treatment following a work injury or within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the MCP. The employee's initial choice of health care provider could then be required to perform an initial evaluation to determine the treatment which is appropriate for the condition. If the

employee's initial choice of health care provider is not the appropriate health care discipline to provide the treatment, that health care provider could simply provide the employee with a list of the participating providers under the MCP within the proper health care discipline.

3. Entities Which May be Certified as MCPs.

Minn. Stat. §176.1351, subd. 1 provides, "any person or entity, other than a workers' compensation insurer or an employer for its own employees, may" be certified as an MCP (emphasis added). The statute specifically prohibits workers' compensation insurers and self-insured employers from becoming certified as MCPs.

Proposed Rules 5218.1000, subp. 1 and 5218.2000, subp. 4, as drafted, would appear to violate this specific statutory prohibition. Therefore, these proposed rules should be redrafted.

4. Peer Review, Utilization Review and Internal Dispute Resolution.

Proposed rules 5218.1000, subp. 1D (7) and 5218.7000 provide MCPs with too much discretion over devising procedures for peer review, utilization review and internal dispute resolution. The Division should attempt to come up with specific rules concerning these procedures. Otherwise, the citizens of this state will be confronted by a myriad of different procedures giving rise to inconsistent treatment of similar injuries.

5. Aggressive Case Management and Early Return To Work Programs.

Proposed Rule 5218.1000, subp. 1D (10) requires MCPs to describe how they will provide aggressive case management, programs for early return to work, and cooperative efforts to promote work place health and safety services without specifying what those terms mean or what, if any, limitations should apply. The Department of Labor and Industry should develop more specific definitions and requirements in order to avoid the development of myriad different rules and limitations resulting in inconsistent treatment of like cases.

6. **Treatment Standards Not Prescribed by the Commissioner.**

Proposed Rule 5218.1000, subp. 1D (11) requires individual MCPs to submit treatment standards for medical services not previously prescribed by the Commissioner. This proposed rule should be eliminated.

It will be completely unworkable and unjust for MCPs to be allowed to develop individualized and differing treatment standards applicable to their member employees. All MCPs should be required to comply with the same treatment standards promulgated by the Commissioner. Prior to the time that the Commissioner has promulgated treatment standards covering all types of medical services, the MCPs should simply be required to provide services which are usual and customary for the provider's health care profession, and which are reasonably required to cure or relieve the effects of the employee's work related injury. Allowing MCPs to develop their own unique treatment standards, even if limited to the period of time prior to the development of uniform standards by the Commissioner will only result in confusion and inconsistent treatment of the injured employees of this state.

7. **Retroactive Application of MCPs.**

Proposed Rule 5218.2000, subp. 3D provides that the MCP rules will apply to employees injured prior to the effective date of the 1992 amendments if the employee requests a change of doctor. The proposed rule provides that an employee who requests a change of doctor must receive further treatment provided by the employer's MCP.

This provision violates the statutory and constitutional prohibition against substantive rights being taken away or affected by the retroactive application of statutory amendments. The law of this State is clear that statutory amendments shall be applied prospectively only, whether or not the amendments are substantive or procedural in nature, unless the legislature specifically provides for retroactive application. The legislature has not provided for the retroactive application of managed care plans. Therefore, any employee injured prior to 10/1/92 cannot be required to receive treatment through a managed care plan even if the employee requests a change of treating physician.

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8. Termination of Participating Providers.

Proposed Rule 5218.4000, subp. 2 allows managed care plans to "cancel" participating health care providers "under the requirements of the managed care plan." This rule effectively provides MCPs with totally unrestricted discretion over when and under what circumstances they may cancel or terminate participating health care providers. This proposed rule should be eliminated.

The legislature specifically created an exhaustive and comprehensive procedure for the investigation and sanction of health care providers who chronically provide inappropriate, excessive or unnecessary treatment to injured employees. This process is set forth in Minn. Stat. §176.103 under the authority of the Medical Services Review Board. This process requires the MSRB to investigate suspected cases of inappropriate, excessive or unnecessary treatment. It authorizes the Department to sanction providers found to be abusing the system. Said sanctions can include a total exclusion from treating injured employees.

The process established by the legislature sets forth specific checks and balances to protect wrongly accused providers from being unjustifiably sanctioned, while enabling the Division to identify and sanction actual abusers.

Obviously, the legislature did not intend to allow MCPs to side step this established process and effectively sanction health care providers without the checks and balances of appropriate due process.

The rules should be changed to allow MCPs to terminate participating health care providers only if the providers are found to have been abusing the system and the provider is sanctioned with exclusion from the workers' compensation system by the Department of Labor and Industry following the MSRB investigation. To provide MCPs with unfettered discretion to terminate health care providers would create a significant risk of abuse in direct contravention of legislative intent.

9. Treatment Provided by Non-Participating Health Care Providers.

Proposed Rule 5218.5000, subp. 1A proposes to limit the ability of an employee to treat with a health care provider who is not a participating health care provider to providers which have

a documented history of treatment with the employee before the date of injury. Minn. Stat. §176.1351, subp. 2(8) does not require that the history of treatment be prior to the date of injury. There is nothing in the statute to suggest that if the employee develops a history of treatment with a health care provider after the date of injury and thereafter wishes to switch the care of their work related injury to that health care provider, that the employee should not be able to do so. The legislature obviously intended to allow employees to treat with doctors in whom they have developed a certain level of confidence. Whether that treatment history and level of confidence is developed before or after the date of injury should not matter.

Proposed Rule 5218.5000, subp. 2B requires health care providers who are not participating health care providers to agree to refer the covered employee back to the managed care plan for "specialized care, which includes, but is not limited to, physical therapy and diagnostic testing". Minn. Stat. §176.1351, subd 2(8) only requires the non-participating health care provider to agree to refer the employee back to the managed care plan for "any other treatment that the employee may require". This would appear to allow the non-participating health care provider to provide any type of treatment he or she is licensed to provide, specifically including physical therapy and diagnostic testing. Therefore, it would appear that this proposed rule goes beyond the statute and is therefore unenforceable.

Respectfully submitted,

WILSON & WULFF, P.A.

David C. Wulff
Attorney at Law

DCW/cmg

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AUG 24 1992
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MEDICAL AFFAIRS

Minnesota
Department of Labor and Industry

443 Lafayette Road
St. Paul, Minnesota 55155
(612) 296-6107

Telecommunication Device
for the Deaf (612) 297-4198

FAX (612) 297-1329

FAX #: 7-2576

DATE:

TIME:

TO: Patti Nolte - Attorney General's Office

FROM: Kate Berger

COMMENTS: Two additional untimely comments on the managed care rules

Number of pages including this cover page: 4

If you do not receive all the pages,

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An Equal Opportunity Employer

Honeywell

John M. Burns, M.D.
FACP, FACPE, MBA
Vice President
Health Management

Honeywell Inc.
Honeywell Plaza (MN12-3247)
P.O. Box 524
Minneapolis, MN 55440-0524
612 870-2175

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SEP 17 1992
Commissioner's Office
Dept. Of Labor & Industry

September 14, 1992

Commissioner John Lennes
Minnesota Department of Labor and Industry
443 Lafayette Road
St. Paul, MN 55155

Dear Commissioner Lennes:

I am writing in support of your proposed regulations to regulate managed care programs for workers compensation as published in the State Register, Monday, July 27, 1992. I have been involved with Honeywell in working on programs to improve quality and manage costs for health care for 11 years. I am a determined believer in the benefits of managed care both for assuring quality in hospital medical care and also for controlling costs in the best way possible. Current economic incentives in the market for health care put a substantial economic premium on elaborate care practice styles that reward the provision of unnecessary care. This is particularly dangerous in workers compensation where excess medical care can also support excess disability and indemnity costs. As a result the cost implications of unnecessary care are even more severe in workers compensation than they are in the health care system in general.

The only way that has been effectively found to control this excess utilization (estimated by the Rand Corporation as much as 30% of medical care currently provided in this country) is to place the responsibility for the management of health care in the hands of health care providers whose incentives are to assure quality and control costs rather than to maximize utilization.

The provision of unnecessary care not only adds to costs and arguably supports increased indemnity costs but also poses a significant risk to the patient. No medical procedure is without its side effects. The provision of unnecessary care increases the risks of those side effects which will have an adverse affect on the patient.

The rules proposed provide the Department with an effective mechanism for assuring that care is managed appropriately and that the risks and costs of unnecessary care are avoided. It gives the Department the authority to restrict access to the workers compensation system to any providers who abuse their resonsibilities and provide unnecessary, inappropriate or excessively expensive care.

Although health care cost control has been a serious problem for business in Minnesota for many years the problem of rising health care costs in the workers compensation system is far worse. The proposed rules merely implement into the workers compensation system a program similar to those implemented by many employers through their regular health care systems and which have been proven to be the most effective ways so far to improve quality and at the same time manage costs.

I would strongly urge the adoption of these rules and their vigorous enforcement by the Department.

Sincerely,

John M. Burns MD

JMBurns, M.D.

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Commissioner's Office
Dept. Of Labor & Industry

MADA
Minnesota Automobile Dealers Association
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September 4, 1992

Mr. John Lennes
Commissioner
Department of Labor & Industry
444 Lafayette Road
St. Paul, MN 55101

Dear John:

I am writing to congratulate you on the job you and your Department have done in drafting the Rules for the implementation of the new Managed Care Program within the Workers' Compensation system.

After reviewing the new Rules, it is our opinion that your Department followed not only the spirit of the law, but went to every effort to get the most savings out of this Managed Care system. Your diligence on behalf of both Minnesota workers and injured employees is to be commended.

Thank you again and congratulations on a job well done.

Sincerely,

Louis W. Claeson
EXECUTIVE VICE PRESIDENT

LWC/pm

Harry A. Sieben, Jr.
Clint Grose (1923-1987)
John E. Von Holtum
Timothy J. McCoy
John W. Carey
Douglas E. Schmidt
Mark R. Kosieradzki
Raymond R. Peterson
Mark G. Olive
James P. Carey
William D. Sommerness
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Susan M. Holden
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Scott H. Soderberg
John B. Wolfe, Jr.
Robert W. Schaumann
Judy L. Emmings

Of Counsel
Miles W. Lord

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OCT 14 1992
Office of the Attorney General
Government Services Section
Capitol Office Bldg., Suite 500
525 Park Street
St. Paul MN 55103

October 12, 1992

Ms. Mary Jo Murray
Special Assistant Attorney General
Office of the Attorney General
Public Finance Division
Capitol Office Building
525 Park Street
St. Paul, MN 55103

VIA FACSIMILE AND U.S. MAIL

RE: Managed Care Emergency Rules

Dear Ms. Murray:

This letter is intended as a brief response to Ms. Kathryn Berger's letter to you of October 9, 1992 regarding the proposed Managed Care Rules. More specifically, Ms. Berger has inaccurately stated our objection to proposed Rule 5000, Subp. 1A. Her misstatement of our objection to this Rule and her representation therein can be found on page 5 of her letter. We did not state in our Comments that "a documented history of treatment" with a provider should not be limited to treatment before the date of injury. Rather, we intended to convey our objection to placing a "two times within four years of the injury date" restriction on the statutory definition. There is no basis to conclude that "two visits within four years of injury date" in any way reasonably defines "documented history of treatment" and is anything other than arbitrary and capricious.

Very truly yours,

Mark G. Olive

FOR THE FIRM

MGO/nkp

TIMELY COMMENTS RECEIVED

AG

HealthEast

August 17,1992

HealthEast Care, Inc.
559 Capitol Boulevard
6 West
St. Paul, MN 55103

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road
St. Paul, MN 55155-4316

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REHABILITATION & MEDICAL AFFAIRS

Dear Ms. Zembal:

I would like to take this opportunity to compliment you and your department on the Proposed Emergency Rules relating to workers' compensation; managed care. There are, however, a few comments that we would like to make about the emergency rules for your consideration. Our comments are briefly summarized below:

1. 5218.1000 subpart 1D93)(f) Access to health care providers

While it appears that the 30 mile requirement for access to health providers is either 30 miles from the employee's place of employment or the employees residence, this statement might be clarified to state a plan which provides one or the other is sufficient for compliance and that it is not necessary to provide an employee with their choice. If this is not the Commissioner's intent, we believe that to provide such a choice would be impractical due to the geographic spread of employees throughout the metropolitan area and suggest either elimination of the "or residence" requirement or alternatively providing a more reasonable 50 mile distance.

2. 5218.1000 subpart 1D(11) Treatment standards

This provision states that the managed care plan must submit treatment standards for medical services not already prescribed by the commissioner. If it is the intent of the Commissioner that these treatment standards be drafted or prescribed by the individual managed care plan, then for clarification purposes, it would be helpful if this is affirmatively stated in the provision. Additionally, if the Commissioner is contemplating any restrictions to the standards prescribed by the managed care plan, these should be specifically set forth in this provision.

3. 5218.1000 subpart 1D(b)

The terms "adequate number of each category of health care providers", "convenient geographic accessibility", and "adequate flexibility to choose" are subject to wide and varying interpretation. It appears that the judgment and determination as to the interpretation of these terms is left to that of the managed care plan. If the Commissioner is intending a more specific definition of these terms, we would suggest additional language to that effect in this provision or some additional direction on the Commissioner's specific interpretation of these terms.

4. **5218.1000 subpart 1 D.3. Initial Evaluation and Referral**

The initial evaluation with choice of three health care providers will be cumbersome and may cause confusion for the injured employee. We propose that this mandatory referral process be eliminated. Our proposal recognizes that the evaluating physician would discuss treatment options and the need for referral directly with the patient and referrals would occur naturally. We request that the Commissioner consider eliminating the requirement that at least three health care providers be made available as referrals by the evaluating provider.

5. **5218.2000 subpart 4 Restrictions**

Minn. Stat. 176.1351 states that any person or entity other than a workers' compensation insurer or employer for its own employees, may apply to be a managed care plan. However, this provision states "When an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, formed, or administered by the employer or insurer". Could the Commissioner please clarify this apparent inconsistency.

Additionally, this provision states, in part, "No employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota Statutes, Chapter 176." One issue that can arise under this provision is whether a managed care plan is triggered when an employer has medical staff on-site, which is available to the employees for treatment prior to treatment under the employers' managed care plan. It appears that an existing on-site medical staff would not trigger the employer as a managed care plan. It appears that this type of treatment would be outside the managed care plan entirely. If it is the Commissioners intent to have a differing interpretation of this provision, clarification should be made with respect to this provision.

Another issue raised in this provision is a situation in which the managed care plan is a wholly-owned subsidiary of the employer. In this situation, we are assuming that the wholly-owned subsidiary of the employer is a separate legal operating entity from the employer, and not merely a shell corporation. It is, therefore, our interpretation that a wholly-owned subsidiary would not be precluded from operating, forming or administering the managed care plan of the employer. We request that the Commissioner confirm this interpretation in these Emergency Rules.

6. **5218.3000 subpart 3 Insures: data**

This provision states "The managed care plan must report to the insurer any data regarding medical services and supplies required by the insurer to determine compensability, and any other data required by rule." Currently, Minnesota Statutes 176.138 allows release of information to the employee, employer, or insurers. However, under these emergency rules, a managed care plan is being asked to release certain information on a specific injured employee to the insurer without having the same rights under Minnesota Statutes 176.138. This is a serious release of information problem for the managed care plans. To preserve

without having the same rights under Minnesota Statutes 176.138. This is a serious release of information problem for the managed care plans. To preserve the intent of this provision, the Commissioner could state that the managed care plan must report any data authorized by the employee.

7. 5218.5000 subpart 1 and subpart 2 Health care providers who are not participating health care providers

These provisions, while desirable, may not be practical due to the lack of enforcement power or control by the managed care plan. Specifically, the managed care plan does not have any enforcement powers with respect to the requirements set forth in subpart 2 either in statute or rule. Additionally, in the instance of emergency treatment, it is likely that the treatment would take place prior to the employee becoming involved in the managed care plan and the managed care plan would not have control over the type of treatments prescribed. The managed care plan does not have any control over the outside health care providers to require compliance with certain requirements. Specifically, the managed care plan would not have any contractual relationship, in many instances, with the health care providers who are not a participating health care provider.

8. 5218.8000 subpart 2 Records

We are concerned that the phrase "all records" in this provision is too broad in nature and may jeopardize patient and provider confidentiality. We believe the Commissioner should consider greater definition of the term "all records" and specifically set forth the records to be disclosed. Additionally, the Commissioner should consider qualifying language that limits the disclosure to those records of a non-confidential nature.

Thank you for this opportunity to share with you some of our comments with respect to these emergency rules. **We would appreciate it if you could advise us of the date of submission to the attorney general and send us a copy of the adopted emergency rules. This information may be sent to me at the address above.**

Very truly yours,

Steven N. Burrows
Executive Vice President
HealthEast Care, Inc.

Harry A. Sieben, Jr.
Clint Grose (1923-1987)
John E. Von Holtum
Timothy J. McCoy
John W. Carey
Douglas E. Schmidt
Mark R. Kosieradzki
Raymond R. Peterson
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James P. Carey
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Miles W. Lord

August 21, 1992

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
Saint Paul, Minnesota 55155-4136

In The Matter of the Proposed Adoption of Emergency Rules of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans.

Dear Ms. Zembal:

The following is intended to represent this firm's comments regarding the above-referenced proposed emergency rules.

First, proposed Rule 5218.1000, Subpart 1D.(3)(c), provides in part that a managed care plan must include a procedure to allow the employee to change health care providers within a managed care plan at least once. Minn. Stat. §176.1351, Subd. 3(11), states that a managed care plan must provide an employee the right to change health care providers under the plan at least once. The proposed rule should reflect the statutory language, rather than attempt to either limit or expand the statutory definition in the absence of any express statutory authority.

Second, Rule 5218.2000, Subpart 3D, correctly applies statutory and case law by providing, in part, that employees with compensable injuries prior to the effective date of the managed care plan contract are not subject to the managed care provisions of Minn. Stat. §176.1351 and proposed Rules 5218.0100 to 5218.9000. However, this proposed rule carves out an exception for those employees who have compensable injuries which pre-date the managed care plan contract if they request a change of doctors. This part of the rule lacks any statutory authority and contravenes clear case law precedent with respect to attempts to retroactively limit rights to workers' compensation benefits which vest and are defined by the law in effect on the date of injury. Further, targeting employees with vested rights under prior statutes who seek to change treating physicians raises a serious constitutional question. Rule 5218.2000, Subpart 3D, should be deleted after the word "contract" on line 25.

Finally, this letter is also intended as our formal request for notification of the date of submission of these proposed rules to the Attorney General.

Respectfully submitted,

Mark G. Olive

FOR THE FIRM

MGO/sjb

HealthCare COMPARE AFFORDABLE℠
2485 Natomas Park Drive Sacramento, CA 95833-2937

July 31, 1992

Pam Zembal
Rehabilitation and Medical Affairs
Department of labor and Industry
43 Lafayette Road, North
St. Paul, Minnesota 55155-4316

RE: Emergency Rule Governing Workers' Compensation Managed Care Programs

Dear Ms. Zembal,

As directed on the "Notice of Intent to Adopt an Emergency Rule", we are requesting to be advised of the submission of this rule to the Attorney General. We also request a copy of the rules as adopted. Address to:

Joanne Wardell
HealthCare COMPARE Corp.
2485 Natomas Park Drive
Sacramento, CA. 95833

Thank you.

Sincerely,

Joanne Wardell

Joanne Wardell

Phone: (916) 925-7700, Ext 2659

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August 18, 1992

Pam Zembal
Rehabilitation and Medical Affairs
MN Dept. of Labor & Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

Minnesota law indicates that rules proposed by a state agency must be reviewed by the state Attorney General's office.

So that we may keep current on the status of the proposed emergency rules for workers' compensation that appeared in the July 27 edition of the State Register, please notify us when you submit those rules to the Attorney General's office for their ten day review.

Thank you for your cooperation.

Sincerely,

Scott L. Mayer
Executive Director

PreferredOne

August 6, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

I wish to receive notification of the date that the emergency rules for managed care plans that have been submitted to the attorney general. In addition, I would like to receive a copy of the adopted rules. You can send them to:

Barbara Daiker
Preferred WorkCare
One Main Street Southeast, Suite 400
Minneapolis, MN 55414-1027

Sincerely Yours,

Barbara L. Daiker, RN,MS
Manager, Preferred WorkCare

BLD/kmo

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One Main Street S.E.
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(612) 623-8282
FAX (612) 623-0984

MCN Medical Consultants Northwest, Inc.

Southdale Office Centre
6600 France Avenue S.
Suite 490
Edina, MN 55435

612 922-2876
1 800 331-6269
FAX 612 922-3413

July 30, 1992

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REHABILITATION & MEDICAL AFFAIRS

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

Please be notified that I would like to request notification of the date of the submission to the Attorney General of the Proposed Emergency Rules Governing Workers' Compensation Managed Care Plans.

Please also send to me a copy of the adopted rules once those are available.

Send notification and mailings to:

Lisa A. Moonen
Medical Consultants Northwest, Inc.
6600 France Ave. So.
Suite 490
Edina, MN 55435

Thank you for your assistance in this matter.

Sincerely,

Lisa A. Moonen
Area Coordinator/Marketing Representative

lam

MORK CLINIC, P.A.
OCCUPATIONAL HEALTH SERVICES

MORK CLINIC - ANOKA
1833 SECOND AVE. SO., ANOKA, MN 55303
(612) 421-3680

MORK CLINIC - ELK RIVER
530 THIRD ST. N.W., ELK RIVER, MN 55330
(612) 441-3660

August 3, 1992

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Rd. N.
St. Paul, MN 55155-4316

Dear Ms. Zembal:

This letter is a formal request that Mork Clinic, P.A. be advised of the submission of proposed emergency rules governing workers' compensation managed care plans to the Attorney General. Mork Clinic, P.A., also wishes to receive a copy of the adopted rules.

Please direct this material to:

Karen Stricker
Occupational Health Services Coordinator
Mork Clinic, P.A.
1833 Second Ave. S.
Anoka, MN 55303

Karen Stricker

Karen Stricker
Occupational Health Services Coordinator

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State of Minnesota
Department of Human Services
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155

August 19, 1992

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Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Mn 55155-4316

Dear Ms Zembal:

Enclosed are comments on the Proposed Emergency Rules Relating to Workers' Compensation Managed Care

Please notify me of the date of submission of the emergency rules as adopted and supporting documents to the Attorney General and send me a copy of the adopted rules.

If you have any questions, please contact me at 297-7078.

Very truly yours,

Shirley A. Sundquist

Shirley A. Sundquist
Workers' Compensation Manager

cc: Eleanor Hoover
Maria Gomez - DOER
Scott Strand - Attorney General Office

comrul

State of Minnesota
Department of Human Services
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155

RECEIVED
AUG 21 1992
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

August 21, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

Dear Ms. Zembal:

The Department of Human Services has the following comments regarding your notice of intent to adopt an emergency rule governing managed care in the workers' compensation system.

I understand that Maria Gomez of the Employee Benefits Division of the Department of Employee Relations has submitted suggested amendments to the proposed rule. My comments are to confirm Ms. Gomez's suggestions.

In general, the rule requires more definition in the following areas:

- -Definition of managed care plan
- -Definition of emergency care
- -Quality of care standards
- -Authority of a managed care plan to limit and direct care

In addition, it is difficult to envision cost savings as a result of this effort, given the absence of financial incentives for the managed care plan.

Thank you for the opportunity for comment. My staff and I would be happy to participate in discussions on these and other issues. If you have any questions, please contact me at 297-4671.

Sincerely,

Mary Konrads for

Patricia MacTaggart, Assistant Director
Health Care Management Division

cc: Maria Gomez

UNIVERSITY OF MINNESOTA

Twin Cities Campus

Division of Health Services Research and Policy
School of Public Health

Box 729
420 Delaware Street S.E.
Minneapolis, MN 55455-0392
612-624-6151
Fax: 612-624-2196

August 18, 1992

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

Dear Ms. Zembal:

I am writing to comment on the Department of Labor and Industry's "proposed Emergency Rules Relating to Workers' Compensation; Managed Care: Notice of Intent to Adopt an Emergency Rule", published in the State Register on July 27, 1992. My understanding is that section 5218.6000, requiring that:

> "The payment by the insurer or the managed care plan to participating and non-participating health care providers for medical services shall be according to the timeframes and procedures in part 5221.0600, subpart 3, and Minnesota Statues, section 176.135, subdivision 6, and shall be the maximum amount allowed under Minnesota Statues, section 176.136."

makes it extremely difficult, if not impossible, for managed care plans with salaried and capitated providers to participate in the workers' compensation program.

I appreciate your effort to explain that section of the rules during our phone conversation, but I'm afraid I find the Department's position untenable. One simply cannot argue that failure to reimburse providers at the workers compensation fee schedule will reduce the quality of care, particularly since many health plans in the state already are providing care to hundreds of thousands of Minnesotans at fees lower than dictated by the schedule.

I'm afraid that Section 5218.600 comes across as a fairly transparent effort to line the already bulging pockets of fee-for-service providers in the state. It does not reflect well on your Department as defender of the public interest, and should be stricken in its entirety from your emergency rules.

Thank you for the opportunity to comment on the emergency rules.

Sincerely,

Bryan E. Dowd, Ph.D.
Associate Professor

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UNIVERSITY OF MINNESOTA

Twin Cities Campus *University Personnel Department* *1919 University Avenue*
St. Paul, MN 55104-3481
Fax: 612-626-1320

MEMORANDUM

TO: Pam Zembal, Rehabilitation and Medical Affairs

FROM: Ellyn Woo, Workers' Compensation Assistant E. W.
Special Employment Programs

DATE: August 3, 1992

RE: Rule Change for Managed Care

Thanks for sending me a copy of the proposed changes in the Workers' Compensation rules. I have the following questions regarding this rule:

1. How would this work if the employee chose to use his/her own doctor?

2. If the employee seeks medical services from the PPO list, does this constitute the employer's doctor? Can the employer still request an IME from a different doctor?

If you have any questions regarding the above, please call me at 624-1892.

EW:db
M.83

cc: Sue Forsyth

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AUG 10 1992
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

SF-00006-05 (4/86)

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT : EMPLOYEE RELATIONS - 2ND FLOOR
CENTENNIAL BUILDING, 658 CEDAR STREET

DATE : August 21, 1992

TO : Pam Zembal
Rehabilitation Medical Affairs
Department of Labor and Industry

FROM : Maria Gomez, Manager
Employee Insurance Division

RECEIVED
AUG 27 1992
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

PHONE : 296-6287

SUBJECT : Comments on the Department of Labor and Industry's Proposed Emergency Rules for Managed Care Plan

Pursuant to the State Register, enclosed please find the Division's comments to the Department of Labor and Industry's Proposed Emergency Rules Governing Workers' Compensation Managed Care Plans. Please be advised that I do request notification of the date the Department of Labor and Industry submits to the Attorney General the adopted emergency rules.

If you wish to discuss these comments further, please contact me.

MG:dc/4335

Enclosures

COMMENTS ON DEPARTMENT OF LABOR AND INDUSTRY'S PROPOSED EMERGENCY RULES FOR MANAGED CARE PLANS

Pursuant to Minnesota Statute 176.1351, subd. 6 (in 1992), the Commissioner of the Department of Labor and Industry is to adopt emergency rules to implement the Managed Care Plan section of the new law. In an uncoded section of that new law, the legislature sets out its legislative intent concerning managed care by stating the Commissioner of Labor and Industry should proceed with certifying managed care organizations as expeditiously as possible, but also "any rules or procedures the commissioner adopts must be designed to assist in the formation of managed care organizations while ensuring quality managed care to injured employees." In addition, the emergency rules own purpose and scope statement indicates the purpose of these rules is to establish "procedures and requirements" relating to the delivery of medical service to injured employees (see 5218.0220). The emergency rules should be designed to meet these objectives. However, these rules do meet the objectives. In many instances the rules do not assist, but impede the formation of managed care organizations because they fail to provide criteria for the standards it sets for an organization to be certified as a Managed Care Plan. In general, the rules make inadequate allowances for how HMO-type plans work; are too bureaucratic; and they set standards or requirements but provide no criteria for them.

The following are specific comments regarding the emergency rules:

5218.0100, subp. 6

The rule definition of health care provider is the broad definition in Minnesota Statutes 176.011, subd. 24 which states, "health care provider means a physician, podiatrist, chiropractor, dentist, optometrist, osteopath, psychologist, psychiatric social worker, or any other person who furnishes a medical or health service to an employee under this chapter but does not include a qualified rehabilitation consultant or approved vendor." (Emphasis added)

This non-specific, open-ended definition will be especially problematic when applying rule 5218.1000, subp. 1D (2),(b) which states a Managed Care Plan may not discriminate against or exclude from participation in the plan any category of health care providers and must include an adequate number of each category of health care providers. Without specific language identifying the types of health care services that will be considered health care providers, an organization seeking to be certified as a Managed Care Plan does not know how to satisfy the requirements of that provision. The rule defining health care providers needs to be much more specific and probably should specifically list the health care services or specialties which will be considered health care providers.

5218.0100, subp. 8

This definition of a Managed Care Plan provides no explanation as to what managed care is or what a Managed Care Plan is and merely recites the provision of the law a plan must satisfy in order to be certified. The definition should be more descriptive and be a functional or working definition of what a Managed Care Plan is.

5218.0100, subp. 9

This very poor definition of a participating health care provider could be rectified by properly defining health care provider in subp. 6 of this rule (see comments above) and then making the following proposed changes to the definition: "Participating health care provider means any health care provider with which the Managed Care Plan has contracts or other agreements to provide health care". The current definition is so broad that a CPA that has a contract or agreement to provide accounting services to a Managed Care Plan would qualify as a participating health care provider. The same would be true of any other person, business or organization that contracts with or has any type of agreement with a Managed Care Plan. Again, this definition should be based on a sound definition of what a health care provider is.

5218.1000, subp. 1B

What's the purpose of this provision and where is the specific statutory authority for this provision or the basis for the formula utilized in this provision?

5218.1000, subp. 1D(2)(a) and (b)

This provision requires that Managed Care Plans provide quality services that meet uniformed treatment standards prescribed by the commissioner, but no treatment standards are defined or set out in the rule. This provision also goes on to require that the care be provided in a manner that is "timely, effective, and convenient for the employee". This provision sets standards for certification and performance, yet it provides no criteria as to what constitutes "timely" "effective" or "convenient for the employee."

Subsection (b) of this provision requires that health care providers provide "an adequate number" of each category of health care providers, give employees "convenient geographic accessibility" to all categories of providers and provide "adequate flexibility" to choose health care providers under their plan. Again, this rule sets standards for certification and performance without providing criteria as to what will satisfy the standards. These rules need to have specific criteria as to what constitutes "an adequate number" of each category of health care providers; what constitutes "convenient geographic accessibility?"; and what constitutes "adequate flexibility?" Without specific criteria, each of these standards is subject to varying interpretations and dispute. Furthermore, as ambiguous as these standards are, it does not assist, but impedes the process for an organization seeking to be certified as a Managed Care Plan.

If the commissioner has intended that other sections of the emergency rules define these various standards, for example, if rule 5218.1000, subp. 1D(3)(f) is intended to define what constitutes "convenient for the employee" pursuant to 5218.1000, subp. 1D(2)(a) and what constitutes "convenient geographic accessibility" pursuant to 5218.100, subp. 1D(2)(b), than each of these rules should incorporate by reference rule 5218.1000, subp. 1,D(3)(f).

Finally, the requirement that the Managed Care Plan provide the employee adequate flexibility to choose health care providers from among those who provide services under the plan appears to restrict the certifiable plans to those organizations having a "freedom of choice" model. This would eliminate organizations that have a primary clinic/gatekeeper model which would include Group Health, Blue Plus, Medica Primary, First Plan HMO, among others.

5218.1000, subp. 1,D,(3),(a)(b) and (c)

These provisions which give the Managed Care Plans the option of permitting initial evaluations of injured workers by a participating chiropractor and requiring direct access to all health care profession disciplines, including chiropractors, will be new for HMO plans and as a result, may eliminate any of these plans from certification. The Managed Care Plans should have control over determining who provides the initial evaluation of the injured worker based on the medical condition of the worker upon admission. Why is chiropractor care singled out as done here as opposed to other medical specialties? Chiropractic care should be considered a referred specialty or consultative specialty such as a neurologist or neurosurgeon, etc.

5228.100, subp. 1D(3)(f)

This provision requires Managed Care Plans to provide access to health care providers within 30 miles of the employee's place of employment or residence, or the distance the employee normally travels to work whichever if furthest. But which health care providers? Must all the health care providers in a Managed Care Plan be within this distance for the employee to be subject to the Managed Care Plan? Just primary care? Furthermore, it is not practical that an employer insurer or managed care plan would know this about each employee. What if the employee moves? As is, this rule raises many issues and needs to be looked at more carefully.

5228.100, subp. 1D(7)

This provision requires the Managed Care Plans have a procedure for peer review, utilization review and internal dispute resolution. The rule fails to provide the criteria of what an acceptable procedure will be for certification. The Managed Care Plans should have fairly uniform procedures for peer review, utilization review and internal dispute resolution. Particularly with the internal dispute resolution procedure, since an employees' rights concerning permanent partial disability - a monetary benefit - is going to be resolved. The procedures in resolving this type of issue should not be significantly different amongst plans or be in any way dependent upon which Managed Care Plan the employer has selected. The employee, the medical providers and the insurers must feel they have been treated fairly and consist with the internal dispute resolution procedures of other Managed Care Plans if the underlying goal of reduced litigation is to be realized. Uniform internal dispute resolution procedures will give credibility to the internal dispute resolution process.

5218.1000, subp. 1D(10)

This rule requires the Managed Care Plans describe how they will provide "aggressive case management" for injured employees and "a program for early return to work" and "cooperative efforts ... to promote workplace health and safety consultative and other services". Again, the rules do not provide any criteria for what will be acceptable for certification of the Managed Care Plan. Establishing criteria would help to ensure that these objectives are sought after the initial certification.

5218.1000, subp. 1D(11)

This requires the Managed Care Plans submit treatment standards not prescribed by the commissioner in its uniform treatment standards. The obvious question is standards such as what? Shouldn't the relevant treatment standards be addressed in the commissioner's uniform standard? The rule does not provide for any criteria. If providers are going to be subject to treatment standards, the rules should provide the criteria for acceptable treatment standards. Again, criteria need to be identified and included in the rule.

5218.1000, subp. 2

This rule deals with modifications of a certified plan. It requires the approval of modifications prior to their implementation, yet it does not specify what criteria will be used in arriving at a decision and it does not set out the procedure for approval of these modifications including who shall approve the modifications. Presumably, the Commissioner of the Department of Labor and Industry shall be approving such modifications, but nowhere in the rule is it stated. Language should be included in this rule setting forth the criteria for approving or denying proposed modifications and the procedure to be followed. Finally, the requirement that the modification be approved before implementation is very rigid and bureaucratic. Depending on the procedure for approving the proposed modifications, this could be problematic.

5218.2000, subp. 2

This rule results in a duplication of work by state agencies since the Minnesota Department of Health already certifies the geographical service area of health care provider organizations. The commissioner should consult the Department of Health and most likely a sharing of information would eliminate the need for this rule. Regardless, this rule fails to provide the procedures to obtain an expansion of geographical service area. In addition, the provision states that injured employees shall not be covered by a Managed Care Plan until the commissioner has approved the proposed expansion of the geographical service area. This makes no sense. Presumably, the intent of this rule is that only injured employees who are <u>within</u> the proposed expanded geographic service area would not be covered until the proposed expansion is approved. Clarifying language for this provision might be as follows: injured employees within the proposed expanded geographical service area shall not be covered by a Managed Care Plan until the commissioner has approved the proposed expansion.

5218.2000, subp. 3B

This provision gives the employee the choice of the Managed Care Plan that will manage his or her care where an insurer contracts with multiple Managed Care Plans. There is no specific language in the statute which gives the employee the right to choose the Managed Care Plan. Pursuant to this statutory provision, the employer retains the right to designate the Managed Care Plan to be utilized irregardless of the number of contracts it may have with Managed Care Plans. Therefore, this rule is in direct conflict with the statute and should be eliminated.

5218.2000, subp. 3D

This provision states that an employee who sustained a compensable workers' compensation injury prior to the effective date of the Managed Care Plan contract is not subject to the Managed Care Plan emergency rules until that employee requests a change of doctor. This rule is contrary to the statute. Nowhere in the statute is there specific language requiring a change of doctors before these types of employees would be subject to the Managed Care Plan. The authority for the employer's right to require that injured workers receive care under a Managed Care Plan is found in section 176.135, subd. 1(f), as discussed above. That provision is effective on October 1, 1992. Therefore, for employees injured on or after October 1, 1992, the employer may require the employee utilize a Managed Care Plan, regardless of whether a managed care plan contract existed at the time of injury and without regard to the employee requesting a change of doctors.

5218.1000, subp. 5

Much of the filing requirements of this provision duplicate the work the Department of Health has already undertaken in licensing health maintenance organizations, etc. The commissioner should review the filing requirements of the Department of Health and determine if those filings will satisfy its needs. As a result, much of the filing requirements of this rule could be omitted. Finally, note that there may be some confidential or trade secret concerns regarding the required submission of "contract agreements or other documents signed by each participating health care provider."

5218.1000, subp. 7

This provision requiring internal dispute resolution procedures is not necessary for the health maintenance organization model since they are already required to have such a procedure.

5218.1000, subp. 8

This rule will be a bureaucratic problem since health care organizations and networks are changing all the time. What is an acceptable procedure to handle all of these changes?

SF-00006-05 (4/86)

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT : EMPLOYEE RELATIONS - 2ND FLOOR
CENTENNIAL BUILDING, 658 CEDAR STREET

DATE : August 21, 1992

TO : Pam Zembal
Rehabilitation Medical Affairs
Department of Labor and Industry

FROM : Maria Gomez, Manager
Employee Insurance Division

PHONE : 296-6287

SUBJECT : Comments on the Department of Labor and Industry's Proposed Emergency Rules for Managed Care Plan

Pursuant to the State Register, enclosed please find the Division's comments to the Department of Labor and Industry's Proposed Emergency Rules Governing Workers' Compensation Managed Care Plans. Please be advised that I do request notification of the date the Department of Labor and Industry submits to the Attorney General the adopted emergency rules.

If you wish to discuss these comments further, please contact me.

MG:dc/4335

Enclosures

bcc: Scott Strand, Assistant Attorney General

SF-00006-05 (4/86)

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT : EMPLOYEE RELATIONS - 2ND FLOOR
CENTENNIAL BUILDING, 658 CEDAR STREET

DATE : August 21, 1992

TO : Pam Zembal
Rehabilitation Medical Affairs
Department of Labor and Industry

FROM : Maria Gomez, Manager
Employee Insurance Division

RECEIVED
AUG 24
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

PHONE : 296-6287

SUBJECT : Comments on the Department of Labor and Industry's Proposed Emergency Rules for Managed Care Plan

Pursuant to the State Register, enclosed please find the Division's comments to the Department of Labor and Industry's Proposed Emergency Rules Governing Workers' Compensation Managed Care Plans. Please be advised that I do request notification of the date the Department of Labor and Industry submits to the Attorney General the adopted emergency rules.

If you wish to discuss these comments further, please contact me.

MG:dc/4335

Enclosures

State of Minnesota
Department of Human Services
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155

August 19, 1992

RECEIVED
AUG 21 1992
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Mn 55155-4316

Dear Ms Zembal:

Enclosed are comments on the Proposed Emergency Rules Relating to Workers' Compensation Managed Care

Please notify me of the date of submission of the emergency rules as adopted and supporting documents to the Attorney General and send me a copy of the adopted rules.

If you have any questions, please contact me at 297-7078.

Very truly yours,

Shirley A. Sundquist
Workers' Compensation Manager

cc: Eleanor Hoover
Maria Gomez - DOER
Scott Strand - Attorney General Office

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COMMENTS EMERGENCY RULES
RELATING TO
WORKERS' COMPENSATION MANAGED CARE

5218.0100 [Emergency] DEFINITIONS. Subp. 3. Emergency Care.

The definition of emergency care fails to differentiate between immediate professional health services needed to preserve life and limb or any professional health services necessary to preserve life or limb even if the need is not immediate.

Suggested Change: Paraphrase a statute that describes emergency care. For instance, M.S.144.344 regarding the requirement of parent or legal guardian consent for emergency treatment of a minor defines emergency as "... in the professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay...."

5218.030 [Emergency] APPLICATION FOR CERTIFICATION .

Subp. 1. Provisional certification. B.

There is no basis in law for this provision.

Suggested Change: Delete this provision.

Subp. 1. Provisional certification. D. (3) (a).

Requires an initial evaluation by a participating physician within twenty four hours of the injury even if the injury is such that the evaluation need not be within twenty four hours or an individual working under the protocol of a physician such as a nurse practitioner or physicians assistant may be qualified to perform the evaluation. In many rural areas and on weekends physicians are not available.

Suggested Change: Delete "participating physician" in line 11 and add "if necessitated by the injury" after "hours" on line 11.

Subp. 1. Provisional certification D. (3) (a) & (b).

Allows the injured worker to decide whether the initial evaluation may be made by a physician or chiropractor whether or not the type of injury falls within the scope of chiropractic care.

Suggested Change: add "providing the type of injury falls within the scope of chiropractic care" at the end of each paragraph.

Subp. 1. Provisional Certification. D. (3) F.

Seems to mandate that all heath care providers/services be available within the required distance including specialists, hospitals and diagnostic equipment. If this is true the distance must be expanded. There are many areas in the State where specialists or equipment are not available within the required distance.

Suggested Change: Expand the distance to meet the 150 mile requirement for IME's or limit the distance requirement to state that the initial evaluation must be within the distance specified and that referrals may be made beyond that distance.

5218.4000 [Emergency] COMMENCEMENT AND TERMINATION OF PARTICIPATING PROVIDERS. Subp. 3. Contracts. B.

Fails to allow for managed care plans which cover different geographical areas. For example, an employer has a statewide operation and has two managed care plans: one covers the northeastern portion of the state; and the second covers the southwestern portion. The two plans do not overlap. With the proposed language, an employee form the northeastern portion of the state may select the plan covering the southwestern portion. This will result in excessive costs such as mileage and time off the job for appointments.

Suggested Change: add "unless each managed care plan covers a different geographical area of the state" to the end of the paragraph.

5218.6000 [Emergency] CHARGES AND FEES.

Requires that all fees be at the maximum amount allowed by the fee schedule. This precludes the employer and managed care plan from negotiating the type and amount of fees to be charged. These fees may be less than the maximum amounts in the fee schedule or on flat rate basis such as an HMO rather than a per service basis.

Suggested Change: If the managed care plan must charge on a per service basis, add "no more than" to the beginning of line 9.

H O N E Y W E L L Interoffice Correspondence

Date: July 16, 1992

Subject: MANAGED CARE: RULE RECOMMENDATIONS

To: Commissioner Lennes	Labor & Industry	From: E. Velasco-Thompson
cc: D. Goldstein	MN12-3172	Org: H&B:D.Benefits
FILE		HED: MN10
D. Houglum	MN10-1456	MS: 1456
Brad McDonald	MN12-1245	HVN: 542-3768
		Doc: MCARE

After pooling my information and resources, there are a few recommendations I would like to present to you for your consideration in the emergency/permanent rule making procedure on managed care.

1. Acknowledging the medical quality vs. the indemnity costs balance, MCOs could save money and get compliance with about 88% of the providers. The real question centers on what to do administratively with the remaining 12%. Easily one could spend all their savings on prolonged legal pursuits. In the design of your system, a definitive end is necessary for both parties. You could design that determination to be made by:

A. a combination of MSRB and WCATF members,
B. your small claims court,
C. commissioner determination,
D. settlement judge ruling, or
E. binding mediation.

2. If you accept the premise that co-pays and deductible have made a difference in other insurance areas and private medical coverage; one can understand that the concept of "paying directly" does having a major influence on an employer's development of cases, their management, & early intervention to foster early return to work outcomes. Insured employers are too removed on the day to day cost mgmt. & involvement with their WC cases.

Insured as well as self-insured employers need to be more involved with their disabled employees to effect their bottom line, workforce productivity, and keeping jobs in the state.

Direct payment of health provider bills or an employer's periodic review of bill pymts. as well as the MCO contract between the employer and the MCO has to be the absolute requisite.

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To Commissioner Lennes	From Ellen Velasco-Thompson
Co. Labor & Industry	Co. Honeywell
Dept.	Phone # 542-3768
Fax # 297-1329	Fax # 542-6887

PAGE 2 - Managed Care: Rule Recommendations

3. Regarding cost effectiveness, fee for service does encourage more services to be completed, to get more fees; with the ultimate protection of changing codes when challenged by the MCO.

I recommend capitation as more effective. Carriers and TPA's have used this method traditionally in other forms of insurance, and it has cut expenses without losing quality. In consideration of incentives under capitation, one could tie a percentage of the "excess saved" to be shared by the providers. To "tie profits to objectives" is a basic premise for old as well as new organizations functioning within WC.

Presently, we are continuing to pay for chosen medical quality with a growing percentage of disabled employees who are not getting better or worse yet, unable to ever return to gainful employment. We can individually deal with that percentage sooner with capitation, and determine whether further medical treatment or other issues may be effecting the road to recovery and work.

4. For the insured or self-insured employers, an employer-MCO contract will allow for better opportunities to negotiate cost & piggy-back of an MCO with their private health insurance, utilizing the same providers. For example, for all health care to be rendered by Group Health would require:

A. that all providers would have to be educated on WC needs,
B. would not allow an abdication of "good doctors" to practice only outside of WC
C. would tie in all of the family history and needs, so that these unrelated (but holistically related) issues could be addressed under their personal health insurance
D. a long term relationship would be necessary between the employer and the MCO in developing a full understanding of their business operations, job modifications, contact people, effective reporting systems to upper mgmt., & normal treatment protocols.

With an employer-MCO contract, employers who really want no WC involvement, can abdicate responsibilities to the insurer. This could be an option, but it cannot be the rule. Ultimate ownership of the problem is on the employer. Carriers can opt out of the risk by not choosing to provide future coverage, since there is no provisions for them to stay. This leaves an employer with a potential double whammy of being stuck with the residual market to obtain WC insurance and what to do with the previous MCO arrangements.

5. To keep MCO selection out of union negotiations, I feel that is should be made clear by the rules, that WC is an entitlement, not a benefit.

6. In dealing with indemnity\return to work issues, an MCO must be reporting their measurements of diagnosis, define complications medical or otherwise, return to work in part-time as well as full-time hours and additionally internal arbitration resolutions and the quantity\quality of their mandatory provider WC education requirements to Labor & Industry, on a quarterly basis.

7. When an MCO refers care outside of the MCO, both parties must act as one. Outside referrals of an MCO must conform to the network standards and expectations. Billing must be issued to the MCO for payment.

Commissioner with your shortage of time, I hope these recommendations are clear enough for you to meet your objectives. As usual, you are welcomed to call me at 542-3768 for further clarification.

Good luck with your efforts,

Elba Velasco-Thompson

INTRACORP

10260 Viking Drive
Suite 120
Eden Prairie, MN 55344
612 941 9061

August 17, 1992

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
State of Minnesota
443 Lafayette Road
St. Paul, MN 55155

Dear Ms. Zembal:

Please consider the following comments regarding the proposed adoption of emergency rules of the State Department of Labor and Industry governing Workers' Compensation Managed Care Plans.

- **5218.100 (Emergency APPLICATION FOR CERTIFICATION)**
  Regarding part III, the Managed Care Plan must include a procedure to insure that the employee will . . . Subpart c - initially choose from at least three health care providers to whom the employee has been referred by the evaluating provider under A or B for treatment and allow the employee to change providers under the managed care plan at least once.

- The concern is that in rural Minnesota, the number of eligible providers by specialty may not equate to the total number of the three required. The geographical requirement of 30 miles within the employer or in the same distance the employee travel to work each day would have to be lifted in such instances.

- **Subpart 3, part f - regarding compensability.**
  Accept as provided in part 5218.5000, an employer may require an employee who is claiming a Workers' Compensation injury to receive treatment from a Managed Care plan before the employer accepts or denies liability for the injury. In such cases, the employer is liable for the cost of any treatment before notice is given to the employee of a denial of liability even if the employer is later determined to be not liable for the claimed injury.

- Clarification is requested regarding this rule. It is our previous understanding, that once an insurer accepts liability for a preexisting condition, such as diabetes, they become responsible for all future costs regarding the diabetic claim. What are the liabilities with the new law?

- **Subpart 4 Restrictions.**
  When an insurer contracts with a single managed care plan coverage for an employer, the plan may not be formed, operated, or administered by the same employer of insurer. When an insurer contracts with multiple managed care plans, one or more of the plans but not all may be operated, formed, or administered by the employer or insurer. No employee shall be required to obtain services under the managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota statutes, chapter 176.

- Clarification is requested regarding this particular subpart in reference to the managed care plan created by an employer. In the instance that an employer does create its own managed care plan, does an alternate plan always need to be offered.

- **5218.6000 Emergency Charges and Fees.**
  The payment by the insurer or the managed care plan to participating and non-participating health care providers for medical services shall be according to the timeframes and procedures in part 5221.0600, subpart III and Minnesota statutes section 176.135, subdivision 6 and shall be the maximum amount allowed under Minnesota statutes 176.136, which is the Minnesota state fee schedule.

- Traditionally, preferred provider organizations and managed care organizations have allowed for reimbursement at a discounted rate. It is apparent that the proposed rules in the workers compensation system in Minnesota are driving for reduced costs. Thus, a managed care organization should have the ability to negotiate a discounted fee with a health care provider and yet maintain quality, appropriate and cost effective medical care to the injured worker. Reducing costs throughout the system appears to be win-win situation for all parties involved.

Thank you for your consideration of these issues. Please do not hesitate to call with any questions you may have regarding these comments.

Very sincerely,

Patty Stuart

Patty Stuart, R.N.
Minnesota Rehabilitation Manager

PS/cs

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August 17, 1992

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor & Industry
443 Lafayette Road North
St. Paul, MN 55155

RE: Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

From review of the proposed plan, I have noted the following:

1. In rural areas, I feel that a number of clinics/hospitals will have a hard time qualifying as Managed Care Plans. Can you, or will you, give clinics/ hospitals any special privileges in rural areas?

2. Can an insurer dictate to an employer that they must use their Managed Care Plan as part of their overall Workers Compensation Program?

3. If an employer or insurer sets up their own Managed Care Plan, as I read the Act, the injured employee would not be required to obtain services from the Managed Care Plan. In other words, the injured employer could receive medical care wherever he or she desired. Is that a correct statement?

4. If the employer or insured selected a Managed Care Plan, then the injured employee would be required to obtain medical care through the Managed Care Plan, provided the Managed Care Plan was not provided by either the employer or insurer.

   If the employee elects not to receive care through the Managed Care Plan, then the employer and insurer would not be required to pay for those services.

   Are these two statements correct?

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5. I would assume that once the Managed Care Plan has been selected, that this Managed Care Plan would have to be posted at the employee's place of employee. If this is correct, where should this be posted?

Thank you for your anticipated cooperation.

Sincerely yours,

Michael Johns
Branch Manager

MJ/pdl

cc: Ingrid Anderson, Alexander & Alexander

STATE FUND MUTUAL INSURANCE COMPANY

August 14, 1992

PATRICIA R. JOHNSON
VICE PRESIDENT AND GENERAL COUNSEL
Direct No. (612) 944-1854

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

Re: Proposed Emergency Rules Relating to Workers' Compensation: Managed Care

Dear Ms. Zembal:

We have had a chance to review the July 20, 1992 draft of the proposed emergency rules relating to workers' compensation managed care plans. We appreciate this opportunity to offer some comments.

We would like to say, at the outset, that we are generally very impressed with the approach the Department of Labor and Industry has taken in drafting these rules. We are also impressed with the care with which they were written. This is particularly noteworthy given the number of difficult issues the Department has been required to address by the 1992 Legislation by way of ruling-making. We appreciate the short period of time within which they were developed. It will be a challenge for employers and insurers, including ourselves, to get managed care plans in place by October 1, when the premium rollback insurance becomes effective and when directed care first becomes possible. But we are determined to do so. We hope that there will be effective managed care plans seeking certification under these rules quickly enough to allow us to have meaningful managed care at the earliest possible date.

We do have some specific comments, concerns and suggestions to offer about the rules:

1. CEO Compensation. The provision on page 3, lines 6-13, while perhaps laudable from a social policy standpoint, does not pass legal muster, in our opinion. There is no statutory authority whatsoever for such a limit. In addition, as an insurer, we are concerned that there may not be a strong interest evidenced by a lot of organizations in becoming certified managed care plans for workers' compensation, at least not for awhile. This limit might eliminate some

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obviously interested managed care plans. Insurers and employers cannot afford to have limited--perhaps no immediately available choices. This provision might eliminate those managed care organizations that provide the broadest coverage and are perhaps most successful at what they do.

State Fund Mutual is certainly not a proponent of excessive executive compensation, but practical realities suggest that this provision would more likely be a shot to the foot of employers, than a wounding of highly compensated executives.

2. Initial Evaluation. Page 4, lines 10-15, require an "initial evaluation by a participating physician within 24 hours of a request for treatment, following a work injury . . .." The language probably requires--though we doubt that this was intended--that a managed care plan allow an injured employee to demand care within an emergency treatment facility, even for a minor injury for which emergency care (and the extraordinary costs associated with emergency care) is clearly unnecessary. A physician is unlikely to be able to schedule a visit at a doctor's office within 24 hours of a request for all injuries. In emergency situations, this is clearly appropriate, but most injuries are not emergency situations. Probably it is intended that there be a specific contact with a participating physician either in person or by phone to discuss the injured worker's condition, to allow the treating physician to assess whether emergency treatment is necessary or whether an appointment can be made during regularly scheduled office hours. Therefore, we recommend that the following clause be added on page 4, line 12, after the semicolon, "the initial evaluation may be in person or by telephone, as appropriate to the condition giving rise to the need for treatment; . . .."

3. Geographic Access To Care. Page 5, line 6, the requirement that the plan assures access to a health care provider within 30 miles of the employer's place of employment, etc., should be increased to 50 miles given the remote locations of significant numbers of Greater Minnesota employers.

4. Insurers Contract with Multiple Managed Care Plans. Page 7, line 11-15, it is assumed that the employee's choice of managed care plans is limited to those plans contracted by the insurer for that employer. However, clarification should be made specifying the limitation in choices. Therefore, we recommend the following language be added at line 13 ". . . each employee shall have initial choice at the time of injury

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to select one of the employer's managed care plans that will manage the employee's care."

5. Reporting Requirements. At page 10, lines 5-9, these reporting requirements, while providing worthy information, may very well discourage managed care plans from certification, particularly if there needs to be a case by case reporting of the review performed, issues involved, and action taken. We think they are excessive and do not provide sufficient benefit for the cost they represent.

6. Care Provided by Non-Participating Health Care Providers. It is certainly obviously intended that continuing care provided after the emergency has "ended" can be required to be obtained through the managed care plan. We suggest, however, that it might be advisable to make this perfectly clear. Consequently, we recommend that the following be added on page 11, line 16, after the semicolon "; subsequent nonemergency treatment and services shall be provided by the managed care plan; or . . .".

At page 11, on lines 21 and 24, the words "agree to" are unnecessary and should be deleted.

Lines 27-35 deal with resolution of disputes with non-participating health care providers. The provision states that these disputes will be resolved in accordance with part 5218.7000. That rule requires that disputes arising between an employee and a managed care plan related to delivery of health services must first be addressed through the dispute resolution process of the managed care plan. If not resolved, the issues will be ordered by the Commissioner to be resolved by administrative conference, petition, or in the new small claims court. Is the non-participating provider required to process through the dispute resolution process of the managed care plan first? This appears to be the case as now drafted. This should be clarified beyond the simple rule cross-reference on page 11, line 30. This comment also applies in regard to the cross-reference on page 11, line 34.

This Subp. 3. refers to a procedure for disputes with non-participating health care providers, but the rule should add a specific subpart 4., in our opinion to state the consequences to a non-participating provider who does not comply with managed care plan treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures. These consequences should include

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nonpayment for care outside the plan's standards, disqualification from further treatment, or other consequences as appropriate to the circumstance, in our opinion.

7. Charges and Fees. We are emphatically opposed to the provisions on page 12, lines 4-10, which appear to require that the insurer or managed care plan pay to participating and non-participating health care providers the maximum amount in the fee schedule. The language appears to require payment of the maximum amount even if the health care provider does not ordinarily charge the maximum amount. This is hardly an effective cost control and will, in effect, mandate an increase in fees.

   There is absolutely no statutory authority for this provision. We would probably be forced to challenge the legality of this provision, unless it is deleted.

   Is is axiomatic that the statute never gave authority or intended that the law set fees. It merely intended to limit them. It is also axiomatic that, as with other managed health care, the payer should be free to negotiate rates that are appropriate for the service provided. Insurers, particularly State Fund Mutual, will take the larger view that quality care is essential to reducing workers' compensation costs and that quality care should be fairly compensated. We believe that it is inappropriate, however, from both a legal and policy standpoint, for the Department to fix costs at the highest permissible charges, or to set minimums of any kind, for that matter.

8. Dispute Resolution. There should be a clear path for resolution of disputes: At page 12, on line 17, "may" should be changed to "shall", in our opinion.

9. Complaints. At page 13 on line 1, it should be specified what parties have standing to submit a written complaint. Certainly the employer/insurer and employee should be identified, and perhaps providers as well. If providers are not included to have standing to complain, this should be explicitly stated.

10. Statutory Cross-reference. There appears to be an inaccurate statutory cross-reference on page 13, line 33. The correct section number is, I believe, 256B.064.

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We appreciate this opportunity to offer our comments and suggestions. We will be happy to provide further clarification or information upon request.

Sincerely,

Patricia R. Johnson
LKB

Patricia R. Johnson
Vice President and General Counsel

PRJ/lkb

August 20, 1992

INSURANCE
FEDERATION
OF
MINNESOTA

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-5213

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RE: Proposed Emergency Rule Relating to Workers' Compensation; Managed Care, 17 S.R. 147

Dear Ms. Zembal:

The following comments on specific sections of the above proposed emergency rules are submitted on behalf of the insurers we represent, who collectively write the majority of private workers' compensation sold in Minnesota.

Part 5218.1000 [Emergency], subpart 1, item B, denying provisional certification where an administrator, director, or executive officer of the managed care plan receives annual compensaion that exceeds tem times the statewide average annual wage. We find absolutely no statutory authorization for this provision. The provision is unrelated to the purpose and objectives of the proposed emergency rules. Notwithstanding the absence of any justification for the proposed limitation, it is troubling to think that an agency of the state can impose compensation principles and standards on an entirely private business and make adherence to those principles and standards a prerequisite to authorization to do business in the state. For these reasons, we urge that the provision be deleted.

Part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (a), (b), and (c). These provisions suggest to us that an evaluating physician's role is to evaluate and refer claimants to other providers, and that an evaluating physician does not actually provide treatment. We do not believe this is intended and urge that the provision be clarified so that evaluating physicians are able to treat employees directly, so as to make certain that there are not multiple levels of providers creating uncessary delay and additional cost.

Part 5218.1000 [Emergency], subpart 1, item D, subitem (3), unit (e), requiring 24-hour access to information or advice regarding medical services available within the managed care plan. We believe that this requirement is unreasonable if the result is that personnel must be available on a 24-hour basis to answer questions regarding medical services available from the plan. We feel that the provision should be amended to require that emergency medical information and advice be available on a 24-hour basis (i.e. through use of recorded messages), and that non-emergency information and advice be available during regular business hours.

Part 5218.1000 [Emergency], subpart 1, item D, subitem (10), requiring managed care plans to provide aggressive case managment, an early return to work program and cooperative efforts to promote workplace health and safety

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consultative services will likely build unnessary costs into managed care plans since many of these services are traditional claims management responsiblities currently provided by insurers. For instance, insurers are required to provide safety consultative services to policy holders. (Minn. Stat. section 79.085). This rule should permit insurers to continue to provide these services, working in conjunction with the managed care plans.

Part 5218.2000 [Emergency], subpart 2, requiring the commissioner's approval to expand the initial geographic service area of a managed care plan. We believe this requirment could unduly delay the desired expansion of managed care throughout the state and serves no useful purpose since the proposed rules contain specific access and quality safeguards in Part 5218.1000. We suggest an amendment so that managed care plans be required to report any expansion of their geographical service area to the commissioner within 30 days of the expansion rather than the prior approval requirement.

Part 5218.5000 [Emergency] Subpart 1, authorizing care by certain non participating health care providers. This rule is overly vague by not more clearly defining what specific treatment history qualifies a non participating provider for coverage (i.e. one visit 15 years ago shouldn't qualify for coverage). Additionally, since a managed care plan would have no legal access to records to verify treatment histories, the employee should have the burden under the rule to supply this information to qualify such a provider for coverage.

Part 5218.6000 [Emergency], requiring that participating and nonparticipating providers be reimbursed at the maximum amount allowed under Minn. Stat. section 176.136. While a strong case can be made to allow insurers and providers to negotiate alternative fee arrangements that fit their mutual needs, which arrangements are a key feature of existing preferred provider organizations and networks, the 1992 workers' compensation reform law (Chapter 510 1992 Session Laws) includes two key reform features whose expedient adoption will significantly reduce medical costs, namely the relative value fee schedule and the treatment guidelines.

We believe these suggested revisions strengthen the excellent framework established by the proposed emergency rules for the introduction of managed care to the medical coverage component of Minnesota's workers' compensation system.

Sincerely,

Bob Johnson

Robert D. Johnson
Executive Vice President

ckl

COR1, ZEMBAL8/20

Attachment A

Proposed Addition Establishing a Plan and Objective Criteria for Measuring Actual Cost Savings

Modify 5218.100 [APPLICATION FOR CERTIFICATION], subpart 1 [Provisional certification] to add a new section (D)(12) as follows:

(12) The managed care plan must describe how it will monitor actual cost savings achieved from the case management of injured employees, the early return to work and other programs which the plan will be offering.

Modify 5218.300 [REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN], subpart 2 [Requirements] to add a new section (F) as follows:

(F) a report of the actual cost savings achieved by the managed care plan addressing at a minimum each of subitems (1) through (4).1]

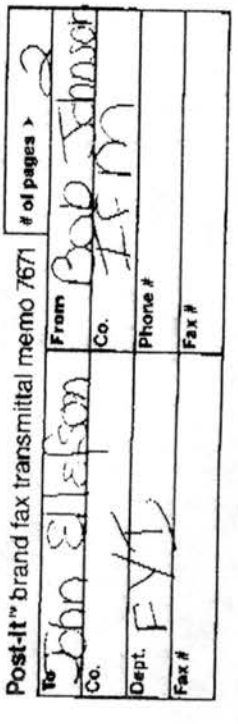
(1) Cost savings achieved from the implementation of uniform treatment standards prescribed by the commissioner and from the implementation of any other uniform treatment standards proposed by the plan's application and approved by the commissioner. This report should at a minimum include (i) the total average number of treatments in each treatment category, (ii) the total and average cost of all treatments for each treatment category, and (iii) the total and average cost savings for each treatment category.

(2) The total and average service denials for each treatment category.

(3) Cost savings achieved from the implementation of the fee reimbursement schedules adopted by the commissioner and from the implementation of any other fee reimbursement schedules proposed by the plan's application and approved by the commissioner. This report should at a minimum include (i) the total and average number of fees paid in each fee reimbursement category, and (ii) the total and average cost savings in each fee reimbursement category.

(4) Cost savings achieved by each of the additional programs described in the plan's application. This report should at a minimum include (i) the total number of active claims, (ii) the total and average indemnity cost paid for each type of injury; (iii) the total and average number of work days lost; and (iv) the aver number of days between the plan's receipt and closure of a claim.

1] This report does not specify that statistics for prior time periods must be supplied for comparative purposes. In the final rules it is recommended that the report also include



comparable data for prior time periods, if available, up to two years.

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THERESA MECKEL
ASSISTANT COUNSEL

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August 20, 1990

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Ms. Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor & Industry
443 Lafayette Road, North
St. Paul, MN 55155-4316

Re: Proposed Emergency Rules Relating to Workers Compensation - Managed Care
Section 218.0100 - Section 218.9000

Dear Ms. Zembal:

Liberty Mutual Insurance Company has reviewed the Department of Labor and Industry's draft emergency rule relating to workers compensation managed care. Liberty Mutual objects to the rule because it takes away from the insurer traditional claims management responsibilities. Liberty Mutual provides its policyholders aggressive case management that fulfills the twin goals of reducing medical costs and properly treating an employee with the goal of returning him to work. While we realize that S.F. 2107 requires that the managed care plan provide many of the services that are traditionally provided for by insurers, we believe that the rule could provide that the insurer can continue to provide these services in conjunction with the managed care organization.

Comments on specific sections of the proposed rule are set forth below:

5218.1000 (1)(D)(2)(b) requires that the managed care plan include an adequate number of each category of health care providers to give employees convenient geographic accessibility to all categories of providers. This section may not take into account those situations when the insurer or managed care organization has persistently attempted to include what the commissioner may prescribe as an "adequate number" of physicians but is not able to do so. For example there may not be an "adequate" number of physicians in rural areas or providers may refuse to contract with the managed care organization. Strict geographic restrictions may have a chilling effect on insurers to implement such plans. We recommend that a managed

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care organization should not be denied certification if it has attempted to comply and sought to have doctors join the managed care organization.

5218.1000 (1)(D)(3)(a) & (b). These sections allow the employee to decide whether the evaluation will be by a physician or a chiropractor. The purpose of the managed care provisions in S.F. 2107 was to give the managed care organization control over medical services and the ability to truly manage the employees medical care. Giving the employee the choice to decide whether the evaluation will be by a physician or a chiropractor takes away the managed care plan's control of the case.

5218.1000 (1)(D)(3)(c). This section allows the employee to initially choose from at least three health care providers to whom the employee has been referred by the evaluating provider and allows the employee to change providers at least once. While we understand that the employee should not be forced to treat with a physician the employee is not happy with, allowing the employee to 1) have the choice to be evaluated by a chiropractor or a physician under subparagraphs (a) and (b) and then 2) be allowed the choice of three health care providers and then 3) to change one more time, compromises the managed care organization's ability to manage the case. A provision that allows the employee a simple procedure to contest the choice of provider would adequately protect the rights of the employee while maintaining the integrity of a truly "managed" care system.

5218.1000 (1)(D)(5) sets forth that the application must include copies of contract agreements signed by each participating health care provider. Nothing in the rule maintains the confidentiality of these contracts. While we would be able to file copies of the standard contract, it would violate our agreements with our PPO's to file actual reimbursement rates. Providing such information would limit competition, therefore we suggest that the contracts remain confidential.

5218.1000 (1)(D)(7) & (10) follow the statute which requires a procedure for utilization review and internal dispute resolution, programs for early return to work and promotion of workplace safety. The insurer, not the managed care organization, should already be providing these services. The regulation should take into consideration the role of the insurer and allow for these functions to be provided by the insurer. Liberty Mutual competes with other insurers in order to provide these services in the most cost effective manner possible. By taking this away from insurers you take away what we do best.

5218.1000 (2) requires the commissioner to notify the managed care organization in writing of approval and denial of certification, however provides no time limit for the commissioner to complete the notification process. We recommend that the commissioner be required to notify the applicant within a specific period of time.

5218.2000 (2) allows the commissioner to designate a managed care organization's initial geographical service area and approve any expansions to that

service area. Again, we suggest that a time limitation be put on the commissioner's ability to do so.

5218.2000 (3)(F) requires employers to be liable for the cost of any treatment given, before compensability is determined, if the employee receives treatment from a managed care plan. This provision does not take into account those cases where the employer's health insurance and workers compensation plans utilize the same managed care facility. In those cases the costs should be paid by the health insurance plan with application of appropriate deductibles or co-payments. Even in those cases where the plans are not the same, health insurance should be primary, however the employee should not have to pay the deductible if he was required to use the workers compensation managed care organization.

5218.3000 (2) requires much detailed information, including a report that summarizes peer review and utilization review performed showing cases reviewed, issues involved, action taken and evaluation of compliance with treatment standards. Such reporting can be quite onerous and expensive and the commissioner should consider what use such information will be made by the commissioner and may want to promulgate standard forms that will allow managed care organizations to provide this information to the commissioner in the simplest and most cost effective way possible.

5218.5000 authorizes a health care provider who is not a participating health care provider to provide medical services to an employee if the health care provider maintained the employees medical records and has a documented history of treatment of that employee before the date of injury. While we understand that S.F. 2107 sets forth this requirement, we believe it need not be interpreted this broadly. The regulation does not require that the physician have a history of treatment of the workers compensation injury or a related injury. Therefore the employee's family physician who has been treating him for general medical problems, such as the common cold, would be allowed to treat the employee for the work related injury. This provision takes the "managed" out of a managed care plan. The purpose of these rules are to give the managed care organization the ability to control the case and the doctor. This provision virtually emasculates the purpose of the rule. The regulation should be amended to provide for some sort of nexus between the prior treatment and the injury.

5218.6000 sets the fees under a managed care plan to the maximum amount allowed under the fee schedule. This provision would undermine the competitive pricing mechanisms that managed care organizations provide, particularly PPO's. Taking away competitive pricing takes away a large portion of the cost savings of the managed care mechanism.

Liberty Mutual congratulates the Department for its work drafting this regulation. We hope you find these comments constructive and hope the proposed regulation will take into account the ability of insurers to provide many of these managed care services and that, in fact, is our job.

In the event of questions please feel free to contact me.

Sincerely yours,

Theresa Meckel

cc: Robert Johnson -- Insurance Federation of Minnesota
Jack Stewart - Alliance of American Insurers

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August 11, 1992

Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Pam:

I have some concerns about the proposed rules to be adopted. There are two areas of concern. The first being the medical reports. It is our belief that any further medical reports from doctors or other data, should be available and given to individual bargaining units that are responsible for protecting the rights of their members. We at the present time receive the First Supervisory Report on workers compensation cases. I request that we receive any further reports including doctors reports or other information concerning employee on workers compensation issues.

Our second concern is the insurers themselves. It is our belief that we should have input as to who the individual municipality use or have contact with on the cases.

If I could be of any help to you on our concerns, please call me.

Sincerely,

Allen L. Berryman
President

ALB/mjh

August 19, 1992

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Ms. Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor & Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

RE: Proposed Emergency Rules on Work Comp Managed Care Plans.

Dear Ms. Zembal,

I have read through the purposed Worker's Comp. rules and I think that the Emergency Rules would cause a great burden and hardship on the tax payers of Minnesota and are not in the good spirit of the law.

I live in America and I deserve the right to choose whichever doctor I feel comfortable with and trust in, Should I be injured while working. I do not think that It is fair for me to have to go to a company doctor that is chosen by the MCO. I feel that my chiropractor would be excluded from the managed care plan and according to the rules, I see no evidence that he will be chosen. The MCO should have to participate with whichever Doctors that want to. They should not be able to pick and choose whoever they want to. If this does happen the only doctors that will be chosen are the ones that the MCO will be able to control, not the Doctors who care about their patients needs.

It is also not fair for me to have to see a M.D. within 24 hours after I am hurt. It may take more than 24 hours before an injury is Noticed. I see that this law is an attempt to control the care that I may Need, or for an M.D. to send me to his

friends, instead of sending me to someone who will help me first as a person and then think about the money instead of the other way around. If I want to see a Chiropractor it is highly unlikley because an M.D. will will not refer me to one because an M.D. has not attended and courses on Chiropractic and has no idea which cases Chiropractic could help.

The treatment guidlines were set up by IME Doctors and pose a danger to the public in the manor that they were designed. They would not allow us to get the care we need or deserve.

The review process is very unfair, they discriminate against the patient and give the MCO to much control. This will only lead to higher cost because of the increased litigation it will cause.

This whole bill is a bogus attempt by the legislature. It's only service is to cut good doctors from the system, give less care to patients then they deserve. Please change these rules before it's to late. This law will take away our freedom of Choice and give it to the MCO. Who will have control. This is not Communist Russia This Is America WERE Freedom is our Choice.

Sincerely,

Jori Elke

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

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Re: Proposed Emergency Rules on Work Comp Managed Care Plans

Dear Ms. Zembal

As a single, working, mother and only source of income for my family, I'm very concerned after reading the purposed rules for the new Work Comp Law. I find that if I were hurt at work I might no longer be able to see the Dr. of my Choice. A Dr. Chosen by the Managed Care Organizatio my not have best interest in mind. Since the insurance Companies pay the bills, Can I get the best care? Who can I trust? Will I simply have a Dr. who follows the rules of the Game or someone I can truly trust to give me the best care and get me back on my feet, to work, and able to support mysely and my family.

As far as I can see these rules show little or no regard to the workers in Minnesota and it comes down to the almighty dollar. It is Clear to me that An MD will not send me to a Chiropractor for a low back injury, but send me to someone who has no

idea how to treat this type of injury. but will be glad to give me as much pain medication as I can swallow. I have no choice, except to do without care because I don't take pain pills.

As far as the treatment guidelines are concerned they are a joke. Anyone knows a good Dr. can't decide a form and the extent of treatment time if he never has seen the patient. What did he use a Crystal ball or the amount of money the insurance company has decided is enough.

We the tax payers and Voters of this State see this as a slap in the face, an insult to our intelligence and an another way for the big money insurance companies to keep a tight grip on the anatomy of Our goverment, while causing the good and honest workers of Minnesota to suffer needless pain and disability and when this is all finished we will have more attorneys hired and higher Work Comp insurance premiums.

Please Consider our requests for the freedom of Choice and our right to good healthcare and Change these rules

Sincerly
Marilyn Hagedorn

· MS Pam Zembal
· Rehab and med affairs
Dept. of Labor and Industry
443 Lafayette Rd. N.
St. Paul, Mn 55155-4316

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RE: Proposed Emergency Rules on Work Comp managed Care Plan

After reading the proposed workers Comp rules I had to do a quick reality check to be sure I was still american and living in America. Perhaps a more cost effective move might be better served by cutting frivolous spending not by refusing the injured worker the care she needs by who he chooses. already work Comp rules are a hardship and its going to get worse? Amazing - why doesn't the Dept. of Labor just say they are on the side of Communist Supporters?
as an injured worker I found Chiropractic most helpful in back to work and therefore not a burden to society isn't that a main objective? I even managed it by choosing my own Dr. I suggest & support the following Changes: Let us have the freedom to

Choose our own Dr. From a complete list not from a select few. I don't feel we need to see an M.D. in every instance. He's not necessarily the most qualified in all situations. also a more objective Review process is needed to protect the little man. namely the injured work. And last I want my treating Dr that I choose to be setting my guidelines not some greedy eye to the main Chance Crook who does not care what happens to me doing so.

With much Disgust & trepidation

Tammy J. Eft

Aug. 19, 1992

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REHABILITATION & MEDICAL AFFAIRS

Ms. Pam Zembal
Rehab + Med. Affairs
Dept Labor + Industry
443 Lafayette Rd N.
St. Paul, MN 55155-4316

Re: Proposed EMG Work Comp Rules

Dear Ms. Zembal,

I have read the proposed work comp rules + object that they are not following the intent of the legislature. I am an employer (5 employees) + have the following suggestions.

This is America, + I deserve Freedom of Choice to choose my own doctor that I trust. I will not go to a company doctor because of his conflicting interest.

I don't want my family chiropractor to be excluded from the MCO, + according to the rules, he may not be included. The MCO's must accept every doctor who applies! They should not be allowed to pick + choose whoever they want. If they don't choose my chiropractor, he + I will left out + that's not okay to me as an employer + taxpayer.

It is not fair that we have to see an MD within 24 hrs of the injury. I need to have my own choice. I don't want to be refered to his friends. And if the MD doesn't know anything about chiropractic, we won't be refered to them due to MD's having no knowledge of chiropractic.

The review process is bad. They are very unfair to an injured worker while favoring the MCO. This is clear descrimination which will eventually lead to increased litigation.

The treatment guidelines are a danger to the public. They will not allow people to get the care they need. Everyone will be pigeon-holed into an arbitrary category. We won't get our needed care which will make our generation live with more disability than we would have had to. The doctors who write the treatment guidelines are the same doctors that insurance companies usually use to cut claims - those doctors have no credibility.

This whole bill is a bad attempt by the legislature. It will only serve to cut bad doctors from the system, give patients less care than they need, fill the managed care organizations with excessive monies, + therefore cause unnecessary costs, pain, suffering + disabilities for Minnesotans.

Please change these rules before it is too late. America was founded on freedom of choice - this law will take that away from us.

Respectfully

David Copp
7647 Paulsen Dr
Eden Prairie, MN 55346

Rec'd aug 21, 1992

MINNESOTA AFL-CIO

525 PARK STREET • SUITE 110 ST. PAUL, MINNESOTA 55103 • PHONE: (612) 227-7647

August 20, 1992

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LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

The Minnesota AFL-CIO has a number of questions, concerns and suggested modifications with regard to the proposed emergency rules related to Workers' Compensation Managed Care. We offer the following comments on the Department of Labor and Industry's proposed rules.

Sincerely,

Bernard L. Brommer

Bernard L. Brommer, President

cc: John Lennes
Leo Eide

5218.0100 (Emergency) Definitions

Subp. 3.: "Emergency care" should mean more than professional health services necessary to preserve life or limb. It is not difficult to imagine instances where emergency care is essential but not necessary to preserve life or limb. For example--scrapes, burns, cuts, and even broken bones may not be life or limb threatening but may necessitate "emergency care."

Subp. 4.: This subpart defines an employee as an employee entitled to treatment of a "work injury". Minnesota Statutes define an injury subject to the act as a "personal injury". We suggest that to avoid possible confusion that the statutory terminology of personal injury be used, rather than a work injury or a "compensable injury" which is a phrase used later in the proposed rules.

Paragraph 5218.1000:

Subp. 1D(2): Particularly in the Metropolitan area it may be difficult for the Managed Care Plan to provide services for an entire county. For the possible convenience of the Plan, the

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providers, and the employees, we suggest that consideration be given to permit service areas of less than a full county.

Subp. 1D(2)(a): Is it appropriate for the Commissioner of Labor and Industry to prescribe uniform medical treatment? Is the Department suggesting treatment protocols? What happens if quality services are provided that exceed "uniform treatment standards?".

Subp. D3(a): Under subp. 1D(2)(b), the Plan shall not discriminate among health care providers. Under that standard, we believe this subpart should require the Managed Care Plan to permit evaluation by the participating chiropractor if that should be the employee's choice. This comment would also apply to the following subp. (b).

(Subp. 1D(3)(b): The employee, who has received treatment by a provider outside the Managed Care Plan, must be evaluated by a participating physician of the Managed Care Plan within five days "of a request for a change of doctor." At whose request for a change?

Subp. 1D (3)(c): Does this mean that treatment by other disciplines in the medical profession for the injured workers is in the sole discretion of the evaluating managed care provider of the insurer?

Subp. D3 (f): We question whether the 30-mile standard will be reasonable in all cases, particularly in the Metropolitan area. We suggest that paragraph be modified to provide that the employee shall have reasonable geographical access to providers, but shall not be required to travel more than 30 miles from the place of employment or residence.

Subp. D3 (4): We interpret this to imply that the plan designates the criteria for employees to go outside the Managed Care Plan. The Commissioner, the most neutral body, should develop this type of criteria.

Subp. D7: We believe this subpart should provide a description of the type of dispute that may be subject to the internal dispute resolution procedure. The paragraph should require that the procedure for resolution of disputes for injury compensation be fair, reasonable and practical.

Subp. D8: To permit the Department to evaluate the effect on employee health care, we would suggest that the "commencement or termination of participating health care providers" be preceded by a 30-day notice to the commissioner.

Subp. D10: The plan should include in the description of case management, the provision for cooperative efforts with a QRC where such a person has been assigned to the employee's case.

Paragraph 5218.2000:

Subp. 3B: This provision provides that the employee must select a Managed Care Plan at the time of injury. Such a choice may be difficult to make at the time of injury. We suggest that the injured employee be given 30 days after an injury to make such a selection.

Subp. D: We are not aware of statutory authority to make the Managed Care Plan retroactive to injuries prior to this act. Accordingly, the application of the Managed Care Plan to an employee with a previous injury who requests a change of doctor, should be deleted.

Subp. E: We think the phrase in the second sentence "may continue to treat with the employee's original health care provider" is unclear. Does this refer to the employee's personal health care provider or the provider under the terminated plan?

Subp. F: We think that the third sentence of the second paragraph of this subpart, which permits the employer to invoke the Managed Care Plan after liability is determined, disregards the importance of the continuity of treatment. A change in medical provider at that point could be highly unproductive. Accordingly, this provision should be deleted.

Subp. 4: We believe the provision that would permit an employer or insurer to form, operate or administer its own Managed Care Plan that treats workers' compensation claimants is contrary to the legislation enacted in 1992. We know about the pressure and coercion that employers and insurance companies can exert on injured workers and this language leaves the door wide open.

Paragraph 5218.3000:

Subp. 3: The plan must submit to the insurer any information which they request which includes individual patient medical records not related to the workers' compensation injury. It is essential that such information not pertinent to the worker's compensation claim be kept confidential.

Paragraph 5218.4000:

Subp. 2: We believe that if a participating provider is terminated, the employee should have the option of continuing treatment by that provider to assure continuity of care.

Paragraph 5218.5000:

Subp. 2A: This should clarify that the commissioner is the party issuing the various requirements.

Subp. 2B: We believe that the referring out of diagnostic testing should not be limited to referral to the Managed Care Plan. We believe this to be an undue restriction upon the medical discretion of a care provider who has a documented history of treatment. At the very least, the emergency rules should make it clear that the results of diagnostic testing done by a Managed Care Provider are to be sent to the care provider who has a documented history of treatment.

BLB:pkd
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HTF

HEALTH TRUST FUND

2231 McKinley Street NE Minneapolis, Minnesota 55418 612/788-2507

Paul Tautges
Chairman

August 19, 1992

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REHABILITATION & MEDICAL AFFAIRS

Ms. Pam Zembal
Rehabilitation and Medical Affairs
MN Dept. of Labor & Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

RE: Proposed Emergency Rules for Workers' Compensation

Dear Ms. Zembal:

The Health Trust Fund is an organization that was founded to assure Minnesotans a free choice of health care and health coverage. It is funded by chiropractors and private citizens.

The Health Trust Fund has reviewed the proposed emergency rules regarding workers' compensation. It is our opinion that they do not follow the intent or the letter of the law passed by the 1992 legislature.

If the concern of the legislature was to save money, they would have followed the cost savings indicated in last year's Department of Labor study on "Workers' Compensation Cost Containment Report" or the statistics in the enclosed report. A chiropractor would be the gatekeeper to all soft tissue or muscle skeletal inquiries. Chiropractors by far are the most conservative and cost effective in health care disciplines. (But, they did not for whatever reason.)

The Health Trust Fund wants the legislation to be enacted in the spirit of its intention as poor as it is for the injured worker.

Enclosed is a summary by Attorney David Wulff. Health Trust Fund's concerns are as he has stated.

The Health Trust Fund has a number of ways to enact a fair cost containing health care component in workers' compensation. They do not include the medical gatekeeper or the company doctor.

Please contact me if you have any questions.

Sincerely,

HEALTH TRUST FUND

Paul R. Tautges
Chairman

PRT:mhp
Enclosure

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August 7, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comment to Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

Please accept this letter as my comments to the proposed emergency rules on managed care plans published on July 27, 1992.

1. Exclusion of Health Care Providers from MCPs.

Two major concerns which should be addressed by the rules on MCPs are (1) the threat that some health care providers may be effectively excluded from treating workers' compensation patients because they are not accepted members of any MCP; and (2) the threat that an injured employee will be forced to treat with a health care provider he or she does not trust rather than a doctor of his or her choice. The proposed emergency rules, and specifically Rule 5218.4000, subp. 1, should require as a prerequisite to certification that all MCPs must accept any health care provider who meets all licensing, registration and certification requirements necessary to practice in Minnesota, and who agrees to abide by the rules and limitations of the MCP. MCPs should not be given unrestricted discretion to pick and choose the doctors who will constitute participating health care providers.

If the MCPs are allowed to choose the health care providers who will participate in their plans, there will be health care providers who are not accepted into any managed care plan. Those providers will be effectively excluded from treating injured employees in this state. Such exclusion will have a devastating impact on those health care providers. Conversely, these practitioners who are accepted into MCPs could receive an unfair windfall of new cases. This was clearly not intended by the legislature.

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Giving such discretion to MCPs will also significantly limit the right of injured employees to choose the health care provider from whom they will receive treatment. The right to choose ones treating doctor has always been jealously protected by both the legislature and the courts of this state. It is significant to note that of the nineteen persons who spoke at the public hearing on the proposed medical rules on 7/16/92, all but two (the two attorneys who spoke on behalf of the IME firms) urged the Division not to limit the right of injured employees of this state to choose their own treating physician. The legislature clearly did not intend to abrogate the fundamental right of the citizens of this state to choose their own treating physicians.

The basic goal of the legislature in adopting the 1992 amendments was to provide a mechanism for reducing or eliminating inappropriate, excessive or unnecessary treatment. The accomplishment of this goal does not require the exclusion of innocent and qualified health care providers from the system. It also does not require the complete abrogation of a citizen's right to choose their own treating physician. The new treatment standards coupled with the MCP peer review utilization review and dispute resolution process, the MSRB investigation/sanction process, and the traditional medical request/claim petition process are adequate to guard against abuses.

Requiring MCPs to accept all health care providers who apply for admission, so long as their license is in good standing and they agree to abide by the rules and limitations of the MCP, would avoid the dual threats of provider exclusion and limitation of choice without endangering the goal of controlling utilization costs. It is a win/win proposal that should be adopted. The authority for such a rule can be found in Minn. Stat. §176.1351, subd. 2(12).

2. Initial Evaluations Under 5218.1000 D(3).

The proposed rule as drafted allows MCPs to require employees to submit to "initial evaluations" by a "physician" (defined to be a medical doctor or a doctor of osteopathy but not a chiropractor) within 24 hours after an employee requests treatment following a work injury. The rule allows MCPs to permit initial evaluations by chiropractors but does not require this. This rule violates the statutory prohibition against MCPs discriminating against any category of health care provider.

The same argument applies to 5218.1000, subp. 1D (3)(b) dealing with initial evaluations within five working days of a request for change of doctor.

The requirement that an employee must submit to an "initial evaluation" within 24 hours of a request for treatment following the work injury, or within five working days after a request for a change of doctor in cases where the employee has received treatment for the work injury by health care provider outside of the MCP, is nothing less than a mandatory adverse examination by a health care provider of the employer's choice. As such, it violates the provisions of M.S. 176.155 and should be eliminated from the proposed rules all together.

Alternatively, if an initial evaluation is to be required, then the employee should be given the right to choose from among all of the MCPs participating health care providers, including the chiropractors. Otherwise, the chiropractic profession will be unlawfully discriminated against, and the injured employee's right to choose his or her own treating physician will be unreasonably and unnecessarily restricted.

Subp. (c) in the same rule provides that the "evaluating provider" who conducts the "initial evaluation" must provide the employee with a list of at least three health care providers with whom the employee may treat. The "evaluating provider" is given the power to determine what treatment is appropriate for the condition and what type of health care profession discipline should provide that treatment. This process effectively gives the "evaluating provider" the power to discriminate against categories of health care providers. Allowing MCPs to simply delegate the authority to discriminate against categories of health care providers would obviously violate the prohibition against such discrimination clearly set forth in the 1992 amendments.

The problems inherent in the initial evaluation process set forth by the Rule as drafted could be minimized if not eliminated by simply requiring MCPs to provide injured employees with a list of the names, addresses and telephone numbers of all participating health care providers within 24 hours of a request for treatment following a work injury or within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the MCP. The employee's initial choice of health care provider could then be required to perform an initial evaluation to determine the treatment which is appropriate for the condition. If the

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employee's initial choice of health care provider is not the appropriate health care discipline to provide the treatment, that health care provider could simply provide the employee with a list of the participating providers under the MCP within the proper health care discipline.

3. Entities Which May be Certified as MCPs.

Minn. Stat. §176.1351, subd. 1 provides, "any person or entity, other than a workers' compensation insurer or an employer for its own employees, may" be certified as an MCP (emphasis added). The statute specifically prohibits workers' compensation insurers and self-insured employers from becoming certified as MCPs.

Proposed Rules 5218.1000, subp. 1 and 5218.2000, subp. 4, as drafted, would appear to violate this specific statutory prohibition. Therefore, these proposed rules should be redrafted.

4. Peer Review, Utilization Review and Internal Dispute Resolution.

Proposed rules 5218.1000, subp. 1D (7) and 5218.7000 provide MCPs with too much discretion over devising procedures for peer review, utilization review and internal dispute resolution. The Division should attempt to come up with specific rules concerning these procedures. Otherwise, the citizens of this state will be confronted by a myriad of different procedures giving rise to inconsistent treatment of similar injuries.

5. Aggressive Case Management and Early Return To Work Programs.

Proposed Rule 5218.1000, subp. 1D (10) requires MCPs to describe how they will provide aggressive case management, programs for early return to work, and cooperative efforts to promote work place health and safety services without specifying what those terms mean or what, if any, limitations should apply. The Department of Labor and Industry should develop more specific definitions and requirements in order to avoid the development of myriad different rules and limitations resulting in inconsistent treatment of like cases.

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6. **Treatment Standards Not Prescribed by the Commissioner.**

Proposed Rule 5218.1000, subp. 1D (11) requires individual MCPs to submit treatment standards for medical services not previously prescribed by the Commissioner. This proposed rule should be eliminated.

It will be completely unworkable and unjust for MCPs to be allowed to develop individualized and differing treatment standards applicable to their member employees. All MCPs should be required to comply with the same treatment standards promulgated by the Commissioner. Prior to the time that the Commissioner has promulgated treatment standards covering all types of medical services, the MCPs should simply be required to provide services which are usual and customary for the provider's health care profession, and which are reasonably required to cure or relieve the effects of the employee's work related injury. Allowing MCPs to develop their own unique treatment standards, even if limited to the period of time prior to the development of uniform standards by the Commissioner will only result in confusion and inconsistent treatment of the injured employees of this state.

7. **Retroactive Application of MCPs.**

Proposed Rule 5218.2000, subp. 3D provides that the MCP rules will apply to employees injured prior to the effective date of the 1992 amendments if the employee requests a change of doctor. The proposed rule provides that an employee who requests a change of doctor must receive further treatment provided by the employer's MCP.

This provision violates the statutory and constitutional prohibition against substantive rights being taken away or affected by the retroactive application of statutory amendments. The law of this State is clear that statutory amendments shall be applied prospectively only, whether or not the amendments are substantive or procedural in nature, unless the legislature specifically provides for retroactive application. The legislature has not provided for the retroactive application of managed care plans. Therefore, any employee injured prior to 10/1/92 cannot be required to receive treatment through a managed care plan even if the employee requests a change of treating physician.

8. **Termination of Participating Providers.**

Proposed Rule 5218.4000, subp. 2 allows managed care plans to "cancel" participating health care providers "under the requirements of the managed care plan." This rule effectively provides MCPs with totally unrestricted discretion over when and under what circumstances they may cancel or terminate participating health care providers. This proposed rule should be eliminated.

The legislature specifically created an exhaustive and comprehensive procedure for the investigation and sanction of health care providers who chronically provide inappropriate, excessive or unnecessary treatment to injured employees. This process is set forth in Minn. Stat. §176.103 under the authority of the Medical Services Review Board. This process requires the MSRB to investigate suspected cases of inappropriate, excessive or unnecessary treatment. It authorizes the Department to sanction providers found to be abusing the system. Said sanctions can include a total exclusion from treating injured employees.

The process established by the legislature sets forth specific checks and balances to protect wrongly accused providers from being unjustifiably sanctioned, while enabling the Division to identify and sanction actual abusers.

Obviously, the legislature did not intend to allow MCPs to side step this established process and effectively sanction health care providers without the checks and balances of appropriate due process.

The rules should be changed to allow MCPs to terminate participating health care providers only if the providers are found to have been abusing the system and the provider is sanctioned with exclusion from the workers' compensation system by the Department of Labor and Industry following the MSRB investigation. To provide MCPs with unfettered discretion to terminate health care providers would create a significant risk of abuse in direct contravention of legislative intent.

9. **Treatment Provided by Non-Participating Health Care Providers.**

Proposed Rule 5218.5000, subp. 1A proposes to limit the ability of an employee to treat with a health care provider who is not a participating health care provider to providers which have

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a documented history of treatment with the employee before the date of injury. Minn. Stat. §176.1351, subp. 2(8) does not require that the history of treatment be prior to the date of injury. There is nothing in the statute to suggest that if the employee develops a history of treatment with a health care provider after the date of injury and thereafter wishes to switch the care of their work related injury to that health care provider, that the employee should not be able to do so. The legislature obviously intended to allow employees to treat with doctors in whom they have developed a certain level of confidence. Whether that treatment history and level of confidence is developed before or after the date of injury should not matter.

Proposed Rule 5218.5000, subp. 2B requires health care providers who are not participating health care providers to agree to refer the covered employee back to the managed care plan for "specialized care, which includes, but is not limited to, physical therapy and diagnostic testing". Minn. Stat. §176.1351, subd 2(8) only requires the non-participating health care provider to agree to refer the employee back to the managed care plan for "any other treatment that the employee may require". This would appear to allow the non-participating health care provider to provide any type of treatment he or she is licensed to provide, specifically including physical therapy and diagnostic testing. Therefore, it would appear that this proposed rule goes beyond the statute and is therefore unenforceable.

Respectfully submitted,

WILSON & WULFF, P.A.

David C. Wulff
Attorney at Law

DCW/cmg

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Facts about HMOs

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An HMO is an organization that provides or arranges for a wide range of health services for a fixed monthly fee. The prepaid fee, or premium, covers "everything" from routine office calls to hospitalization. Membership in an HMO is a form of health insurance.

There are four kinds of HMOs:

- *The staff model* HMO provides health services from one or more central locations. Doctors are salaried and are hired directly by the HMO.
- *The group practice model* is similar to the staff model except that doctors contract with the HMO to perform health care services rather than being salaried HMO employees.
- *The Individual Practice Association (IPA)* provides health care to enrollees from a physician's private office, rather than from a central location.
- *The network HMO* is a group of more than one multispecialty or single-specialty group practices that contract with the HMO. Usually the practitioners provide health care in their own facilities.

Popularity growing. Although most of the nation's larger HMOs are staff model HMOs or group practices, IPA and network HMOs have experienced the greatest rate of growth in recent years.

During the last 11 years, HMO membership has nearly tripled. In 1971, there were 39 HMOs in the U.S. serving over 3.5 million households, according to the U.S. Department of Health and Human Services. At the end of September, 1981, an estimated 273 HMOs served over 10.5 million people. Trends show HMO membership will continue to increase at a similar or faster rate, although the number of new HMOs will not increase as rapidly as in the past. Today, HMOs can be found in 40 states and the District of Columbia.

Cost effectiveness. Although HMO premiums are not significantly lower than premiums for other prepaid health plans, a typical HMO provides its members "more for their money." Unlike traditional health insurance plans, HMOs by and large cover more services and allow unlimited visits and hospitalization. And instead of covering only 80 percent of the bill, most HMOs charge nothing or one very minimal fee (copayment) for their services.

HMOs are not only a good buy for individuals but also can save large employers millions of dollars. The Ford Motor Company began offering its employees HMO health care in 1970. Within one year, the company saved over half a million dollars. By 1982, the Ford's savings had increased to $5 million.

Hospitalizations reduced. Because HMOs provide many diagnostic and therapeutic services in-office, their patients are hospitalized less frequently than members of other prepaid health insurance plans. In a 1979 study, statistics showed the average inpatient hospitalization rate for Blue Cross/Blue Shield enrollees in 1978 was 730 days per 1,000 members. In contrast, the hospitalization rate for all HMO plans was 412 days per 1,000 members. In short, hospitalizations for HMO patients were 30 percent lower than those for the Blue Cross/Blue Shield patients.

Chiropractic optional. One reason why few HMOs work with chiropractors is that chiropractic services are not required under federal HMO law. Under the HMO Act of 1973, federally sponsored HMOs must provide certain basic health care services. Other health services not included in the definition of "basic services" are called "supplemental services." Chiropractic is considered a supplemental service; thus HMOs receiving federal funding can, but do not have to, provide it. Most federally sponsored organizations have opted *not* to include chiropractic services.

Of approximately 275 HMOs currently in existence, almost half are federally sponsored. Privately owned HMOs are not bound by federal law, but they are required to adhere to any state laws affecting their operations.

Future federal support unlikely. If the federal definition of "basic services" was expanded to include chiropractic care, chiropractic would be mandated in over half of the 275 HMOs, and chiropractors' involvement in HMOs would increase. Expanding HMO services is unlikely, however, particularly in light of the Reagan Administration's proposals to eliminate federal funding of HMOs. Although Congress has modified these proposals, the Administration is still pursuing this goal and also actively encourages private-sector investment in HMOs.

State laws. Because federal involvement in HMOs is decreasing, state laws governing their operations have become more important. To date, 40 states have passed legislation governing HMOs. Many states have included HMO laws with their state health insurance equality laws.

Last year, the Florida Chiropractic Association successfully lobbied for the passage of a landmark amendment to the state HMO law. It reads: "For an appropriate additional premium, the HMO shall make available, according to the standards and procedures of such an organization, physician care provided by . . . osteopaths, chiropractors, and podiatrists."

Florida chiropractor Mark Silverman calls the amendment a first step that paves the way for more DCs in his state to offer their services to HMOs. "It forces HMOs to include chiropractic," he notes, "but it doesn't force them to include any set number of chiropractors." DCs therefore should actively negotiate agreements with HMOs, he says, adding that the laws will only be as effective as chiropractors and their patients make them.

amount on disc surgery and related back problems. Since I became enlightened about the benefits of chiropractic care, AV-MED's costs in this area have plummeted. Your conscientious approach in treating patients conservatively with due concern about what MMI (Maximum Medical Improvement) really is has kept many useless hospitalizations and surgery from occurring."

Q: *Do you see any prospects for adding other chiropractors to your HMO?*

A: Yes. Up until recently, I was the only chiropractor caring for AV-MED patients in Dade County but we just added another chiropractor from Broward County. I was just asked to find chiropractors in Tampa and St. Petersburg. Eventually, even more will be added.

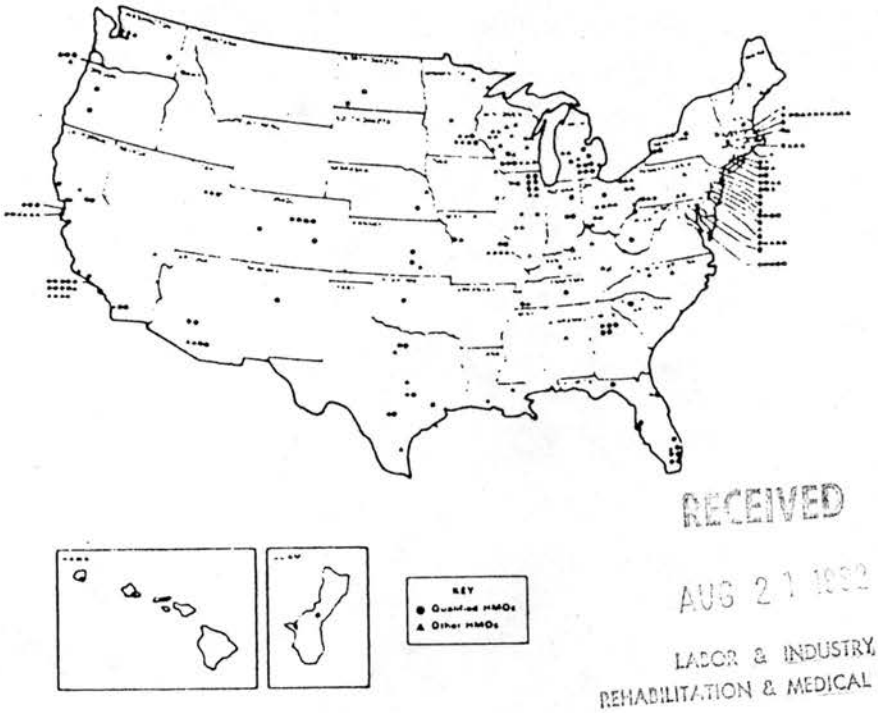
Q: *How does the HMO pay you for your services?*

A: I am paid on a per visit basis, as are each of the specialists at AV-MED. The general medical practitioners work under a "capitation" basis, which means they are paid a certain amount of money per patient, regardless of which services the patient receives. The purpose of this method is to discourage providers from unnecessarily seeing patients repeatedly.

Q: *How are patients referred to you?*

A: At our HMO, no patient is admitted to the hospital without the clearance of the medical director, Dr. Davis. Whenever possible, these patients are encouraged to have a chiropractic consultation prior to admittance to a hospital for traction or surgery. Because of the good results obtained with these cases, more and more GPs (primary care physicians) are receptive to referring patients to my office. I sometimes receive as many as five to ten personal referrals in a week. The medical community *is* open to being educated when it can see the results.

GEOGRAPHIC DISTRIBUTION OF HMOs



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Charts courtesy of the Department of Health and Human Services, Office of Health Maintenance Organizations.

Q: *What advice do you have for DCs in other states who want to join an HMO?*

A: Recognize that the doors are generally open, or just need a little push to get them open! A lot of chiropractors assume HMOs are not going to be receptive to their services. But if you go in with documented evidence of the cost-effectiveness of chiropractic care, most HMO executives will listen. By "documented evidence," I don't necessarily mean elaborate nation-wide studies, but successful cases from your own practice. Of course, you can't merely *tell* an HMO director that chiropractic care is successful and inexpensive; you have to prove it through your services to patients. But once you start showing results, the HMO will send you as much business as you can handle. What I have done here in Florida can be done anywhere in the country.

What are your views on HMOs?

ICA would like to receive your feedback on this article and the issue of chiropractic inclusion in HMOs for consideration in formulating model state legislation in the future. When writing your views, you may wish to respond to the following questions:

- What do you think chiropractic's role and relationship with HMOs should be in the future?
- Are your currently participating in HMOs, attempting to gain HMO inclusion, or lobbying the issue on the state level?
- Do you have access to copies of state laws or bills, articles, publications, and chiropractors' agreements with individual HMOs?

Please direct your comments and relevant information to ICA's Department of Government Relations, 1901 L Street, N.W., Suite 800, Washington, D.C. 20036.

A: It didn't happen overnight. It took a great deal of time and persistence to overcome medical prejudices against chiropractic care. In the beginning, my most valuable support came from two patients — two attorneys who happened to represent the local HMO, called "AV-MED." My professional relationship with these patients and their families went back many years. They had sent me many referrals and had always been impressed with the results of chiropractic care. They trusted me, and the HMO trusted them.

From time to time, they would suggest to the chairman of AV-MED — Dr. Herbert Davis — that a chiropractor would be helpful to the HMO. They would talk about positive experiences they and other patients had had with chiropractic care. "It's too bad you can't use Dr. Silverman in your HMO," they would tell the director and then go on to relay an incident in which a patient showed a dramatic turnaround as a result of chiropractic care. In one instance, a patient they referred to me was on the verge of being admitted to the hospital for traction. "But after three visits to the chiropractor," they explained to Dr. Davis, "he was walking without pain."

During this time, I was continually writing Dr. Davis requesting an informational interview with him. Eventually I met with Tom Baumgart, then president of AV-MED. Tom was very enthusiastic when I told him about my results with patients suffering from back and neck problems. Partly due to his support, I finally had the opportunity to meet with Dr. Davis himself.

In that meeting, I again emphasized chiropractic's efficacy. I did not try to sell him on the philosophy of chiropractic but found common elements we could discuss about chiropractic — that, is getting people well safely, quickly, and inexpensively. He seemed impressed but was noncommital about offering chiropractic through the HMO. "Maybe we'll consider it in the future," he said at the end of our meeting.

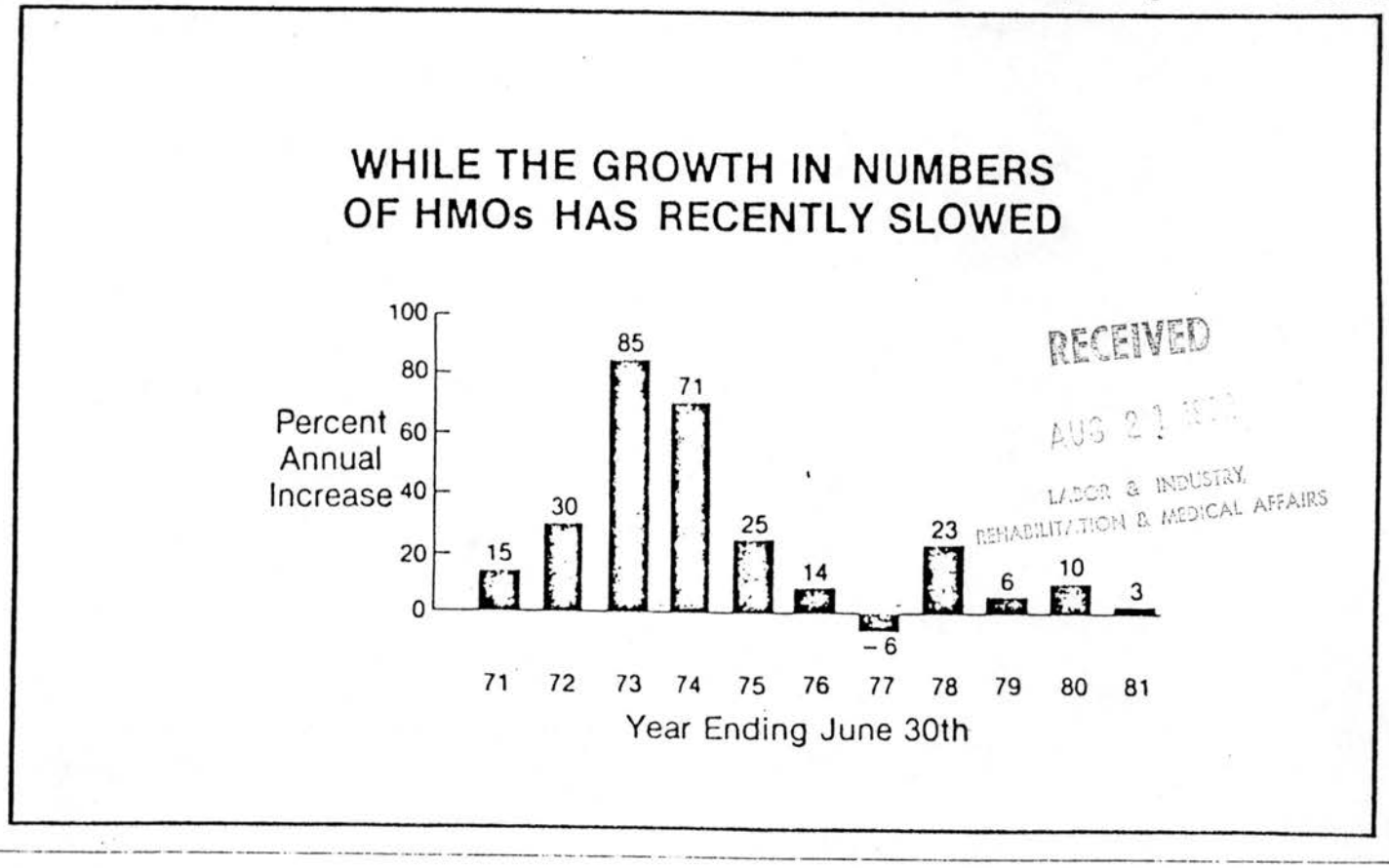
Shortly after that meeting, Davis phoned me. "Mark," he said, "I have a patient in the Baptist Hospital emergency room. He's already seen several doctors. They want to put him in the hospital, and I think they want to operate on him. Would you take a look at him?" Of course, I agreed.

The patient himself was reluctant to see a chiropractor. The only reason he came to see me, he said, was because the HMO had recommended me. I assured him he was not obliged to be under chiropractic care and that he was free to choose the operation. But I added that I would be glad to examine him. At that point, he agreed. Although this man's symptoms were very severe, he was pain-free 48 hours after receiving an adjustment. So he was favorably impressed, as was Dr. Davis, who then began to refer more patients to me.

His first 30 referrals responded very well. All of them had seen at least two medical doctors before coming to me.

Q: *So there was a definite shift in the medical director's attitude toward chiropractic?*

A: Yes, definitely. A few months ago, Dr. Davis wrote me a letter acknowledging the usefulness of chiropractic. In the letter, he said, "until we started using your services, we were spending a considerable



"distance." Few HMOs offer chiropractic care, and few chiropractors have sought to affiliate with them. As a result, some chiropractors regard HMOs as a threat. As these comprehensive prepaid health plans gain popularity, they reason, fewer patients will be willing to spend additional money outside of the HMO for chiropractic services. Other DCs disagree. They see HMOs as an opportunity for increased interprofessional cooperation and tremendous growth for the profession. But whether pro or con, most doctors agree: the health maintenance organization is a challenge to be faced, not ignored.

In the following article, ICA speaks with Dr. Silverman to learn about his HMO involvement and how DCs around the country can benefit from his experiences.

Q: *Do you think chiropractors should participate in health maintenance organizations?*

A: Yes! Or they may risk losing large numbers of patients.

HMOs cost less than other health insurance plans. As health-care costs continue to rise, the gap between HMO and insurance company costs will grow, and more and more people will join HMOs. Patients who decide to enroll in an HMO must go to the doctors in that HMO or pay for the office visit out of their pockets, in addition to the HMO premium. Chiropractors who aren't part of an HMO can't help but be affected by the trend.

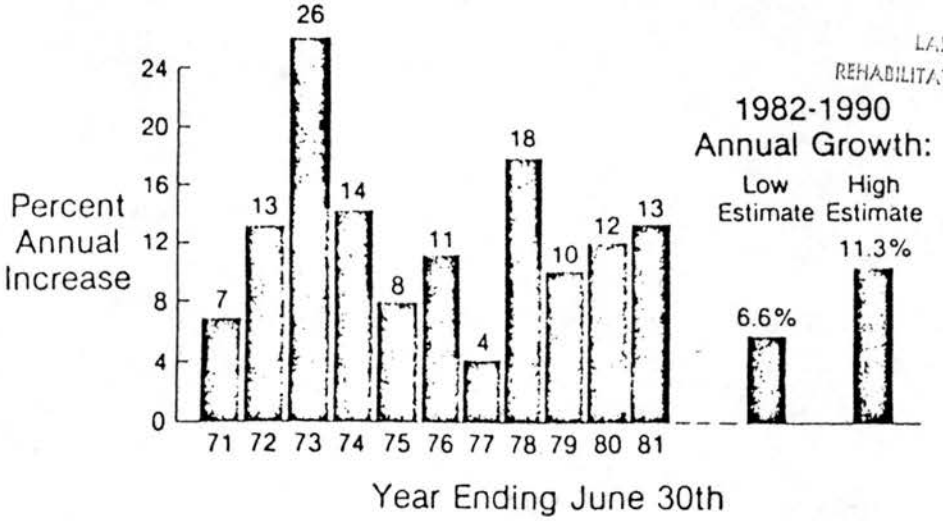
Even insurance companies are expressing an increasing interest in HMOs. I know that Prudential has invested in a plan called Pru-care, and that Blue Cross/Blue Shield is involved in an HMO here in Florida. I think this involvement is going to grow. Organizing an HMO — that is, finding a group of doctors who are willing to work within a certain fee structure — is a good way for insurance companies to keep their costs down.

I think chiropractic offers HMO owners a tremendous opportunity. These owners are in business primarily to give patients the care they need, but they also have to be very conscious of the bottom line; they have to turn a profit. If chiropractors can help patients without putting them through surgery and a long stay in the hospital, it won't be long before HMOs nation-wide will want to use chiropractors for back, neck, and other problems.

Q: *Why were you initially interested in HMOs?*

A: Like many chiropractors in Florida, I found myself with a growing number of patients who were members of HMOs. None of the HMOs in the state employed chiropractors either as salaried staff or on a contractual basis at that time. As a result, patients had to choose whether they wanted to pay for chiropractic care in addition to their HMO membership premium or do without chiropractic care. So many patients came to me with this dilemma, I gradually came to two conclusions. First, I realized HMOs were a growing force within the health care industry. Secondly, I knew that HMO owners and patients alike could benefit from having a chiropractor available through an HMO. It was at that point I decided to see if I could become a participating provider through a local HMO.

Q: *How did you join your HMO?*



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STUDY OF THE FIRST 100 PATIENTS

REFERRED TO THE SILVERMAN CHIROPRACTIC CENTER

BY AV-MED

As the title of this study implies, the following data were collected from a computer print-out of the first one hundred patients referred to the Silverman Chiropractic Center by Herbert Davis, M.D., then medical director of AV-MED and now president and chairman of the board.

Originally, AV-MED patients were referred for chiropractic care on a trial basis. Dr. Davis personally chose the first 30 cases.

Patients were polled by telephone about the results of their treatment-- 97 were reached. Because we haven't had the time to secure legal releases from each of the patients, we have obscured their last names on the enclosed copy of the study. Furthermore, we have not had sufficient time to fully massage the data and draw all the relevant conclusions the data support.

Nevertheless, the study findings are significant. In particular, we'd like to note that:

* 1212 patient visits were recorded

* average age was 37.5 years

* total cost of treatment was $32,676

* average cost per patient was $326.76

* average cost per patient visit was $26.96

* average number of visits was 12.1

PRIOR TO RECEIVING CHIROPRACTIC CARE--

* all but 20 patients had been treated by an M.D.

* the average patient had seen 1.6 doctors

* 17 had been diagnosed as having disc problems

* 4 had received treatment in emergency rooms

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* 2 had been hospitalized

* 12 had been diagnosed as needing surgery

AFTER RECEIVING CHIROPRACTIC TREATMENT--

* the average patient saw 0.21 doctors

* none required surgery

* 86% did not see a physician after treatment

****

Dr. Davis has stated that chiropractic treatment has saved AV-MED hundreds of thousands of dollars in treatment costs.

One patient in the study required 49 treatments at a cost of $936. However, this patient had been hospitalized on two occasions and was diagnosed as needing surgery. By successfully treating the patient without surgery, AV-MED saved a minimum of $20,000.

Based on the fact that 12 patients were diagnosed as needing surgery and none required same after chiropractic treatment, one may conclude that the savings on the 100 patient sample was in the range of $200,000 tO $250,000.

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AV-MED HEALTH PLAN

9400 SO. DADELAND BOULEVARD, SUITE 200, MIAMI, FLORIDA 33156 • DADE (305) 665-5437 BROWARD (305) 462-2520

Herbert H. Davis, M.D.
Medical Director

March 9, 1983

I would like to give you a brief summary of AV-MED's history as it pertains to chiropractic services. AV-MED has grown to be the largest HMO in the southeastern United States, and so far as I know the only profitable one. The key to profitability for HMO's is not growth but cost containment and I would like to express my gratitude to you for your help in this achievement. Until we started using your services we were spending a considerable amount on disc surgery and related back problems. Since I became enlightened about the benefits of chiropractic care, AV-MED's costs in this area have plummeted. Your conscientious approach in treating patients conservatively with due concern about what MMI really is has kept many useless hospitalizations and surgery from occurring.

I practiced medicine for twenty years and had certain prejudices about chiropractic care. You have certainly opened my eyes as to its true merit.

Yours truly,

AV-MED HEALTH PLAN

Herbert H. Davis, M.D.

HHD/hm

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An Open Letter to Stephen Barrett, M.D.
and William Jarvis, Ph.D.

The Actual Cost of Chiropractic Versus Medical Care

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By George P. McAndrews, Esq.

Hypothesis:
A Tentative Assumption Made In Order To Draw Out And Test Its Logical Or Empirical Consequences — *Webster's*
Postulate:
A Hypothesis Advanced As An Essential Presupposition, Condition, Or Premise Of Reasoning — *Webster's*
Theory:
Implies A Greater Range Of Evidence And Greater Likelihood Of Truth — *Webster's*
Quack:
A Pretender To Medical Skill — *Webster's*

Dear Drs. Barrett[1] and Jarvis[2]:

I address you both as "doctor" even though I know one of you was trained as a medical physician psychiatrist, and one as a Ph.D. with no direct involvement in the delivery of health care. The term "doctor" primarily means "teacher" and, as I have noted over the years, a significant amount of your "teachings" juxtapose the word "fraud" with the word "chiropractic."

Dr. Jarvis was directly involved in the New Zealand study and in the *Wilk v. AMA* case — in each situation in a manner adverse to the interests of the chiropractors involved.

Dr. Barrett's works were considered by the Royal Commission of Inquiry on Chiropractic in New Zealand but the commission stated that "nothing [you have] written on chiropractic that we [the commission] have considered can be relied on as balanced." (NZR p. 105).

Each of you has, I believe, lamented the outcome of the New Zealand and *Wilk* hearings.

I write you with a request that you add balance to your teaching. My family and I are health-care consumers, members of my family are doctors of chiropractic and, as you know, as a lawyer, I have represented doctors of chiropractic for the last 15 years in the *Wilk* case. In fact, I have had the privilege of cross-examining you, Dr. Jarvis, on at least two occasions. My bias should be evident. I believe the bias of each of you is also evident but, unfortunately, I do not believe the readers of your articles may appreciate the glaring lack of balance in your written presentations because, unlike the New Zealand Commission or the Court in the *Wilk* case, many of your "students" or readers are not trained to be discriminating when reading biased material.

I would like to request that you broaden your horizons. Assume, for argument's sake, that modern, mainstream medicine is still very primitive in the absolute sense. Assume that most consumers of health care do not realize that and that you should feel obligated to so inform them of that fact. As recently as February of this year, newspapers around the country headlined the following story:

> On a muggy morning in June 1989, Robert M. Centor, a prominent doctor of internal medicine from Richmond, Va., sat down at a congressional witness table and made a remarkable confession.
>
> When a patient comes to see him with a complaint, such as a sore throat, or an aching back, Centor said he lacks the tools he needs to make a sound decision because medical science cannot tell him what kind of treatment works best for many common ailments.
>
> "In order for me to make a good judgment, I need to have some data. And right now I don't have enough data to make that decision," said Centor, chairman of the division of general medicine and primary care at the Medical College of Virginia.
>
> Centor's testimony — delivered on behalf of the 65,000 members of the American College of Physicians — reflects

[1] Dr. Barrett has been chairman of the board of directors of the Lehigh Valley Committee Against Health Fraud, Inc. and is author of "The Spine Salesmen," a chapter in the book "The Health Robbers."

[2] Dr. Jarvis was a co-founder of the National Council Against Health Fraud and is a frequent lecturer on issues of consumer health and a faculty member of Loma Linda University.

a crisis of confidence that is just now being widely acknowledged in medicine.

With surprising candor, doctors are admitting that they aren't sure what really helps their patients and what is useless or even harmful. Near the end of a century of extraordinary medical progress and generally improving health, doctors still don't know what works.

* * *

Meanwhile, however, doctors and surgeons continue to be plagued by doubts and disagreements about the accuracy of medical tests and diagnoses, about the value and safety of new machines and procedures — and about when, where and how to cut, bore and slice the human body.

"We don't know what we're doing in medicine," bluntly declared Dr. David Eddy, director of the Duke University Center for Health Policy Research, at a health-care conference in Atlanta. "The imperative for the 1990s is to fix that problem."

"The embarrassment of our ignorance about the efficacy of health-care practices is both hard for us to admit and hard for our clients to accept," Dr. Donald Berwick, vice president of the Harvard Community Health Plan, wrote in *Medical Care, the Journal of the American Public Health Association.*

"It is difficult to face the disillusionment of the patients and the anger of the payers who ask: 'But how could this be? I thought you knew what you were doing.' "

Part of the evidence that much of modern medicine is still based on guesswork comes from the pioneering work of Dr. John Wennberg, a professor of community and family medicine at Dartmouth Medical School. For almost 20 years, Wennberg and his colleagues have been collecting evidence of inexplicable variations in treatment patterns between different cities, hospitals — and even different doctors — without any appreciable difference in outcome for the patient. (*Fort Wayne News-Sentinel,* Friday, February 2, 1990.)

Sounds exactly like your criticisms of chiropractic. But I don't remember seeing this type of criticism of medicine in the "Health Robbers," or in Dr. Jarvis' works. You seem to look for mosquitoes when an elephant is at your door.

Please assume with me that the failure of the medical spokespeople to clearly inform the public of the shortcomings of medicine may well come under the loosely defined term of FRAUD that each of you utilize freely in your attacks on chiropractic. While freedom to critique the profession of chiropractic is admitted, let me suggest that your excessive, unbalanced criticism does science and sick people a disservice. Please remember the irony of United States District Court Judge Susan Getzendanner's statement that the medical physicians delegated by the AMA with the task of destroying the profession of chiropractic "did not have minds open to pro-chiropractic arguments or evidence." She did this while also stating:

> But, according to the court (and this is unchallenged), at the same time, there was evidence before the committee that chiropractic was effective, indeed more effective than the medical profession, in treating certain kinds of problems, such as back injuries. The committee was also aware, the court found, that some medical physicians believed chiropractic could be effective and that chiropractors were better trained to deal with musculoskeletal problems than most medical physicians.[4] (p.12).

[4]The trial court also specifically found that: "Even the AMA's economic witness, Mr. Lynk, assumed that *chiropractors outperformed medical physicians* in the treatment of certain conditions and he believed that was a reasonable assumption. (Tr. 1414) (Emphasis added.)

Perhaps you might want to attack this type of fraud by silence that I refer to by informing your students, or readers, or listeners, with prominent emphasis, that, under certain circumstances, lives, the quality of life, pain, suffering and financial distress may be at risk by a person's choosing to see a closed-minded medical physician rather than a doctor of chiropractic. Many mainstream, honest medical physicians are "quacks," under definitions you seem to use, because they pretend to have knowledge that they clearly do not have and, in particular, they lack medical knowledge in areas where doctors of chiropractic clearly do have scientifically proven, superior knowledge and skills. Does that surprise you? Let me direct your thoughts to the following:

Postulate: Let us suppose, for argument's sake only, that 1. the state of Iowa has fewer hospital admissions for low back pain, per capita, than any other state, 2. more people in Iowa entrust essential health care to doctors of chiropractic and, 3. there are more doctors of chiropractic, per capita, in the state of Iowa than in any other state. What a fruitful field for study. Why haven't those and related studies been done by the medical community with its vast government and foundation funded resources? Perhaps what follows may provide an explanation.

Remember, if you will, that, in 1976, medical physicians in Los Angeles County, Calif., went on strike. Their collective action may or may not have accomplished its political purpose. It did cause the medical profession grave embarassment because subsequent audits demonstrated that the death rate in Los Angeles County dropped substantially during the one month the medical physicians were on strike. The studies show "there were likely between 55 and 153 deaths that did not occur as a result of the amount of elective surgery that was not performed during the month of January 1976," alone (*AJPH,* 1979, Vol. 69, No. 5, p. 439.) I would suggest the possibility that medical physicians might have rented the Goodyear blimp to proclaim the fact if even one or two patients died under chiropractic care in Los Angeles County alone during a one month period.

You are also aware of the very recent Harvard University study of unnecessary deaths and injuries, *in New York hospitals alone,* that concluded:

> By extrapolating their findings to the 2.7 million patients hospitalized in New York in 1984, the researchers concluded that nearly 99,000 patients had experienced injury because of the medical treatment they received, with one-quarter of those injuries resulting from negligence. The panel estimated that negligence had contributed to the deaths of

more than 13,000 patients. The incidence of negligence had been higher in hospitals run by state, county or city governments than in private or nonprofit hospitals.

Only a small fraction of patients injured by negligence had filed malpractice suits, the study found.

Overall, the study estimated that injuries occurring in hospitals had cost patients $894 million in New York State in 1984. (Harvard Medical Practice Study, 1990).

Extrapolate those figures to the entire United States and it represents mayhem on a massive scale.

Because of the medical physician boycott of doctors of chiropractic in the United States, made possible, in part I would suggest, by the total lack of balance in health-care reporting, effective cooperative studies and research have had to be conducted in other countries such as New Zealand, Canada, Italy and Great Britain. The most recent research study, reported in the *British Medical Journal,* scientifically proves the superiority of chiropractic care over medical physician, osteopathic, and physical therapist care in the treatment of low back pain of mechanical origin — an area where too much elective surgery takes place. More about that English study later. Please keep it in mind, however, while you read the following. I would hope the following would induce you to begin challenging the medical profession to at least recognize its shortcomings in its battle against chiropractic. Who knows? Your challenge might result in lives saved; the reduction of unnecessary and costly (and possibly life threatening) hospital admissions; the amelioration of much pain; enormous cost savings to the government and third party payers; efficiencies in the work place; the easing of burdens on families unfortunate enough to have a patient who should see a doctor of chiropractic but who may be risking his health (or his life) by seeing an untrained, unprepared medical physician.

In 1975, a 1972 retrospective study of 629 workmen's compensation cases in California by C. Richard Wolf, M.D., was published. It showed that doctors of chiropractic were twice as effective as medical physicians, for comparable injuries, in returning injured workers to work at every level of injury severity:

Average lost time per employee — 32 days in the M.D.-treated group, 15.6 days in the chiropractor-treated group.

Employees reporting no lost time — 21 percent in the M.D.-treated group, 47.9 percent in the chiropractor-treated group.

Employees reporting lost time in excess of 60 days — 13.2 percent in the M.D.-treated group, 6.7 percent in the chiropractor-treated group. *(Industrial Back Injury,* by C. Richard Wolf, M.D.)

Also, in 1972, Roland A. Martin, M.D., medical director of the Oregon Workmen's Compensation Board, published a study, again based on a retrospective study of comparable workmen's industrial injuries, and independently concluded that same two-to-one advantage of chiropractic care:

Examining the forms of conservative therapy the majority received, it is interesting to note the results of those treated by chiropractic physicians.

A total of 29 claimants were treated by no other physician than a chiropractor. Of these workers, 82 percent resumed work after one week of time loss. Their claims were closed without a disability award.

Examining claims treated by the M.D., in which the diagnosis seems comparable to the type of injury suffered by the workmen treated by the chiropractor, 41 percent of these workmen resumed work after one week of time loss. (A study of time loss back claims, Workmen's Compensation Board, state of Oregon, March 1971.)

The above should have raised some suspicions among fair minded medical physicians, or their allies, that society was paying a terrible "human suffering cost" and "economic cost" for entrusting these workmen's compensation cases to medical physicians "pretending" to have skills in this area of health care. Instead, medical physicians, crushing all common sense between the twin bookends of arrogance and ignorance, downplayed the significance of these facts by talking about the inadequacies of retrospective studies, the lack of controls, placebo effects, etc. Those people can run but they cannot hide. The word "pretending" is used advisedly in the above discussion because there is a chronologically parallel line of evidence suggesting that medical physicians may clearly lack skills in the area of musculoskeletal injuries. Let me explain.

In 1967 the AMA was told by John C. Wilson, Jr., M.D., chairman of the AMA's section on orthopedic surgery and, later, president of the American Academy of Orthopedic Surgeons that medical doctors and orthopedic surgeons were essentially ignorant of the causes or corrections of low back problems:

When queried about the lower back a medical student soon to graduate from a far Western university revealed an enormous gap in his professional education. One instructor had given him a list of 125 causes of low back pain, from which the student had concluded that probably everyone with sciatica had a ruptured disc requiring surgery; another instructor had delivered a one-hour lecture on anterior interbody fusion. This young man, well informed concerning the cause and treatment of cardiac arrhythmias, electrolyte imbalance, and alterations in the DNA chain, displayed a disturbing ignorance of the cause and treatment of low back and sciatic pain — one of mankind's most common afflictions.

The teaching in our medical schools of the etiology, natural history, and treatment of low back pain is inconsistent and less than minimal. The student may or may not have heard a lecture on the subject, he may have been instructed solely by a neurosurgeon, or the curriculum committee may have decided that clinical lectures are "out" and more basic sciences "in." The orthopedic surgeon, to his distress, often sees his hours in the curriculum pared to the barest minimum.

A survey of orthopedic residents graduating from an approved program in a large urban area disclosed several alarming deficiencies in their training. They know very little about the natural history of degenerative disc disease in the lower part of the spine. The importance of the physician's personally taking an accurate, detailed patient history had escaped them. They were too unsure of the technique of careful lumbar spine examination to include a search for early stages of neurologic deficit. They had too often been satisfied with interpretations of technically inferior roentgenograms, and their insufficient knowledge of diagnostic aids seldom permitted them to select the one most helpful in accurately establishing the level of a lesion. They knew least when to use a particular surgical procedure.

At the postgraduate level, symposia and courses concerning the cause and treatment of low back and sciatic pain are often ineffective because of prejudices and controversy.
These inconsistencies spawn disastrous sequelae:

1. patients operated upon after inadequate evaluations;
2. reliance by physicians on poor quality X-ray films;
3. surgery done only because of an abnormality in a myelogram without reference to plain films of the lower spine;
4. exploratory surgery upon the lower back done without sufficient clinical basis;
5. extensive surgery done for solely subjective complaints;
6. repeated attempts at spinal fusion — sometimes six or eight — by surgeons of limited experience;
7. surgery authorized by industrial accident commissions comprised exclusively of laymen; and
8. extensive removal of posterior vertebral elements by neurosurgeons, making stabilization of the lower portion of the spine technically difficult if not impossible.

(*Journal of the American Medical Association,* May 22, 1967, "Low Back Pain and Sciatica.")

Dr. Wilson may also have included "many unnecessary deaths" from elective surgery if we are to believe the Los Angeles County and Harvard studies as well as the latest confessions of the confusion engulfing medicine — the "We don't know what we're doing" syndrome.

Obviously, Dr. Wilson's critique was a call to arms directed to his colleagues. He is to be commended for his observations and his vision. Unfortunately, the medical physician community, too often trained to believe that health-care knowledge is theirs alone, by divine right, and that efficacy is only defined by prescriptions for expensive pharmaceuticals, hospitalization, etc., appears to have ignored Dr. Wilson's entreaties. They also ignored the obvious benefits of conservative chiropractic care. "Ignore" is an understatement or misstatement. Actually, they continued to damn it, attempted to destroy it, and ignored its obvious benefits. Some even went so far as to call it a "fraud."

By 1979, a Royal Commission of Inquiry on Chiropractic in New Zealand, following an in-depth study, was concluding (some 12 years after Dr. Wilson's critique):

34. The Commission has found it established beyond any reasonable degree of doubt that chiropractors have a more thorough training in spinal mechanics and spinal manual therapy than any other health professional. It would therefore be astonishing to contemplate that a chiropractor, in those areas of expertise, should be subject to the directions of a medical practitioner *who is largely ignorant of those matters simply because he has had no training in them.**** (NZR, p. 305).

* * *

79. ***Dr. Haldeman, in the course of his evidence, said that 12 months full-time training in spinal manipulative therapy following a medical degree would be appropriate. (NZR, p. 244). (Chiropractic in New Zealand Report, 1979, Government Printer, Wellington, New Zealand.)

Please note that the foregoing investigation was in New Zealand. Other studies that followed were from Canada, Italy and, just this year, Great Britain. Could it be that the anticompetitive nature of America's medical physicians (the Major Deity syndrome), and of their spokespeople and institutions, has precluded essential interprofessional scientific investigations into the efficacy and cost efficiency of chiropractic care versus medical physician care? We talk here about the true economic cost of pain, disruption in the work place, absence from work, training of substitute workers, disruption in the home *and* the out-of-pocket payments made to the hospital, drugstore, professional, etc.

I propose to each of you that the evidence demonstrates that chiropractic care: 1. keeps a large number of patients out of hospitals; 2. keeps many more employees actively working while undergoing care; 3. helps get hospitalized orthopedic (and possibly other) patients out of the hospital faster; and 4. generally reduces pain and suffering at an earlier date than traditional, relatively ineffective, medical care. In other words, chiropractic care may be both more effective and more efficient than medical care for some very significant health problems. Does lack of this knowledge by the general public amount to fraudulent failure by the medical physician community to disclose?

In 1980, fully 13 years after the warning by Dr. Wilson, quoted above, medical orthopedist and professor of physiatry at eight American medical schools, John McMillan Mennell, M.D., testified, under oath, that medical physicians have almost no education in the musculoskeletal system:

A. I think my testimony was that if you ask a bunch of new residents who come into a hospital for the first time how long they spent in studying the problems of the musculoskeletal system, they would, for the most part reply, "Zero to about four hours." I think that was my testimony.

* * *

Q. The musculoskeletal system comprises what portion of the body?
A. As a system, about 60 percent of the body.
Q. Is it your testimony that the residents to whom you just referred told you they had no trai ing whatsoever re-

lating to problems as to 60 percent of the body?
A. And that is just about right.

* * *

Q. Is it your testimony that it is your understanding that the entire medical school curriculum is devoted to about 40 percent of the body?

A. Yes, sir.

* * *

Q. The normal medical practitioner goes through first four years of undergraduate school, is that correct?
A. Yes.
Q. And then the practitioner goes through four years of medical school, is that correct?
A. Correct.
Q. Then the practitioner goes through one to five years of residency, is that correct?
A. Yes.
Q. So that is anywhere from nine to 14 years, 13 years.
A. They still come out of school and say pain in the elbow is tennis elbow. I don't know what that means.
Q. During that nine — I think I added it quickly, it is 13 years — during that nine to 13 years that training is devoted to 40 percent of the body, is that correct?
A. That is correct.

(Transcript of Testimony of John McMillan Mennell, M.D., who taught at numerous American Medical Schools from 1950 through 1980. Tr. pp. 2090-2093.)

In view of the above and Dr. Wilson's statements, Dr. Barrett, I wonder how you determined that the four-year-old girl who you sent to five chiropractors was "perfectly well" as recounted in your article entitled "The Spine Salesmen." Perhaps the members of your Committee were dead wrong and the chiropractors were right in evaluating her musculoskeletal conditions.

In 1985 Dr. Kirkaldy-Willis, professor emeritus of orthopedics and director of the Low-Back Pain Clinic at the University Hospital, Saskatoon, Canada, and Dr. Cassidy, a chiropractor, published their joint research paper "Spinal Manipulation in the Treatment of Low-Back Pain" in *Canadian Family Physician,* Vol. 31, p. 535, March 1985. Again, the public had to look to foreign medical physicians for open-mindedness and concern for patient welfare.

In 1987, Per Frietag, an orthopedic surgeon, with a Ph.D. in anatomy, testified, under oath, that, in his experience, orthopedic patients cut their average stay in hospitals in half when they concurrently received in-hospital chiropractic care.

Q. All right. Are you interested in getting these patients better faster?
A. Absolutely.
Q. For how long a period of time have you been caring for patients at Lutheran General?
A. Since the summer of 1978.
Q. For how long a period of time have you been caring for patients at J.F.K.?
A. Since May of last year.
Q. Can you tell us, in your experience, at which hospital are you able to get your patients better faster?
A. At the John F. Kennedy.
Q. Have you been able to reach a conclusion as to the reason for that?
A. The only difference that I can see is that the patients at John F. Kennedy get chiropractic manipulations. And in my experience, the patients at J.F.K., almost without fail, get out of the hospital in a week, six, seven days. At Lutheran, it usually takes, oh, not uncommonly 14 days.
Q. Is that — is it a benefit to the patient in your experience to be able to get them out of the hospital quicker?
A. Absolutely.

Then in 1987, a study of 17,142 patients in Italy by medical physicians and chiropractors concluded:

> The clinical-statistical survey carried out by the 22 static clinics located throughout Italy, the results of which I have the honor of presenting in this publication, lies within the above-described scope and is aimed at developing investigation efforts within every aspect of the Italian health system that has proved successful and that has helped curtail health costs in general and hospitalization costs in particular.
>
> The Static Clinics are designed for the treatment of patients suffering from painful syndromes affecting the spinal column, which may be referred to the specific rachidial segment.
>
> The recurrence rate of rheumatic diseases (arthrosis, arthritis, etc.) is very high in Italy and rank first among the chronic-degenerative pathologies, so much so that they are considered social diseases.
>
> These disorders entail *considerable costs,* not only in terms of health expenditure (essentially due to the occupation of hospital beds), insurance costs and social welfare, but, primarily in terms of loss of productive forces caused by prolonged periods of inactivity or reduced productivity in the work place.
>
> Treatment involving manipulation integrated by traction and mechanical therapy has proved that all the effects of staticodynamic disorders can be successfully eliminated.
>
> The results of our survey presented herein, are clear and incontrovertible: our sample population of over seventeen thousand patients treated with chiropractic for at least two years showed that this treatment could lead to a *75.55 percent reduction in the number of daily absences from work and could cut down the number of hospitalized patients by 87.60 percent* vis-a-vis other currently used forms of treatment (pharmacological, physiokinesitherapic, surgical, etc.)
>
> A most meaningful indicator of the effectiveness of chiropractic is the improvement it produces in the *quality of life,* not only because of its curative effect but also thanks to its preventive and rehabilitative functions.
>
> (Chiropractic — Therapeutical effectiveness — Social importance. Incidence on Absence from Work and Hospitalization, Survey on a sample of 17,142 patients, Italy, 1987, Professor F. Splendori.)

While the above developments were taking place, the medical physician community was being told that only *four* orthopedic surgical procedures during the years 1979-1984 had been subjected to appropriate randomized clinical trials for efficacy. "The Randomized Clinical Trial in Orthopaedics: Obligation

or Option: *Journal of Bone and Joint Surgery*, October 1985. I wonder where the balance is or was. Did either of you report on these specifics? Have you ever told your "students" that much of medicine (70 percent) is pure art (with potentially lethal consequences) that has not been scientifically evaluated. Have you told them that the medical community appears to have three standards: 1. drug testing required by law; 2. physical procedures done by medical physicians that may or may not be scientifically tested; and 3. physical procedures performed by doctors of chiropractic for which the medical community demands drug-like testing proof.

When the medical community ventured into "researching" chiropractic it was done with a preconceived bias reflected in such pre-test statements as "I am now setting up experiments to blow their profession." Letter of Dr. Crelin to Ray Sullivan dated January 24, 1972 (PX 1483A), prior to his publishing "A Scientific Test of the Chiropractic Theory," *American Scientist*, September-October 1973. By the way, please compare his research findings on spines removed from cadavers with the "pedicular kinking" referred to, and illustrated in the American Academy of Orthopedic Surgeons Symposium on the Spine, 1965 p. 105, Figs. 6-13 and 6-14.

Moreover, the "unbiased" study requested by Congress that resulted in the 1968 HEW Report was *preceded* by such "scientific" correspondence between the AMA and those to be involved in the study as:

> ". . . There was complete acceptance (by Health Insurance Benefits Advisory Council) of the concept of preparing the decision on the basis of lack of scientific merit." (PX 1414, Letter of Dr. Sam Sherman to Doyl Taylor of the AMA of March 11, 1968, five months before the study commenced.)

Compare that science with the results of tests now coming out of Canada, Italy and Great Britain.

While the Congress grapples with a $600 billion national health-care bill and the medical physician community urges government, third party payers, and self insured groups to eliminate chiropractic care or benefits, while at the same time preventing veterans' and other teaching hospitals from doing necessary cooperative research involving chiropractic care, the results of a new study were just released in Great Britain. The results should not be surprising. The progress of chiropractic, the above studies and commentary, and common sense all dictated what the results would be.

This latest study is remarkable. The conclusions to be drawn therefrom are inescapable. The abstract of the study, printed in the June 2, 1990 issue of the *British Medical Journal*, gives a good summary of the extensive, prospective study entitled "Low Back Pain of Mechanical Origin: Randomised Comparison of Chiropractic and Hospital Outpatient Treatment."

Abstract

Objective — To compare chiropractic and hospital outpatient treatment for managing low back pain of mechanical origin.

Design — Randomised controlled trial. Allocation to chiropractic or hospital management by minimisation to establish groups for analysis of results according to initial referral clinic, length of current episode, history, and severity of back pain. Patients were followed up for up to two years.

Setting — Chiropractic and hospital outpatient clinics in 11 centers.

Patients — 741 Patients aged 18-65 who had no contraindications to manipulation and who had not been treated within the past month.

Interventions — Treatment at the discretion of the chiropractors, who used *chiropractic manipulation* in most patients, or of the hospital staff, who most commonly used Maitland mobilization or manipulation, or both.

Main outcome measures — Changes in the score on the Oswestry pain disability questionnaire and in the results of tests of straight leg raising and lumbar flexion.

Results — Chiropractic treatment was more effective than hospital outpatient management, mainly for patients with chronic or severe back pain. *A benefit of about 7 percent points on the Oswestry scale was seen at two years. The benefit of chiropractic treatment became more evident throughout the follow up period. Secondary outcome measures also showed that chiropractic was more beneficial.*

Conclusions — For patients with low back pain in whom manipulation is not contraindicated *chiropractic almost certainly confers worthwhile, long term benefit in comparison with hospital outpatient management.* The benefit is seen mainly in those with chronic or severe pain. Introducing chiropractic into NHS practice should be considered.

The rest of the complex study is what is so intriguing. Under "Economic Implications" the authors write:

> The potential economic, resource, and policy implications of our results are extensive. The average cost of chiropractic investigation and treatment at 1988-9 prices was $273.90 per patient compared with $184.26 for hospital treatment. Some 300,000 patients are referred to hospital for back pain each year, "of whom about 72,000 would be expected to have no contraindications to manipulation." If all these patients were referred for chiropractic instead of hospital treatment the annual cost would be about $6,640,000. *Our results suggest that there might be a reduction of some 290,000 days in sickness absence during two years,* saving about $21,580,000 in output and $4,814,000 in social security payments. As it was not clear, however, that the improvement in those treated by chiropractic was related to the number of treatments the cost of essential chiropractic treatment might be substantially less than $6,640,000. The possibility that patients treated in hospital would need more treatment during the second year than those treated by chiropractic also has to be borne in mind. There is, therefore, economic support for use of chiropractic in low back pain, *though the obvious clinical improvement in pain and disability attributable to chiro-*

practic treatment is in itself an adequate reason for considering the use of chiropractic.

Please note the fact that even though the "direct" payment to the chiropractor exceeds the direct payment for the hospital outpatient care, the researchers conclude that chiropractic care results in enormous cost savings to the *system.*

Even if we merely assume English wages and costs, and also assume the U.S. population, we can see extrapolated savings of over $100,000,000 from the use of doctors of chiropractic versus medical physicians, orthopedic physicians or physical therapists.

Assuming realistic, non-socialized, American health-care costs, wages, medicare and other third party payments for back care, both in and out of hospitals, conservative savings from the use of doctors of chiropractic could well exceed $500,000,000 per year in the United States. The economic savings pale when compared to the savings in pain, unnecessary hospitalization, unnecessarily prolonged hospitalization, time off work, work place and family disruption, and freedom from unnecessary drugs and their side effects.

Doctors Barrett and Jarvis: I would like to solicit your resources in combatting the health-care fraud being perpetrated by medical physicians who are pretending to have knowledge they clearly do not have. It would appear that lives may be lost; vast sums of money are wasted on unnecessary hospitalization or unnecessarily prolonged hospitalization; and millions of people suffer needlessly both from their condition and from drug related side effects, because people do not know of the medical physicians false claims to expertise in this area. You should point it out. I suspect that more damage to the public has been done by this "fraud" than by all of the fraud you attribute to the chiropractic profession.

Perhaps it is not unreasonable to demand that Congress or private foundations fund extensive research into just why it is that every single study done by medical physicians, on the comparison of medical care versus chiropractic care for non-surgical musculoskeletal problems shows, beyond peradventure, that the *overall* effectiveness and cost efficiency of chiropractic care exceeds that of medical care.

The focus of cost studies has obviously been misplaced. It has been to the economic advantage of the medical profession to ignore the tremendous societal cost of 1. the obvious ignorance and lack of training of medical physicians in this area; 2. deaths due to elective, but unnecessary, back surgery; 3. unnecessary time off work that could be obviated if chiropractors replaced medical physicians as the primary portal of entry providers for back injuries; 4. work place and family disruption; 5. unnecessary hospitalization or unnecessarily prolonged hospitalization costs; and 6. the real costs of unmitigated suffering resulting from improperly treated musculoskeletal ailments.

Finally, I refer you to a sad event in the nation's health-care history. In 1966 the AMA was informed by one of its trustees, a noted orthopedic surgeon and professor at the University of Colorado College of Medicine, Dr. Irvin Hendryson, that he had conducted a private, randomized test of chiropractic on Guadalcanal in World War II. He praised the chiropractor's (his orderly) skills and the results obtained. Then, in the cover letter to his report to the AMA, he got very specific about chiropractic, back pain, manipulation, and pregnant women:

> As a final note in this regard, I must cite two cases which I think are of clinical significance. The first is that of an All-American football player who was "down on his back." This man was definitely not in the psychosomatic class nor was he neurotic. He was a commanding officer in an engineer battalion on Guadalcanal and about as tough a man as I have ever seen in my life. However, in reaching over to pick something out of his footlocker, his back "went out." Being the type of individual he was, he preferred to perform duty with the help of the medication given by his battalion medical officer but finally reached the place where he was completely incapacitated. Finally, he was sent to us and fell into the class of the next case for manipulation and after the routine million dollar roll, the osteopathic roll, the chiropractic punch and the osteopathic leg length maneuvers, this man was able to get off the table and say, "This is the best I've felt in days." I was impressed by this case and I still am. Grantedly, had he sought more competent medical attention early in the phase of his complaint, he may well have been ready to return to duty at the end of ten days. However, this was impressive.
>
> The second case, and one that I am not really at liberty to report objectively because it has to do with my own life (and yet I have heard from my friend in obstetrics and also in recent years in practice). However, it is commonly known that in the third trimester of pregnancy, unrelenting back pain is one of the prices that is paid for perpetuation of the race. I have learned from personal experience that general manipulations of backs in this particular condition has given these women a great deal of physical relief and has permitted them to go on to term and deliver without having to be bedfast during the latter term of this pregnancy. I would not for an instant indicate that it is manipulation alone that permits these women to go on and carry on normally for at the present time we are giving them manipulation to relieve them of their acute symptoms and also fitting them with support which is a well recognized medical practice. However, I must say that I am impressed by the many cases who are able to go on to term, to manage their households, to lead a comparatively comfortable third trimester without having to be hospitalized for traction, heat, support and all the rest of it.
>
> In spite of the fact that there are many more questions that I could raise as well as other analysts in this matter, I must say quite honestly that there are still aspects of the manipulative therapy itself which impress me and which I feel practicing clinicians should be using in the management of

low back pain. Whether there is value in chiropractic or not, I am not prepared to say. However, I would also agree, as will you, that it has prospered through the years and it is a difficult thing to quarrel with success.

(Private letter of AMA trustee, Irvin Hendryson, M.D., to the legislative council of the American Medical Association in 1966 on the results of a study conducted by Dr. Hendryson on Guadalcanal in World War II using a doctor of chiropractic who had been assigned as Dr. Hendryson's orderly.)

Tie in Dr. Hendryson's comments about pregnant women with those of Dr. Freitag, some 21 years later.

Q. Doctor, have you ever referred pregnant women to chiropractors?
A. A few times.
Q. Can you tell us for what reason?
A. Well, I — during pregnancy, of course, back pain and sciatica is very common. And I don't remember even where I first heard about the idea of manipulating pregnant women, but I tried it on a few patients as an alternative to epidural steroid injections. And it seemed to work, at least in the few that I came in contact with.
Q. What is an epidural steroid injection?
A. Well, epidural injections is probably the primary means of anesthesia for childbirth these days. The so-called epidural space is right inside the bony canal outside where the dura and the spinal cord runs. What the anesthesiologist does during childbirth is basically to inject novocain there. For treatment you usually use a mixture of cortisone, salt water and some long-acting novocain, it calms down the nerve roots and thereby relieves the pain and the irritation around the nerve root.
Q. And did the chiropractor use epidural steroids, do you know?
A. Of course not.
Q. What did the chiropractor do?
A. Well, he basically does spinal distriction.
Q. All right. And you have found that to be beneficial to the patients?
A. In the few that I have referred to here, yes.
(Trial Transcript pp. 810-812, 815-816).

The Hendryson report was suppressed by the AMA because it was feared that it might be deemed by the public to be favorable to chiropractic. How many pregnant women have needlessly suffered due to the closed minds of medical physicians?

I do not want to close this letter about "costs" without commenting on the use of chiropractic for problems affecting other than the musculoskeletal system. You, Dr. Jarvis, have acknowledged the problem of referred pain and the mimicked disease syndrome. A cardiac invalid who merely suffers retrosternal pain referred from a spine distortion is, nevertheless, a serious problem for all concerned. Chiropractors should check that patient *before* heroic chemical or surgical intervention takes place. Similar examples are legion.

You do, however, appear to take issue with the structure-affects-function or neuromechanical-organ dysfunction-disease concepts of chiropractic. You are reticent to accept the adage that the plural of "anecdote" is "data." In other words, most chiropractors believe that nerve pressure can result in organ dysfunction that can lead to susceptability of the organ to disease.

Perhaps the concept is easier for non-chiropractors to understand if you will read the treatment of "Cervical Spondylosis" on page 280 of the 1982 *The American Medical Association Family Medical Guide.*

> The main symptom of cervical spondylosis is a stiff neck. Pressure on the nerves that lead from the affected area to your hands and arms may cause such symptoms as tingling, "pins and needles," numbness, and, occasionally, pains in the shoulders or arms.
>
> Pressure within the neck may in time affect other portions of the spinal cord. Thus, if cervical spondylosis becomes increasingly severe, there may be a gradual weakening of the legs, and perhaps problems with bladder control. Sometimes, too, blood vessels that run through the neck vertebrae to the brain can become constricted because of this disorder, and this can cause symptoms such as headache, dizziness, unsteadiness, or double vision, especially if you try to bend your neck.

Sounds suspiciously like a chiropractor's ad, doesn't it? I recognize that the chiropractor's concept of subluxation is not synonomous with cervical spondylosis but the reference makes the point. If the bladder doesn't function properly, it is prone to microbial infection. Antibiotics might clear up the infection but only relief of the pressure on the nerve will allow the bladder to work properly and avoid recurring infection. Even the medical community agrees with that.

I suggest that the cost of medical physician intransigence on the chiropractic issue has become intolerable. Common sense indicates that chiropractors have needed expertise that the medical community lacks. Sick people cannot accept the cost of the medical model's ignorance in this important area.

Please use your influence to urge the medical community to become more scientific in the area of neuromusculoskeletal problems and related ailments. Urge medical physicians to cooperate with the chiropractic community. I'll continue to urge chiropractors to continue their quest for validation of all their theories and to discard those that prove to be wrong.

Only patients can benefit from an open mind. ■

George P. McAndrews, Esq., is a graduate of Notre Dame and the Notre Dame Law School. He served as a law clerk for U.S. Court of Appeals Judge Luther M. Swygert before joining a Chicago law firm in 1963. He is a principal in the law firm of McAndrews, Held and Malloy, Ltd., also in Chicago. Mr. McAndrews is currently the ACA general counsel who, over the past several years, has guided the chiropractic profession through some of its most important litigation including the landmark Wilk *case.*

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More Productive
A current Italian study of 17,142 patients indicates that chiropractic treatment could lead to a **75% reduction** in the number of daily absences from work and could cut down the number of hospitalized patients by 87%.

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Stephen E. Martini, D.C.

August 21, 1992

Department of Labor & Industry
Rehabilitation and Medical Affairs
443 LaFayette Road North
St. Paul, MN 55155-4316

RECEIVED
AUG 21 1992
LABOR & INDUSTRY
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ATTN: Ms. Pam Zembal

RE: Manage Care Plans

Dear Ms. Zembal:

I am greatly concerned about the new Rules and Regulations of manage care plans. A large part of my practice is treating injured patients from work related accidents. I am concerned that myself as well as many other chiropractic physicians would be excluded from treating patient's under the new workmans compensation regulations. If the MCPS are given the choice of what doctors they want to participate in their plan I feel this would be very unfair to the doctors who are left out. This would limit the freedom of choice for the patient. I feel that the MCP should be required to accept all health care providers who meet the appropriate requirements.

I am also concerned about the "initial evaluations" required by a medical doctor on the injured worker. It is no secret that the medical profession has for a very long time discriminated against the chiropratic profession. Although our relationship has improved and medical doctors and chiropractic doctors are working in a more cooperative fashion for the benefit of the patient it is still rare for medical doctors to refer patients to chiropractors. The evaluating medical doctor is not a chiropractor and really does not know first hand what chiropractors do. It is very unlikely that he would determine that the chiropractic care would be appropriate for the patient after the initial evaluation. Chiropractors would be discriminated against right from the start if this system works this way. Chriopractors would essentially be eliminated from treating these patients. The chiropractic profession has grown so rapidly in recent times because the patients consistantly have received relief from their symptoms and made progress that they were unable to obtain from the medical profession. However, chiropractic care has been effective in helping injured workers to return to their jobs. Chiropractic care in many respects has been

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superior to that of the medical profession in treating these type of injuries. If these new changes are put into effect the way they are presently outlined there is no doubt that the patient will loose their freedom of choice for the type of provider they want for care of their injuries and the care that they will receive will be in my opinion of less quality. I feel that the patient should be allowed to choose from any of the participating health care providers and not be directed toward one, two or three by the evaluating company doctor.

I feel that many of the new rules and regulations that are being put into effect will force doctors to go against our own ethical commitments to the patients care and will restrict the use of our own clinical judgment based upon our experience and training and the quality of the care provided to the patient will become inferior than it is at the present.

Sincerely,

Stephen E. Martini, D.C.

SEM/vlb

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DR. JAMES J. ABELER
DR. J. JOSEPH ABELER
DR. STEPHEN R. ABELER



Abeler CHIROPRACTIC CLINIC, 600 E. MAIN ST., ANOKA, MINN. 55303 421-3722

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W. C. ADMINISTRATIVE OPERATIONS

Aug. 21, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comment to Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

Please accept this letter as my abbreviated comments on the proposed emergency rules on managed care plans published on July 27, 1992.

I am a licensed Minnesota doctor of Chiropractic for the past 43 years. My right to be a primary care provider has been a privilege I have dearly cherished and respected. It has also pleased me to see so many studies recently conducted by unrelated researchers showing that Chiropractic care reduces lost time, and of course reduced costs for the employer.

The Managed Care Plan fails to recognize our primary care rights as well our track record in achieving excellent results in less time and expense.

Doctors of Chiropractic MUST be included in the list of physicians approved or recommended for the "initial evaluation". This is a violation of a Minnesota statute which prohibits MCP discrimination against categories of health care providers. I believe the provision is M.S. 176.155.

The "Evaluating Provider", who in the proposed ruling is a non-Chiropractor, who could then further recommend, if he/she chooses to refer to another provider, and would in all likelihood not choose someone in my profession.

I was able to attend the Logan College of Chiropractic right after World War II. Our government thought enough about my

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Ms. Pam Zembal
August 21, 1992

chosen studies to provide G.I. Bill funding. For all these years I/we have fought to provide a valuable non-duplicating service to those, who on their own volition chose to receive Chiropractic services, some of whom finally received help after having exhausted the "usual options" for health care. This MCP document is going to cancel this option to these persons unless they are extraordinarily well informed on all the clauses, and this document also sends me a message that the Government of the United States made an error in funding my education in this "now no longer worthy" profession. The absurdity of this is too obvious.

Please, Ms. Zembal, take action and see that these unfair inclusions be deleted where appropiate, and the term Doctors of Chiropractic be inserted where entry is appropiate.

Respectfully submitted,

James J. Abeler Sr. D.C.

James J. Abeler Sr. DC MN License # 704

DR. DIXIE A. JEPSON
CHIROPRACTOR

506 Prior Avenue N. • St. Paul, Minnesota 55104 • (612) 293-1897

August 21, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Dept. of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

Dear Ms. Zembel:

Thirteen years ago I became a chiropractor with the attitude that people no matter what their race, creed or financial powers should be given the opportunity to have good health care at a fair price and beable to resume their usual activities of daily living as soon as possible. My attitude remains the same today as it did then. Managed health care like many forms of government has it's good and it's bad points. I believe that if all health care providers work together for the betterment of the injured worker within a managed health care atmosphere we can all benefit. However, the managed health care cannot be only looking at the financial side and exclude access to any health care provider with out in the long run endangering our work force as a whole, and many individual injured workers.

It is my understanding that the department of agriculture which includes federal and state, presently have more employees than there are farmers. We all recognize this has not brought food prices down. Let's not do the same thing with health care.

I know that everyone at your place of business is very busy and I appreciate you taking the time to read this. I would also like to extend toyou an invitation to discuss any points of my letter and to have any one come and visit our office. We like the majority of health care offices and state emplyees are hard working, caring people and I do believe that out of all this chaos good will prevail.

Sincerely,

Dr. Dixie A. Jepson

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BAYPORT CHIROPRACTIC OFFICE

324 North 5th Avenue
Bayport, Minnesota 55003 • Phone: 439-7621

August 20, 1992

DR. DAVID W. WIEDEN

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

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Dear Ms. Zembal,

I am writing this letter in response to the proposal emergency rules on managed care plans which were published on July 27, 1992.

I am greatly concerned, as is the chiropractic profession, over the threat that some health care providers may be excluded from treating injured workers because they are not network members of any Managed Care Plan. If the MCP's are allowed to choose network providers, ther will be a great number of health care providers who will not be included for various reasons. This exclusion could have a devastating effect upon the excluded providers. Why should a select few receive an unfair wind fall from new cases? I doubt whether this was the intent of the legislature. Allowing the MCP's to choose their own provider network would elliminate the freedom of choice of the patient to choose their own treating doctor. Once again this was not the intent of the legislature.

The legislature was attempting to reduce or elliminate treatment which was excessive or unnecessary. This could and should be accomplished without the loss of the patient's freedom of choice or the exclusion of qualified chiropractic care providers.

The MCP's should be required to accept all health care providers who apply, have a license in good standing, and agree to follow the guide lines and limitations of the MCP's

In closing I would like to refer you to the letter, dated August 7, 1992, sent to you by David C. Wwulff, Attorney at Law. I am in complete agreement with the comments set forth by him in that letter.

I trust that you and the Department of Labor and Industry will consider my concerns, in addition to those of other chiropractors and the working population of Minnesota.

Sincerely,

David W. Wieden, D.C.

Dr. David W. Wieden, D.C.

BRETT CHIROPRACTIC CLINIC

DR. JOHN C. BRETT
Chiropractor

August 18, 1992

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Rehabilitation and Medical Affairs Division
of Department of Labor and Industry
443 Layette Rd.
St. Paul, MN 55155
Attn: Ms. Pam Zembal

Dear Ms. Zembal:

This letter is written to comment on the Workers Compensation Emergency rules. The rules are confusing in that they talk about physicians or chiropractors, when chiropractors are licensed physicians in the state of Minnesota. By saying physicians or chiropractors you are implying chiropractors are not physicians, that will put chiropractors at a disadvantage to be equally accessed by employees/patients. The wording should be changed to chiropractic physician or medical physician. In lines 10 - 11 page 4 the rules state that the managed care plan must include a procedure to ensure that the employee receive initial evaluation by a participating physician within 24 hours, this statement implies a medical physician and not including chiropractic physician since the language differentiates the two. In lines 12 -15 page 4 the rules state the managed care plan may permit initial evaluations by a participating chiropractor , instead this should say the managed care plan must permit initial evaluations by a participating chiropractic physician or the managed care plan may decide to not allow initial evaluations by a chiropractic physician . In lines 14 - 15 page 4 it states that the employee may decide whether the evaluation will be by a physician or a chiropractor, this statement once again implies that chiropractors are not physicians, the statement on lines 14 - 15 page 4 should read the employee must be able to decide whether the evaluation will be by a chiropractic physician or medical physician. This same type of language continues in lines 20 - 24 and 29 - 34 page 4, which gives the managed care plans plenty of loop holes to have patients see medical physicians first which would virtually end any chance of the patient to see a chiropractor as happens now in managed care plans with medical physician gate-keepers. The history of managed health care plans has been to set up a system that tells the patient they will be able to see a chiropractic physician but they should see a medical physician first to determine if it is a medical or chiropractic case and then the medical physician virtually never considers it a chiropractic condition.

Enclosed please find a copy of the rules and changes written in with arrows point to where words should be entered to make these rules something that would allow equal access to chiropractic physicians and medical physicians by choice of the patients.

If you have any further questions regarding this matter please contact me at my office (612) 881 - 9129.

Sincerely,

Dr. John C. Brett

Dr. John C. Brett
JCB/lll

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed
Adoption of Emergency Rules of the State
Department of Labor and Industry,
Governing Workers' Compensation
Managed Care Plans

NOTICE OF INTENT
TO ADOPT AN
EMERGENCY RULE

Notice is hereby given that the State Department of Labor and Industry intends to adopt the above-entitled emergency rules. The statutory authority to adopt the emergency rules is contained in Minnesota Statutes, section 176.1351, subd. 6 (1992 Laws of Minnesota, Chapter 510, Article 4, § 13). The agency, in adopting the rules, is following the procedures set forth in the Administrative Procedure Act for adopting emergency rules in Minnesota Statutes, sections 14.29 to 14.36.

All persons have 25 days after publication to submit data and views on the proposed emergency rules or any part or subpart of the rules in writing. Comments must be received by 4:30 p.m. on August 21, 1992. Comments must be submitted to:

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316
Telephone: (612) 297-5213

A copy of the proposed rules is attached to this notice.

A free copy of the proposed emergency rules is available by contacting Janice Keesling, Rehabilitation and Medical Affairs at (612) 296-8213.

The proposed emergency rules may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed emergency rules as noticed.

Upon adoption of the emergency rules by the agency, the emergency rules as adopted and its supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rules, must submit the written request to Pam Zembal at the above address.

The emergency rules will take effect five working days after approval by the Attorney General and be effective for 180 days. The emergency rules will be continued in effect for an additional 180 days if the agency gives notice of continuation in accordance with Minnesota Statutes, section 14.35.

A fiscal note is not required by Minnesota Statutes § 14.11 because the rules do not require the expenditure of public money by local public bodies.

7/20/92
Date

JOHN B. LENNES, JR.
Commissioner

KB/cj (190-1)

Department of Labor and Industry

Proposed Emergency Rules Relating to Workers' Compensation; Managed Care

Rules as Proposed (all new material)

5218.0100 [Emergency] DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 5218.0100 to 5218.9000 [Emergency] have the meanings given them in this part.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Labor and Industry or a designee.

Subp. 3. **Emergency care.** "Emergency care" means professional health services necessary to preserve life or limb.

Subp. 4. **Employee.** "Employee" means an employee entitled to treatment of a work injury under Minnesota Statutes, section 176.135.

Subp. 5. **Geographical service area.** "Geographical service area" means those counties in which a managed care plan has been certified to provide comprehensive health care services to injured employees.

Subp. 6. **Health care provider.** "Health care provider" has the meaning given in Minnesota Statutes, section 176.011, subdivision 24.

Subp. 7. **Insurer.** "Insurer" means the insurer providing workers' compensation insurance required by Minnesota Statutes, chapter 176, and includes a self-insured employer.

Subp. 8. **Managed care plan.** "Managed care plan" means a plan certified by the commissioner that provides for the management of treatment to injured employees under Minnesota Statutes, sections 176.135 and 176.1351.

Subp. 9. **Participating health care provider.** "Participating health care provider" means any person, provider, company, professional corporation, organization, or business entity with which the managed care plan has contracts or other

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agreements.

Subp. 10. **Physician.** "Physician" has the meaning given in Minnesota Statutes, section 176.135, subdivision 2a.

Subp. 11. **Revocation.** "Revocation" means a permanent revocation of a managed care plan's certification to provide services under parts 5218.0100 to 5218.9000 [Emergency].

Subp. 12. **Suspension.** "Suspension" means a stopping by the commissioner of the managed care plan's authority to enter into new contracts with insurers for a specified period of time.

5218.0210 [Emergency] AUTHORITY.

Parts 5218.0100 to 5218.9000 [Emergency] are adopted under the commissioner's emergency rulemaking authority under Minnesota Statutes, section 176.1351, subdivision 6.

5218.0220 [Emergency] PURPOSE AND SCOPE.

The purpose of parts 5218.0100 to 5218.9000 [Emergency] is to establish procedures and requirements relating to the delivery of medical services to injured employees within the workers' compensation system under a managed care plan certified by the commissioner under Minnesota Statutes, sections 176.135, subdivision 1, paragraph (f), and 176.1351.

5218.0230 [Emergency] EFFECTIVE DATE.

A managed care plan certified under the emergency rulemaking authority will receive provisional certification that will expire 60 days after adoption of the permanent rules unless otherwise provided for in the permanent rules.

5218.1000 [Emergency] APPLICATION FOR CERTIFICATION.

Subpart 1. Provisional certification. Any person or entity may make written application to the commissioner to provide managed care to injured employees for injuries and diseases compensable under Minnesota Statutes, chapter 176, under a plan certified by the commissioner. To obtain provisional certification of a plan, the requirements in items A to D must be complied with and documented.

A. The plan must identify any directors and officers

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of the managed care plan; the title and name of the person to be the day-to-day administrator of the managed care plan; the title and name of the person to be the administrator of the financial affairs of the managed care plan; and the name, address, and telephone number of a contact person.

B. The total annual compensation paid to an administrator, director, or executive officer of the managed care plan shall not exceed ten times the average annual wage as calculated in Minnesota Statutes, section 176.011, subdivision 20. The limit on compensation under this subpart does not include payment received by a health care provider for actual medical services rendered to an employee under Minnesota Statutes, chapter 176.

C. Each application for certification must be accompanied by a nonrefundable fee of $1,500.

D. Additional documentation must be submitted as specified in subitems (1) to (11).

(1) The managed care plan must provide a list of the names, addresses, and specialties of the participating health care providers who will provide services under the managed care plan, together with a statement that all licensing, registration, or certification requirements have been met for the health care provider to practice in Minnesota.

(2) The managed care plan must provide a description of the times, places, and manner of providing services under the plan, including a description of the initial geographical service area, designated by county. The plan must comply with units (a) and (b).

(a) The managed care plan must provide quality services that meet uniform treatment standards prescribed by the commissioner and all medical and health care services that may be required by Minnesota Statutes, chapter 176, in a manner that is timely, effective, and convenient for the employee.

(b) The managed care plan may not discriminate against or exclude from participation in the plan

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any category of health care providers and must include an adequate number of each category of health care providers to give employees convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan, provided that the treatment is medically appropriate.

(3) The managed care plan must include a procedure to ensure that the employee will:

(a) receive initial evaluation by a participating physician within 24 hours of a request for treatment, following a work injury; the managed care plan may permit initial evaluations by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or a ~~chiropractor~~;

(b) receive initial evaluation by a participating physician within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan under part 5218.5000 [Emergency], subpart 1, item A. The managed care plan may permit an initial evaluation by a participating chiropractor in which case the employee may decide whether the evaluation will be by a physician or ~~chiropractor~~;

(c) initially choose from at least three health care providers to whom the employee has been referred by the evaluating provider under unit (a) or (b) for treatment, and allow the employee to change providers within the managed care plan at least once. The procedure to allow the employee to select a health care provider must provide direct access to all health care profession disciplines if the treatment is determined to be appropriate for the condition by the evaluating health care provider under unit (a) or (b) or if the insurer approves the treatment;

(d) receive treatment or consultation by a physician in cases requiring emergency

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in-patient hospitalization;

(e) receive information or advice on a 24-hour basis regarding medical services available within the managed care plan; and

(f) have access to health care providers within 30 miles of the employee's place of employment or residence, or the distance the employee normally travels to work, considering the normal patterns of travel, whichever is furthest.

(4) The managed care plan must designate the procedures and criteria for approval of services from a health care provider outside the managed care plan according to part 5218.5000 [Emergency].

(5) The application must include copies of contract agreements or other documents signed by each participating health care provider. Contractual provisions must be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency]. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts submitted must include a list of signatories to the contract.

(6) The managed care plan must designate the name, address, and phone number of a communication liaison for the department and the insurer.

(7) The managed care plan must include a procedure for peer review, utilization review, and internal dispute resolution in accordance with Minnesota Statutes, section 176.1351, subdivision 2, paragraph (4), including a method to resolve complaints by injured employees, medical providers, and insurers.

(8) The managed care plan must include a procedure to notify the commissioner of the commencement or termination of participating health care providers.

(9) The managed care plan must describe how employers and insurers will be provided with information that will inform employees of all choices of medical service

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providers within the plan and how employees can gain access to those providers.

(10) The managed care plan must describe how it will provide aggressive case management for injured employees, and a program for early return to work and cooperative efforts by the employees, the employer, and the managed care plan to promote workplace health and safety consultative and other services.

(11) The managed care plan must submit treatment standards for medical services not already prescribed by the commissioner. All managed care plan health care providers and health care providers described in part 5218.5000 [Emergency] will be governed by these standards.

Subp. 2. **Notification; approval or denial.** The commissioner shall notify the applicant in writing of the approval or denial of certification. If certification is granted, the commissioner shall notify the managed care plan applicant of the effective date of the certification and the initial geographical service area approved. If the certification is denied, the applicant will be provided with the reason for the denial. The commissioner must require an in-person meeting if necessary to determine compliance with parts 5218.0100 to 5218.9000 [Emergency]. Modification of the plan as certified shall require approval before it may be implemented.

5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN.

Subpart 1. **Scope.** A managed care plan shall provide comprehensive medical services according to its certification and Minnesota Statutes, chapter 176, and all other applicable statutes and rules.

Subp. 2. **Geographical service area; expansion.** The commissioner shall designate a managed care plan's initial geographical service area and approve any expansions to the managed care plan's service area. Injured employees shall not

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be covered by a managed care plan until the commissioner has approved the proposed expansion of the geographical service area.

Subp. 3. **Contracts.** When a managed care plan contracts with an insurer to provide services, the contract shall specify those employers covered by the contract and the estimated number of covered employees. The managed care plan contract must include the terms and conditions in items A to F.

A. The employer's place of employment must be within the authorized geographical service area.

B. Insurers may contract with multiple managed care plans to provide coverage for employers. When insurers contract with multiple managed care plans to cover the same employer, each employee shall have initial choice at time of injury to select the managed care plan that will manage the employee's care.

C. An employee with a compensable injury under Minnesota Statutes, chapter 176, occurring on or after the effective date of the managed care plan contract shall receive medical services in the manner prescribed by the terms and conditions of the managed care plan contract.

D. The requirements established in parts 5218.0100 to 5218.9000 [Emergency] do not apply to an employee with a compensable injury under Minnesota Statutes, chapter 176, that occurred before the effective date of the managed care plan contract, until the employee requests a change of doctor. At that time, further services shall be provided by the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by health care providers who are not participating providers must be delivered according to part 5218.5000 [Emergency].

E. To ensure continuity of care, the managed care plan contract shall specify the manner in which an injured employee with a compensable injury will receive medical services when a managed care plan contract terminates. When managed care plan coverage for an injured employee is being transferred from

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one managed care plan to another, the employee may continue to treat with the employee's original health care provider until the employee requests a change of doctor. At that time further services shall be provided under the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by providers who are not participating providers must be performed according to part 5218.5000 [Emergency].

F. Except as provided in part 5218.5000 [Emergency], an employer may require an employee who is claiming a workers' compensation injury to receive treatment from a managed care plan before the employer accepts or denies liability for the injury. In such cases the employer is liable for the cost of any treatment given before notice is given to the employee of a denial of liability, even if the employer is later determined to be not liable for the claimed injury.

The employee may receive treatment from any health care provider chosen by the employee after a notice of denial of liability has been given to the employee, or if the employer does not require the employee to receive treatment from a managed care plan prior to accepting liability for a claimed injury. If the employer later accepts liability or is determined by the commissioner, a compensation judge, or an appellate court to be liable for the claimed injury, the employer is responsible for the cost of all reasonable and necessary medical treatment received by the employee. Once the employer has admitted liability for the claimed injury or once the employer has been determined to be liable for the claimed injury, the employer may require that further medical treatment be received through the managed care plan unless the employee had a documented history of treatment with the health care provider as described in part 5218.5000 [Emergency], before the injury.

Subp. 4. **Restrictions.** When an insurer contracts with a single managed care plan for coverage for an employer, the plan may not be formed, operated, or administered by the same

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employer or insurer. When an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, formed, or administered by the employer or insurer. No employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota Statutes, chapter 176.

5218.3000 [Emergency] REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN.

Subpart 1. **Contracts; modifications.** A managed care plan shall provide the commissioner with a copy of a managed care plan insurer contract and managed care plan participating provider contract agreements, signed by the parties, within 30 days of execution of the contracts. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts shall include a list of signatories. Amendments and addendums to the contracts shall also be submitted to the commissioner within 30 days of execution. Contract provisions shall be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency].

Subp. 2. **Requirements.** Within six months of provisional certification, each managed care plan shall provide the following information in a form and format prescribed by the commissioner:

A. a current listing of participating health care providers, including provider names, specialty, business address, and phone number, and for any new health care provider the information required by part 5218.1000 [Emergency], subpart 1, item D, subitem (1);

B. a listing of all health care providers outside of the managed care plan who provided services to employees under part 5218.5000 [Emergency];

C. a listing of all employers covered by each contract including the employer's names, unemployment insurer's

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identification number, and estimated number of employees governed by the managed care plan contract;

D. a summary of any sanctions or punitive actions taken by the managed care plan against its members;

E. a report that summarizes peer review and utilization review performed showing cases reviewed, issues involved, and action taken. The review must include, but is not limited to, evaluation of compliance with treatment standards adopted by the commissioner; and

F. any proposed changes to the managed care plan as certified by the commissioner.

Subp. 3. **Insurers; data.** The managed care plan must report to the insurer any data regarding medical services and supplies required by the insurer to determine compensability, and any other data required by rule.

Subp. 4. **Monitoring.** The commissioner shall require additional information from the managed care plan as necessary to monitor the managed care plan's compliance with parts 5218.0100 to 5218.9000 [Emergency] and Minnesota Statutes, section 176.1351.

5218.4000 [Emergency] COMMENCEMENT AND TERMINATION OF PARTICIPATING PROVIDERS.

Subpart 1. **Commencement.** Prospective new participating health care providers under a managed care plan shall submit an application to the managed care plan. A director, executive director, or administrator may approve the application under the requirements of the managed care plan. The managed care plan shall verify that each new participating health care provider meets all licensing, registration, and certification requirements necessary to practice in Minnesota.

Subp. 2. **Termination.** A participating provider may elect to terminate participation in the managed care plan or be subject to cancellation by the managed care plan under the requirements of the managed care plan. Upon termination of a provider, the managed care plan shall make alternate

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arrangements to provide continuing medical services for an affected injured employee under the plan.

5218.5000 [Emergency] HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subpart 1. **Authorized services.** The managed care plan shall authorize a health care provider who is not a participating health care provider to provide medical services to an employee in the following circumstances:

A. if the health care provider maintains the employee's medical records and has a documented history of treatment of that employee before the date of injury. If the employee requests a change of doctor, further services shall be provided by the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c);

B. for emergency treatment; or

C. when referred outside the managed care plan for medical services by the managed care plan.

Subp. 2. **Requirements.** A health care provider who is not a participating health care provider must:

A. agree to comply with the managed care plan treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures; and

B. agree to refer the covered employee to the managed care plan for specialized care, which includes, but is not limited to, physical therapy and diagnostic testing.

Subp. 3. **Disputes.** Any dispute under subpart 1 or 2 relating to the employee's selection of a health care provider who is not a managed care plan participating health care provider shall be resolved according to part 5218.7000 [Emergency]. Any dispute relating to a health care provider's compliance with the managed care plan standards and procedures or treatment standards adopted by the commissioner shall be resolved according to part 5218.7000 [Emergency] or Minnesota Statutes, section 176.103.

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5218.6000 [Emergency] CHARGES AND FEES.

Billings for medical services under a managed care plan shall be submitted in the form and format as prescribed in part 5221.0700, subpart 2. The payment by the insurer or the managed care plan to participating and nonparticipating health care providers for medical services shall be according to the timeframes and procedures in part 5221.0600, subpart 3, and Minnesota Statutes, section 176.135, subdivision 6, and shall be the maximum amount allowed under Minnesota Statutes, section 176.136.

5218.7000 [Emergency] DISPUTE RESOLUTION.

Disputes that arise between the employee and the managed care plan related to delivery of health services shall first be processed through the dispute resolution process of the managed care plan. The managed care plan dispute resolution process must be completed within 30 days of receipt of a request. If the dispute cannot be resolved, the commissioner may issue an order to resolve the dispute under Minnesota Statutes, sections 176.106 and 176.305 or 176.2615.

5218.8000 [Emergency] MONITORING.

Subpart 1. **Audits.** The commissioner shall monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements.

Subp. 2. **Records.** All records of the managed care plan and its participating health care providers shall be disclosed on request of the commissioner when necessary to ensure compliance with Minnesota Statutes, section 176.1351. These records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes.

5218.9000 [Emergency] SUSPENSION; REVOCATION.

Subpart 1. **Complaints; investigation.** Complaints pertaining to violations of parts 5218.0100 to 5218.9000 [Emergency] by the managed care plan shall be directed in

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writing to the commissioner. On receipt of a written complaint, or after monitoring the managed care plan operations, the department shall investigate the alleged rule violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the department determines on completion of the investigation that there has been a rule violation warranting suspension or revocation of provisional certification, the commissioner shall initiate a contested case proceeding under Minnesota Statutes, chapter 14.

Subp. 2. **Criteria.** Under Minnesota Statutes, section 176.1351, subdivision 5, the provisional certification of a managed care plan issued by the commissioner shall be suspended or revoked by the commissioner if:

A. service under the plan is not being provided according to the terms of the certified plan;

B. the plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of parts 5218.0100 to 5218.9000 [Emergency] or Minnesota Statutes, section 176.1351;

C. the managed care plan fails to comply with Minnesota Statutes, section 176.1351, parts 5218.0100 to 5218.9000 [Emergency], and requirements of utilization and treatment standards adopted under Minnesota Statutes, section 176.83;

D. any false or misleading information is submitted by the managed care plan or a member of the plan; or

E. the managed care plan continues to use the services of a health care provider whose license has been suspended or revoked by the licensing board, or under Minnesota Statutes, section 176.103, or who is ineligible to provide treatment to an injured employee under Minnesota Statutes, section 256B.0644.

Subp. 3. **Effects.** All contracts with insurers are void if a managed care plan's provisional certification is revoked. Upon suspension of certification, the managed care plan may

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continue to provide services under contracts in effect if the commissioner determines injured employees will continue to receive necessary medical services under Minnesota Statutes, section 176.135.

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Carol A. Mortensen, B.A., D.C. • Doctor of Chiropractic • 5841 Cedar Lake Road • St. Louis Park, MN 55416 • (612) 541-0768

8-14-92

RECEIVED
AUG 17 1992
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

RE: Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembel:

I have been a practicing Doctor of Chiropractic for 14 years. On October 1, 1992, I will be in effect shut out from caring for injured Minnesota workers because I am not a provider for any managed care plan. This is also the case for a very substantial portion of my chiropractic colleagues. I have tried for the past several years to join a MCP. When I inquire, however, I am told they have no positions available but I can send in my resume and be placed on file. I have also contacted ChiroCare which has had no openings available for several years to my knowledge.

I believe managed care can be a positive way to contain health care costs, however, I also believe quality of care will suffer if the number of providers is limited. As you know, in the well known medical managed plans in the state there is little or often no provision for chiropractic providership. In plans known to provide chiropractic care, membership has been limited in my view in order to allow a few doctors to " have all the patients." I believe this is wrong. A patient must be able to have their doctor of choice even within a managed system. A patient will not choose a doctor who provides inadequate care and thus the quality of care will be enhanced in the managed system. However, if only a few chiroprators can participate, there will be far less pressure from the patient-consumer market when a small monopoly of providers receive all the patients.

I believe it is wrong for the state of Minnesota to shut out hundreds of its licensed chiropractors from treating injured workers. This law will not have the same effect on Doctors of Medicine (M.D) because they all have easy and multiple access to managed care plans.

I believe that Minnesota must permit all chiropractors the opportunity to provide managed care to its injured workers. I believe that under the Proposed Emergency Rules on Managed Care Plans that the State of Minnesota must require that an MCP in order to be certified must accept any health care provider who meets the requirements to practice in Minnesota.

Sincerely,



Jay M. Greenberg, D.C.
Marya Greenberg, D.C.

RED WING CHIROPRACTIC CLINIC, P.A.
The Back Treatment Center
Route 3, Highway 58 South
Red Wing, Minnesota 55066
(612) 388-8294



August 12, 1992

Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor
443 Lafayette Road
St. Paul, MN 55155

Dear Ms. Zembal:

I am writing relative to the proposed emergency rules published on July 27, 1992.

I take sharp disagreement with the fact that providers especially chiropractic providers will effectively be excluded from treating injured employees in Minnesota due to your proposed emergency plan.

This is surely and clearly not in the language of the law nor was it the legislature's intent to exclude any providers. The fact that patients would not be allowed freedom of choice seems to go against the grain of history in Minnesota, whereby the people of Minnesota have always taken pride in the fact that they were allowed to chose whatever health provider they felt most comfortable with in the worker's compensation realm. The concept of having an evaluating provider determining which medical direction to go in is truly a farce. In my practice of chiropractic for over 16 years I have yet to receive one referral from either an insurance company or from a medical provider. These rules simply assure that I would never receive a referal from a medical provider. Is it the intention of your department to exclude chiropractic from the public or to merely make it nearly impossible for a prospective patient to see a chiropractor.

I am also in disagreement with the concept that there would be a geographically correct number of providers in a given area and that they would have to be within 30 miles of the place of employment. It is my opinion that this would make it very inconvenient for people to get any care at all. The way the rules are set up presently will cause a bureaucratic nightmare as well as scores if not hundreds of lawsuites by injured patients who have been disallowed the rights that they were previously guaranteed. It is my opinion that the rules should be completely rewritten so that the legislature's intent allowing all doctors equal access would be fullfilled.

Sincerely,

Jay M. Greenberg D.C.
JMG/ds
SBNR

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AUG 17 1992
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

DR. DAVID P. MONSON, D.C.
6142 Brooklyn Boulevard
Brooklyn Center, MN 55429

Telephone: (612) 566-9330

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August 19, 1992

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

RE: Proposed Emergency Rules on Managed Care Plan

Dear Ms. Zembal:

I am writing to you today to express my concerns over the proposed emergency rules that are being put forth by the Department of Labor and Industry in answer to the legislative changes this past year. I feel that it is imperative that the right of an injured worker to choose his/her method and provider of care is a foremost concern.

Currently, in an average chiropractic practice, I would estimate anywhere from 20-30% of our current patients are workers who have been injured on the job and have expressly sought out chiropractic health care and it is very likely that in the future this type of worker would not have that choice.

I know that the rules do provide for chiropractors to be allowed into the managed care health plans, however, it has been my experience and the experience of other doctors who have made application to these managed care organizations, that they simply are not interested in allowing more than a token few chiropractors to become members of their plan. Certainly, this is not the intent of the legislation that was passed and it would be of detriment to the health and welfare of the workers of Minnesota.

The second concern with the proposed changes would be that of the personal effect on this practice. As I have already noted, anywhere from 20-30% of the current patients are injured workers. Certainly there must be a procedure for review and some type of a hearing procedure before these types of rules, that would have such a profound impact on an individual's right to make a living, could be adopted.

I would welcome any opportunity to provide further information to your department which would help in establishing the effectiveness of the work that is done through this office. I feel that if it would be of benefit for personal appearances of either myself or of patients who have been treated or are currently treated in this office, there would be a possibility of having a presentation made to your panel.

Thank you for taking the time to read these comments and for your consideration.

Respectfully submitted,

David P. Monson QT

David P. Monson, D.C.
DPM/QT/lo

Columbia Heights - Fridley Chiropractic Clinic

Dr. Mark W. Lampman
5188 Central Avenue
Columbia Heights, MN 55421

Phone: 612/571-8960

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LABOR & INDUSTRY,
REHABILITATION & MEDICAL AFFAIRS

August 19, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

RE: Comment to Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

I am writing your office with concerns about the changes in the worker's compensation law that will be occurring in the near future.

Some of the proposed changes in the new law, such as the "New Standards of Care" are necessary and are long over due to reduce the abuses that are occurring in the workers' compensation system. Many chiropractor's, as myself, take pride in our ability to treat the injured worker, aid in a speedy and cost effective recovery and return him or her to work. Under the current system, there is no process in which the industry can identify and utilize providers who provide quality cost effective care.

It has been proposed that the use of Managed Care Plans will be able to control cost for workers' compensation as it has for HMO's, PPO's, etc. My objections to this is those doctors who may be best qualified to treat the patients may be excluded by virtue of not being accepted as a plan doctor in a Managed Care Plan. These plans will not be required to accept every doctor who applies for membership and is willing to abide by their guidelines. This is the current system for many Managed Care Plans and has been a problem for my patients who would have treated with me in the past and would like to continue when there is a need. When I have contacted these Managed Care Plans, they had no formal application process and have no plans to open their enrollment. The number of these Managed Care Plans have been increasing steadily and many have no provision for chiropractic cervices.

Many other chiropractors I have talked to have complaints concerning the proposed treatment standards, peer and utilization review and referral practices. I personally do not have a problem with having to abide by guidelines. I do strongly object to not being a part of the system, especially when you have strived to provide affordable quality care for your patients.

I hope you consider this one aspect of the new changes that will be taking place. Thank you for your time and consideration.

Sincerely,

M. Mark Lampman

Dr. Mark Lampman

ML:cs

Anderson Chiropractic Clinic

Dr. Daniel Anderson
P.O. Box 584 North Branch, MN 55056
(612) 674-8391

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AUG 21 1992
LABOR & INDUSTRY
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August 20, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comment to proposed emergency rules on managed care plans.

Dear Ms. Zembal:

Please accept this letter as my comments to the proposed emergency rule on managed health care.

1. Exclusions of health care providers from managed health care plans. I feel that Rule 5218.44 Subpart 1 should require as a prerequisite to allow providers to qualify that managed care plans except health care providers who meet all licensing and registration and certification required to practice in the state of Minnesota and agree to follow the rules set aside by the specific MCP, I do not feel that the managed care plan should have the unrestricted right to pick and choose providers of their choice. Obviously if the MCPs have the ability to decide who will participate in their group, this will eliminate a good portion of the health care providers and exclude them from treating injured workers, this would result in a very negative impact on the health providers. In addition, it limits the patient's ability to choose the provider of their choice, causing inconvenienced and unsatisfied patients.

2. Treatment standards not prescribed by the Commissioner proposed rule 5218.100 Subpart 1D (11) requires individual MCPs to submit treatment standards for medical services not previously prescribed by the commissioner.

This proposal should be eliminated. All MCPs should adopt and follow similar treatment protocols, these standards should follow the providers usual and customary procedures for that specific health care profession which would be considered reasonable and necessary for the specific condition. This would seem to be the easiest and most effective way to determine treatment standards in the emergency period before the Commissioner develops his own.

Anderson Chiropractic Clinic

Dr. Daniel Anderson
P.O. Box 584 North Branch, MN 55056
(612) 674-8391

3. Retroactive application of managed health care plans proposed rule 5218.2000 Subpart 3D state that MCP rules will apply to employees injured prior to the effective date of the 1992 amendment in the request for a change of doctor. If a patient wishes to change physicians this patient would need to receive treatment from the employers's MCP. The legislature did not provide retroactive application of managed health care plans, therefore any injured worker before the 10/01/92 under any circumstances should not have to treat through a managed care plan.

4. Initial evaluations proposed rule 5218.1000 D(3). This rule proposes that a MCP requires employees to submit to an initial evaluation by physician, (this definition of physician does not include a chiropractor) within 24 hours after the employer requests treatment following a work injury. This rule allows managed health care plans to permit chiropractors to do initial evaluations, but does not require it. In addition, rules 5218.1000 Subpart 1D (3) (b) initial evaluations within five working days of request of change of doctor. The requirement that an employee must be seen for an initial evaluation within 24 hours of a request for treatment following a work injury or within five days after a request for a change of doctor in cases where the injured worker is receiving treatment for a work related injury from a health provider who is not a part of the MCP sounds like an automatic adverse examination, these proposed rules should also be eliminated.

5. Treatment provided by a non-participating health care providers proposed rule 5218.5000 Subpart 1A limits the ability of the employee to treat with a health care provider who is not a participating health care provider to providers who have a documented history of treatment with the employer before the date of the injury. There is nothing in Minnesota statute 176.1351 Subpart 2 (8) that states that an employee who develops a history of treatment with a specific provider after the date of their work related injury and following this wishes to switch their care of their work related injury to their specific health care provider that the employee should not be able to do this. The legislature intended the employee to treat with a doctor who they have a level of trust and confidence in, whether that history of trust developed before or after their work related injury.

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Anderson Chiropractic Clinic

Dr. Daniel Anderson
P.O. Box 584 North Branch, MN 55056
(612) 674-8391

Ms. Zembal please consider the preceding comments.

Sincerely yours,

Daniel G. Anderson, D.C.

DGA/kj

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CHIROPRACTIC CARE OF MINNESOTA, INC.

August 20, 1992

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

This letter is to comment on the proposed Emergency Rules of the State Department of Labor and Industry governing Workers' Compensation Managed Care Plans.

If it was the intention of the Legislature, in granting the authority for the adoption of Emergency Rules, to have the said Rules control the escalating health care costs for Workers' Compensation, I want to bring to your attention an issue which may cause the cost to escalate rather than decrease.

C
C C M I

Section 5218.1000, Subpart 1.D. Number 3, paragraphs A and B, of the proposed rules allows for the managed care plan to use a medical gatekeeper for determination of necessary care for the injured worker. This same rule allows for the option of a chiropractic gatekeeper. Since a significant number of the conditions for which workers seek health care are neuromusculoskeletal injuries, direct access to chiropractic management is appropriate and data would argue necessary to control the cost of care. No evidence exists to suggest a medical gatekeeper will appropriately refer to or utilize the chiropractic physician despite research supporting chiropractic management efficiency being superior to medical management.

I strongly urge that the medical gatekeeper mandate be removed from this section. This could be accomplished by striking on Line 12 "may" and inserting "shall". And on Line 21 striking "may" inserting "shall".

Studies in the literature have shown that in treatment of common compensable work injuries, chiropractic care is more cost effective than hospital or medical care. Cost per Case Comparison of Back Injury Claims of Chiropractic vs. Medical Management for Conditions with Identical Diagnostic Codes by Kelly B. Jarvis, D.C., Reed B. Phillips, D.C.,Ph.D. and Elliot K. Morris, J.D., MBA, published in the Journal of Occupational Medicine, Vol. 33, No. 8, August 1991. This study of Utah Workers'Compensation claims extracted from the period December 1988 to February 1989, looked at 3,062 total cases in the study. Surgical cases, cases treated by both M.D.s and chiropractors as well as cases treated by non-M.D., or non-D.C.s were excluded from the study so as not to skew the data. Common ICDA-9 codes were looked at, costs of medical care and

costs of indemnity or time-loss costs were compared and the study clearly shows that for those patients that were treated by chiropractors rather than M.D. had a 56% decrease in the cost for that worker's compensation injury.

Another study from the proceedings of the 1992 International Conference on Spinal Manipulation titled Determination of Chiropractic Necessity: Chiropractic Prospective Utilization Review vs. Medical Gatekeeper Systems by McElhern, D.C., White, D.C., Ayres, D.C., Hansen, D.C., and Sollecito, D.C., compared the medical gatekeeper system in an IPA model HMO in Washington state with a prospective chiropractic utilization review system where patients had direct access to chiropractors. The results of the HMO gatekeeper system reflected an annual cost 11.7% higher than the prospective chiropractic utilization review system where patients had direct access.

A study by Professor Miron Stano, Ph.D., School of Business Administration, Oakland University, focused on the on overall cost of care when various different health providers were utilized. The project looked at MEDSTAT Systems, Inc. of Ann Arbor data. MEDSTAT is a health benefits consulting firm. MEDSTAT provided this study with a data base of 2 million beneficiaries in a fee for service sector group health. The study focused on 400,000 beneficiaries who had claims for one or more of 502 codes representing common neuromuskulosketal conditions that would be treated by both M.D.s and D.C.s. The data base was from July 1988 through June of 1990. A study of the data showed that the total insurance payments for chiropractic patients are substantially lower than for those receiving only medical care. The overall difference was in excess of $1000 over a two year period when all patients and disorders were compared.

These studies indicate that if injured workers are prevented from seeing chiropractors, prevention through the medical only gatekeeper system, that costs of treatment for neuromuskulosketal conditions will likely increase.

There are dozens of other studies that show that in a Workers' Comp. environment chiropractors return the worker to work faster with a lower medical cost that do M.D.s. The preponderance of evidence indicates that rather than promoting a medical only gatekeeper system, the Dept. of Labor and Industry should be promoting the use of chiropractors for the treatment of work-related injuries.

Sincerely,

Thomas J. Allenburg, D.C.
President

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REHABILITATION & MEDICAL AFFAIRS

TJA/AA/lb

[WorkComp.AA]

RAMSEY CHIROPRACTIC CENTER

Dr. Timothy Pollock D.C.
15243 Nowthen Blvd. Ramsey, MN 55303

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AUG 21 1992

LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

August 21, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor & Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

RE: Comments on Emergency Rules for Managed Care Plans

Dear Ms. Zembal

I am writing to express my concerns to the proposed emergency rules on managed care plans published on July 27, 1992.

I have serious concerns about many of the areas in the proposed rules. My concerns are best expressed in a letter sent to you by Attorney David Wulff. I wholeheartedly agree with the statements made by Mr. Wulff and therefore I am enclosing a copy of his letter to you. Please accept the concerns, as stated by Mr. Wulff, to be in complete agreement with my own.

Respectfully submitted,

Timothy J. Pollock D.C. F.A.S.A.

Wilson & Wulff, P.A.

Suite 200
1380 Energy Lane
St. Paul, MN 55108
(612) 659-0051
Fax 659-0309

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LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

August 7, 1992

Scott Wilson

David C. Wulff

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comment to Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

Thomas J. Lyons
of Counsel

Ann Moore
Legal Assistant

Please accept this letter as my comments to the proposed emergency rules on managed care plans published on July 27, 1992.

1. **Exclusion of Health Care Providers from MCPs.**

Two major concerns which should be addressed by the rules on MCPs are (1) the threat that some health care providers may be effectively excluded from treating workers' compensation patients because they are not accepted members of any MCP; and (2) the threat that an injured employee will be forced to treat with a health care provider he or she does not trust rather than a doctor of his or her choice. The proposed emergency rules, and specifically Rule 5218.4000, subp. 1, should require as a prerequisite to certification that all MCPs must accept any health care provider who meets all licensing, registration and certification requirements necessary to practice in Minnesota, and who agrees to abide by the rules and limitations of the MCP. MCPs should not be given unrestricted discretion to pick and choose the doctors who will constitute participating health care providers.

If the MCPs are allowed to choose the health care providers who will participate in their plans, there will be health care providers who are not accepted into any managed care plan. Those providers will be effectively excluded from treating injured employees in this state. Such exclusion will have a devastating impact on those health care providers. Conversely, these practitioners who are accepted into MCPs could receive an unfair windfall of new cases. This was clearly not intended by the legislature.

Giving such discretion to MCPs will also significantly limit the right of injured employees to choose the health care provider from whom they will receive treatment. The right to choose ones treating doctor has always been jealously protected by both the legislature and the courts of this state. It is significant to note that of the nineteen persons who spoke at the public hearing on the proposed medical rules on 7/16/92, all but two (the two attorneys who spoke on behalf of the IME firms) urged the Division not to limit the right of injured employees of this state to choose their own treating physician. The legislature clearly did not intend to abrogate the fundamental right of the citizens of this state to choose their own treating physicians.

The basic goal of the legislature in adopting the 1992 amendments was to provide a mechanism for reducing or eliminating inappropriate, excessive or unnecessary treatment. The accomplishment of this goal does not require the exclusion of innocent and qualified health care providers from the system. It also does not require the complete abrogation of a citizen's right to choose their own treating physician. The new treatment standards coupled with the MCP peer review utilization review and dispute resolution process, the MSRB investigation/sanction process, and the traditional medical request/claim petition process are adequate to guard against abuses.

Requiring MCPs to accept all health care providers who apply for admission, so long as their license is in good standing and they agree to abide by the rules and limitations of the MCP, would avoid the dual threats of provider exclusion and limitation of choice without endangering the goal of controlling utilization costs. It is a win/win proposal that should be adopted. The authority for such a rule can be found in Minn. Stat. §176.1351, subd. 2(12).

2. **Initial Evaluations Under 5218.1000 D(3).**

The proposed rule as drafted allows MCPs to require employees to submit to "initial evaluations" by a "physician" (defined to be a medical doctor or a doctor of osteopathy but not a chiropractor) within 24 hours after an employee requests treatment following a work injury. The rule allows MCPs to permit initial evaluations by chiropractors but does not require this. This rule violates the statutory prohibition against MCPs discriminating against any category of health care provider.

The same argument applies to 5218.1000, subp. 1D (3)(b) dealing with initial evaluations within five working days of a request for change of doctor.

The requirement that an employee must submit to an "initial evaluation" within 24 hours of a request for treatment following the work injury, or within five working days after a request for a change of doctor in cases where the employee has received treatment for the work injury by health care provider outside of the MCP, is nothing less than a mandatory adverse examination by a health care provider of the employer's choice. As such, it violates the provisions of M.S. 176.155 and should be eliminated from the proposed rules all together.

Alternatively, if an initial evaluation is to be required, then the employee should be given the right to choose from among all of the MCPs participating health care providers, including the chiropractors. Otherwise, the chiropractic profession will be unlawfully discriminated against, and the injured employee's right to choose his or her own treating physician will be unreasonably and unnecessarily restricted.

Subp. (c) in the same rule provides that the "evaluating provider" who conducts the "initial evaluation" must provide the employee with a list of at least three health care providers with whom the employee may treat. The "evaluating provider" is given the power to determine what treatment is appropriate for the condition and what type of health care profession discipline should provide that treatment. This process effectively gives the "evaluating provider" the power to discriminate against categories of health care providers. Allowing MCPs to simply delegate the authority to discriminate against categories of health care providers would obviously violate the prohibition against such discrimination clearly set forth in the 1992 amendments.

The problems inherent in the initial evaluation process set forth by the Rule as drafted could be minimized if not eliminated by simply requiring MCPs to provide injured employees with a list of the names, addresses and telephone numbers of all participating health care providers within 24 hours of a request for treatment following a work injury or within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the MCP. The employee's initial choice of health care provider could then be required to perform an initial evaluation to determine the treatment which is appropriate for the condition. If the

employee's initial choice of health care provider is not the appropriate health care discipline to provide the treatment, that health care provider could simply provide the employee with a list of the participating providers under the MCP within the proper health care discipline.

3. **Entities Which May be Certified as MCPs.**

Minn. Stat. §176.1351, subd. 1 provides, "any person or entity, other than a workers' compensation insurer or an employer for its own employees, may" be certified as an MCP (emphasis added). The statute specifically prohibits workers' compensation insurers and self-insured employers from becoming certified as MCPs.

Proposed Rules 5218.1000, subp. 1 and 5218.2000, subp. 4, as drafted, would appear to violate this specific statutory prohibition. Therefore, these proposed rules should be redrafted.

4. **Peer Review, Utilization Review and Internal Dispute Resolution.**

Proposed rules 5218.1000, subp. 1D (7) and 5218.7000 provide MCPs with too much discretion over devising procedures for peer review, utilization review and internal dispute resolution. The Division should attempt to come up with specific rules concerning these procedures. Otherwise, the citizens of this state will be confronted by a myriad of different procedures giving rise to inconsistent treatment of similar injuries.

5. **Aggressive Case Management and Early Return To Work Programs.**

Proposed Rule 5218.1000, subp. 1D (10) requires MCPs to describe how they will provide aggressive case management, programs for early return to work, and cooperative efforts to promote work place health and safety services without specifying what those terms mean or what, if any, limitations should apply. The Department of Labor and Industry should develop more specific definitions and requirements in order to avoid the development of myriad different rules and limitations resulting in inconsistent treatment of like cases.

6. Treatment Standards Not Prescribed by the Commissioner.

Proposed Rule 5218.1000, subp. 1D (11) requires individual MCPs to submit treatment standards for medical services not previously prescribed by the Commissioner. This proposed rule should be eliminated.

It will be completely unworkable and unjust for MCPs to be allowed to develop individualized and differing treatment standards applicable to their member employees. All MCPs should be required to comply with the same treatment standards promulgated by the Commissioner. Prior to the time that the Commissioner has promulgated treatment standards covering all types of medical services, the MCPs should simply be required to provide services which are usual and customary for the provider's health care profession, and which are reasonably required to cure or relieve the effects of the employee's work related injury. Allowing MCPs to develop their own unique treatment standards, even if limited to the period of time prior to the development of uniform standards by the Commissioner will only result in confusion and inconsistent treatment of the injured employees of this state.

7. Retroactive Application of MCPs.

Proposed Rule 5218.2000, subp. 3D provides that the MCP rules will apply to employees injured prior to the effective date of the 1992 amendments if the employee requests a change of doctor. The proposed rule provides that an employee who requests a change of doctor must receive further treatment provided by the employer's MCP.

This provision violates the statutory and constitutional prohibition against substantive rights being taken away or affected by the retroactive application of statutory amendments. The law of this State is clear that statutory amendments shall be applied prospectively only, whether or not the amendments are substantive or procedural in nature, unless the legislature specifically provides for retroactive application. The legislature has not provided for the retroactive application of managed care plans. Therefore, any employee injured prior to 10/1/92 cannot be required to receive treatment through a managed care plan even if the employee requests a change of treating physician.

8. **Termination of Participating Providers.**

Proposed Rule 5218.4000, subp. 2 allows managed care plans to "cancel" participating health care providers "under the requirements of the managed care plan." This rule effectively provides MCPs with totally unrestricted discretion over when and under what circumstances they may cancel or terminate participating health care providers. This proposed rule should be eliminated.

The legislature specifically created an exhaustive and comprehensive procedure for the investigation and sanction of health care providers who chronically provide inappropriate, excessive or unnecessary treatment to injured employees. This process is set forth in Minn. Stat. §176.103 under the authority of the Medical Services Review Board. This process requires the MSRB to investigate suspected cases of inappropriate, excessive or unnecessary treatment. It authorizes the Department to sanction providers found to be abusing the system. Said sanctions can include a total exclusion from treating injured employees.

The process established by the legislature sets forth specific checks and balances to protect wrongly accused providers from being unjustifiably sanctioned, while enabling the Division to identify and sanction actual abusers.

Obviously, the legislature did not intend to allow MCPs to side step this established process and effectively sanction health care providers without the checks and balances of appropriate due process.

The rules should be changed to allow MCPs to terminate participating health care providers only if the providers are found to have been abusing the system and the provider is sanctioned with exclusion from the workers' compensation system by the Department of Labor and Industry following the MSRB investigation. To provide MCPs with unfettered discretion to terminate health care providers would create a significant risk of abuse in direct contravention of legislative intent.

9. **Treatment Provided by Non-Participating Health Care Providers.**

Proposed Rule 5218.5000, subp. 1A proposes to limit the ability of an employee to treat with a health care provider who is not a participating health care provider to providers which have

a documented history of treatment with the employee before the date of injury. Minn. Stat. §176.1351, subp. 2(8) does not require that the history of treatment be prior to the date of injury. There is nothing in the statute to suggest that if the employee develops a history of treatment with a health care provider after the date of injury and thereafter wishes to switch the care of their work related injury to that health care provider, that the employee should not be able to do so. The legislature obviously intended to allow employees to treat with doctors in whom they have developed a certain level of confidence. Whether that treatment history and level of confidence is developed before or after the date of injury should not matter.

Proposed Rule 5218.5000, subp. 2B requires health care providers who are not participating health care providers to agree to refer the covered employee back to the managed care plan for "specialized care, which includes, but is not limited to, physical therapy and diagnostic testing". Minn. Stat. §176.1351, subd 2(8) only requires the non-participating health care provider to agree to refer the employee back to the managed care plan for "any other treatment that the employee may require". This would appear to allow the non-participating health care provider to provide any type of treatment he or she is licensed to provide, specifically including physical therapy and diagnostic testing. Therefore, it would appear that this proposed rule goes beyond the statute and is therefore unenforceable.

Respectfully submitted,

WILSON & WULFF, P.A.

David C. Wulff
Attorney at Law

DCW/cmg

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LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed
Adoption of Emergency Rules of the State
Department of Labor and Industry,
Governing Workers' Compensation
Managed Care Plans

NOTICE OF INTENT
TO ADOPT AN
EMERGENCY RULE

Notice is hereby given that the State Department of Labor and Industry intends to adopt the above-entitled emergency rules. The statutory authority to adopt the emergency rules is contained in Minnesota Statutes, section 176.1351, subd. 6 (1992 Laws of Minnesota, Chapter 510, Article 4, § 13). The agency, in adopting the rules, is following the procedures set forth in the Administrative Procedure Act for adopting emergency rules in Minnesota Statutes, sections 14.29 to 14.36.

All persons have 25 days after publication to submit data and views on the proposed emergency rules or any part or subpart of the rules in writing. Comments must be received by 4:30 p.m. on August 21, 1992. Comments must be submitted to:

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316
Telephone: (612) 297-5213

A copy of the proposed rules is attached to this notice.

A free copy of the proposed emergency rules is available by contacting Janice Keesling, Rehabilitation and Medical Affairs at (612) 296-8213.

The proposed emergency rules may be modified if the modifications are supported by data and views submitted to the agency and do not result in a substantial change in the proposed emergency rules as noticed.

Upon adoption of the emergency rules by the agency, the emergency rules as adopted and its supporting documents will be delivered to the Attorney General for review as to legality and form to the extent form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rules, must submit the written request to Pam Zembal at the above address.

The emergency rules will take effect five working days after approval by the Attorney General and be effective for 180 days. The emergency rules will be continued in effect for an additional 180 days if the agency gives notice of continuation in accordance with Minnesota Statutes, section 14.35.

A fiscal note is not required by Minnesota Statutes § 14.11 because the rules do not require the expenditure of public money by local public bodies.

7/20/92
Date

JOHN B. LENNES, JR.
Commissioner

KB/cj (190-1)

Department of Labor and Industry

Proposed Emergency Rules Relating to Workers' Compensation; Managed Care

Rules as Proposed (all new material)

5218.0100 [Emergency] DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 5218.0100 to 5218.9000 [Emergency] have the meanings given them in this part.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Labor and Industry or a designee.

Subp. 3. **Emergency care.** "Emergency care" means professional health services necessary to preserve life or limb.

Subp. 4. **Employee.** "Employee" means an employee entitled to treatment of a work injury under Minnesota Statutes, section 176.135.

Subp. 5. **Geographical service area.** "Geographical service area" means those counties in which a managed care plan has been certified to provide comprehensive health care services to injured employees.

Subp. 6. **Health care provider.** "Health care provider" has the meaning given in Minnesota Statutes, section 176.011, subdivision 24.

Subp. 7. **Insurer.** "Insurer" means the insurer providing workers' compensation insurance required by Minnesota Statutes, chapter 176, and includes a self-insured employer.

Subp. 8. **Managed care plan.** "Managed care plan" means a plan certified by the commissioner that provides for the management of treatment to injured employees under Minnesota Statutes, sections 176.135 and 176.1351.

Subp. 9. **Participating health care provider.** "Participating health care provider" means any person, provider, company, professional corporation, organization, or business entity with which the managed care plan has contracts or other

Approved by Revisor MEO

Doctors of Chiropractic are also primary care providers (i.e. they are "Physicians")

agreements.

Subp. 10. **Physician.** "Physician" has the meaning given in Minnesota Statutes, section 176.135, subdivision 2a.

Subp. 11. **Revocation.** "Revocation" means a permanent revocation of a managed care plan's certification to provide services under parts 5218.0100 to 5218.9000 [Emergency].

Subp. 12. **Suspension.** "Suspension" means a stopping by the commissioner of the managed care plan's authority to enter into new contracts with insurers for a specified period of time.

5218.0210 [Emergency] AUTHORITY.

Parts 5218.0100 to 5218.9000 [Emergency] are adopted under the commissioner's emergency rulemaking authority under Minnesota Statutes, section 176.1351, subdivision 6.

5218.0220 [Emergency] PURPOSE AND SCOPE.

The purpose of parts 5218.0100 to 5218.9000 [Emergency] is to establish procedures and requirements relating to the delivery of medical services to injured employees within the workers' compensation system under a managed care plan certified by the commissioner under Minnesota Statutes, sections 176.135, subdivision 1, paragraph (f), and 176.1351.

5218.0230 [Emergency] EFFECTIVE DATE.

A managed care plan certified under the emergency rulemaking authority will receive provisional certification that will expire 60 days after adoption of the permanent rules unless otherwise provided for in the permanent rules.

5218.1000 [Emergency] APPLICATION FOR CERTIFICATION.

Subpart 1. **Provisional certification.** Any person or entity may make written application to the commissioner to provide managed care to injured employees for injuries and diseases compensable under Minnesota Statutes, chapter 176, under a plan certified by the commissioner. To obtain provisional certification of a plan, the requirements in items A to D must be complied with and documented.

A. The plan must identify any directors and officers

Approved by Revisor N/O

of the managed care plan; the title and name of the person to be the day-to-day administrator of the managed care plan; the title and name of the person to be the administrator of the financial affairs of the managed care plan; and the name, address, and telephone number of a contact person.

B. The total annual compensation paid to an administrator, director, or executive officer of the managed care plan shall not exceed ten times the average annual wage as calculated in Minnesota Statutes, section 176.011, subdivision 20. The limit on compensation under this subpart does not include payment received by a health care provider for actual medical services rendered to an employee under Minnesota Statutes, chapter 176.

C. Each application for certification must be accompanied by a nonrefundable fee of $1,500.

D. Additional documentation must be submitted as specified in subitems (1) to (11).

(1) The managed care plan must provide a list of the names, addresses, and specialties of the participating health care providers who will provide services under the managed care plan, together with a statement that all licensing, registration, or certification requirements have been met for the health care provider to practice in Minnesota.

(2) The managed care plan must provide a description of the times, places, and manner of providing services under the plan, including a description of the initial geographical service area, designated by county. The plan must comply with units (a) and (b).

(a) The managed care plan must provide quality services that meet uniform treatment standards prescribed by the commissioner and all medical and health care services that may be required by Minnesota Statutes, chapter 176, in a manner that is timely, effective, and convenient for the employee.

(b) The managed care plan may not discriminate against or exclude from participation in the plan

Approved by Revisor SO.A.

any category of health care providers and must include an adequate number of each category of health care providers to give employees convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan, provided that the treatment is medically appropriate.

(3) The managed care plan must include a procedure to ensure that the employee will:

(a) receive initial evaluation by a participating physician within 24 hours of a request for treatment, following a work injury; the managed care plan may permit initial evaluations by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or a chiropractor;

Mandatory: employee will be told this immediately

(b) receive initial evaluation by a participating physician within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan under part 5218.5000 [Emergency], subpart 1, item A. The managed care plan may permit an initial evaluation by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or chiropractor;

(c) initially choose from at least three health care providers to whom the employee has been referred by the evaluating provider under unit (a) or (b) for treatment, and allow the employee to change providers within the managed care plan at least once. The procedure to allow the employee to select a health care provider must provide direct access to all health care profession disciplines if the treatment is determined to be appropriate for the condition by the evaluating health care provider under unit (a) or (b) or if the insurer approves the treatment;

Due to prejudice by the medical community, this could very well be a "gate keeping" system, used to discriminate against Chiropractors

(d) receive treatment or consultation by a managed care plan physician in cases requiring emergency

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in-patient hospitalization;

(e) receive information or advice on a 24-hour basis regarding medical services available within the managed care plan; and

(f) have access to health care providers within 30 miles of the employee's place of employment or residence, or the distance the employee normally travels to work, considering the normal patterns of travel, whichever is furthest.

(4) The managed care plan must designate the procedures and criteria for approval of services from a health care provider outside the managed care plan according to part 5218.5000 [Emergency].

(5) The application must include copies of contract agreements or other documents signed by each participating health care provider. Contractual provisions must be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency]. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts submitted must include a list of signatories to the contract.

(6) The managed care plan must designate the name, address, and phone number of a communication liaison for the department and the insurer.

(7) The managed care plan must include a procedure for peer review, utilization review, and internal dispute resolution in accordance with Minnesota Statutes, section 176.1351, subdivision 2, paragraph (4), including a method to resolve complaints by injured employees, medical providers, and insurers.

(8) The managed care plan must include a procedure to notify the commissioner of the commencement or termination of participating health care providers.

(9) The managed care plan must describe how employers and insurers will be provided with information that will inform employees of all choices of medical service

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providers within the plan and how employees can gain access to those providers.

(10) The managed care plan must describe how it will provide aggressive case management for injured employees, and a program for early return to work and cooperative efforts by the employees, the employer, and the managed care plan to promote workplace health and safety consultative and other services.

(11) The managed care plan must submit treatment standards for medical services not already prescribed by the commissioner. All managed care plan health care providers and health care providers described in part 5218.5000 [Emergency] will be governed by these standards.

Subp. 2. **Notification; approval or denial.** The commissioner shall notify the applicant in writing of the approval or denial of certification. If certification is granted, the commissioner shall notify the managed care plan applicant of the effective date of the certification and the initial geographical service area approved. If the certification is denied, the applicant will be provided with the reason for the denial. The commissioner must require an in-person meeting if necessary to determine compliance with parts 5218.0100 to 5218.9000 [Emergency]. Modification of the plan as certified shall require approval before it may be implemented.

5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN.

Subpart 1. **Scope.** A managed care plan shall provide comprehensive medical services according to its certification and Minnesota Statutes, chapter 176, and all other applicable statutes and rules.

Subp. 2. **Geographical service area; expansion.** The commissioner shall designate a managed care plan's initial geographical service area and approve any expansions to the managed care plan's service area. Injured employees shall not

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be covered by a managed care plan until the commissioner has approved the proposed expansion of the geographical service area.

Subp. 3. Contracts. When a managed care plan contracts with an insurer to provide services, the contract shall specify those employers covered by the contract and the estimated number of covered employees. The managed care plan contract must include the terms and conditions in items A to F.

A. The employer's place of employment must be within the authorized geographical service area.

B. Insurers may contract with multiple managed care plans to provide coverage for employers. When insurers contract with multiple managed care plans to cover the same employer, each employee shall have initial choice at time of injury to select the managed care plan that will manage the employee's care.

C. An employee with a compensable injury under Minnesota Statutes, chapter 176, occurring on or after the effective date of the managed care plan contract shall receive medical services in the manner prescribed by the terms and conditions of the managed care plan contract.

D. The requirements established in parts 5218.0100 to 5218.9000 [Emergency] do not apply to an employee with a compensable injury under Minnesota Statutes, chapter 176, that occurred before the effective date of the managed care plan contract, until the employee requests a change of doctor. At that time, further services shall be provided by the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by health care providers who are not participating providers must be delivered according to part 5218.5000 [Emergency].

E. To ensure continuity of care, the managed care plan contract shall specify the manner in which an injured employee with a compensable injury will receive medical services when a managed care plan contract terminates. When managed care plan coverage for an injured employee is being transferred from

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one managed care plan to another, the employee may continue to treat with the employee's original health care provider until the employee requests a change of doctor. At that time further services shall be provided under the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c). Services by providers who are not participating providers must be performed according to part 5218.5000 [Emergency].

F. Except as provided in part 5218.5000 [Emergency], an employer may require an employee who is claiming a workers' compensation injury to receive treatment from a managed care plan before the employer accepts or denies liability for the injury. In such cases the employer is liable for the cost of any treatment given before notice is given to the employee of a denial of liability, even if the employer is later determined to be not liable for the claimed injury.

The employee may receive treatment from any health care provider chosen by the employee after a notice of denial of liability has been given to the employee, or if the employer does not require the employee to receive treatment from a managed care plan prior to accepting liability for a claimed injury. If the employer later accepts liability or is determined by the commissioner, a compensation judge, or an appellate court to be liable for the claimed injury, the employer is responsible for the cost of all reasonable and necessary medical treatment received by the employee. Once the employer has admitted liability for the claimed injury or once the employer has been determined to be liable for the claimed injury, the employer may require that further medical treatment be received through the managed care plan unless the employee had a documented history of treatment with the health care provider as described in part 5218.5000 [Emergency], before the injury.

This is bull. The injured employee should have a right to treat with the Doctor of his or her choice

Subp. 4. **Restrictions.** When an insurer contracts with a single managed care plan for coverage for an employer, the plan may not be formed, operated, or administered by the same

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employer or insurer. When an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, formed, or administered by the employer or insurer. No employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota Statutes, chapter 176.

5218.3000 [Emergency] REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN.

Subpart 1. **Contracts; modifications.** A managed care plan shall provide the commissioner with a copy of a managed care plan insurer contract and managed care plan participating provider contract agreements, signed by the parties, within 30 days of execution of the contracts. Standard contracts may be submitted instead of individual contracts if no modifications are made. Standard contracts shall include a list of signatories. Amendments and addendums to the contracts shall also be submitted to the commissioner within 30 days of execution. Contract provisions shall be consistent with Minnesota Statutes, section 176.1351, and parts 5218.0100 to 5218.9000 [Emergency].

Subp. 2. **Requirements.** Within six months of provisional certification, each managed care plan shall provide the following information in a form and format prescribed by the commissioner:

A. a current listing of participating health care providers, including provider names, specialty, business address, and phone number, and for any new health care provider the information required by part 5218.1000 [Emergency], subpart 1, item D, subitem (1);

B. a listing of all health care providers outside of the managed care plan who provided services to employees under part 5218.5000 [Emergency];

C. a listing of all employers covered by each contract including the employer's names, unemployment insurer's

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identification number, and estimated number of employees governed by the managed care plan contract;

D. a summary of any sanctions or punitive actions taken by the managed care plan against its members;

E. a report that summarizes peer review and utilization review performed showing cases reviewed, issues involved, and action taken. The review must include, but is not limited to, evaluation of compliance with treatment standards adopted by the commissioner; and

F. any proposed changes to the managed care plan as certified by the commissioner.

Subp. 3. **Insurers; data.** The managed care plan must report to the insurer any data regarding medical services and supplies required by the insurer to determine compensability, and any other data required by rule.

Subp. 4. **Monitoring.** The commissioner shall require additional information from the managed care plan as necessary to monitor the managed care plan's compliance with parts 5218.0100 to 5218.9000 [Emergency] and Minnesota Statutes, section 176.1351.

5218.4000 [Emergency] COMMENCEMENT AND TERMINATION OF PARTICIPATING PROVIDERS.

Subpart 1. **Commencement.** Prospective new participating health care providers under a managed care plan shall submit an application to the managed care plan. A director, executive director, or administrator may approve the application under the requirements of the managed care plan. The managed care plan shall verify that each new participating health care provider meets all licensing, registration, and certification requirements necessary to practice in Minnesota.

Subp. 2. **Termination.** A participating provider may elect to terminate participation in the managed care plan or be subject to cancellation by the managed care plan under the requirements of the managed care plan. Upon termination of a provider, the managed care plan shall make alternate

by whose jurisdiction, and by what legal and ethical review system.

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arrangements to provide continuing medical services for an affected injured employee under the plan.

5218.5000 [Emergency] HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subpart 1. **Authorized services.** The managed care plan shall authorize a health care provider who is not a participating health care provider to provide medical services to an employee in the following circumstances:

A. if the health care provider maintains the employee's medical records and has a documented history of treatment of that employee before the date of injury. If the employee requests a change of doctor, further services shall be provided by the managed care plan in accordance with the procedures set forth in part 5218.1000 [Emergency], subpart 1, item D, subitem (3), units (b) and (c);

B. for emergency treatment; or

C. when referred outside the managed care plan for medical services by the managed care plan.

Subp. 2. **Requirements.** A health care provider who is not a participating health care provider must:

A. agree to comply with the managed care plan treatment standards, utilization review, peer review, dispute resolution, and billing and reporting procedures; and

B. agree to refer the covered employee to the managed care plan for specialized care, which includes, but is not limited to, physical therapy and diagnostic testing.

Subp. 3. **Disputes.** Any dispute under subpart 1 or 2 relating to the employee's selection of a health care provider who is not a managed care plan participating health care provider shall be resolved according to part 5218.7000 [Emergency]. Any dispute relating to a health care provider's compliance with the managed care plan standards and procedures or treatment standards adopted by the commissioner shall be resolved according to part 5218.7000 [Emergency] or Minnesota Statutes, section 176.103.

No! Doctors of Chiropractic are better trained and should not be required to refer for P.T. Again medical bureaucracy is woven into the fabric.

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5218.6000 [Emergency] CHARGES AND FEES.

Billings for medical services under a managed care plan shall be submitted in the form and format as prescribed in part 5221.0700, subpart 2. The payment by the insurer or the managed care plan to participating and nonparticipating health care providers for medical services shall be according to the timeframes and procedures in part 5221.0600, subpart 3, and Minnesota Statutes, section 176.135, subdivision 6, and shall be the maximum amount allowed under Minnesota Statutes, section 176.136.

5218.7000 [Emergency] DISPUTE RESOLUTION.

Disputes that arise between the employee and the managed care plan related to delivery of health services shall first be processed through the dispute resolution process of the managed care plan. The managed care plan dispute resolution process must be completed within 30 days of receipt of a request. If the dispute cannot be resolved, the commissioner may issue an order to resolve the dispute under Minnesota Statutes, sections 176.106 and 176.305 or 176.2615.

5218.8000 [Emergency] MONITORING.

Subpart 1. **Audits.** The commissioner shall monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements.

Subp. 2. **Records.** All records of the managed care plan and its participating health care providers shall be disclosed on request of the commissioner when necessary to ensure compliance with Minnesota Statutes, section 176.1351. These records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes.

5218.9000 [Emergency] SUSPENSION; REVOCATION.

Subpart 1. **Complaints; investigation.** Complaints pertaining to violations of parts 5218.0100 to 5218.9000 [Emergency] by the managed care plan shall be directed in

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writing to the commissioner. On receipt of a written complaint, or after monitoring the managed care plan operations, the department shall investigate the alleged rule violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the department determines on completion of the investigation that there has been a rule violation warranting suspension or revocation of provisional certification, the commissioner shall initiate a contested case proceeding under Minnesota Statutes, chapter 14.

Subp. 2. **Criteria.** Under Minnesota Statutes, section 176.1351, subdivision 5, the provisional certification of a managed care plan issued by the commissioner shall be suspended or revoked by the commissioner if:

A. service under the plan is not being provided according to the terms of the certified plan;

B. the plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of parts 5218.0100 to 5218.9000 [Emergency] or Minnesota Statutes, section 176.1351;

C. the managed care plan fails to comply with Minnesota Statutes, section 176.1351, parts 5218.0100 to 5218.9000 [Emergency], and requirements of utilization and treatment standards adopted under Minnesota Statutes, section 176.83;

D. any false or misleading information is submitted by the managed care plan or a member of the plan; or

E. the managed care plan continues to use the services of a health care provider whose license has been suspended or revoked by the licensing board, or under Minnesota Statutes, section 176.103, or who is ineligible to provide treatment to an injured employee under Minnesota Statutes, section 256B.0644.

Subp. 3. **Effects.** All contracts with insurers are void if a managed care plan's provisional certification is revoked. Upon suspension of certification, the managed care plan may

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continue to provide services under contracts in effect if the commissioner determines injured employees will continue to receive necessary medical services under Minnesota Statutes, section 176.135.

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SPORTS INJURIES & REHABILITATION CLINIC

Thomas Lake Center
1565 Cliff Road • Eagan, Minnesota 55122
R.J. Reidt D.C. / Jeffrey J. Bymers D.C.
612-688-0452

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AUG 21 19[illegible]

LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

August 21, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155 -4316

RE: PROPOSED EMERGENCY RULES RELATING TO WORKERS' COMPENSATION: MANAGED CARE

Dear Ms. Zembal:

This letter will serve as my comments to the proposed emergency rules 5218.0100 through 5218.9000 published on July 27, 1992.

1. Rule 5218.4000, subpart 1. The concern with this rule is that it will effectively exclude some health care providers from treating workers' compensation patients because the providers are not accepted members of any Managed Care Plan (MCP). The rule should require as a prerequisite to certification that all MCPs must accept any health care provider who meets all licensing registration and certification requirements necessary to practice in Minnesota and who agrees to abide by the rules and limitations of the MCP.

The second concern with this rule is that by allowing the MCPs to choose participating providers, the rule will be significantly limiting the right of injured employees to choose the health care provider from whom they will receive treatment. Minnesota has always guarded the right to choose one's treating doctor.

2. Rule 5218.1000, subpart 1 D (3). This proposed rule allows MCPs to require employees to submit to initial evaluations by a physician. Definition of physician does not specifically include chiropractors and states that the MCP <u>may</u> (emphasis added) permit initial evaluations by a participating chiropractor. This rule violates the statutory prohibition against MCPs descriminating against any category of health care provider. The injured employee should be allowed to be evaluated by any physician or chiropractor within the network of providers.

Subpart C of this rule provides that the evaluating provider who conducts the initial evaluation must provide the employee with a list of at least three health care providers with whom the employee may treat. This effectively gives the evaluating provider the power to determine what treatment is appropriate for the condition and what type of health care disciplins should provide treatment is appropriate for the condition and what type of health care disciplins should provide [illegible] the evaluating provider the power to discriminate against

provide the injured employee with a list of all the participating health care providers. If the employee's initial choice of health care provider, after performing the intital evaluation, determines that the employee's health care discipline is not the appropriate one, then the initial health care provider would provide the employee with a list of allthe participating providers within the proper health care discipline.

3. Rules 5218.1000, subpart 1 and 5218.2000, subpart 4. These rules are not clear on the exclusion of workers' compensation insurers or self-insured employers from becoming certified as MCPs. These two groups are specifically prohibited from becoming MCPs by Minnesota statutory law (Section 176.13511, subdivision 1).

4. Rule 5218.2000, subpart 3D. This rule provides for the retroactive application of the MCP rules in the case of an employee injured prior to the effective date of the 1992 amendments requesting a change of doctor. This provision violates the statutory and constitutional prohibition against substantive rights being taken away or affected by the retroactive application of statutory amendments.

5. Rule 5218.4000, subpart 2. This rule allows MCPs to terminate participating health care providers under the requirements of the managed care plan. This rule provides MCPs with unrestricted discretion over when and under what circumstances they may terminate or cancel participating health care providers. The legislature has already provided a procedure for the sanction of health care providers who provide unnecessary or inappropriate treatment to injured employees. This procedure falls under the authority of the Medical Services Review Board (MSRB). The rules should be changed to allow MCPs to terminate participating health care providers only if the providers are found to have been abusing the system and the provider is sanctioned with exclusion from worker's compensation system by the Department of Labor and Industry, after investigation by the MSRB.

6. Rule 5218.5000, subpart 1(A). This rule does not provide for the case of an employee who develops a relationship with a non-participating health care provider after the date of the employee's work injury to switch to that provider if the employee desires. Minnesota Statute Section 176.1351, subpart 2(B) does not require that the history of treatment be prior to the date of injury.

7. Rule 5218.5000, subpart 2B. This proposed rule requires the non-participating provider of medical services to an employee to refer the employee back to the managed care plan for specialized care which includes but is not limited to physical therapy and diagnostic testing. It is my understanding that Minnesota Statute section 176.1351, subdivision 2(B) only requires non-participating health care providers to agree to refer the employee back to the managed care plan for any other treatment that the employee may require. This would appear to allow the non-participating health care provider to provide any type of treatment he or she is licensed to provide, including physical therapy and diagnostic testing.

Respectfully submitted,

Jeffrey J. Byrnes DC

E • A • G • A • N
CHIROPRACTIC
SPORTS INJURIES & REHABILITATION CLINIC

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August 21, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155 - 4316

RE: PROPOSED EMERGENCY RULES RELATING TO WORKERS' COMPENSATION: MANAGED CARE

Dear Ms. Zembal:

This letter will serve as my comments to the proposed emergency rules 5218.0100 through 5218.9000 published on July 27, 1992.

1. Rule 5218.4000, subpart 1. The concern with this rule is that it will effectively exclude some health care providers from treating workers' compensation patients because the providers are not accepted members of any Managed Care Plan (MCP). The rule should require as a prerequisite to certification that all MCPs must accept any health care provider who meets all licensing registration and certification requirements necessary to practice in Minnesota and who agrees to abide by the rules and limitations of the MCP.

The second concern with this rule is that by allowing the MCPs to choose participating providers, the rule will be significantly limiting the right of injured employees to choose the health care provider from whom they will receive treatment. Minnesota has always guarded the right to choose one's treating doctor.

2. Rule 5218.1000, subpart 1 D (3). This proposed rule allows MCPs to require employees to submit to initial evaluations by a physician. Definition of physician does not specifically include chiropractors and states that the MCP may (emphasis added) permit initial evaluations by a participating chiropractor. This rule violates the statutory prohibition against MCPs descriminating against any category of health care provider. The injured employee should be allowed to be evalutated by any physician or chiropractor within the network of providers.

Subpart C of this rule provides that the evaluating provider who conducts the initial evaluation must provide the employee with a list of at least three health care providers with whom the employee may treat. This effectively gives the evaluating provider the power to determine what treatment is appropriate for the condition and what type of health care discipline should provide that treatment and thus giving the evaluating provider the power to discriminate against categories of health care providers. This problem could be remedied by simply having the MCP

provide the injured employee with a list of all the participating health care providers. If the employee's initial choice of health care provider, after performing the intital evaluation, determines that the employee's health care discipline is not the appropriate one, then the initial health care provider would provide the employee with a list of allthe participating providers within the proper health care discipline.

3. Rules 5218.1000, subpart 1 and 5218.2000, subpart 4. These rules are not clear on the exclusion of workers' compensation insurers or self-insured employers from becoming certified as MCPs. These two groups are specifically prohibited from becoming MCPs by Minnesota statutory law (Section 176.13511, subdivision 1).

4. Rule 5218.2000, subpart 3D. This rule provides for the retroactive application of the MCP rules in the case of an employee injured prior to the effective date of the 1992 amendments requesting a change of doctor. This provision violates the statutory and constitutional prohibition against substantive rights being taken away or affected by the retroactive application of statutory amendments.

5. Rule 5218.4000, subpart 2. This rule allows MCPs to terminate participating health care providers under the requirements of the managed care plan. This rule provides MCPs with unrestricted discretion over when and under what circumstances they may terminate or cancel participating health care providers. The legislature has already provided a procedure for the sanction of health care providers who provide unnecessary or inappropriate treatment to injured employees. This procedure falls under the authority of the Medical Services Review Board (MSRB). The rules should be changed to allow MCPs to terminate participating health care providers only if the providers are found to have been abusing the system and the provider is sanctioned with exclusion from worker's compensation system by the Department of Labor and Industry, after investigation by the MSRB.

6. Rule 5218.5000, subpart 1(A). This rule does not provide for the case of an employee who develops a relationship with a non-participating health care provider after the date of the employee's work injury to switch to that provider if the employee desires. Minnesota Statute Section 176.1351, subpart 2(8) does not require that the history of treatment be prior to the date of injury.

7. Rule 5218.5000, subpart 2B. This proposed rule requires the non-participating provider of medical services to an employee to refer the employee back to the managed care plan for specialized care which includes but is not limited to physical therapy and diagnostic testing. It is my understanding that Minnesota Statute section 176.1351, subdivision 2(8) only requires non-participating health care providers to agree to refer the employee back to the managed care plan for any other treatment that the employee may require. This would appear to allow the non-participating health care provider to provide any type of treatment he or she is licensed to provide, including physical therapy and diagnostic testing.

Respectfully submitted,

Jeffrey J. Bymers, DC

River Ridge Professional Services, Inc.

Rehabilitation Consultants and Services

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REHABILITATION & MEDICAL AFFAIRS

August 18, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

I am responding to the proposed emergency rules relating to worker's compensation, managed care. I am employed as the Director of Physical Therapy for River Ridge Professional Services in Stillwater. River Ridge operates a fairly new out patient clinic providing physical therapy, occupational therapy, and speech-language pathology services. Approximately 5% of our business is reimbursed through worker's compensation.

The managed care concept may be a good approach to controlling costs of worker's compensation claims but I have a number of serious concerns about a managed care system based on my experience with current managed care plans in Minnesota.

First, the managed care plan will be able to limit access to providers on the basis of "geographic accessibility." Our company has been denied contracts with such groups as Preferred One and Group Health because there are "other providers in your area." Quality of care or competitive pricing are completely ignored with this mind set. In my opinion, if geographic accessibility is used as a criteria for determining contracts with health care providers, trade would be restricted and the positive effects of business competition would be lost. In the long run, this could have serious negative implications on the quality of care provided to injured workers. From a purely business perspective, small out patient clinics such as ours could lose a significant amount of business to larger organizations. I propose that any reference to "geographic accessibility" be deleted.

Secondly, reimbursement issues are another concern. Most managed care plans currently subtract subscriber fees or carrier liabilities from the allowed charge. It is not clear in the proposed rules if this will be allowed. If this is allowed, it

will have a negative effect on our bottom line. Also, will the managed care plan require any prior authorization for worker's compensation claims? I currently see HMO's using prior authorizations as a way of limiting reasonable and necessary rehabilitation care. If prior authorization is required, it would be imperative to require that the authorization process be managed by the same health professional as is requesting the care (e.g. a physical therapist should decide if physical therapy should be authorized). Guidelines for the number of allowable visits should also be written in the regulations.

Overall, this managed care plan could be workable if these concerns are clearly addressed in the regulations. My preference would be for worker's compensation costs to be managed through the fee schedule, professional peer review organizations, and treatment guidelines developed through the Medical Service Review Board of the Department of Labor and Industry.

Thank you for your consideration.

Sincerely,

Rick Szopinski PT

Rick Szopinski, P.T.
Director of Physical Therapy

RS/jf

cc: Betty Smith, President

NRC

National
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Western Minnesota

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Moorhead, Minnesota 56560
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Southern Minnesota

Subway Kahler Hotel
20 Second Ave. S.W.
Rochester, Minnesota 55902
(507) 281-1900

360 Pierce Ave., Ste. 207
North Mankato, Minnesota 56003
(507) 345-8296

August 19, 1992

Mr. John Lennes Jr.
Commissioner
Department of Labor and Industry
443 Lafayette Road N.
St. Paul, MN 55155-4316

Dear Mr. Lennes:

On behalf of the senior management staff at National Rehabilitation Consultants I am writing you with our concerns regarding the proposed Emergency Rules governing Workers Compensation and Managed Care Plans. I am referring specifically to 5218.1000 Application for Certification, Section D, Subdivision 10 which states:

> **"The managed care plan must describe how it will provide aggressive case management for injured employees, and a program for early return to work and cooperative efforts by the employees, the employer, and the managed care plan to promote workplace health and safety consultative and other services."**

We want you to include language defining the qualifications of a Case Manager to help ensure that quality services are provided. We highly recommend the Case Manager be nationally certified as a CRC or CIRS which will provide for the vocational component in dealing with employers rather than another medical professional such as a nurse.

We also recommend that the Case Manager be autonomous from the MCO to ensure more objective services. Furthermore in order to comply with the Rules in providing aggressive case management and safety consultation an on-site visit with the employer is necessary.

If you should have any questions regarding this input, feel free to call me directly.

Sincerely,

Connie John Swanson

Connie John Swanson, MS, QRC
Case Services Director

cc: Leo Eide
David Sherwood Gabrielson

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ORTHOPAEDIC SPORTS, INC.
specialized physical therapy

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FOREST LAKE OFFICE
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August 13, 1992

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REHABILITATION & MEDICAL AFFAIRS

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 LaFayette Rd. N.
St. Paul, MN 55155-4316

Dear Ms. Zembal,

I am writing you regardng the Proposed Rules of the State Department of Labor and Industry governing workers compensation managed care plans. I am one of the owners of Orthopaedic Sports, Inc., private physical therapy clinics located in Stillwater, Woodbury, Maplewood and Forest Lake. We have one office, The Work Center, which deals primarily with work related injuries utilizing functional rehabilitation including functional capacity evaluations and work hardening programs along with various other services provided to industries.

I am very concerned about the proposed rules regarding managed care plans in the workers compensation system. The fact that managed care plans will be structured such that they must include at least three physicians would make it difficult for the small business owners/physical therapist to compete with the larger, more powerful corporations such as Health East, Health One, and Fairview. Since approximately 35 to 40 percent of our business is workers compensation, we would lose a great deal of our business if we did not see the injured worker. I have further concerns that by limiting the number of providers in the managed care plan that injured workers would have limited access to physical therapy care, and this would certainly delay rehabilitation and recuperation and thus delay their return to work. This would certainly add cost to the system.

The managed care plan seems to me to essentially be "a company doctor" system which limits the injured worker's choice in choosing a health care provider.

Although I am certainly not an expert in the Americans With Disabilities Act, the restrictions placed in the managed care system for an injured worker, who may be considered as having a disability, may lead to a conflict between the ADA and new workers compensation rules. This could lead to significant

litigation in many cases.

Because of my concerns I do feel that these rules should be closely scrutinized and altered. I would recommend that cost control be attained through the fee schedule, peer review of the various professions by their respective professionals, and treatment guidelines developed by Medical Services Review Board of the Department of Labor and Industry.

Thank you very much for your consideration. I sincerely desire to provide high quality of care for the injured worker and facilitate optimal return to work at an appropriate time frame. All health care providers have an obligation to try to reduce health care costs and provide high quality care, and I do feel that we can do this without restricting access or potentially causing health care providers to go out of business.

Sincerely,

James A. Hoyme, PT
President,
Orthopaedic Sports, Inc.

JAH/czu

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'92 AUG 20 P1:56
DEPT. OF LABOR & INDUSTRY
SPECIAL COMP. FUND

FAX TO: Pam Zembal, Rehab. & Medical Affairs

FROM: Allie Hafez, OTR, QRC, CIRS, Vital Link Consulting

RE: Proposed adoption of emergency rules governing workers' comp. managed care plan/organizations

DATE: August 19, 1992

Please consider this my request that a public hearing be held to discuss issues relevant to Managed Care within the workers' compensation system.

I believe that there are serious issues and concerns remaining for the rule-making body to hear before adoption of the rules, emergency or otherwise; and hope that my request is supplemented by the minimum number required to get a hearing scheduled.

Thank you.

(end of fax transmission)

ISERNHAGEN WORK SYSTEMS
ISERNHAGEN & ASSOCIATES, INC.
2202 WATER STREET
DULUTH, MN 55812

PHONE: (218) 728-6455
FAX: (218) 728-6454

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AUG
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REHABILITATION & MEDICAL AFFAIRS

August 14, 1992

Pat Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St Paul MN 55155-4316

Dear Ms. Zembal:

We are responding to the request for views on the proposed Emergency Rules of the State Department of Labor and Industry, Governing Worker's Compensation Managed Care Plans.

We are supportive of the managed care concept for individuals who have been injured at work. We provide training in the area of work injury management and prevention throughout the United States, Canada, Australia and Europe and advocate this concept. We have seen managed care, when done appropriately, benefit all parties concerned. The employer benefits by getting the injured worker back to work quicker and safer thus decreasing the financial losses associated with Worker's Compensation. The employee benefits by returning to work quicker and safer and maintaining his or her part in the company, minimizing the personal physical, financial and psychological problems associated with worker's compensation. The Worker's Compensation insurance carrier benefits by a decrease in expenditures for Worker's Compensation dollars, thus resulting in a more positive financial picture.

The proposed Emergency Rules present some major obstacles to providing an effective managed care program. One of the major obstacles is the potential of an injured employee not having a choice of health care provider. Even through it is implied on pages 3(b, 2, b) "The managed care plan may not discriminate against or exclude from participation in the plan any category of health care providers and must include adequate numbers of each category of health care providers to five the employee convenient geographic accessibility to all categories of providers and adequate flexibility to choose health care providers from among those who provide services under the plan, provided that the treatment is medically appropriate." The procedures that the managed care plan must include that are described on (Page 4, part 3a, b, c) limit the access to the services and providers described earlier.

This part of the Emergency Rules also appears to go against the Americans with Disabilities Act, in that the employer may not have a choice of medical provider in preventing discrimination from occurring. The law appears to require an employee to go to the employer's choice of managed care provider.

The new Worker's Compensation Law can prevent an employee from finding and selecting physicians and other health care providers who can adequately determine their qualifications, need for reasonable

accommodations and help determine if discrimination is occurring. Under the new law, there will not be this choice and the only avenue the employee will have is to seek thier own medical provider at their own expense.

Another point of concern is the "antitrust" implications. The antitrust laws prevent the abuse of power when monopolies or segregation of the marketplace takes place. Antitrust laws exist so that the consumer is allowed access to necessary services. Already in the state are antitrust suits against health care providers. One case already has been settled in St. Cloud and another case against health care providers in Duluth, Minnesota is under investigation.

The new law and the Emergency Rules invite increased opportunities for large providers in areas where there is a limited number of providers to be band together and exclude the smaller groups, even though the smaller group provides high quality, cost effective services. This type of an activity feed the antitrust situation.

To prevent the above from happening, all smaller independent providers who meet criteria of quality as designated by the managed care system, must be allowed to belong to the managed care system. They will be following the guidelines of the managed care system, but will be guaranteed access to the employers and employees.

If allowed, the large managed care providers can exclude the smaller independent provider which will create a monopolizing situation. This type of a situation is in direct violation of the antitrust law. In addition, a monopolized system increases costs rather than decreases costs.

These are some of the more significant obstacles that the new laws and rules present. We appreciate the opportunity to express our concerns. If you have any questions, please do not hesitate to contact us.

Sincerely,

Susan J. Isernhagen, PT
President

Dennis D. Isernhagen, PT
Vice President

ram

sji\zembal

ISERNHAGEN WORK SYSTEMS
ISERNHAGEN & ASSOCIATES, INC.
2202 WATER STREET
DULUTH, MN 55812

PHONE: (218) 728-6455
FAX: (218) 728-6454

FACSIMILE TRANSMITTAL SHEET

DATE: 8-19-92

NUMBER OF PAGES: 2

TO: Pam Zembal

FAX NUMBER: 612-296-9634

FROM: ISERNHAGEN & ASSOCIATES
2202 WATER STREET
DULUTH, MN 55812

PHONE: 218-728-6455
FAX: 218 728 6454

Ann Wacker/ka

MESSAGE

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W.C. ADMINISTRATIVE OPERATIONS

ISERNHAGEN WORK SYSTEMS
ISERNHAGEN & ASSOCIATES, INC.
2202 WATER STREET
DULUTH, MN 55812

PHONE: (218) 728-6455
FAX: (218) 728-6454

August 19, 1992

FAX TO: Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
(612) 296-9634

As the Director of Clinical Performance for Isernhagen Clinics in Duluth, MN, I am requesting a public hearing on the Department of Labor and Industry's Proposed Adoption of Emergency Rules Governing Worker's Compensation Managed Care Plan.

We have some major concerns with the proposed rules.

Sincerely,

Ann M. Walker, OTR
Director of Clinical Performance

ram

aw\zembal

Peak Performance Therapy Center
4225 White Bear Parkway, Suite 700
White Bear Lake, MN 55110
(612) 429-2044

August 14, 1992

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LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
Saint Paul, MN 55155-4316

Dear Ms. Zembal,

I am writing in regards to the adoption of Emergency Rules of the State Department of Labor and Industry governing Workers' Compensation Managed Care Plan. Peak Performance Therapy Center is a small, privately owned practice. The patient load is at least 50-60% Workers' Compensation insureds. This bill limiting patient's choice of providers will have a grave effect on this practice as well as all the other practices in Minnesota just like Peak Performance Therapy Center.

The Emergency Rules stipulates a geographical area limit which could create a transportation problem for patients. A 30 mile geographical area does not seem like much to a healthy person but to someone suffering with a back injury it can seem like a lifetime in a car. Some patients cannot ride in a car for more than 10 minutes at a time, 30 miles would be impossible. Some patients arrange rides or take cabs to therapy because they are unable to drive due to their injury. It is difficult in most cases to find a ride that can take you 30 miles 3 times per week for physical therapy and the cost of a 30 mile cab ride is a mint.

I hope someone on Capitol Hill remembers the small but very valuable medical providers when dealing with this proposal. It will profoundly affect the economic structure of the medical community in Minnesota and greatly inconvenience our most important resource--the Minnesota work force.

Sincerely,

Katy Ponferrada, Office Manager
Peak Performance Therapy Center

OCCUPATIONAL MEDICINE CONSULTANTS, LTD.
6500 Barrie Road
Edina, Minnesota 55435
Phone: (612) 920-5663
Fax: (612) 920-9031

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REHABILITATION MEDICINE AFFAIRS

August 17, 1992

Pam Zimbla
Rehabilitation Medicine Affairs
Department of Labor and Industry
443 LaFayette Road North
St. Paul, MN

RE: Notice of Attempt to Adopt Emergency Rule

Dear Ms. Zimbla:

I reviewed the proposal for Emergency Rules. The Managed Care concept seems to be well established. One question I have is "What is the role of the corporate physician in treating for those companies that have on-site physician coverage? Is it necessary for the corporation or the physicians to develop and submit a Managed Care plan to be able to continue to treat the company's injured workers if this done a contractual in-house basis? Do these contracts have to be subject to development of a Managed Care plan as well?"

I think these are important questions as many companies find this is a more cost effective way of providing treatment by having an in-house physician rather than a fee-for-service basis. The contract physician already provides essentially the services of Managed Care for the company and I would perceive Managed Care being a duplication of services already provided, yet providing less control than is presently accomplished through Corporate Management itself.

One other question, how does the Emergency Rules effect Worker's Compensation coverage for federal employees?

Yours truly,

Thomas C. Jetzer, MD, MPH

TCJ/lrn

ASSOCIATED
Medical Services
ASSESSING AND VERIFYING HEALTH CARE

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REHABILITATION & MEDICAL AFFAIRS

Aug 17, 1992

Dear Gloria & Pam Zembal,

In reviewing the Emergency Rules for the Managed Care Plans & after hearing your responses at the Work Comp Task Force I have just a few areas that need further clarification.

One under 5218.1000, the inclusiveness of all categories of health care providers, I am reading this to mean Doctors, Specialists, Physical Therapist, Chiropractors, Doctors of Osteopath, Nurse Midwives & Nurse Practitioners. If not & as our discussion was at the Task Force I would feel you are eliminating the options of care available.

In 5218.2000, the requirement of employee claiming a workers comp injury to receive treatment from a managed care plan before employer accepts or denies liability appears unclear & would allow for a large medical bill to be run up before liability is accepted & yet requires the employee to pay all expenses incurred. It would appear to me that

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Criteria should be developed for an initial assessment for W/C injuries, so provider cannot perform any number of tests before liability is established.

In section 5218.5000, the authorization of a health care provider who is not a participating health managed care plan to provide medical services, unless he "maintains the employees medical records + documented history before the W/C injury, are there any limitations as to how long ago pt may have treated with this Doctor?

Also it appears to eliminate the sole practitioner from treating W/C injured individuals As long as there will be a standards of care for specific injuries, that would be the only specification to treating? I not asked to belong to a large managed care plan, they are left out.

Thankyou for your time + responses.

Sincerely,

MaryJean Siepen
Associated Services

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NNESOTA
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Disability

5100 Glenwood Avenue
Minneapolis, MN 55422
(612) 541-0963

August 20, 1992

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C. ADMINISTRATIVE OPERATIONS

Ann Zenobel
Rehabilitation & Medical Affairs
Department of Labor & Industry

RE: Public hearing

I would like to request a public hearing on the Department of Labor & Industry's Proposed Adoption of Emergency Rules Governing Worker's Compensation Managed Care Plans.

Both occupational & physical therapists would like an opportunity to address concerns & issues regarding these rules.

Thank you!

Pat Schaber Brantigan OTR

Renew
Rehabilitation, inc.
enhancing independence with occupational physical and speech therapy services
(612) 646-4061

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August 1992

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry

Dear Ms. Zembal:

I am requesting a public hearing regarding the proposed emergency rules governing workers compensation.

This is a major change in the delivery of services under the State Department of Labor and Industry, and I believe it is essential to allow those most affected by these changes an opportunity to voice their concerns.

Historically there has been a great deal of controversy regarding the effects of managed care. The concern has been both positive and negative; therefore, it is essential that the department issues rules which will best serve the injured as well as the providers. These rules need to be clear, and reflect that the historical concerns that have arisen in the managed care model.

Thank you for you consideration of these very key issues in the formation of the departments rules.

Sincerely,

Moria Malat Gallagher OTR
Moria Malat Gallagher, OTR
President Renew Rehabilitation

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August 20, 1992

Pam Zemlak
Rehabilitation & Medical Affairs
Department of Labor & Industry

RE: Public hearing

I would like to request a public hearing on the Department of Labor & Industry's Proposed Adoption of Emergency Rules Governing Worker's Compensation Managed Care Plans.

Both occupational & physical therapists would like an opportunity to address concerns & issues regarding these rules.

Thank you!

Gloria Brown, OTR

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Pam Zesbaugh
Rehabilitation & Medical Affairs
Department of Labor & Industry

RE: Public hearing

I would like to request a public hearing on the Department of Labor & Industry's Proposed Adoption of Emergency Rules Governing Worker's Compensation Managed Care Plans.

Both occupational & physical therapists would like an opportunity to address concerns & issues regarding these rules.

Thank you!

Patricia A. Brar, OTR

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August 20, 1992

Sam Zemhal
Rehabilitation & Medical Affairs
Department of Labor & Industry

RE: Public hearing

I would like to request a public hearing on the Department of Labor & Industry's Proposed Adoption of Emergency Rules Governing Worker's Compensation Managed Care Plan.

Both occupational & physical therapists would like an opportunity to address concerns & issues regarding these rules.

Thank you!

Jill D. Cramer, OTR

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August 20, 1992

Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor & Industry

RE: Public Hearing

I would like to request a public hearing on the Department of Labor & Industry's Proposed Adoption of Emergency Rules Governing Worker's Compensation Managed Care Plans.

Both occupational & physical therapists would like an opportunity to address concerns & issues regarding these rules.

Thank you!

Julie Weighter, OTR

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August 20, 1992

Jean Zemke
Rehabilitation & Medical Affairs
Department of Labor & Industry

RE: Public hearing

I would like to request a public hearing on the Department of Labor & Industry's Proposed Adoption of Emergency Rules Governing Worker's Compensation Managed Care Plan.

Both occupational & physical therapists would like an opportunity to address concerns & issues regarding these rules.

Thank you!

Joan Tam R.P.T.

ROZMOND H. KENNON, R.P.T.
REGISTERED PHYSICAL THERAPIST

August 19, 1992

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REHABILITATION & MEDICAL AFFAIRS

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Rd. N.
St. Paul, MN 55155-4316

Dear Ms. Zembal:

I am writing to you with concern for the proposed rules of the State Dept of Labor and Industry governing workers's compensation managed care plans. I am a physical therapist, and owner of a private physical therapy clinic at 1518 East Lake Street, Suite 206, Minneapolis, MN. At the current time, I do have occasion to treat patients in need of physical therapy after a workman's compensation disability. As such, we have scrupulously attempted to return these patients to work as rapidly as their conditions would allow. This has meant a cooperative effort between my office, the referring physician, QRCs and other providers. This includes functional capacity evaluations and work hardening programs.

My concern about the proposed rules is that it will allow the larger groups such as Health East, Health One, Life Span and the Fairview system to have a monopoly working with these workman's compensation cases. Attorney General Humphrey has gone on record in opposition, with the argument that the effect might raise health care costs. My small clinic and many other equally small clinics, will be excluded from the process and will lose a great deal of business if this comes about. An example is an existing situation with MHP who turned me down, as a provider for them, with the reason that my opertion was not large enough.

Are there any safeguards with respect to allowing the "ma and pa" operations to still be included in the specialized care that is necessary to return these workers to their optimal condition. If such small groups as myself are excluded from this process, geographically, this raises a question of whether the workers will be seen on a timely basis, and whether they will receive the quality care that I feel some of the smaller clinics are now affording.

Another question I raise, is that the managed care plan, as

1518 EAST LAKE STREET • SUITE 206 • MINNEAPOLIS, MINNESOTA 55407 • OFFICE: 724-8232

I understand it, has an element that seemingly railroads the patients to a company doctor, who may or may not have the injured workman's best interest in mind, thereby losing a very important one-on-one relationship that often exists between a private provider and the patient.

I am, as a health care provider, committed to attempting to do my part in reducing the health care costs, and provide the high quality care that the worker is entitled too. I do not feel restricting access and placing private providers at risk is a very prudent way to achieve this goal.

As you are the person to direct these complaints to, I hope that these letters will be beneficial in stating and showing our cause. Not everyone can be in the BIG LEAGUE, but that does not mean that we do not give quality, concerned care to these injured people.

Sincerely,

ROZMOND H. KENNON, RPT, PA

Rozmond H. Kennon

RHK:mdm

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ORTHOPAEDIC SPORTS, INC.
specialized physical therapy

FAX TRANSMITTAL SHEET

DATE:

FAX TO: Pam Zembal FAX 296-9634
Rehab & Medical Affairs

OF: Department of Labor & Industry

NUMBER OF PAGES (INCLUDING THIS SHEET): 3

FROM: BARBARA LARSON

OF: The Minnesota Occupational Therapy Association

SENDER'S PHONE NUMBER: 439-9509

COMMENTS:

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MAPLEWOOD OFFICE FAX	(612) 770-9786
WOODBURY OFFICE FAX	(612) 738-9486
FOREST LAKE OFFICE FAX	(612) 464-8547

STILLWATER OFFICE
1700 TOWER DRIVE WEST
STILLWATER, MINNESOTA 55082
(612) 439-8540

MAPLEWOOD OFFICE
1555 BEAM AVENUE - SUITE 308
MAPLEWOOD, MINNESOTA 55109
(612) 779-8543

WOODBURY OFFICE
2025 WOODLANE DRIVE SUITE 100
WOODBURY, MINNESOTA 55125
(612) 738-8270

FOREST LAKE OFFICE
146 NORTH LAKE STREET
FOREST LAKE, MINNESOTA 55025
(612) 464-8502

THE WORK CENTER
1410 FRONTAGE ROAD WEST
STILLWATER, MINNESOTA 55082
(612) 439-9509

MOTA

Minnesota Occupational Therapy Association

August 20, 1992

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W. C. ADMINISTRATIVE OPERATIONS

Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor & Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

RE: Proposed Emergency Rules of the State Department of Labor & Industry, Governing Worker's Compensation Managed Care Plans.

Dear Ms. Zembal:

The Worker's Compensation Special Issues committee of the Minnesota Occupational Therapy Association has reviewed the Worker's Compensation law and the proposed emergency rules to be enacted by the Department of Labor & Industry.

The proposed emergency rules, in our opinion, raise ethical and legal questions and conflict with a society which promotes free enterprise and professes access to and choice of health care as an individual right. Our concerns include the following:

* Language in the proposed rules limiting employee choice and access to health care and service providers.

* The legal and ethical issues raised by allowing employers and insurers to own Managed Care Plans.

* The exclusion or elimination of service providers and the potential for a few providers to have a monopoly on the market.

* The potential for increasing costs by limiting employee access and choice to health care.

While we feel it is the intent of the law to establish a system which controls costs, insures quality, and decreases over-utilization, we have serious concerns about the impact of the proposed emergency rules if promulgated as written.

2810 Aquila Avenue So. . P.O. Box 26532 . Minneapolis, MN 55426 . (612) 938-3123

Printed on recycled paper

We encourage you to consider the following:

* Use existing peer review systems to monitor the appropriateness of care. The Minnesota Occupational Therapy Association has an established peer review system.

* Provide an environment which treats providers equally, promotes healthy competition and allows access and choice to the employee.

We request a public hearing be scheduled in order to provide further input on these issues.

If you have any questions, please contact me at (612) 430 9509.

Sincerely,

Barbara A. Larson

Barbara A. Larson, OTR

BAL/cj

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W. C. ADMINISTRATIVE OPERATIONS

Select Care

August 21, 1992

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REHABILITATION & MEDICAL AFFAIRS

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

Select Care is a preferred provider organization, which is fully accredited by the American Accreditation Program, Inc. intends to become a Workers' Compensation managed care plan. We have reviewed the Proposed Emergency Rules Relating to Workers' Compensation; Managed Care and have a number of comments:

1. There appears to be an inconsistency between the statute and the regulations, in the ability of insurers and employers to form managed care plans. The statute (176.1351 Subd.1) states that "any person or entity, other than a workers' compensation insurer or an employer for its own employees, may make written application to the commissioner to have a plan certified that provides management of quality treatment to injured workers...". The regulations (5218.2000, Subp.4.) state that "when an insurer contracts with multiple managed care plan, one or more of the plan, but not all, may be operated, formed, or administered by the employer or insurer." The statute does not allow an insurer or employer to be a managed care plan while the regulations allow an insurer or employer to be a managed care plan as long as at least one other managed care plan is also offered.

   A managed care plan that is a subsidiary of another large organization should be allowed to provide managed care services to all related organizations and its own employees.

2. The regulations require managed care plans to assure that employees receive an initial evaluation within 24 hours of a request for treatment. There are many medical situations which clearly require immediate evaluation and treatment. There are many other conditions, however, which do not require evaluation within 24 hours. It is unreasonable to expect managed care providers to evaluate <u>all</u> injured workers who request treatment within 24 hours. Provisions should be allowed for non-urgent problems to be treated and/or evaluated during normal clinic/provider hours. Since most practices are not open for non-emergent care on holidays or weekends, they should not be required to provide evaluations on these days unless medically necessary.

1700 West 82nd Street
Suite 100
Bloomington, MN 55431
612-885-5700

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REHABILITATION & MEDICAL AFFAIR

3. The regulations require an initial evaluation within five working days of a request for a change of doctor. This may not allow adequate time for the managed care provider to obtain copies of medical records from the non-participating provider. Access to such records is critically important to the appropriate management of the patient.

4. The regulations require that the evaluating physician give the patient the choice of at least three providers from whom to receive care. In many cases this requirement may be unduly broad:

   - in many cases the initial evaluating physician can most appropriately provide follow-up care. (E.g. removal of sutures following repair of a laceration)
   - in some communities, there are limited numbers of providers.

   The regulation could be changed to: "The patient shall have the choice of at least three treating providers unless appropriate care can be completed by the evaluating provider."

5. The regulations state that the "managed care plan include a procedure to ensure that the employee will receive information or advice on a 24 hour basis regarding medical services available within the managed care plan." If the intent of this regulation is to require managed care plans to have staff available at all times, I would strongly disagree with the regulation as an unnecessary expense for managed care plans. I would, however, support regulations which require managed care plans to assure that injured employees have access to emergency care 24 hours a day and instructions on how to access such care.

6. The regulations require that payment for services to participating and non-participating providers must be the maximum amount allowed under Minnesota Statutes, section 176.136. This precludes managed care plans from achieving potentially significant savings from negotiated contracts. The statute requires that managed care plans provide "appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service." The regulation appears to directly contradict the statute in this area. I would recommend allowing plans broad authority to exercise creativity in developing financial incentives to provide appropriate health care at a reasonable cost. This is especially critical in that the 16% reduction in Workers' Compensation Insurance premiums must be recovered through care management and pricing.

   In the event that the Department chooses to require payment at the level of the Workers' Compensation fee schedule, the regulation should be clarified to state that payment shall be at the lessor of the billed charge or the Workers' Compensation fee schedule.

7. Successful managed care plans devote a great deal of effort to selecting providers for participation in the plan who share a managed care philosophy. This philosophy is one of providing care to patients that is appropriate to their needs in an efficient manner in order to achieve optimal outcome. As a result of the shared philosophy, managed care plans minimize their role of policing health services. Allowing patients to see non-participating providers who agree to comply with the managed care organization's rules assumes that these "rules" are the source of the effectiveness of the managed care plan. I believe that it is important to clarify the situations in which an employee is able to continue care with a non-participating provider.

   The rules should be further clarified to state that any non-participating provider who has been involuntarily terminated from a managed care plan or who loses a license to practice, or has been otherwise sanctioned, may be prohibited from receiving payment for services provided to injured employees.

Select Care looks forward to working with the Department of Labor and Industry in implementing managed care plans for injured workers. Managed care plans, working in conjunction with insurers, employers and providers, can assure appropriate and cost effective medical care for injured workers in Minnesota.

Sincerely,

Barbara O. Johnson

Barbara O. Johnson, M.P.H.
Director, Managed Care

BOJ:mh82192a

cc: Jack Davis
Mike Thielen
Leroy Meyering

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

Medica is pleased to have this opportunity to submit comments to the Emergency Rules of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans as published in the July 27 State Register.

Medica is the parent company for Medica Choice and Medica Primary, both licensed health maintenance organizations under Chapter 62. Combined enrollment in Medica is over 530,000 members.

Medica respectfully submits the following comments:

5218.0100 [Emergency] DEFINITIONS.

Subd. 3, Emergency Care. The proposed definition is overbroad and inconsistent with other State agency definitions. The most recent Department of Human Services definition contained in their contract with managed care plans defines medical emergency as "a condition that if not immediately treated could cause a person serious physical or mental disability, continuation of severe pain, or death." Medica would prefer consistency with the Department of Human Services definition.

Subd. 5, Geographical Service Area. This definitions should clarify that the service area approved by the Department of Labor & Industry for provision of comprehensive health services to injured employees must be consistent with the geographic area approved by the Commissioner of Health under Chapter 62D. While the managed care plan should not have to provide workers' compensation services in all areas approved by the Minnesota Department of Health, it should not be allowed to provide only

workers' compensation services in areas where the Minnesota Department of Health has not approved the geographic expansion for health care services.

Subd. 9. Participating Health Care Provider. This definition needs to be expanded to include providers who are employed by a managed care organization.

Subd. 12. Suspension. It strikes us as unusual that the suspension definition allows a managed care plan to continue providing services under existing contracts despite the fact that the rules specify the same criteria for revocations as suspensions.

5218.1000 [Emergency] APPLICATION FOR CERTIFICATION.

Subpart 1.B. The attempt to deny certification to a managed care plan based on executive compensation is wholly outside the intent of the law.

Subpart 1.D.(2)(a). The requirement that a managed care plan "must provide" quality services relates only to managed care organizations that directly employ providers. The following language should be added after "services" "or assure through its contracts quality services."

Subpart 1.D.(2)(b). This provision requires clarification of "geographic accessibility to all categories of providers." Does this mean that the geographic accessibility standards must be applied to specialty care?

Subpart 1.D.(3)(a). This provision requires clarification of the phrase "within 24 hours of a request." Who makes the request and to whom is the request made?

Subpart 1.D.(3)(b). Clarification is necessary as to who pays for this initial evaluation. Is it paid for by the managed care organization or the insurer?

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Subpart 1.D.(3)(c). This provision requires two clarifications. In the first sentence, the referral reference refers only to a gatekeeper model of managed care plan. Medica Choice is a direct access plan that requires no referral. Language should be added clarifying that the choice of three providers is required only when the managed care plan limits direct access by requiring referrals. The second clarification relates to the language in the second sentence "or if the insurer approves the treatment." Should this be expanded to also include the managed care plan if the insurer has contracted with the managed care plan to make that decision?

Subpart 1.D.(3)(d). The reference to managed care plan physician should not apply to an emergency situation. In an emergency situation, care should be sought from the nearest available provider.

Subpart 1.D.(3)(f). Does the 30 mile provision relate to all health care providers or simply primary care providers? The provision should not apply to specialty services.

Subpart 1.D.(5). This provision requires clarification in the following areas: 1) trade secret protection must be granted to any individual contracts submitted; 2) a provider listing should suffice to meet the requirement of including a list of signatories.

Subpart 1.D.(7). The standards that the managed care plan must meet should be consistent with the standards imposed by the 1992 legislation for utilization review activities and the internal dispute resolution requirements of Chapter 62D.

Subpart 1.D.(11). This provision does not take into consideration that every managed care plan has developed its own treatment standards, based on their model type (e.g. staff model v. IPA model). While the standards may be only comparable, these standards do reflect important model difference. From our perspective the standards crated by each plan should be used by that plan's providers.

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5218.0200 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN

Subpart 1. Scope. This section requires that a managed care plan meet its certification requirements as well as Chapter 176. The rules need to address what regulation has priority if there is a discrepancy.

Subpart 2. Geographical Service Area; Expansion. Medica has the same concern as expressed earlier. The managed care plan's geographic area for worker's compensation should not extend beyond the geographic area approved by the Department of Health for provision of health services.

Subpart 3. Contracts B. It is unclear to us why multiple managed care plans are allowed for one employer. The multiple options may create adverse selection as well as further complicate the relationship between the workers' compensation managed care plan and any managed care plan the employer may use for primary health care coverage.

Subpart 3E. With respect to the requirement regarding continuity of care when a contract terminates, the obligation, including the financial obligation, should be on the insurer and not the managed care plan.

5218.3000 [Emergency] REPORTING REQUIREMENTS FOR PROVISIONALLY CERTIFIED MANAGED CARE PLAN.

Subp. 1. Since a managed care plan is allowed to submit standard contracts, will the provider listing and subsequent updates meet the requirements of this subpart? Second, contract provisions also need to be consistent with other regulatory requirements for the managed care plan. Third, trade secret protection is necessary for any contracts that are filed.

D. A managed care plan does not sanction or take punitive actions against its members.

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E. Reports of utilization review and peer review activities must be consistent with the requirements of Minn. Stat. 145.61.

5218.4000 [Emergency] COMMENCEMENT AND TERMINATION OF PARTICIPATING PROVIDERS.

Subp. 2, Termination. This section appears to apply to a managed care plan that limits the access of an injured worker to providers. In an open access plan where an injured worker can select whatever provider they wish, it is unclear why the managed care plan should be responsible for making the arrangements to provide continuing medical services.

5218.5000 [Emergency] HEALTH CARE PROVIDERS WHO ARE NOT PARTICIPATING HEALTH CARE PROVIDERS.

Subp. 2, Requirements. It is unclear what consequences the nonparticipating provider will have for failure to follow these requirements. May the managed care plan or insurer refuse to pay the provider?

5218.6000 [Emergency] CHARGES AND FEES.

Billings for managed care plan services must be consistent with the form and format established by the managed care plan. Second, it is not appropriate to require a managed care plan to pay the maximum amount allowed under the statutes. There are two reasons for this: a) the legislature clearly identified its intention to introduce managed care into workers' compensation. Fundamental to the managed care system is the ability to negotiate payment arrangements with providers; and b) this requirement fails to take into consideration the various types of payment arrangements a plan may have with its network (e.g. capitation arrangements).

5218.7000 [Emergency] DISPUTE RESOLUTION.

There appears to be dual regulatory authority under this provision. Since the managed care plan must follow its regulatory dispute resolution process, which would include either the Department of Health or Commerce, it is unclear which regulatory authority supersedes in this instance.

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5218.9000 [Emergency] SUSPENSION; REVOCATION.

Subp. 2, Criteria A. Since a managed care plan's responsibility is to monitor the medical necessity of care provided, there will be instances where based on a medical necessity determination care is not provided. This section needs clarification to exclude medical necessity determinations.

C. This provision should be broadened to include references to other statutory provisions relating to utilization review.

D. A managed care plan should not be held responsible for any false information submitted by a member.

E. Is there any appeal mechanism for the managed care plan?

Medica is pleased to have been able to respond to these rules. We look forward to working with the Department in implementing managed care in the workers' compensation system.

Very truly yours,

Lois Wattman

Lois Wattman
Director of Public Policy Development

LBW:sb

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Blue Cross and Blue Shield of Minnesota

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August 19, 1992

HAND DELIVERED

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

RE: Comments on Proposed Emergency Rules Governing Workers' Compensation Managed Care Plans

Dear Ms. Zembal:

In response to the Department of Labor and Industry's request for written comments on the proposed emergency rules governing workers' compensation managed care plans, the following comments are respectfully submitted by Blue Cross and Blue Shield of Minnesota.

Thank you for the opportunity to comment on the proposed emergency rules. In the event you have any questions or would like to discuss the statements and recommendations made by Blue Cross and Blue Shield of Minnesota, please contact me.

Sincerely,

Kurt Schwarzkopf

KIS:fc

Enclosure

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BLUECROSS BLUESHIELD OF MINNESOTA
COMMENTS ON PROPOSED EMERGENCY RULES
GOVERNING WORKERS' COMPENSATION MANAGED CARE PLANS

Rule 5218.0100, Subp. 3

Comment -This definition of "emergency care" arguably extends beyond the initial treatment to include most non-emergency follow-up services.

Recommendation - Adopt the definition stated in Minnesota Rules 4685.0100, Subp. 5A by amending page 1, lines 13 and 14 as follows:

> Subp. 3. **Emergency care**. "Emergency Care" means professional health services immediately necessary to preserve life or ~~limb~~ stabilize health.

Rule 5218.0100, Subp. 5

Comment - Due to health care provider demographic realities it may be difficult to comply with the access requirements of the proposed emergency rules if the smallest area of certification is a county.

Recommendation - Amend page 1, lines 18 - 21, as follows:

> Subp. 5. **Geographic service area**. "Geographic service area" means those counties or portion of counties in which the managed care plan has been certified to provide comprehensive health services to injured employees.

Rule 5218.0100, Subp. 8

Comment - See comments on Rule 5218.1000, Subp. 1D(3). If the intent of the Department is to require that managed care plans have a minimum of three health care providers and at least one of the three must be a physician, this requirement belongs in the definition section and not buried elsewhere in the rules.

Recommendation - Amend page 1, lines 28 - 31, as follows:

> Subp. 8. **Managed care plan**. "Managed care plan" means a plan certified by the commissioner that provides for the management of treatment to injured employees under Minnesota Statutes, section 176.135

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and 176.1351 and consisting of at least three participating health care providers with at least one of three required to be a physician.

Rule 5218.1000, Subp. 1B

Comment - Blue Cross challenges this rule as being wholly outside the scope of the authority granted to the Department by Minnesota Statutes 176.1351, subd. 6. In the event this subpart is not deleted from the proposed rules, Blue Cross seeks clarification as to what constitutes "annual compensation" and whether a certification of compliance with this subpart by the managed care plan without release of actual compensation amounts would satisfy this rule.

Rule 5218.1000, Subp. 1D(2)(a)

Comment - Because many managed care plans including Blue Cross would contract with health care providers to provide services to covered employees, such plans cannot directly provide quality services as required by this rule.

Recommendation - Amend page 3, lines 29 - 34, as follows:

(a) The managed care plan must provide or assure through contract with participating health care providers quality services that meet uniform treatment standards prescribed by the commissioner and all medical and health care services that may be required by Minnesota Statutes, chapter 176, in a manner that is timely, effective, and convenient for the employee.

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Rule 5218.1000, Subp. 1D(3)

Comment - The initial evaluation and choice of provider process outlined in subsection (a) - (c) is confusing, cumbersome and impractical. As drafted these sections appear to require the provider doing the initial evaluation to advise employees of a right to self refer to a different provider and to identify three providers as referrals. If the provider doing the evaluation is qualified to treat the condition, notification and identification of referral providers does not seem necessary. The required identification and choice among referral providers would greatly compromise the plan's ability to

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manage the employee's care. Sections (a) and (b) do not provide direction for situations involving an employee who is incapable of requesting treatment. Subsection (c) appears to require direct access to all provider disciplines, this contradicts other parts of the proposed emergency rules which require a physician or chiropractor gatekeeper. See comment and recommendation above on Rule 5218.0100, Subp. 8., if the intent of the Department is to establish the minimum provider requirements of a managed care plan by this section (c), than such requirements should appear in the definition section.

Recommendation - Amend page 4, lines 8 - 34 as follows:

(3) The managed care plan must include a procedure to ensure that the employee will:

(a) receive initial evaluation by a participating physician within 24 hours of a request for treatment by the employee, or when required by the employer, following a work injury; the managed care plan may permit initial evaluations by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or a chiropractor;

(b) receive initial evaluation by a participating physician within five working days of a request for a change of ~~doctor~~ health care provider in cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan under part 5218.5000 [Emergency], subpart 1, item A. The managed care plan may permit an initial evaluation by a participating chiropractor, in which case the employee may decide whether the evaluation will be by a physician or a chiropractor;

(c) ~~initially choose from at least three health care providers to whom the employee has been referred by the evaluating provider under unit (a) or (b) for treatment, and~~ allow the employee to change providers within the managed care plan at least once~~. The procedure to allow the employee to select a health care provider must provide direct access to all health care profession disciplines if the treatment is determined to be appropriate for the condition by the evaluating health care provider under unit (a) or (b) or if the insurer approves the treatment;~~

Rule 5218.2000, Subp. 1D(11)

Comment - Due to the ever changing nature and evolution of medical treatment standards this subsection would greatly hamper the plan's ability to manage care. In addition, this subsection appears to state that a

plan could not apply any standard until it had been filed. In many instances there simply are no written standards and entities which manage health care are required to rely upon peer review of the treatment in order to determine an appropriate standard. If the Department's intent behind this rule is to obtain the various standards used by plans to assist the Department in the future development of uniform standards, the recommended change accomplishes this objective.

Recommendation - Amend page 6, lines 9 - 13 as follows:

> (11) The managed care plan must ~~submit~~ make available to the commissioner upon request treatment standards not already prescribed by the commissioner. All managed care plan health care providers and health care providers described in part 5218.5000 [Emergency] will be governed by these standards.

Rule 5218.2000 Subp. 2

Comment - The last sentence of this subpart is confusing. If the rule is intended to require that a managed care plan be capable (in terms of meeting the geographic access requirements) of servicing a injured worker before an injured worker can be required to seek treatment from the managed care plan, this sentence should be restated.

Recommendation - Amend page 6, line 32 - 35 and page 7, lines 1 - 2 as follows:

> Subp. 2. Geographic service area; expansion. The commissioner shall designate a managed care plan's initial geographical service area and approve any expansions to the managed care plan's service area. ~~Injured employees shall not be covered by a managed care plan until the commissioner has approved the proposed expansion of the geographic service area~~ A managed care plan's approved geographic service area must meet the requirements of Rule 5218, Subp. 1 before an injured employee can be covered by the managed care plan.

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Rule 5218.2000, Subp. 3B

Comment - This subpart which allows an employee to choose at the time of injury among multiple managed care plans, causes practical and administrative problems. Managed care plans are required by this rule and rule 5218.3000, Subp. 2C to provide an estimate of the number of employees covered by the plan. However, because employees are not required to choose a plan until the time of injury there is no way for the plan to determine the number of covered employees. Allowing the employee to defer choice until the time of injury will create confusion among the plans as to which plan is responsible to manage the care of an injured employee who is incapable of choosing a plan at the time of injury due to the severity of injury, or who, at the time of injury, opts to treat with a allowed non-participating provider. The recommendation below merely changes the timing of the employee's choice, while maintaining the employee's right to choose among multiple plans.

Recommendation - Amend page 7, lines 12-15 as follows:

> B. Insurers may contract with multiple managed care plans to provide coverage for employers. When insurers contract with multiple managed care plans to cover the same employer, each employee shall have initial choice ~~at the time of injury~~ to select the managed care plan that will manage the employee's care <u>from any managed care plan authorized to cover the employee at the time the employee commences employment or at the time a managed care plan contracts with the insurer to cover the employee's employer</u>.

Rule 5218.2000, Subp. 3F

Comment - This provision is drafted more broadly than necessary to correct the underlying potential problem. As drafted the employer could arguably be liable for all treatments from any provider that treated the employee prior to the employee's treatment being directed by the employer.

Recommendation - Amend page 8, lines 9 - 14 as follows:

> F. Except as provided in part 5218.5000 [Emergency], an employer may require an employee who is claiming a workers' compensation injury to

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receive treatment from a managed care plan before the employer accepts or denies liability for the injury. In such cases the employer is liable for the cost of any treatment given by the managed care plan and relating to the condition for which the employer required the employee to receive treatment from the managed care plan before notice is given to the employee of a denial of liability, even if the employer is later determined to be not liable for the claimed injury.

Rule 5218.6000

Comment - Minnesota Statute 176.1351, subd. 2(3) requires: *the Commissioner shall certify a managed care plan if the Commissioner finds that the plan... provides appropriate financial incentives to reduce service costs and utilization without sacrificing quality of service.* Minnesota Statutes 176.136, subd. 1a states: *the liability of an employer for services included in the medical fee schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or the provider's actual fee,* ***whichever is lower*** (emphasis added). Rule 5218.6000 requires that managed care plans reimburse providers on a fee for service bases at the statutory fee schedule amount. However, the statutes quoted above recognize that providers have the right to charge a fee that may be lower than the statutory fee schedule. In addition, the statutes require, as a condition of certification, that managed care plans provide financial incentives to control cost. Blue Cross believes this rule directly conflicts with the statutory requirements for certification. As a practical matter, Blue Cross is concerned that this rule requires managed care plans to micro manage the delivery of health care to injured workers to assure appropriate quality care and avoid the abuses of fee-for-service reimbursement resulting from strict adherence to the statutory fee schedule. Through its years of managed care experience, Blue Cross has found that a reimbursement system built upon economic principles of financial incentives and penalties provides a more efficient and effective means of assuring appropriate delivery of quality health care services. Economic incentives such as risk sharing and payments based at least in part on outcomes are accepted methods by which providers negotiate their actual fee with health carriers. Such negotiations result in rewarding quality providers and allowing providers to correct problems of over utilization, ineffective, and inappropriate services, without having the manage care plan reviewing each service rendered by the provider.

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Recommendation - Amend page 12, lines 2 - 10 as follows:

Billings for medical services under a managed care plan shall be submitted in the form and format as prescribed by the managed care plan and consistent with ~~in~~ part 5221.0700, subpart 2. The payment by the insurer or the managed care plan to participating providers and nonparticipating health care providers authorized under Rule 5218.5000 for medical services shall be according to the timeframes and procedures in part 5221.0500, subpart 3, Minnesota Statutes, section 176.136, subdivision 1a, and Minnesota Statutes, section 176.135, subdivision 6~~, and shall be the maximum amount allowed under Minnesota Statutes, section 176.136~~. The managed care plan and participating providers may enter into negotiated payment arrangements consistent with Minnesota Statutes, section 176.1351, subdivision 2 to establish the provider's actual fee for services rendered to employees covered by the managed care.

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Comments on Emergency Rules
Jeannine Churchill

I. 5218.0100 Definitions

Subp. 3. definition of "Emergency care"

This definition can arguably extend beyond the initial treatment to include most services. For example, the follow-up services for a broken leg are necessary to preserve the leg; however, most health payers would not consider normal recasting or cast removal to be "emergency care"

II. 5218.1000 Application for certification

Subp. 1. paragraph B. annual compensation of administrator

- Does this imply that a filing include salaries of staff? What is included in "annual compensation"?
- Where are the average annual wages published and how often are they updated?

Subp. 1. paragraph D. section (3)

- The initial evaluation and choice of physician process in paragraphs (a) through (c) appears cumbersome and impractical. It appears that any physician who does the initial evaluation is required to advise the employee of their right to referral and to identify three physicians as referrals. If the physician who performs the evaluation is qualified to treat the employee's condition, is this necessary?
- Who makes the provider selection for an employee injured to the extent that he/she cannot make a selection? How does this work in a critical emergency such as multiple compound fractures?
- To what extent would a plan's ability to manage care be compromised if the choice of three treating providers was not offered?

Subp. 1. paragraph D. section (3) (f) provider access

- To what extent may an employer use a managed care plan for employees who work on the road or at distributed service sites?
- Do all of the three referral providers offered have to be within the geographic requirements?

Subp. 1. paragraph D. section (11) treatment standards

Does this mean any treatment standards we develop for workers' comp must be submitted prior to use? What are we allowed to do in the situation where no standards are published, eg. new technology?

III. 5218.2000 Coverage responsibility of managed care plan

Subp. 2. Geographic service area

- The last sentence says an injured employee is exempt from a managed care plan until the plan is certified for that area. Does this mean the work site or the employees' residence?

- Does this mean the employee is totally exempt not only from the provider network but also from all medical appropriateness determinations?

Subp. 3. paragraph B. Contracts

Giving each employee the right to designate a managed care plan at the time of injury (when an employer has more than one) has the potential for chaos:

- What happens to the unconscious employee?

- What happens to the employee working in Duluth who selects the plan in Rochester?

- How do the managed care plans bill for their services?

- Who accepts the responsibility if the employee uses a non-network provider? Which plan manages the care to make sure the non-network provider complies?

Subp. 3 paragraph D.

To what extent are pre-existing injuries subject to treatment protocols and medical necessity? Does this mean that providers currently delivering unnecessary care can continue to abuse the system?

Subp. 3. paragraph F.

The wording of the first part of this section implies that an employee injured at home can receive workers' compensation benefits simply by claiming workers' comp, receiving care from a non-network provider and then being required to receive care within the network. Eg. employee is injured while on vacation and receives care in another state; employee returns to work and claims the injury occurred at work and became worse, requiring care in the other state; employer requires evaluation by network provider, employer is now liable for all care given to point of denial.

Subp. 4. Restrictions

This section does not agree with §176.1351 which prohibits a workers' compensation insurer from being certified as a managed care plan. There is no exception allowed in statute for an insurer (or for a self-insured employer).

IV. 5218.3000. Reporting requirements

Subp. 1. Contracts.

What is the purpose of reporting all customers?

Subp. 2. Requirements. paragraph B.

How is a managed care plan going to know about services delivered by non-network providers? If two or more plans are available, which plan reports these?

Subp. 2. paragraph C.

If two or more plans are offered by the same employer, how does each plan estimate the number of employees?

V. 5218.6000. Charges and fees

- Does the billing form and format allow for electronic billing? Is this HCFA format or Minnesota DHS format?

- What flexibility does a managed care plan have in regard to provider reimbursement to comply with §176.1351, Subd. 2 (3) which requires financial incentives to reduce costs and utilization. Mandating a payment level in the rules appears to be contradictory to the statutory requirement. §176.136 as amended 1992 limits an employer's liability to the fee schedule but does not restrict the managed care plan beyond the maximum employer liability.

General question

It appears that the managed care plan can contract only with self-insured employers and workers' comp insurers. What can an employer do if the insurer refuses to contract with a managed care plan but the employer cannot go self-insured?

BLUE CROSS AND BLUE SHIELD OF MINNESOTA
INFORMAL COMMENTS ON EMERGENCY RULES GOVERNING
WORKERS' COMPENSATION MANAGED CARE PLANS

ISSUE # 1: Rule 5218.6000 [Emergency] CHARGES AND FEES. (pg 12 lines 1-10).

Minnesota Statute 176.135.1, subdivision 2(3) requires "the Commissioner shall certify a managed care plan if the Commissioner finds that the plan... provides appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service." Minnesota Statute 176.136, subdivision 1a states "the liability of an employer for services included in the medical schedule is limited to the maximum fee allowed by the schedule in effect on the date of the medical service, or **the provider's actual fee, whichever is lower**" (emphasis added). Rule 5218.6000 as proposed would require a Managed Care Plan (MCP) to pay all providers at rates not less than the fee schedule. However, the statutes quoted above recognize that the provider fee may sometimes be lower than the fee schedule requires MCP's to have financial incentives that will control costs and utilization. If a MCP cannot negotiate price, it has lost an important tool in controlling costs. This proposed rule becomes even more significant in light of the fact that such a requirement could arguable prohibit a MCP from including risk sharing arrangements with providers which result in a net reimbursement less than the fee schedule. Such arrangements are commonly used by health insurer with preferred provider networks as a means of controlling costs and utilization. For Blue Cross, being forced to pay at the fee schedule would require us to pay considerably higher rates than Blue Cross can negotiate for our regular health insurance business.

RECOMMENDATION: Blue Cross strongly urges the Department to modify this Rule by adding the underlined term so that page 12, lines 8-10, read "Minnesota Statutes, section 176.135, subdivision 6, and the rules of the managed care plan, and shall be no greater than the maximum amount allowed under Minnesota Statutes, section 176.136.

ISSUE #2: Rule 5218.2000 [Emergency] COVERAGE RESPONSIBILITY OF MANAGED CARE PLAN, Subp. 3.B.

The requirements of this Subpart allowing an employee to choose **at the time of injury** among multiple MCPs offered to the employer by an insurer, causes severe administrative and reporting difficulties for the MCP. The MCP is required by Subpart 3 of this rule and Rule 5218.3000 Subpart 2.C. to provide an estimated number of employees governed by the MCP contract. However, because employees are not required to choose a MCP until the time of injury, there is no way for a MCP to provide a realistic estimate of covered employees. In addition, by not requiring an employee to choice a MCP until the time of injury, the MCP is

effectively prevented from pricing the MCP services on a per covered employee charge because there is no way to determine the number of covered employees. The MCP is effectively limited to pricing its services on an incident basis. Lastly, it is possible that of the multiple MCPs covering the same employer, only one MCP is actually available to the employee due to the 30 miles from place of employment or residence access requirements of Rule 5218.1000, Subp. 1.D.(3)(f).

RECOMMENDATION: Modify Rule 5218.2000 Subp. 3.B. such that page 7, lines 12-15 read as follows: "with multiple managed care plans to cover the same employer, each employee shall have initial choice ~~at the time of injury~~ to select the managed care plan that will manage the employee's care from any managed care plan authorized to cover the employee at the time the employee commences employment or at the time the insurer contracts with a managed care plan.

ISSUE #3: Rule 5218.2000, Subp. 3.F. (page 8, lines 9-16).

This provision is drafted more broadly than necessary to correct the underlying potential problem. As drafted, an employer could arguably be liable for services that are wholly unrelated to the condition for which the employer directed the employee to seek care from the MCP.

RECOMMENDATION: Add the underlined terms at page 8, line 14 "any treatment, relating to the condition for which the employer required the employee to receive treatment from a managed care plan, given before notice is given to the employee of a." employer is resp. for any treatment delivered by MCP at his direction

ISSUE #4: Rule 5218.2000, Subp. 3.A. (page 7, lines 8-9).

Clarify the related requirements between authorized geographic service area and employer's place of employment. Could an employer with multiple employment sites require all of its employees to be covered by a MCP if one of the employer's employment sites was within the MCP's authorized geographic service area, while other employment sites were outside the MCP's service area. (Example: Blue Cross as Employer).

ISSUE #5: Rule 5218.2000, Subp. 3, (page 7, lines 3-7).

This rule creates a certain "Catch-22" for Blue Cross as an employer that also plans to operate a MCP. Because of this rule, an MCP will be prohibited from running its own employees through the MCP that it is offering to others.

ISSUE #6: Rule 5218.1000, [Emergency] APPLICATION FOR CERTIFICATION Subp. 1.D. (3) (f) (page 5, lines 5-9).

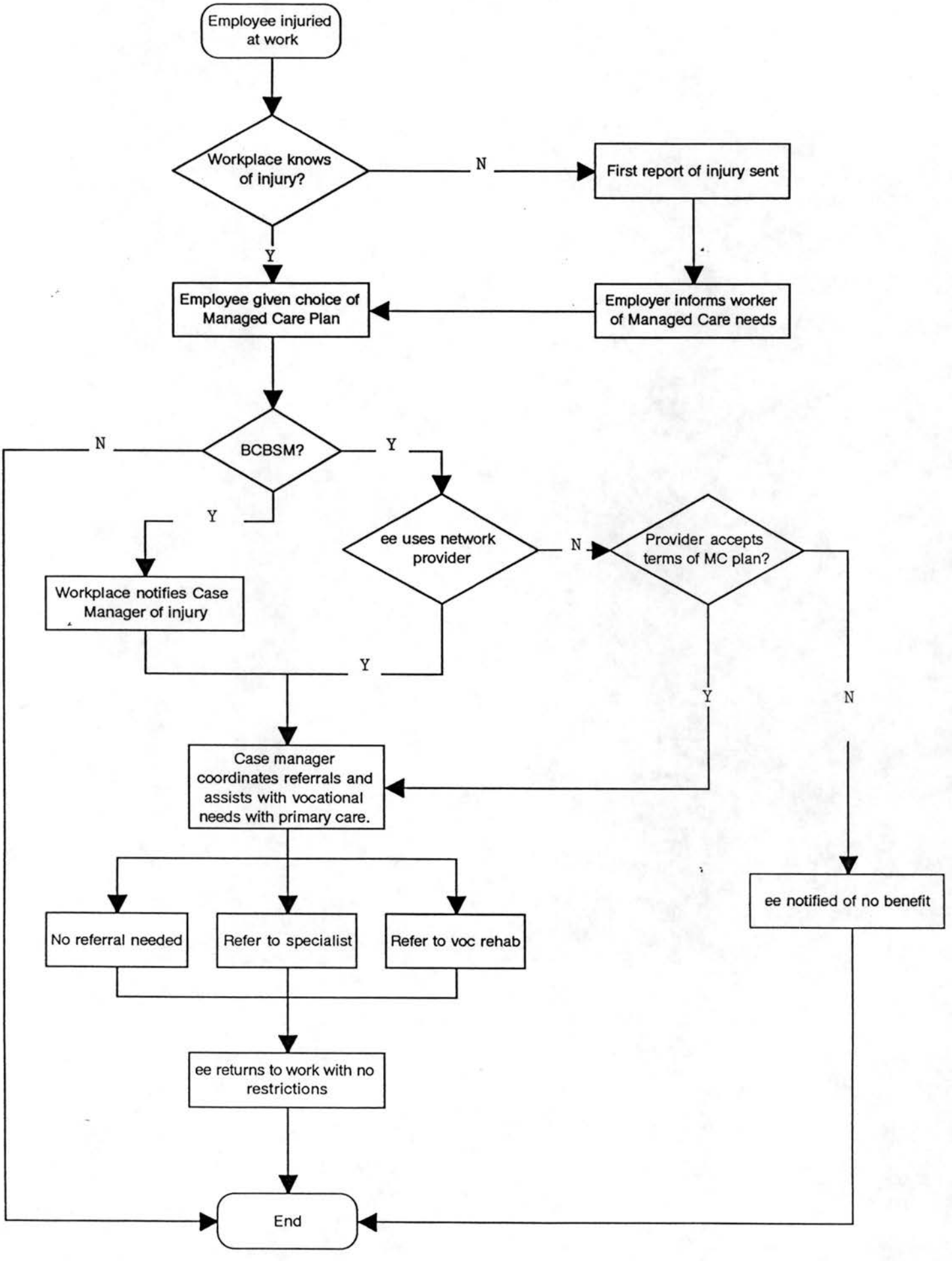
Lack of health care providers in certain rural areas of the State may make this requirement impossible to obtain for MCP wishing to service some employers. Would it be possible for a MCP to apply for a waiver of this requirement upon supplying the Commissioner with proper documentation.

ISSUE #7: Rule 5218.1000, Subp 1.D. (3) (a-c), (page 4, lines 8-34).

What is the minimum number of providers required for a MCP? The answer appears to be 4, the physician gatekeeper of (a) and (b) and three provider referrals. Can the evaluating provider refer care to himself? Can all three referral providers recommended to the employee practice at the same clinic?

KIS:fc

Work Comp Managed Care



Blue Cross and Blue Shield of Minnesota

Hometown service



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*ALSO ADMITTED IN WISCONSIN

RECEIVED
AUG 21 1992
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

August 21, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

Dear Ms. Zembal:

Enclosed for your consideration are the CorVel Corporation's comments on the proposed Emergency Managed Care Plan Rules.

Perhaps it should be noted that "CorVel" is the new name of the organization that had been named "Fortis." "Fortis," in turn, is the former "AAD&K" firm, which has been active in local workers' compensation matters for quite some time.

If you have any questions or if we may provide further assistance, please call the undersigned or Ms. June McLean ((612) 642-1717).

Thank you for the opportunity to offer our comments.

Very truly yours,

John E. Diehl, for
LARKIN, HOFFMAN, DALY & LINDGREN, Ltd.

JED:kla
Enclosure
cc: CorVel Corporation

JED:TR4s

STATE OF MINNESOTA

DEPARTMENT OF LABOR AND INDUSTRY

RECEIVED
AUG 21 1992
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

In the Matter of the Proposed Adoption of Emergency Rules of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

CORVEL CORPORATION COMMENTS ON PROPOSED EMERGENCY RULE

CorVel Corporation is a nation-wide business organization providing a variety of services to workers' compensation insurance carriers and self-insured employers, including medical utilization review, medical audit, and rehabilitation and vocational counseling services. In other states CorVel operates managed care organizations and it is interested in providing these services in Minnesota. CorVel respectfully submits the following comments relative to the proposed Emergency Rules as circulated with the Department's Notice of July 20, 1992.

5218.0100 [Emergency] Definitions. Except for the provisions set forth as Subparts 3 (Emergency Care) and 5 (Geographical Service Area), we have no comments regarding the definitional provisions as stated except that we feel that these are appropriate terms for definition and the definitions that are offered seem appropriate.

With regard to Rule 5218.0100, Subp. 3 [Emergency], we note that the term "emergency care" is defined by using the term "professional health services" but that term is not a defined term. Perhaps this should refer to physician and/or hospital services rather than "professional health services."

The Department might also consider an approach that would use two defined terms, "emergency" and "emergency care." This might be addressed, as follows:

> "Emergency" means a situation in which an employee has an illness or injury and a delay in treatment presents a risk of death, irreversible complications, or a significant extension of a probable disability.

And:

> "Emergency care" means physician and hospital services necessary to treat an employee in the case of an emergency.

With regard to the definition of a "Geographical Service Area," we note that this at least implies that a service area cannot be a geographic area that is smaller than an entire

county. When one takes into account the related standard that services must be available within 30 miles (proposed Rule 5218.1000, Subp. 1(D)(3)(f) [Emergency]), we note that this would preclude the certification of service areas where appropriate services are available according to this standards for parts of counties but not the entire county. This would occur in our relatively large counties and in counties where the necessary concentration of medical services is away from the geographic center of the county or in a community in an adjacent county. Perhaps it would be better to define "Geographical Service Area" to mean those geographic areas for which the Department certifies that appropriate services are "available and accessible in accord with the standards set forth in parts 5218.0100 to 5218.9000 [Emergency]."

Finally, with reference to the substantive rule (Part 5218.1000, Subp. 1(D)(2)(b) [Emergency]) that Managed Care Organizations may not discriminate against categories of providers, it might be appropriate to establish and define a new term (which might be "Core Providers" or "Basic Providers") that must at a minimum be included in the provider network. Then, the provision against discrimination could relate to this "subset" of providers, rather than the current ambiguous reference to "all" providers. The "universe" of professionals that might be included in this more specific definition might relate to those referenced in Minn. Stat. § 176.135, subd. 1 or subd. 2.

5218.0210 [Emergency] Authority. No comment.

5218.0220 [Emergency] Purpose and Scope. No comment.

5218.0230 [Emergency] Effective Date. It is assumed that the effective date of these rules will be as stated in the final publication, and in any event, this proposed rule does not address the effective date of the rules. If the Department wishes to have such a provision it would appear that this should be a separate rule or an additional provision in this rule.

Similarly, this proposed rule seems to address the duration of a certificate issued under the Emergency Rules, and it would appear that there should be a different "caption" or "title" for this rule that would better reflect the substance of this provision.

Finally, we object to the proposition that one's initial certification will expire, especially in view of the rather expensive application fee that is being proposed. We feel it would be better to merely "announce" that provisionally certified plans will have to conform to any new or different standards under the permanent rules.

5218.1000 [Emergency] Application for Certification. We have a number of comments regarding this proposed rule.

First, in order for this provision to be legally sound it should incorporate the statutory standards. Minn. Stat. § 176.1351, subd. 1 provides in this regard:

> Any person or entity, other than a workers' compensation insurer or an employer for its own employees, may make written application to the commissioner to have a plan certified . . . . [Emphasis added.]

Obviously, this also will affect the provisions in proposed Rule 5218.2000, Subp. 3(B) and 5218.2000, Subp. 4 [Emergency].

With regard to proposed Rule 5218.1000, Subp. 1(B) [Emergency] relating to the maximum compensation of the executive management of a managed care organization, while probably well intended, we question the legal authority for this provision. We are aware of news reports that the chief executive officer of at least one "TPA" and of a company that manages a major local HMO received annual compensation in the range of $7 million and we recognize that this might be considered counterproductive to cost containment objectives. Nevertheless, we see no statutory authority for this type of rule and any limit of this sort would by its nature be rather arbitrary (for instance, the limit that might be reasonable for a business that is limited to these activities on the local level may not be reasonable as applied to the chief executive officer of a more complex organization). And, the means of circumventing this requirement (establishing a separate corporate entity) is so obvious and relatively easy to accomplish this apparent attempt to avoid funneling patient care money into administrative overhead would probably be ineffective.

However, if there is to be a limit on salaries the rule must be altered to clarify exactly whose salary is regulated. Would this be the local office manager or administrator, the C.E.O. of a larger enterprise, or what?

With regard to proposed Rule 5218.1000, Subp. 1(C) [Emergency], we feel that the $1,500 application fee is extraordinarily high and unreasonable. This is especially pertinent in view of Part 5218.0230 [Emergency] which suggests that we will be "starting over" when permanent rules are adopted.

With regard to proposed Rule 5218.1000, Subp. 1(D)(2)(a) [Emergency], we feel that this should be clarified to better indicate whether "all medical and health care services that may be required" must be available within the Geographic Service Area. We do not feel that that is required by law or that it should be a part of these regulations, but if that is the intent it should be made more clear.

As indicated, however, it is our view that a plan should be able to include a geographic area where only certain "basic" or "core" services are available if the managed care organization

demonstrates arrangements with a more complete set of providers that are as convenient to the service area as possible.

With regard to proposed Rule 5218.1000, Subp. 1(D)(2)(b) [Emergency], as indicated in our comments relative to the definitions, this proposed rule needs to be narrowed or the terms need to be better defined. The term "health care provider" is defined in the statutes to include anyone that provides health care service, and it seems to us that this is an ill-defined, ambiguous reference. There is an enormous range of professionals that might be deemed to provide "health care service," and we assume that it could be acceptable to have a provider panel that includes something short of this total range of providers. Hence, this provision should not prohibit the exclusion of "any" category of providers and should not require the involvement of an adequate number of "all" categories of providers.

With regard to proposed Rule 5218.1000, Subp. 1(D)(3)(c) [Emergency] we have a similar concern (relative to the word "all" at the end of line 30 on page 4) about the scope of the providers that must be involved pursuant to this rule.

With the further reference to this provision, we feel that the reference to the "evaluating provider" should be modified to specify the "managed care organization's evaluating provider."

With regard to proposed Rule 5218.1000, Subp. 1(D)(3)(d) [Emergency] (which requires procedures to assure that employees will receive treatment from participating physicians in certain emergency situations), it seems to us that this needs to be expanded and/or clarified. Definitionally, an emergency case may very well require medical and hospital attention outside of the managed care organization and it is quite likely in such situations that no one would even know that a managed care organization is responsible for the care of the patient. We agree with the concept in this rule, but it should be revised to better address these circumstances.

With regard to proposed Rule 5218.1000, Subp. 1(D)(3)(e) [Emergency], we feel that this is ambiguous and, depending on how it is applied, unduly burdensome. This should be clarified to better indicate how this information should be made available, and, given the fact that most employment activity occurs during normal business hours, this should not require managed care organizations to be open 24 hours per day. (This new system is vastly different than comprehensive care programs, such as H.M.O.s.)

With reference to proposed Rule 5218.1000, Subp. 1(D)(3)(f) [Emergency] we have two observations/comments. First, assuming that this rule as construed in light of proposed Rule 5218.1000, Subp. 1(D)(2)(a) [Emergency], seems to suggest that all necessary medical, other professional and institutional health care services must be within 30 miles of the employee's place of

employment or residence, etc. As indicated, above, some medical service specialties may not be available to every employee within 30 miles, and relative to our comments on the definitional provisions, we feel that the accessibility under a managed care organization must be at least equal to services in general, but it does not seem necessary or reasonable to require greater accessibility in order to establish and provide service through a managed care organization. The requirement ought to relate to availability and accessibility that is no less burdensome than would otherwise be the case.

Second, the employee's commuting distance may not be an appropriate measurement in determining whether a particular injured worker can be required to receive health care services under the workers' compensation system through a managed care organization (which would be a case-by-case assessment), and it is not a standard by which the Department could ever measure the Geographic Service Areas that would be certified as a part of a managed care organization. This proposed rule seems to be applying the former test to the latter situation and this does not seem feasible. And, we wonder whether it is rational and reasonable to, in effect, require a sick or injured person to travel the same distance to receive health care services as he or she might travel to his or her daily employment; and we wonder whether this test, in fact, relates to daily commuting distances, or whether it might relate to the furthest distance that an employee might occasionally travel if his or her work assignments vary from place to place. In summary, we feel that this provision needs vast improvement.

With regard to proposed Rule 5218.1000, Subp. 1(D)(11) [Emergency] (and, for that matter, proposed rule 5218.1000, Subp. 1(D)(2)(a) [Emergency]) we feel that the rules should specifically address what might occur if a managed care organization has "treatment standards" that differ from those established by the Department. It seems at least possible that different groups of conscientious, well-qualified managed care organizations might develop different standards, and the rules ought to specifically address this possibility. In doing so, we respectfully submit that it would be inappropriate to arbitrarily indicate that either standard would prevail. Rather, it is our view that an individual managed care organization's standards should be permissible notwithstanding somewhat different Department standards so long as the Department determines that compliance with the managed care organization's standards would not result in inadequate care of an injured or sick worker or excessive treatment costs.

5218.2000 [Emergency] Coverage Responsibility of Managed Care Plan. We have four comments relative to this proposed rule. First, we suggest that the last sentence in Part 2518.2000, Subp. 2 [Emergency] should be broadened. This sentence presently deals only with expansion of service areas, while it probably should relate to the direction of employees in service areas more

generally. We suggest that this sentence should read: "Injured employees shall not be required to receive services through a managed care plan until the commissioner has approved the managed care organization for the Geographical Service Area applicable to the employee."

Second, we note that proposed Rule 5218.2000, Subp. 3(B) [Emergency] is overly broad; it should be limited to the situation where multiple plans have been certified as having an appropriate Geographical Service Area for the particular employee. And, more importantly, we feel that the substantive thrust of this rule (selection of a panel on a case-by-case basis at the time of injury) is unnecessary and extremely ill-advised. Proposed Rule 5218.1000, Subp. 1(D)(3)(c) requires that each plan must have at least three providers from which an employee can choose his or her care-giver, so patients' "freedom of choice" is already assured. And, the concept of managed care is based in large measure on the idea that a "team" of care-givers will assume responsibility for a <u>defined</u> patient population. If employees can opt in and out of various plans at the "point of service" it seems unlikely that the system will be improved in any meaningful way.

Third, we respectfully submit that there is no statutory authority for the Department to adopt Part 5218.2000, Subp. 3(F) [Emergency] insofar as that rule seeks to mandate workers' compensation coverage of noncompensable events.

Similarly, proposed Rule 5218.2000, Subp. 4 [Emergency], which implicitly allows and deals with the situation which an insurer owns/controls a managed care organization, is contrary to the explicit statutory provision in the first sentence of Minn. Stat. § 176.1352, subd. 1. It is conceivable that there could be a limited rule of this sort as it would relate to self-insured employers, but the statute expressly prohibits workers' compensation insurers from owning or controlling managed care organizations.

<u>5218.3000 [Emergency] Reporting Requirements for Provisionally Certified Managed Care Plan</u>. We have comments regarding Subparts 1, 2 and 4 of this proposed rule.

With regard to proposed Rule 5218.3000, Subp. 1 [Emergency], we urge that the Department take whatever steps are necessary to assure that contracts that are filed pursuant to this proposed rule are maintained in a confidential manner. The proprietary business relationships between health care institutions and professionals and a managed care organization could be very sensitive and proprietary in nature and the general public or competing organizations should not be able to have access to this information. Accordingly, this rule should provide that this information is "private" and unavailable to anyone other than authorized Department officials and the plan that files the documents, that only sample documents need be filed (excluding

proprietary information), or that pertinent documents shall be reviewed as "private" documents and then returned to the managed care organization.

With regard to proposed Rule 5218.3000, Subp. 2(E) [Emergency] (with further reference to issues of confidentiality) we feel it is extremely important that this rule acknowledge the confidentiality standards that are associated with peer review and utilization review activities. We recommend that this be accomplished by explicitly providing that these reporting requirements to the confidentiality standards of Minn. Stat. §§ 145.61 through 145.67 (which, by the terms of those statutes, is probably the case in any event).

With further reference to this particular clause, the rule indicates that "the review" must include evaluation of compliance with treatment standards adopted by the commissioner. This would imply that every review must address this issue, yet it is clear that certain types of peer review or utilization review may have nothing to do with "treatment standards." This suggests that this part of the rule should either relate to such reviews "when applicable," or should set forth a more concrete standard relating to the number and/or frequency of these studies.

Finally, Rule 5218.3000, Subp. 4 [Emergency] allows the commissioner to seek all other information "necessary" to monitor managed care plans. This is a very broad standard and we respectfully submit that this could become unduly burdensome and counterproductive. We would suggest that this be modified at least to say that these reviews may be conducted as "reasonably necessary."

5218.4000 [Emergency] Commencement and Termination of Participating Providers. No comment.

5218.5000 [Emergency] Health Care Providers Who Are Not Participating Health Care Providers. No comment.

5218.6000 [Emergency] Charges and Fees. The portions of this proposed rule that adopt existing statutory and regulatory billing standards are, of course, perfectly acceptable. However, this proposed rule goes on to provide that ". . . payment by the . . . managed care plan . . . shall be the maximum amount allowed under Minnesota Statutes, section 176.136." That statute as previously enacted and recently amended provides that the Department is to establish criteria to determine the reasonableness of charges for health care services and, in some instances, establish a schedule of acceptable maximum fees. By reference to the charges made by "health care providers" this includes all professional and institutional providers, and this proposed rule, in essence, indicates that those maximum fees are, in effect, the minimum amount that may be paid for these services.

We respectfully submit that the Department is without legal authority to establish minimum fees under any circumstance and we further submit that, even if the Department were thus empowered, it is contrary to the public interest and the legislative intent in Laws of Minnesota Chapter 549, Article 4 to set forth minimum costs in this manner.

Among other things, the introduction of managed care organizations sets the stage for a variety of different payment methodologies, including the possibility of capitation payments or partial payments with additional consideration based on achievement of goals related to efficiency and quality. Part of the possibility for greater efficiency in workers' compensation health care service is the concentration of these services within a more discreet group of providers and should that occur the related benefits of higher volume would justify fees that are lower than the maximums. Finally, by way of further example, it is possible that a managed care plan would provide for more prompt payment than set forth as the minimum standard established by the statutes, and that, too, might justify reductions in fees.

Based on these observations, it is respectfully submitted that the Department does not have the authority to promulgate the portion of this proposed rule that sets fee minimums, and that such minimums are ill-advised in any event.

5218.7000 [Emergency] Dispute Resolution. No comment.

5218.8000 [Emergency] Monitoring. We have three comments regarding this proposed rule. First, relative to Subp. 1 (page 12, line 23), this should be modified to read ". . . as reasonably necessary . . . ."

Similarly, the same modifier should be introduced in Subp. 2 (page 12, line 27).

Third, the provision in proposed Rule 5218.8000, Subp. 2 [Emergency] relating to the records of participating health care providers must be limited to those providers records relating to their dealings with managed care plans and the care of patients covered under such plans.

5218.9000 [Emergency] Suspension; Revocation. No comment.

Respectfully submitted,

CORVEL CORPORATION
1380 Energy Lane, Suite 205
St. Paul, Minnesota 55108

By: LARKIN, HOFFMAN, DALY & LINDGREN, LTD.

By: _____
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JED:TQ8s

PHYSICIANS HEALTHCARE CENTERS INC.

August 10, 1992

RECEIVED
AUG 13 1992
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

The Honorable Phillip Carruthers
Minnesota House of Representatives
575 State Office Building
St. Paul, MN 55155

Dear Representative Carruthers,

This letter serves to notify you that Physicians HealthCare Centers, Inc. is registering a complaint against the Department of Labor and Industry's current proposed rules regarding managed care and is asking the Commission (LCRAR) to investigate the legality of the proposed rules.

The proposed emergency rules as outlined by the Minnesota Department of Labor and Industry governing workers' compensation managed care plans are inconsistent with the new legislation (Minn. Stat. [176.1351]).

Section 13 (Minn. Stat. [176.1351]), Subdivision 1 states, "Any person or entity, other than a workers compensation insurer or an employer for its own employees, may make written application to the commissioner to have a plan certified...".

The Department of Labor and Industry's proposed rules state in Part 5218.2000, Subpart 4, "when an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, formed, or administered by the employer or the insurer."

The intent of the legislature was clear in not allowing insurers or employers the ability to form or operate managed care plans. The legislature specifically and without question did not want the choice of physician left in the hands of the employer, for a "company physician" would become the primary care physician mandated by law.

In regards to charges and fees, the rules and procedures run contrary to normal business practice. Specifically, refer to part 5218.6000 wherein it states, "The payment by the insurer or the managed care plan to participating providers for medical services ...shall be the maximum amount allowed under Minnesota Statutes, section 176.136."

This rule specifically denies the right of a managed care plan to reduce any medical fees, whereby denying any competition among managed care plans in regards to cost of medical services. In essence, not only is there no incentive to reduce one's fees in order to compete for business, but state law will make it an illegal practice.

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Under the proposed rules the worker's compensation program becomes a State run healthcare program. Essentially the State run program will mandate new standard treatment protocols, the amount paid to providers per the mandated fee schedule, and with whom the employee will treat via employer/insurer controlled managed care plans. There will be no ownership and no incentive for the healthcare providers to deliver quality care. Medicine is currently evolving into a market driven service where product definition and differentiation is essential to establish a competitive marketplace. Only after a competitive marketplace is established will there be an overall reduction in worker's compensation costs while increasing the quality of care.

Thank you for your attention to this matter. We look forward to hearing the outcome of your review. If we can be of further assistance please feel free to call.

Sincerely,

Scott A. Sexton
Area Manager

Cynthia L. Ballard, R.N.
Regional Manager

RECEIVED
AUG 13 1992
LABOR & INDUSTRY

cc: John Lennes, Commissioner
Department of Labor and Industry

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry

Mary Anne Hruby
LCRAR

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HealthEast

August 17,1992

HealthEast Care, Inc.
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6 West
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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road
St. Paul, MN 55155-4316

RECEIVED
AUG 19 19[illegible]
LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Dear Ms. Zembal:

I would like to take this opportunity to compliment you and your department on the Proposed Emergency Rules relating to workers' compensation; managed care. There are, however, a few comments that we would like to make about the emergency rules for your consideration. Our comments are briefly summarized below:

1. **5218.1000 subpart 1D93)(f) Access to health care providers**

   While it appears that the 30 mile requirement for access to health providers is either 30 miles from the employee's place of employment or the employees residence, this statement might be clarified to state a plan which provides one or the other is sufficient for compliance and that it is not necessary to provide an employee with their choice. If this is not the Commissioner's intent, we believe that to provide such a choice would be impractical due to the geographic spread of employees throughout the metropolitan area and suggest either elimination of the "or residence" requirement or alternatively providing a more reasonable 50 mile distance.

2. **5218.1000 subpart 1D(11) Treatment standards**

   This provision states that the managed care plan must submit treatment standards for medical services not already prescribed by the commissioner. If it is the intent of the Commissioner that these treatment standards be drafted or prescribed by the individual managed care plan, then for clarification purposes, it would be helpful if this is affirmatively stated in the provision. Additionally, if the Commissioner is contemplating any restrictions to the standards prescribed by the managed care plan, these should be specifically set forth in this provision.

3. **5218.1000 subpart 1D(b)**

   The terms "adequate number of each category of health care providers", "convenient geographic accessibility", and "adequate flexibility to choose" are subject to wide and varying interpretation. It appears that the judgment and determination as to the interpretation of these terms is left to that of the managed care plan. If the Commissioner is intending a more specific definition of these terms, we would suggest additional language to that effect in this provision or some additional direction on the Commissioner's specific interpretation of these terms.

4. **5218.1000 subpart 1 D.3. Initial Evaluation and Referral**

The initial evaluation with choice of three health care providers will be cumbersome and may cause confusion for the injured employee. We propose that this mandatory referral process be eliminated. Our proposal recognizes that the evaluating physician would discuss treatment options and the need for referral directly with the patient and referrals would occur naturally. We request that the Commissioner consider eliminating the requirement that at least three health care providers be made available as referrals by the evaluating provider.

5. **5218.2000 subpart 4 Restrictions**

Minn. Stat. 176.1351 states that any person or entity other than a workers' compensation insurer or employer for its own employees, may apply to be a managed care plan. However, this provision states "When an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, formed, or administered by the employer or insurer". Could the Commissioner please clarify this apparent inconsistency.

Additionally, this provision states, in part, "No employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota Statutes, Chapter 176." One issue that can arise under this provision is whether a managed care plan is triggered when an employer has medical staff on-site, which is available to the employees for treatment prior to treatment under the employers' managed care plan. It appears that an existing on-site medical staff would not trigger the employer as a managed care plan. It appears that this type of treatment would be outside the managed care plan entirely. If it is the Commissioners intent to have a differing interpretation of this provision, clarification should be made with respect to this provision.

Another issue raised in this provision is a situation in which the managed care plan is a wholly-owned subsidiary of the employer. In this situation, we are assuming that the wholly-owned subsidiary of the employer is a separate legal operating entity from the employer, and not merely a shell corporation. It is, therefore, our interpretation that a wholly-owned subsidiary would not be precluded from operating, forming or administering the managed care plan of the employer. We request that the Commissioner confirm this interpretation in these Emergency Rules.

6. **5218.3000 subpart 3 Insures: data**

This provision states "The managed care plan must report to the insurer any data regarding medical services and supplies required by the insurer to determine compensability, and any other data required by rule." Currently, Minnesota Statutes 176.138 allows release of information to the employee, employer, or insurers. However, under these emergency rules, a managed care plan is being asked to release certain information on a specific injured employee to the insurer without having the same rights under Minnesota Statutes 176.138. This is a serious release of information problem for the managed care plans. To preserve

without having the same rights under Minnesota Statutes 176.138. This is a serious release of information problem for the managed care plans. To preserve the intent of this provision, the Commissioner could state that the managed care plan must report any data authorized by the employee.

7. **5218.5000 subpart 1 and subpart 2 Health care providers who are not participating health care providers**

These provisions, while desirable, may not be practical due to the lack of enforcement power or control by the managed care plan. Specifically, the managed care plan does not have any enforcement powers with respect to the requirements set forth in subpart 2 either in statute or rule. Additionally, in the instance of emergency treatment, it is likely that the treatment would take place prior to the employee becoming involved in the managed care plan and the managed care plan would not have control over the type of treatments prescribed. The managed care plan does not have any control over the outside health care providers to require compliance with certain requirements. Specifically, the managed care plan would not have any contractual relationship, in many instances, with the health care providers who are not a participating health care provider.

8. **5218.8000 subpart 2 Records**

We are concerned that the phrase "all records" in this provision is too broad in nature and may jeopardize patient and provider confidentiality. We believe the Commissioner should consider greater definition of the term "all records" and specifically set forth the records to be disclosed. Additionally, the Commissioner should consider qualifying language that limits the disclosure to those records of a non-confidential nature.

Thank you for this opportunity to share with you some of our comments with respect to these emergency rules. **We would appreciate it if you could advise us of the date of submission to the attorney general and send us a copy of the adopted emergency rules. This information may be sent to me at the address above.**

Very truly yours,

Steven N. Burrows
Executive Vice President
HealthEast Care, Inc.

United Pain Center
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(612) 220-7246

United Hospital

A **Health One** Hospital

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August 12, 1992

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-5213

Dear Ms. Zembal:

Thank you for your time and assistance during our telephone conversation today. As I stated, each time I read the rules I am more impressed with their comprehensive structure and flexibility.

I will pursue the notion that the United Pain Center, operated by Pain Management Concepts, Inc., may be the provider for pain services to other managed care organizations. I am not sure whether it would be beneficial to use United Hospital or Pain Management Concepts, Inc. as the contracting organization. If you have any additional feedback you could provide would be appreciated.

Once again, thank you.

Sincerely,

David Jones

David Jones, Ph.D.
President

DRJ:cj

Ridgeview
MEDICAL CENTER

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August 19, 1992

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Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

RE: Proposed Emergency Rules For Managed Care Plans
(M.S. 176.1351)

Dear Ms. Zembal:

We understand that the Department of Labor and Industry is accepting input in regards to the proposed emergency rules the Department will be issuing to implement Minnesota Statute 176.1351, which concerns managed care plans under Minnesota's Worker's Compensation Act. On behalf of Ridgeview Medical Center and Business Health Services (BHS), a division of Ridgeview Medical Center, we respectfully submit the following input concerning the proposed rules:

1. Geographical Service Areas. It appears from the proposed emergency rules that the "geographical service areas" for managed care plans will be nonexclusive, and there will be no limit on the number of managed care plans which can serve any particular county. We respectfully submit that the rules would be clearer if they expressly stated such.

2. Minimum Size Requirements. As for proposed Rule 5218.1000, subp. 1.D.(2)(b) which states that a managed care plan must have an "adequate number" of providers to be certified, it would be helpful if the rules gave some guidance as to what will be considered "an adequate number of each category of health care providers ...." BHS submits that the public would be best served by allowing both large and small plans to exist.

3. Treatment Standards. Proposed Rule 5218.1001, subp. 1.D.(11) requires a managed care plan to submit treatment standards for medical services not already prescribed by the commissioner. BHS would like to see the Rules made more specific as to how detailed these treatment standards must be.

4. Time Frame. The emergency rules do not state that applications to be a managed care plan must be made within any particular time frame. BHS would like to see the Rules specifically state that applications can be made at any time. BHS would appreciate knowing that should it not choose to apply as a managed care plan at this time, that it could still apply in the future if it chooses to do so.

Thank you for your consideration. Thank you also for your continued efforts to assure the best possible patient care at a reasonable cost.

Yours very truly,

RIDGEVIEW MEDICAL CENTER

John P. Devins
President/CEO

JPD:jah

GROUP HEALTH INC.

2829 UNIVERSITY AVE., S.E. MINNEAPOLIS, MN 55414-3295

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August 21, 1992

Ms. Pamela Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Emergency Rules Governing Managed Care Plans

Dear Ms. Zembal:

Group Health would like to thank you and Ms. Gephard for taking the time to meet with interested parties from the HMO industry last week to discuss the managed care plans rulemaking. We appreciated your openness to our comments and would like to submit the highlights of that discussion in writing at this time. Group Health requests that these comments be made a part of the rulemaking record.

1. Service Area

Section 5218.0100, subp. 5 and Section 5218.1000, subp 1.D.(3)(f) address the need for a service area designation so that employees are adequately served by the managed care plan's provider network. We request that you incorporate additional flexibility and reduce some of the administrative burden in obtaining certification by recognizing that a licensed health maintenance organization (HMO) in Minnesota must pass stringent tests under the Department of Health for obtaining an HMO service area. If a managed care plan applicant is also a Minnesota-licensed HMO and will be using all or substantially all of its HMO network for the workers compensation plan, the Department of Labor and Industry should grant the same service area as the Department of Health. The same employers which currently purchase HMO coverage for their employees will want to purchase the Workers Compensation coverage; establishing two different service areas will hamper the effective marketing of managed care plans. Such a change in these rules would expedite applications during the critical first year of this program while more formal criteria for service area designations can be developed under the permanent rules.

2. Executive Salary Cap

We were quite surprised to see the executive salary cap expressed in Section 5218.1000, subp. 1.B., because we can find absolutely no statutory authority for such a provision. Group Health is a nonprofit organization with no for-profit management company in our affiliated company structure, and we understand the public outrage when executives in the health care industry are paid exorbitant salaries. However,

the Department should recognize that creative lawyering and the use of corporate shells can easily overcome the purported limitation currently set forth in the rules and render it meaningless in practical effect. Leaving such a provision in the final rule will undermine the credibility of the Department because the provision will surely fail any legal challenge. We respectfully suggest that the provision be dropped in its entirety.

3. Initial Evaluations by a Physician

Section 5218.1000, subp. 1.D.(3)(a) sets forth a requirement that an injured employee receive an initial evaluation by a participating physician within 24 hours of a request for treatment following an injury. We believe the rule should be clearer that the managed care plan is not obligated to allow any other health practitioner to perform an initial evaluation. The reference in the rule to an initial evaluation by a participating chiropractor should be amended to clarify that at all times, the managed care plan has the discretion to determine whether or not an initial evaluation is conducted by a physician.

4. Panel of Three Health Care Providers

Section 5218.1000, subp. 1.D.(3)(c) should be clarified so that managed care plans are required to have available at least three health care providers to treat an injured employee and that it is not necessary to give each injured employee the names of three providers and allow the patient to choose where he/she will receive treatment.

5. "Direct Access"

Section 5218.1000, subp. 1.D.(3)(c) states a managed care plan must provide "direct access" to all health care disciplines. We strongly recommend that this be clarified so it is not confused with the concept of "self-referral". The cornerstone of today's most effective managed care organizations is the concept of a primary care physician who manages a patient's care by appropriate referrals to necessary specialists. From our discussions with the Department, we understand you fully support the concept of referral based specialty care (whether that be surgery, physical therapy, or chiropractic, for example). However, use of the words "direct access" in this part of the rule appears to permit self-referral and will certainly lead to confusion and litigation in this regard. We request you clarify that specialty care may be managed through the use of a referral requirement.

6. Emergency Inpatient Hospitalization

Section 5218.1000, subp. 1.D.(3)(d) should be clarified so that an inpatient hospitalization does not necessarily require treatment or consultation by a participating physician, so long as the managed care plan is satisfied that the patient is receiving appropriate care through the providers at that facility. In addition, for case management purposes, it is critical that the managed care plan be informed of inpatient hospitalizations as soon as possible. We request language be added to this

section to enable a managed care plan to work out a procedure with the employer, whereby the patient and the patient's providers must notify the managed care plan immediately of any inpatient stay.

7. **Information on a 24-hour Basis**

We request that Section 5218.1000, subp. 1.D.(3)(e) be clarified to indicate that only medically necessary advice from a health care provider (similar to a physician's answering service) need be available on a round-the-clock basis. The current rule seems to imply that benefit and administrative information must be available 24 hours a day.

8. **Criteria for Approval of Services**

Section 5218.1000, subp. 1.D.(4) requires a plan to have in place procedures and criteria for approval of services from a non-participating provider. This section should be clarified to read that a plan need not have a set of criteria for every anticipated service, but must have in place a procedure whereby services can be evaluated under the plan's definitions of emergency care and medically appropriate care.

9. **Providers' Charges and Fees**

We have saved the most controversial part of these rules for our final comment. The resolution of the provisions set forth in Section 5218.6000 may be the ultimate determinant of which HMOs elect to apply for managed care plan certification. The proposed rule states that payment by the insurer or managed care plan to the participating or non-participating provider must be the amount set forth in the Workers Compensation fee schedule. This rule ignores the reality of the managed care industry in Minnesota which has evolved into partnerships between plans and providers whereby providers are willing to grant significant discounts to the plans in exchange for a predictable patient base and other desirable commitments. Contracts are already in force for providers to receive adequate compensation for Workers Compensation services, and these providers have voluntarily entered into these contracts with the health plans. If the Department insists on attempting to void these arrangements, many HMOs may refuse to participate as managed care plans.

There is no statutory authority for the Department to mandate the payment of the fee schedule amount. Minn. Stat. Section 176.136 clearly states that the fee schedule shall be the limit on payments; the legislature has never prohibited the parties to the transaction from mutually agreeing to a reimbursement which is less than the limit. To eliminate these prevailing arrangements will drive up costs to the employers who are already fed up with the fact that it costs significantly more to treat an injury under Workers Compensation that it costs to treat the same injury under a traditional employer health plan. The rule as proposed would perpetuate this incongruity and force the payors to spend more health care dollars than they currently must spend.

Providers have agreed to such discounts because it is in the providers' economic self interest to obtain from payors volume commitments, exclusivity, and other financial rewards for delivering efficient, quality care. If the Department does not give managed care plans the flexibility to privately negotiate reimbursement with providers, HMOs will decline to participate as managed care plans because they will not want to disturb existing contractual arrangements which are the foundation of their mainstream business.

We strongly urge the Department to delete this requirement at this time, and if inclined to proceed on this topic, to take it up during the permanent rulemaking. At an absolute minimum, the rule should be clear that provider contracts which are already in effect will not be affected by the emergency rulemaking on this topic.

Thank you for taking these comments into consideration. We look forward to working with you on the permanent rules.

Sincerely,

Claire M. Zajac
Associate Counsel

CMZ/ag

Wilson & Wulff, P.A.

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August 7, 1992

Scott Wilson

David C. Wulff

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Comment to Proposed Emergency Rules on Managed Care Plans

Dear Ms. Zembal:

Thomas J. Lyons
of Counsel

Please accept this letter as my comments to the proposed emergency rules on managed care plans published on July 27, 1992.

Ann Moore
Legal Assistant

1. Exclusion of Health Care Providers from MCPs.

Two major concerns which should be addressed by the rules on MCPs are (1) the threat that some health care providers may be effectively excluded from treating workers' compensation patients because they are not accepted members of any MCP; and (2) the threat that an injured employee will be forced to treat with a health care provider he or she does not trust rather than a doctor of his or her choice. The proposed emergency rules, and specifically Rule 5218.4000, subp. 1, should require as a prerequisite to certification that all MCPs must accept any health care provider who meets all licensing, registration and certification requirements necessary to practice in Minnesota, and who agrees to abide by the rules and limitations of the MCP. MCPs should not be given unrestricted discretion to pick and choose the doctors who will constitute participating health care providers.

If the MCPs are allowed to choose the health care providers who will participate in their plans, there will be health care providers who are not accepted into any managed care plan. Those providers will be effectively excluded from treating injured employees in this state. Such exclusion will have a devastating impact on those health care providers. Conversely, these practitioners who are accepted into MCPs could receive an unfair windfall of new cases. This was clearly not intended by the legislature.

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Giving such discretion to MCPs will also significantly limit the right of injured employees to choose the health care provider from whom they will receive treatment. The right to choose ones treating doctor has always been jealously protected by both the legislature and the courts of this state. It is significant to note that of the nineteen persons who spoke at the public hearing on the proposed medical rules on 7/16/92, all but two (the two attorneys who spoke on behalf of the IME firms) urged the Division not to limit the right of injured employees of this state to choose their own treating physician. The legislature clearly did not intend to abrogate the fundamental right of the citizens of this state to choose their own treating physicians.

The basic goal of the legislature in adopting the 1992 amendments was to provide a mechanism for reducing or eliminating inappropriate, excessive or unnecessary treatment. The accomplishment of this goal does not require the exclusion of innocent and qualified health care providers from the system. It also does not require the complete abrogation of a citizen's right to choose their own treating physician. The new treatment standards coupled with the MCP peer review utilization review and dispute resolution process, the MSRB investigation/sanction process, and the traditional medical request/claim petition process are adequate to guard against abuses.

Requiring MCPs to accept all health care providers who apply for admission, so long as their license is in good standing and they agree to abide by the rules and limitations of the MCP, would avoid the dual threats of provider exclusion and limitation of choice without endangering the goal of controlling utilization costs. It is a win/win proposal that should be adopted. The authority for such a rule can be found in Minn. Stat. §176.1351, subd. 2(12).

2. Initial Evaluations Under 5218.1000 D(3).

The proposed rule as drafted allows MCPs to require employees to submit to "initial evaluations" by a "physician" (defined to be a medical doctor or a doctor of osteopathy but not a chiropractor) within 24 hours after an employee requests treatment following a work injury. The rule allows MCPs to permit initial evaluations by chiropractors but does not require this. This rule violates the statutory prohibition against MCPs discriminating against any category of health care provider.

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The same argument applies to 5218.1000, subp. 1D (3)(b) dealing with initial evaluations within five working days of a request for change of doctor.

The requirement that an employee must submit to an "initial evaluation" within 24 hours of a request for treatment following the work injury, or within five working days after a request for a change of doctor in cases where the employee has received treatment for the work injury by health care provider outside of the MCP, is nothing less than a mandatory adverse examination by a health care provider of the employer's choice. As such, it violates the provisions of M.S. 176.155 and should be eliminated from the proposed rules all together.

Alternatively, if an initial evaluation is to be required, then the employee should be given the right to choose from among all of the MCPs participating health care providers, including the chiropractors. Otherwise, the chiropractic profession will be unlawfully discriminated against, and the injured employee's right to choose his or her own treating physician will be unreasonably and unnecessarily restricted.

Subp. (c) in the same rule provides that the "evaluating provider" who conducts the "initial evaluation" must provide the employee with a list of at least three health care providers with whom the employee may treat. The "evaluating provider" is given the power to determine what treatment is appropriate for the condition and what type of health care profession discipline should provide that treatment. This process effectively gives the "evaluating provider" the power to discriminate against categories of health care providers. Allowing MCPs to simply delegate the authority to discriminate against categories of health care providers would obviously violate the prohibition against such discrimination clearly set forth in the 1992 amendments.

The problems inherent in the initial evaluation process set forth by the Rule as drafted could be minimized if not eliminated by simply requiring MCPs to provide injured employees with a list of the names, addresses and telephone numbers of all participating health care providers within 24 hours of a request for treatment following a work injury or within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the MCP. The employee's initial choice of health care provider could then be required to perform an initial evaluation to determine the treatment which is appropriate for the condition. If the

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employee's initial choice of health care provider is not the appropriate health care discipline to provide the treatment, that health care provider could simply provide the employee with a list of the participating providers under the MCP within the proper health care discipline.

3. Entities Which May be Certified as MCPs.

Minn. Stat. §176.1351, subd. 1 provides, "any person or entity, other than a workers' compensation insurer or an employer for its own employees, may" be certified as an MCP (emphasis added). The statute specifically prohibits workers' compensation insurers and self-insured employers from becoming certified as MCPs.

Proposed Rules 5218.1000, subp. 1 and 5218.2000, subp. 4, as drafted, would appear to violate this specific statutory prohibition. Therefore, these proposed rules should be redrafted.

4. Peer Review, Utilization Review and Internal Dispute Resolution.

Proposed rules 5218.1000, subp. 1D (7) and 5218.7000 provide MCPs with too much discretion over devising procedures for peer review, utilization review and internal dispute resolution. The Division should attempt to come up with specific rules concerning these procedures. Otherwise, the citizens of this state will be confronted by a myriad of different procedures giving rise to inconsistent treatment of similar injuries.

5. Aggressive Case Management and Early Return To Work Programs.

Proposed Rule 5218.1000, subp. 1D (10) requires MCPs to describe how they will provide aggressive case management, programs for early return to work, and cooperative efforts to promote work place health and safety services without specifying what those terms mean or what, if any, limitations should apply. The Department of Labor and Industry should develop more specific definitions and requirements in order to avoid the development of myriad different rules and limitations resulting in inconsistent treatment of like cases.

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6. Treatment Standards Not Prescribed by the Commissioner.

Proposed Rule 5218.1000, subp. 1D (11) requires individual MCPs to submit treatment standards for medical services not previously prescribed by the Commissioner. This proposed rule should be eliminated.

It will be completely unworkable and unjust for MCPs to be allowed to develop individualized and differing treatment standards applicable to their member employees. All MCPs should be required to comply with the same treatment standards promulgated by the Commissioner. Prior to the time that the Commissioner has promulgated treatment standards covering all types of medical services, the MCPs should simply be required to provide services which are usual and customary for the provider's health care profession, and which are reasonably required to cure or relieve the effects of the employee's work related injury. Allowing MCPs to develop their own unique treatment standards, even if limited to the period of time prior to the development of uniform standards by the Commissioner will only result in confusion and inconsistent treatment of the injured employees of this state.

7. Retroactive Application of MCPs.

Proposed Rule 5218.2000, subp. 3D provides that the MCP rules will apply to employees injured prior to the effective date of the 1992 amendments if the employee requests a change of doctor. The proposed rule provides that an employee who requests a change of doctor must receive further treatment provided by the employer's MCP.

This provision violates the statutory and constitutional prohibition against substantive rights being taken away or affected by the retroactive application of statutory amendments. The law of this State is clear that statutory amendments shall be applied prospectively only, whether or not the amendments are substantive or procedural in nature, unless the legislature specifically provides for retroactive application. The legislature has not provided for the retroactive application of managed care plans. Therefore, any employee injured prior to 10/1/92 cannot be required to receive treatment through a managed care plan even if the employee requests a change of treating physician.

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8. Termination of Participating Providers.

Proposed Rule 5218.4000, subp. 2 allows managed care plans to "cancel" participating health care providers "under the requirements of the managed care plan." This rule effectively provides MCPs with totally unrestricted discretion over when and under what circumstances they may cancel or terminate participating health care providers. This proposed rule should be eliminated.

The legislature specifically created an exhaustive and comprehensive procedure for the investigation and sanction of health care providers who chronically provide inappropriate, excessive or unnecessary treatment to injured employees. This process is set forth in Minn. Stat. §176.103 under the authority of the Medical Services Review Board. This process requires the MSRB to investigate suspected cases of inappropriate, excessive or unnecessary treatment. It authorizes the Department to sanction providers found to be abusing the system. Said sanctions can include a total exclusion from treating injured employees.

The process established by the legislature sets forth specific checks and balances to protect wrongly accused providers from being unjustifiably sanctioned, while enabling the Division to identify and sanction actual abusers.

Obviously, the legislature did not intend to allow MCPs to side step this established process and effectively sanction health care providers without the checks and balances of appropriate due process.

The rules should be changed to allow MCPs to terminate participating health care providers only if the providers are found to have been abusing the system and the provider is sanctioned with exclusion from the workers' compensation system by the Department of Labor and Industry following the MSRB investigation. To provide MCPs with unfettered discretion to terminate health care providers would create a significant risk of abuse in direct contravention of legislative intent.

9. Treatment Provided by Non-Participating Health Care Providers.

Proposed Rule 5218.5000, subp. 1A proposes to limit the ability of an employee to treat with a health care provider who is not a participating health care provider to providers which have

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a documented history of treatment with the employee before the date of injury. Minn. Stat. §176.1351, subp. 2(8) does not require that the history of treatment be prior to the date of injury. There is nothing in the statute to suggest that if the employee develops a history of treatment with a health care provider after the date of injury and thereafter wishes to switch the care of their work related injury to that health care provider, that the employee should not be able to do so. The legislature obviously intended to allow employees to treat with doctors in whom they have developed a certain level of confidence. Whether that treatment history and level of confidence is developed before or after the date of injury should not matter.

Proposed Rule 5218.5000, subp. 2B requires health care providers who are not participating health care providers to agree to refer the covered employee back to the managed care plan for "specialized care, which includes, but is not limited to, physical therapy and diagnostic testing". Minn. Stat. §176.1351, subd 2(8) only requires the non-participating health care provider to agree to refer the employee back to the managed care plan for "any other treatment that the employee may require". This would appear to allow the non-participating health care provider to provide any type of treatment he or she is licensed to provide, specifically including physical therapy and diagnostic testing. Therefore, it would appear that this proposed rule goes beyond the statute and is therefore unenforceable.

Respectfully submitted,

WILSON & WULFF, P.A.

David C. Wulff
Attorney at Law

DCW/cmg

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August 19, 1992

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

RE: Proposed Emergency Rules/Managed Care Plans

Dear Ms. Zembal:

Please accept this letter as my comments and position with respect to the proposed emergency rules. I am an attorney working in the field of workers' compensation and feel that some of these rules are inconsistent with the callings of the 1992 legislative changes.

My understanding that the basic intent of the legislature in adopting the amendments to the rules was that they were concerned over the skyrocketing costs and wanted to reduce the number of unnecessary treatments with respect to health care. It is also my understanding of the law that individual medical care providers were not to be discriminated against.

I feel that proposed rules do unfairly and unjustly signal out the chiropractic profession and is directly contrary to what the legislature intended and wrote.

By adopting these emergency rules, I feel that the commissioner is using a small window of opportunity in the law to adopt these emergency rules eventhough he knows them to be contrary to the law. By getting these rules temporarily into effect, it will be much easier for the permanent rules to be adopted. As we all know once the amendment is in place, it will be more difficult to override in the future.

Specifically, I feel that the initial evaluations under the proposed Rule 5218.1000(d)3, is in direct contradiction with the law. I believe that these initial evaluations are quite clearly against the calling of the law and require that a licensed medical doctor make the decision whether or not chiropractic care is appropriate. I believe that the physicians that make the decisions will no doubt be discriminatory as this has been in the past

towards chiropractors and will leave the chiropractic trade out, as if to line their own pockets.

I have also had a chance to review a letter which I have enclosed from the law firm Wilson & Wulff, P.A. which summarizes some of the programs and after discussing some of these items with Mr. Wulff, I will wholeheartedly agree with his suggestions and his interpretations of these various rules.

Lastly, and most importantly what really concerns me is the attitude which the department has taken with respect to these matters. It is my opinion that they are trying to use a small window in the law to rewrite the way we provide health care to Minnesotans. We recently enacted a Minnesota Health Right Act and the Act in itself was monumental. Now the department seems to be taking their own approach with respect to these matters and disregarding legislature entirely. What the legislature gave the Department of Labor and Industry seems to be taking away. Under the proposed emergency rules, health care will not be a right but a luxury. I note that at various conferences and CLE's, some officers from the Department for the Department have been particularly boisterous with concerns with respect to these matters and they have said they are going to dictate how things will be. These cannot be just oversight and errors on the part of the department, but I feel are conscious efforts on the part of a few to diminish the rights of working people. I believe that the department is trying to put these changes into effect and I am sure that litigation will come about if these changes, which are directly in contrast to the law. I would hope that you would make some changes prior to their enactment so that all parties are treated equally, and the rules are consistent with the law.

Thank you for this opportunity to comment on these rules.

Very truly yours,

GORMAN & GORMAN, LTD.

By: Richard D. Gorman
Richard D. Gorman

RDG:slb
cc: Jay Greenberg

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August 19, 1992

Ms. Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor & Industry
443 Lafayette Road
St. Paul, MN 55155

Dear Ms. Zembal:

I am writing in regard to proposed emergency rules on managed care plans published on July 27, 1992. It strikes me that to potentially exclude a entire area of health care providers, chiropractors, based upon these rules is bad policy, unfair and probably discriminatory and therefore, unconstitutional. Further, to require an injured employee to treat with a health care provider that he does not select but which is selected for him is not good health care practice. It strikes me that the rules should be substantially modified to provide injured employees with the freedom to choose their health care provider.

Very truly yours,

FOR THE FIRM:

Bernie M. Dusich

BMD/dk

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08/11/92

Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

The following letter is written in response to the Notice Of Intent To Adopt An Emergency Rule regarding managed care. I have some very serious concerns regarding 5218.1000 Subpart 1 D. (3) (a)(b)(c). These sections are a blatant attempt by the Department of Labor and Industry to create a "medical gatekeeper". Practically speaking, this emergency rule will substantially reduce the availability of chiropractic care to injured workers. This section of the emergency rules is in direct violation of MSA 176.1351 Subdivision 1 (10) and MSA 176.135 Subdivision 4.

Passage of this emergency rule will lead to intense litigation. It was NOT the intent of the legislature to create a "gatekeeper".

Sincerely,

LEIGHTON, KARNEY & CRABTREE

T Crabt

Todd A. Crabtree

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August 21, 1992

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Ms. Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
Saint Paul, Minnesota 55155-4136

In The Matter of the Proposed Adoption of Emergency Rules of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans.

Dear Ms. Zembal:

The following is intended to represent this firm's comments regarding the above-referenced proposed emergency rules.

First, proposed Rule 5218.1000, Subpart 1D.(3)(c), provides in part that a managed care plan must include a procedure to allow the employee to change health care providers within a managed care plan at least once. Minn. Stat. §176.1351, Subd. 3(11), states that a managed care plan must provide an employee the right to change health care providers under the plan at least once. The proposed rule should reflect the statutory language, rather than attempt to either limit or expand the statutory definition in the absence of any express statutory authority.

Second, Rule 5218.2000, Subpart 3D, correctly applies statutory and case law by providing, in part, that employees with compensable injuries prior to the effective date of the managed care plan contract are not subject to the managed care provisions of Minn. Stat. §176.1351 and proposed Rules 5218.0100 to 5218.9000. However, this proposed rule carves out an exception for those employees who have compensable injuries which pre-date the managed care plan contract if they request a change of doctors. This part of the rule lacks any statutory authority and contravenes clear case law precedent with respect to attempts to retroactively limit rights to workers' compensation benefits which vest and are defined by the law in effect on the date of injury. Further, targeting employees with vested rights under prior statutes who seek to change treating physicians raises a serious constitutional question. Rule 5218.2000, Subpart 3D, should be deleted after the word "contract" on line 25.

Finally, this letter is also intended as our formal request for notification of the date of submission of these proposed rules to the Attorney General.

Respectfully submitted,

Mark G. Olive

FOR THE FIRM

MGO/sjb

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REGULATORY & MEDICAL AFFAIRS

MINNESOTA
CHIROPRACTIC
ASSOCIATION

1700 W. Highway 36, Suite 130 ■ Roseville, Minnesota 55113-4057 ■ 612/639-0663 ■ MN WATS 1-800-279-1627 ■ Fax 612/639-1951

August 13, 1992

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REHABILITATION & MEDICAL AFFAIRS

Pam Zembal
Rehabilitation and Medical Affairs
MN Dept. of Labor & Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

RE: Proposed Emergency Rules for Workers' Compensation

Dear Ms. Zembal:

The Minnesota Chiropractic Association has reviewed the proposed rules regarding workers' compensation that have appeared in the July 27, 1992 edition of the Minnesota State Register. It is this association's opinion that they do not follow the intent or the letter of the law passed by the 1992 legislature.

The workers' compensation enabling legislation passed earlier this year is designed to utilize a managed care mechanism that can help contain costs without depriving injured workers of the care to which the legislature says they are entitled.

If the only concern of the legislature was to save money, that goal would not have been difficult - severely diminish employees' accessibility to care by limiting employees to a couple of different providers within one provider group.

However, that is not what the legislators did.

What they did was pass legislation that prohibits discrimination by managed care organizations against health care provider groups. Minn. Stat. 176.1351 Subd. 2 (10) states that the managed care organizations cannot "discriminate against or exclude from participation in the plan any category of health care provider . . ."

Minn. Stat. 176.1351 Subd. 4 states that a managed care organization can have its certification revoked if it "unfairly restricts direct access within the managed care plan to any health care provider profession." The legislature goes on to define the term "unfairly restricts" to mean "if direct access is denied and the treatment or service sought is within the scope of practice of the profession to which direct access is sought and is appropriate under the standards of treatment adopted by the managed care plan or, in instances where the commissioner has adopted standards of treatment, the standards adopted by the commissioner."

This association believes that the proposed rule 5218.1000 [Emergency] subpart 1, item D, subitem 3. conflicts with statute. Subitems 3(a) and (b) state that the managed care plan will have a procedure to allow the employee evaluation by a medical doctor, and may have a procedure to allow evaluation by a chiropractic doctor.

Both doctors of chiropractic and doctors of medicine are licensed by the State of Minnesota to diagnose a patient presenting to the practitioner, and then treat those diagnosed conditions falling within their respective scopes of practice.

The rule discriminates against the chiropractic provider by establishing a standard of participation different than that set for the medical provider. By explicitly stating that discrimination is prohibited, the legislature did not intend that the injured employee be potentially prohibited from seeing a category of health care provider that, by law, can diagnose his/her condition. Rather than allow the employee the opportunity to select the category of health care provider, the rules allow the insurer to make the decision.

Subitem 3(c) allows the initial evaluating health care provider the right to determine what category of health care provider can appropriately treat an employee's condition.

Because Subitems 3(a)and 3(b) create a discriminatory advantage for the medical provider, Subi. 3(c) worsens the discriminatory effect against the employee seeking care from a chiropractic provider. With the adoption of Subi. 3(c), a medical doctor will be able to determine whether an employee can or cannot have access to a doctor of chiropractic.

Putting a medical doctor in charge of deciding whether other providers will have any authority to treat does not follow the legislation passed. Legislators were well aware that some insurers were intending to remove the chiropractic option from employees, and made it clear in committee hearing, and by passing this legislation, that they wanted to prohibit what these rules in effect will accomplish.

The Department has the opportunity through rule-making to craft a managed health care component in workers' compensation, that lays new ground in creating an efficient mechanism for containing health care costs and allowing for the delivery of quality care. The MCA has always supported treatment standards and a relative value fee schedule as innovative ways of accomplishing these goals. The Department does not have to rely on a "company doctor" mechanism that shuts the employee out from needed care. Minnesota's injured workers deserve better than that.

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So that the rules promulgated by your department adhere to statutory law, we advise that proposed rule 5218.1000 [Emergency] subpart 1, item D, subitem 3 be revised as attached. Thank you for your consideration. If you have any questions, please do not hesitate to contact me.

Please reply with an analysis of our response.

Sincerely,

Scott L. Mayer
Executive Director

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SUGGESTION FOR REVISION OF 5218.1000 [EMERGENCY] APPLICATION FOR CERTIFICATION:

(3) The managed care plan must include a procedure to ensure that the employee will:

(a) receive initial evaluation by a participating ~~physician~~ doctor of medicine or chiropractic within 24 hours of a request for treatment, following a work injury; the managed care plan ~~may permit initial evaluations by a participating chiropractor, in which case~~ will allow the employee ~~may~~ to decide whether the evaluation will be by a ~~physician~~ medical doctor or a chiropractor;

(b) receive initial evaluation by a participating ~~physician~~ doctor of medicine or chiropractic within five working days of a request for a change of doctor in cases where the employee has received treatment for the work injury by a health care provider outside the managed care plan under part 5218.5000 [Emergency], subpart 1, item A. The managed care plan ~~may permit an initial evaluation by a participating chiropractor, in which case~~ will allow the employee ~~may~~ to decide whether the evaluation will be by a ~~physician~~ medical doctor or chiropractor;

(c) initially choose from at least three health care providers to whom the employee has been referred by the evaluating provider under unit (a) or (b) for treatment, and allow the employee to change providers within the managed care

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plan at least once. The procedure to allow the employee to select a health care provider must provide direct access to all health care profession disciplines ~~if the treatment is determined to be appropriate for the condition by the evaluating health care provider under until (a) or (b) or if the insurer approves the treatment~~;

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MINNESOTA
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1700 W. Highway 36, Suite 130 ■ Roseville, Minnesota 55113-4057 ■ 612 /639-0663 ■ MN WATS 1-800-279-1627 ■ Fax: 612 /639-1951

August 19, 1992

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LABOR & INDUSTRY
REHABILITATION & MEDICAL AFFAIRS

Pam Zembal
Rehabilitation and Medical Affairs
MN Dept. of Labor & Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Dear Ms. Zembal:

As you are aware, the Minnesota Chiropractic Association (MCA) submitted comments in correspondence dated August 13, 1992 regarding the proposed emergency rules for workers' compensation that appeared in the July 27, 1992 edition of the MN State Register.

The comments already submitted address proposed rule 5218.1000 [Emergency] subpart 1, item D, subitem 3. It is the MCA's position that this rule does not follow the intent or letter of the law passed earlier this year, and furthermore, if it becomes effective, will nearly eliminate the ability of an injured worker to receive chiropractic care. To clarify our position, the purpose of this correspondence is the following: 1) to document the legislative events that preceded the final passage of the workers' compensation legislation; and 2) to document the difficulty in receiving chiropractic care for an injured worker under a managed care system such as implemented by the proposed rules.

1) DOCUMENTATION OF LEGISLATIVE EVENTS. To our best recollection, the first draft of the workers' compensation language did not contain the language prohibiting discrimination by managed care organizations that is now Minn. Stat. 176.1351 Subd. 2 (10) or the direct access language that is now Minn. Stat. 176.1351 Subd. 4.

After reviewing that draft, MCA representatives met with Senate Employment Committee Chair Florian Chmielewski to determine if, in fact, his intent in drafting the legislation was to allow the workers' compensation system to potentially discriminate against workers seeking chiropractic care. He indicated that was not his intent, and, in fact, believed that the original draft of the language did not discriminate against the chiropractic patient or the chiropractic profession.

We then met with Senate Counsel John Fuller who indicated that the original draft would accomplish what we had feared; it would allow for a medical gatekeeper system such as that in place by some of the HMOs in Minnesota, which would operate to deny injured workers chiropractic care. We then conveyed that message to Sen. Chmielewski.

Upon Sen. Chmielewski's instructions, the next draft of the workers' compensation language contained the anti-discrimination language cited as Minn. Stat. 176.1351 Subd. 2 (10), which states that the managed care organizations cannot "discriminate against or exclude from participation in the plan any category of health care provider . . .".

Although this language was very helpful in eliminating the discriminatory problems we felt would arise under the workers' compensation system, we believed that adding language ensuring direct access to all provider groups would eliminate all possibility that chiropractic patients would be denied the care that they are currently denied under the medical gatekeeper system used by some HMOs.

After discussing this with Sen. Chmielewski and the other members of the Employment Committee, Sen. Chmielewski agreed that direct access to chiropractic care should be incorporated in the workers' compensation legislation, and that amendment was adopted by a voice vote of the Employment committee, and now is Minn. Stat. 176.1351 Subd. 4.

This history demonstrates the intent of the legislature in passing legislation to ensure that injured workers be allowed direct access to chiropractic care on a basis equal to that access allowed for medical care.

The fact that the language prohibiting discrimination against health care providers and ensuring direct access to all providers was <u>added</u> to the original draft of the legislation and not a part of the original language lends persuasion to our analysis that the legislators were aware of the arguments for addition of the language and intended, by their affirmative vote, to see the language incorporated into Minnesota law.

2) DIFFICULTY IN RECEIVING CHIROPRACTIC CARE. The proposed rule would create a managed care system almost identical to the medical gatekeeper system currently utilized by most Minnesota HMOs. Historical data has proven that such a system virtually eliminates chiropractic care for those patients requesting it, even though, on its face, it indicates that chiropractic care is available.

As an example, the attached materials document the case of a patient belonging to Share HMO. A chiropractic patient requested a referral from a Share medical doctor to a doctor of chiropractic. The gatekeeper, Dr. Sharon Allen, indicated in a letter dated October 14, 1987, that "Share will not pay for referral for chiropractic care". However, in a letter dated November 30, 1987, Lynn Gruber, Director of Share Medical Delivery Services, indicates that Share does pay for chiropractic care. However, in a letter dated December 12,

1988, a medical doctor once again reiterates that chiropractic care is not possible, because, "I don't feel it is philosophically consistent for a doctor of medicine to refer patients to chiropractic practitioners."

This example, representative of thousands of cases, illustrates the frustration chiropractic patients are subjected to when attempting to receive chiropractic care in an HMO managed care setting. Many medical doctors have a bias which precludes the right of a patient to appropriate chiropractic care, and even when a medical doctor finds it appropriate to refer to a chiropractor, the HMO plan will not allow it (although it's indicated in writing that the care is permissible.)

This example is bolstered by a survey conducted by Mr. Charles Tharaldson, a consumer who attempted to obtain chiropractic care through his HMO. As his attached letter indicates, a survey of the 227 doctors of chiropractic in his area who were listed in the telephone directory concluded that none of them ever had a referral from his HMO.

All evidence indicates that implementation of the proposed managed care rules would yield the same result for an injured worker seeking chiropractic care that has been obtained by an HMO insured seeking chiropractic care.

Just as the managed care rules promulgated by the Dept. of Labor & Industry promises "direct access to all health care profession disciplines", so does the language in HMO contracts. The exclusionary clause, however, is the next phrase which states "if the treatment is determined to be appropriate for the condition by the evaluating health care provider. . .". It is this clause which effectively allows the managed care entity from rarely, if ever, determining that chiropractic care is appropriate.

An in-house appeals process is not helpful. In all HMO cases, the appeals process adheres to the opinion of the medical gatekeeper.

We are hopeful that the clarification of legislative intent as well as the practical reality of adopting a "gatekeeper" system will assist you in reaching a determination that results in the adoption of our suggested changes submitted to you earlier.

Thank you for your consideration.

Sincerely,

Scott L. Mayer
Executive Director

Dr. Lawrence E. Taylor

McKNIGHT/36 CHIROPRACTIC CLINIC
2100 11th AVENUE EAST • NORTH ST. PAUL, MN 55109
(612) 777-5055

October 9th, 1987

Dr. Sharon Allen
Payne Avenue Medical Association
1239 Payne Avenue
St. Paul, Minnesota 55101

Dear Dr. Allen:

I am writing regarding patient . She is being seen by you for psychiatric problems. She also has musculoskeletal complaints which I think could be treated with Chiropractic methods.

To be paid by SHARE, I do need a referral from her medical doctor, and I am requesting that you allow me to treat Mary for her musculoskeletal complaints.

Please respond in writing within seven (7) days, as I believe prompt initiation of treatment would benefit Mary greatly.

Sincerely,

Lawrence E. Taylor, D.C.

LET/jki

PAYNE AVENUE MEDICAL ASSOCIATES
(DIVISION OF RICE STREET CLINIC, P.A.)
1239 PAYNE AVENUE
SAINT PAUL, MINNESOTA 55101
TELEPHONE 771-5577

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SHARON S. ALLEN, M.D.
DENNIS D. WALSTON, D.O.
DANIEL M. GOLDBLATT, M.D.
CAROLYN A. JOHNSON, M.D.

MICHAEL D. HOOLEY, M.D.
JOHN H. KAPSNER, M.D.
PETER J. OLSON, M.D.
BETTY CULLEN, Clinic Manager

October 14, 1987

Dr. Lawrence E. Taylor
McKnight/36 Chiropractic Clinic
2100 11th Avenue East
North St. Paul, MN 55109

Dear Dr. Taylor,

Thank you for your letter of October 9, 1987, on -- At this point, we feel that her psychiatric problems are her major problem. We have been working with Metropolitan Medical Center on this.

I realize that she has some musculoskeletal complaints but, at this point, we feel that we need to concentrate on her psychiatric problems. Somatic complaints don't often resolve unless we can also totally treat the patient, in terms of psychiatric care.

Thank you for your concern at this time. However, as you are aware, SHARE will not pay for referral for chiropractic care and at this time we do not feel this is needed.

Thank you.

Sincerely,

Sharon Allen M.D.,
Sharon S. Allen, M.D.

SSA:kj

Copy

Share

3600 West 80th Street • Bloomington, Minnesota 55431 • (612) 830-3166

November 30, 1987

Mr. Scott L. Mayer
Director of Professional Affairs
Minnesota Chiropractic Association
2353 Rice Street, Suite #125
St. Paul, MN 55113

Dear Mr. Mayer:

I am responding to your letter of October 28 in which you seek clarification of Share's policy concerning chiropractic coverage.

Share covers chiropractic services when an enrollee's primary care physician determines that manual manipulation of the spine should be instituted to correct subluxation of the spine. You were correct in noting that, as with all services not provided by the primary care physician, a written referral authorization from the member's primary care physician is required for a Share enrollee to receive coverage for chiropractic services from a chiropractor.

Share is a "closed panel" system of capitated health care whereby an enrollee must select a primary care medical office from a finite list of primary care physicians. The primary care physician then has the responsibility of managing the enrollee's total care needs by determining when a member's health care needs require a referral to a specialist, including a chiropractor and other licensed non-physician health care professionals, and, then closely monitoring the referral specialist's treatment, recommendations and services. Consequently, the member's primary care physician determines whether a referral should be made and the services to be provided pursuant to the referral. Share will then pay 100% of the claims submitted for services that are within the scope of the referral.

Should you have further questions about Share, do not hesitate to call.

Sincerely,

Lynn R. Gruber
Director, Medical Delivery Services

LRG/tlh

FAMILY PHYSICIANS, P.A.

OUR PHYSICIANS

R.O. Quello, M.D. (Emeritus)
E. Duane Engstrom, M.D.
Freeman D. Kovack, M.D.
Bernard L. O'Neil, M.D.
Brian T. Ebeling, M.D.
Robert T. Falk, M.D.
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John S. Gay, M.D.
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Leonard J. Warren, M.D.
J. Richard Skeely, M.D.
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Patrick J. Taillefer

540 Southdale Medical Bldg.
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920-4676

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Burnsville, MN 55337
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16570 West 78th Street,
#2 Prairie Professional Building
Eden Prairie, MN 55344
937-1332

Crossroads Medical Clinic
County Rd. 42 & Highway 13
Prior Lake, MN 55372
447-1700

Braemar Sports Medicine Bldg.,
7201 Washington Avenue, South
Edina, MN 55435
944-7483

[illegible] Ensign Road
[illegible]den Ridge
Bloomington, MN 55438
941-4550

17599 Kenwood Trail,
Lakeville, MN 55044
435-3680

December 12, 1988

Minneapolis, MN 55410

Dear Mrs.

As you recall during your visit to my office on December 1, 1988, we discussed at some length, chiropractic referrals. As I pointed out at that time, the area of disease, as explained by doctors of chiropractic and doctors of medicine, has long been an issue. Therefore, I don't feel it is philosophically consistent for a doctor of medicine to refer patients to chiropractic practitioners if they don't share the same beliefs. Furthermore, since some of the treatment modalities of chiropractic are in fact used by physical therapists. Any need for such physiotherapy can be ordered by a physician, working with a physical therapist. As I stated to you, that avenue is available to you but you indicated that you preferred to continue to see a chiropractor. That certainly is your individual right but it is not within the scope of your health maintenance organization since the same service is available through physical therapy.

Sincerely,

Daniel C. Smith, M.D.
Family Physicians, P.A.

DCS:dkm

3801 WEST 50TH STREET
MINNEAPOLIS, MINNESOTA 55410
612-920-4528

January 30, 1989

Mr. Scott Mayer
Minnesota Chiropractic Association
2353 Rice St.
Saint Paul, MN 55113

RE: Mrs.

Dear Mr. Mayer:

Mrs. came into this office complaining of numbness in both arms and legs and stiffness in the neck. These symptoms were a result of a fall down on her sister's stairs.

She saw her doctor 3 to 4 times over 2 years for her complaints. They never told her the root of the problem and therefore she did not elect to try physical therapy.

When she came here she was examined and diagnosed as a Cervical Cord Compression resulting from her Cervical Subluxations. If she would have gone to physical therapist it would probably would have been a waste of time since the modalities at their disposal would not have been able to realign her spine. The main therapy used on her was Specific Spinal Manipulation, a service physical therapists are not trained in or are permitted to administer by law.

The lack of knowledge and the cost constraints of her Share doctor are the real problem restricting the patient from proper corrective care.

Sincerely,

Dr. Wayne H. Sullwold
WHS/ab

PRESENTATION BEFORE CONSUMER AFFAIRS COMMITTEE OF SHARE ON AUGUST 9, 1988

My presentation will consist of reading letters and reports exchanged between Share, FAmily Physicians and myself. If needed, an occasional comment

First of all, I have a copy for each of you of a letter questionaire sent on Dr. Chatterton's letterhead to chiropractors in Minneapolis. A return envelope was inclosed addressed to Dr. Chatterton. I want to emphasize, except for personalizing the letter and adding some of his personal comments, this is not a joint project. I paid for the printing of the questionaires, and for both kinds of envelopes used in the mailing.

The result of the mailing was exceptionally pleasing:

1. We sent 227 letters and received 175 replies. I consider a 75 percent return very good. Of the 175 returns 100 percent of the chiropractors had not had a referral from either Family Physicians or Share. We will talk about this in greater depth a little later.

2. I found friends I never knew existed.Offers of help from total strangers and organizations made me realize I was not alone in my cause. Several were from St. Paul even though we limited our mailings to Minneapolis.

3. I also have a copy for each of you of a letter I sent to Bill Pavik of Share. I will read it, and you will understand the purpose.

   Here again, we had an unexpected response. We now have access to the X-rays and X-ray evaluations we were previously denied.

   Later we will expand on the X-ray situation. We feel Dr. Decesare's report was more favorable to us than it was to Family Physicians. More on this later.

4. I also have a copy for each of you of the first correspondence I had with Share and Family Physicians. At this point, I wish to emphasize that all correspondence was sent, not only to Share and Family Physicians, but also to the Minnesota Department of Health who deals with HMO's rather than the State Insurance comission.

   As we proceed, additional materials will be handed to you. Most of what you will receive is already on file here at Share and at FAmily Physicians as well as the Minnesota Department of Health.

Charles Tharaldson

CHESTNUT & BROOKS
PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW

JACK L. CHESTNUT
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3700 PIPER JAFFRAY TOWER
222 SOUTH NINTH STREET
MINNEAPOLIS, MINNESOTA 55402
(612) 339-7300
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KELLY INN, SUITE 820
161 ST. ANTHONY AVENUE
ST. PAUL, MINNESOTA 55103
(612) 291-1900

August 19, 1992

Scott Mayer, Esquire
Minnesota Chiropractic Association
1700 West Highway 36
Suite 130
Roseville, Minnesota 55113

Re: Workers' Compensation Insurers as Managed Care Organizations

Dear Scott:

This is in response to your recent request to me regarding the new workers' compensation law (Laws Minn. 1992, chapter 510). You have stated to me that it is your understanding that workers' compensation insurers intend to make application for certification of a plan wherein the company would be, or would control, the managed care organization. You have directed my attention to Proposed Emergency Rule 5218.1000, which states that, "Any person or entity may make written application to the commissioner to provide managed care to injured employees for injuries and diseases compensable under Minnesota Statutes, chapter 176, under a plan certified by the commissioner." Your question is, can a workers' compensation insurer be the managed care organization?

The answer to your question is no. The reasons are as follows: While rulemaking by agencies has, in recent times, become as authoritative as legislation, there are limits on agencies with rulemaking authority. There are a number of valid purposes for rulemaking. In some instances, the agency has been given a policy or a plan by the legislature through enactment of legislation, and the agency, within the parameters of the adopted policy, is supposed to fill in the details of the plan.

Another common form of agency rulemaking authority is to provide definitive criteria when the agency has been given discretionary

authority. Likewise, agencies have the authority, through rulemaking, to provide clarity and to specify procedures. Agencies are generally reigned in when they attempt, through rulemaking authority, to embark into new areas or create new law. The law prohibits agencies from enacting rules that contradict the statute, as is the case herein.

The agency rule itself says "any person or entity." This language does not say that a workers' compensation insurer may make application. The statute itself limits the categories of persons or entities that can make application, and the statute absolutely controls. What you have explained to me is that the general statement set forth in the rule is, in fact, going to be utilized in a manner that will allow workers' compensation insurers to make application. If this indeed is the effect of the rule, then the rule is invalid. The statute clearly limits those persons or entities that may make application.

Specifically excluded from that category is workers' compensation insurers and employers relative to their own employees. These two categories are specifically excluded, and they may not make application. Also, since they are excluded by specific statutory language, they may not do indirectly what the statute prohibits them from doing directly. Therefore, if they were to form a separate entity, which they completely controlled, then this entity would likewise be excluded.

The legislative intent here is specific, and the language can be given its plain meaning. Furthermore, this concept is bolstered by the fact that the legislature has specifically included non-profit health service corporations under chapter 62C, HMOs under chapter 62D and Preferred Provider organizations subject to chapter 72A. The specific designation of certain entities, coupled with the categorical exclusion of others, leaves no room for interpretation or clarification. If the rule in question allows the excluded parties to make application, then the rule is invalid.

Sincerely,

CHESTNUT & BROOKS, P.A.

Cort C. Holten

/nls

MOTA

Minnesota Occupational Therapy Association

August 20, 1992

Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor & Industry
443 Lafayette Road North
St. Paul, Minnesota 55155-4316

RE: Proposed Emergency Rules of the State Department of Labor & Industry, Governing Worker's Compensation Managed Care Plans.

Dear Ms. Zembal:

The Worker's Compensation Special Issues committee of the Minnesota Occupational Therapy Association has reviewed the Worker's Compensation law and the proposed emergency rules to be enacted by the Department of Labor & Industry.

The proposed emergency rules, in our opinion, raise ethical and legal questions and conflict with a society which promotes free enterprise and professes access to and choice of health care as an individual right. Our concerns include the following:

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* Language in the proposed rules limiting employee choice and access to health care and service providers.

* The legal and ethical issues raised by allowing employers and insurers to own Managed Care Plans.

* The exclusion or elimination of service providers and the potential for a few providers to have a monopoly on the market.

* The potential for increasing costs by limiting employee access and choice to health care.

While we feel it is the intent of the law to establish a system which controls costs, insures quality, and decreases over-utilization, we have serious concerns about the impact of the proposed emergency rules if promulgated as written.

2810 Aquila Avenue So. · P.O. Box 26532 · Minneapolis, MN 55426 · (612) 938-3123

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We encourage you to consider the following:

* Use existing peer review systems to monitor the appropriateness of care. The Minnesota Occupational Therapy Association has an established peer review system.

* Provide an environment which treats providers equally, promotes healthy competition and allows access and choice to the employee.

We request a public hearing be scheduled in order to provide further input on these issues.

If you have any questions, please contact me at (612) 439-9509.

Sincerely,

Barbara A. Larson

Barbara A. Larson, OTR

BAL/cj

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apta
American Physical Therapy Association
Minnesota Chapter

August 19, 1992

Rec'd 8-21-92 10 AM

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Pam Zembal
Rehabilitation & Medical Affairs
Department of Labor & Industry
443 LaFayette Road North
St. Paul, MN 55155-4316

IN THE MATTER OF PROPOSED RULES OF THE STATE DEPARTMENT OF LABOR & INDUSTRY, GOVERNING WORKERS' COMPENSATION MANAGED CARE PLANS

Dear Ms. Zembal:

The Minnesota Chapter of the American Physical Therapy Association (MN APTA) in representing the interests and concerns of the profession, establishes, monitors, and guides practice standards including appropriateness and reasonableness of care; identifies and monitors legal and ethical issues; and serves as spokespersons for physical therapists in Minnesota.

The Workers' Compensation Subcommittee of the MN APTA Government Affairs Committee has thoroughly reviewed the statutory language in the new workers' compensation law and the emergency rules proposed to be enacted by the Department of Labor & Industry pursuant to the authority granted in that law. We believe that certain aspects of the proposed rules exceed statutory authority, conflict with the statutory purpose, are vague or ambiguous, conflict with other laws, and are unreasonable. The following are our concerns, objections, and recommendations to meet the purpose and intent of the legislation:

1. The language in the proposed rules significantly limits the employee choice of and access to health care providers. This is unreasonable and inconsistent with the statutory language. Because the rules do not specify the number of physical therapy providers within a managed care plan's geographic area, it may be very difficult for an injured worker to gain access to a physical therapy provider in a timely manner. This could delay the rehabilitation process and ultimately delay return to work. Theoretically, one physical therapy provider could contract with several managed care plans thus limiting the injured worker's choice of providers, as well as access. Under the proposed rules, a physician-owned physical therapy clinic could meet the certification requirements and refer all physical therapy patients to their own physical therapy practice. This may encourage referral for profit situations. Further more, what choice does the employee/patient have to change provider?

2. Under the category "application for certification", rules state that managed care plans do not discriminate against or exclude from participation

1711 West County Road B, Suite S-101, Roseville, MN 55113-4036 (612) 635-0902, Fax (612) 635-0903

in the plan any category of health care providers and must include an adequate number of each category of health care providers to give employees convenient geographical accessibility to all ..., however other than medical doctors, specific health care professionals/providers to be included are not listed. This may allow for inability for the injured worker to gain access to a specific category of health care provider.

3. Under the category "coverage responsibility of managed care plan", language states that the injured employee shall have an initial choice at time of injury to select the managed care plan. This could potentially restrict choice. The worker should be able to make this choice prior to an injury.

4. Antitrust laws prevent the abuse of power when types of monopolies or segregation of the market place takes place. Antitrust laws exist so that the consumer is allowed to have access to necessary provision of services. Antitrust suits have taken place in St. Cloud and are ongoing in Duluth. The language of the managed care plan provision would make it much easier for a large health care group to band together to exclude smaller groups or private clinics. Monopolistic activities may preclude an individual from having an opportunity to attain the services of other vendors. It is likely that the independent provider would be "locked out" of the system with only the "large players able to play". We would appreciate consideration of antitrust laws regarding this managed care rule proposal.

5. We believe the rules raise serious legal and ethical questions in allowing employers and insurers to own managed care plans. Although no employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer, it is likely that the employer would direct injured workers to that plan. This may lead to problems with respect to choice of provider or conflicts of interest.

6. One of the purposes of the statute was to utilize managed care for the purpose of health care cost containment. The language in the proposed rules which will restrict choice and limit access may lead to increased cost due to a delay in the initiation of appropriate treatment and slower return to work. Administrative costs may actually increase rather than lower health care costs. This is supported by the attached Wall Street Journal article.

7. We believe that some aspects of these rules may be in conflict with the federal Americans with Disabilities Act (ADA). For example, an employee with a work-related back injury may be considered as having a disability. The ADA allows for those people with disabilities to seek services of a provider of their choice. Under this managed care plan, however, the injured would not be given that choice. Conflict with the ADA may be even more involved and, therefore, these rules should be closely scrutinized relative to the ADA.

8. The MN APTA has an established, respected peer review system utilized by a number of insurance companies. We support the use of an established peer review system which reflects a full understanding of their appropriateness

and reasonableness of treatment for a specific diagnosis. The proposed rules are not specific enough with respect to the use of peer review standards or requirements.

9. The requirement that an employee drive up to 30 miles for treatment is not reasonable nor appropriate in certain situations, e.g.; in the case of a low back injury which limits ability to drive/sit. Driving a long distance, may in addition to being inconvenient, may also cause further aggravation to the injury.

Managed care may be implemented in many different ways. If cost saving, reduction of over utilization, and maintenance of quality care are the purposes of the statue, we make the following recommendations to the Department of Labor & Industry:

A. Establishment of treatment standards for diagnoses which are treated in the workers' compensation system.

B. Utilization of established peer review to monitor appropriateness and reasonableness of care.

C. Establish certification requirements for health care providers to participate in the workers' compensation system.

D. Maintain a fee schedule for all providers regardless of setting.

E. Promulgate rules that treat providers equally in a competitive environment and expand choice and accessibility rather than restricting it.

In summary, the MN APTA believes that the proposed emergency rules are seriously flawed with legal and ethical problems and will not accomplish the purpose of the legislation.

Sincerely,

Adele A. DiGiovanna PT
President
MN Chapter of Physical Therapy Associates

jp

cc: Skip Humphrey, Attorney General

VOL. LXXIII NO. 202

Second Opinion

Firms That Promise Lower Medical Bills May Increase Them

Cost Police Pile Paper Work On Physicians, Hospitals, Which Pass On Expense

Is Patient Care Suffering?

By THOMAS M. BURTON
Staff Reporter of THE WALL STREET JOURNAL

CHICAGO — The University of Chicago Medical Center has hired 15 employees to specialize in a new area of health care. They aren't treating patients or operating high-tech equipment. Rather, the sole task of the workers, who are costing the hospital $500,000 a year, is to answer questions from medical cost cutters known as utilization review companies.

In recent years, such firms have become immensely popular with employers seeking to control their health-care costs. According to a survey conducted by trade publisher Faulkner & Gray Inc., U.S. employers and insurance companies this year alone will pay an estimated $7 billion to have their medical expenses reviewed. Utilization review firms perform that service by questioning the necessity both of recommended treatment and treatment already administered.

But a backlash against these new companies is gathering momentum. Increasingly, doctors and other health-care officials complain that these firms are denying required care to people with serious problems.

Defeated Purpose

And now doubt is growing about the new industry's most basic promise—lower medical costs. While utilization review often does cut such costs for employers, the administrative burden it imposes on doctors and hospitals may actually be increasing rather than lowering the nation's total medical bill. For every form a utilization firm sends out and every phone call one of its employees makes, someone in the medical community must respond, usually with equal or greater effort.

"It's a cost that ends up getting passed on," says Sandra Harden Austin, executive vice president of the University of Chicago hospital. J. Ian Morrison, president of the Institute for the Future, a private research group in Menlo Park, Calif., that has researched medical economics, contends: "There's no evidence [utilization review] saves money."

embodies a Catch-22 of medical economics: Efforts to police costs add to the industry's administrative burden. In a New England Journal of Medicine article last year, Harvard University physicians Steffie Woolhandler and David Himmelstein wrote that utilization review and similar programs "have required an army of bureaucrats to eliminate modest amounts of unnecessary care." They calculated that at current growth rates, administrative spending, including such things as utilization review, would account for half of total health-care costs by the year 2020, up from one-fifth now.

Widespread Scrutiny

Today, there are more than 350 review firms nationwide, and many insurance companies have created departments with a similar function. About 80% of Americans have their medical treatment scrutinized by some type of utilization review, says the American Psychiatric Association.

Employers who hire utilization review firms don't always see past the initial savings. Their expenses appear to go down by more than the fee charged by the utilization review company as it cuts services. But the costs eventually come back in the form of higher fees charged by hospitals and doctors required to offset their own increased expenses in dealing with the increased paper work, health economists say.

Even some in the medical review industry worry about this. The increase in administrative costs "is a valid concern; we do add to the administrative cost burden," says Vicki Merrill, president of Pacific Review Services in Cypress, Calif. Even so, she contends, the best medical review companies can target real cases of unnecessary care and save money.

Losing Proposition

In 1990, the inspector general of the U.S. Health and Human Services Department looked at review companies' scrutiny of 500,000 cataract operations paid for by Medicare. The conclusion: The U.S. paid $13.3 million to utilization reviewers to save $1.4 million in possibly unnecessary surgery.

Utilization review companies remain unregulated in many states. In 20 states, anyone with a telephone can become a medical reviewer and interrogate doctors with years of medical training. Seven other states have passed laws, but their regulations aren't in effect yet. Because of complaints arising from the widespread annoying of doctors, other state legislatures are expected to pass laws concerning review companies in coming months.

Meanwhile, the complaints about the industry's impact on patient care are receiving more attention. "Utilization review can be an attempt to intimidate people out of using their benefits," charges Laura Wimbish, a Northwestern University psychologist. Jack Pickleman, chief of general surgery at Loyola University Medical Center in suburban Chicago, contends that utilization review "largely boils down

Please Turn to Page A6, Column 1

July 28, 1993 Wall Street J

Continued From First Page

to harassment of physicians that is an insidious incursion into medicine."

Defenders of the industry point out that doctors and mental-health professionals have an obvious ax to grind: They are the ones financially hurt by reviewers' cutbacks. Industry officials also claim that utilization review firms offer medical information and expertise that doctors often find of value.

Even so, critics' points are borne out by individual cases such as Iris Serrano's. The 38-year-old woman had a 101-degree fever and sharp chest pain when she arrived at the emergency room of Chicago's Northwestern Memorial Hospital on May 15, 1991. The internist who saw her suspected pulmonary blood clots or pneumonia and admitted her instantly.

After Mrs. Serrano was released from Northwestern three days later, recovering from pneumonia, Sunderbruch Corp., a review firm of West Des Moines, Iowa, concluded her insurer shouldn't pay for her hospitalization because she was on a normal diet while in the hospital, and thus couldn't have been as sick as the doctors had said she was. The hospital replied that a liquid diet isn't recommended for pneumonia, but Sunderbruch still refused to approve half of the $6,000 hospital bill.

Reversed Position

James Schroeder, a Northwestern doctor involved in the matter, says, "The analysis by which this utilization review firm issued a denial is discouragingly superficial and without substance." (Later, Northwestern doctors informed the company that had hired Sunderbruch that this newspaper was looking into Mrs. Serrano's case. Subsequently – about 10 months after she was treated – she says she received payment. Sunderbruch declines to comment on the case.)

To deal with criticism, the Utilization Review Accreditation Commission in Washington, a group composed of utilization review companies and hospitals, drew up standards last year so review companies would "cause minimal disruption to the health-care delivery system."

The new standards include a requirement that a licensed medical specialist make decisions in his or her speciality. That is designed to curb the problem of nurses second-guessing doctors and dermatologists second-guessing complex surgical decisions. Ms. Merrill, president of Pacific Review Services, says she knows of one review firm "where the nurse was just told to subtract one day" of recommended hospitalization in each case.

Another problem has been protracted delays in approving or disapproving recommended medical treatment. Under the new standards, review firms are expected to give a verdict in two days. Intracorp Inc., based in Berwin, Pa., perhaps the largest utilization review company with some $300 million in annual revenue, says it can dispatch a reviewer to any hospital within the U.S. in four hours to evaluate the most urgent cases. "Abuses do exist in our industry, but I think they're decreasing," says Doug Leland, a vice president of the Cigna Corp. subsidiary.

Payment Denied

To stop the indiscriminate harassing of doctors and hospitals, some review firms are using computers to analyze health-care data and focus on those doctors, hospitals and procedures most plagued by inefficiency.

Still, the industry's record is spotty. In Connecticut in 1990, a panel of psychiatrists selected by the state insurance department evaluated another Cigna Corp. unit, MCC Managed Behavioral Care Inc., and found "many cases" of "serious compromises of care." In one case, MCC wouldn't approve hospitalization of a 10-year-old boy who had pulled a knife on his teacher and, on a separate occasion, threatened to jump off the roof of his school. (The report didn't provide the outcome of the case.) The panel also concluded that in many cases MCC required patients in need of individual psychiatric treatment to engage in less costly group therapy.

Theodore Zanker, a Yale psychiatry professor who chaired the Connecticut panel, says its study of MCC proves that "some [review firms] just set lower medical standards."

MCC says problems highlighted in the report were fixed by "significant procedural changes" in late 1990.

In a 1991 survey of San Diego psychologists, 60% reported that medical reviewers had denied clearly necessary medical benefits; 39% reported that one or more patients had deteriorated because of improperly denied coverage. Also, clinics dealing with alcohol and drug dependency report medical reviewers often find ways of recommending denial of coverage when insurance policies appear to pay for such treatment.

Legal Danger

The legal implications of denied medical care are beginning to make some corporations skittish. Although experts don't know of any big judgments yet against employers, "utilization review is growing area of potential liability for t employer," says Nancy Severson, a De ver attorney who represents employers managed-care issues. Indeed, a Californi appellate court recently ruled that en ployers and insurers "can be held legall accountable when medically inappropriat decisions result from defects in the desig or implementation of cost containmen mechanisms."

Some courts already have allowed mas sive punitive damages against the reviev firms or insurers' review offices. Take th case of 21-year-old Patrick Hughes. De spite two suicide attempts – one in whic he stabbed himself repeatedly with a screwdriver – the utilization review sec tion of Blue Cross of Northern California deemed him, after 11 weeks of in-patient therapy, no longer in need of it.

After his parents sued, evidence emerged that the Blue Cross consultant who recommended denying coverage spent an average of 12 minutes reviewing such claims – and hadn't looked at the entire Patrick Hughes file. After a state court jury in San Francisco assessed $700,000 in punitive damages and $150,000 in compensatory damages against Blue Cross, an appellate court upheld the award, finding that Blue Cross used "a standard of medical necessity substantially at variance with community standards."

In court documents, Blue Cross defended its decision, saying 11 weeks in the hospital was sufficient for Mr. Hughes.

Diminishing Returns

The argument for utilization review might be compelling—even given the occasional mistreatment of patients – if the service truly saved America lots of money on health-care costs. At first, it did. A study in the journal Medical Care analyzed 223 insured groups from 1984 to 1986 and concluded utilization review reduced hospital admissions 13% and cut overall medical costs 6%. But the industry was relatively new then. As the percentage of health-insurance plans covered by utilization review rose from 3% in 1984 to 65% in 1988 to an estimated 80% now, the law of diminishing returns set in.

"Insurance companies, whose money is on the line, have calculated that utilization review is worth about 2% to 5% today," says Stephen C. MacGill, a principal at Godwins Inc., the international benefits consulting firm. Yet he notes that all or virtually all of that "saving" is just a shifted cost to another insurer or the patients themselves – a kind of health-insurance shell game.

At McDonnell Douglas Corp., Daniel C. Smith, until recently director of the company's employee assistance program, says utilization review "holds out great promise to reduce costs, but that doesn't appear to be sustained over time."

As a result, some see a major shakeout looming in the utilization-review industry. Peter Boland, a health-benefits consultant who has audited review firms, predicts, "Fewer than 10% of the utilization review companies will be in business in three years performing the same service."

MINNESOTA
HOSPITAL
ASSOCIATION

August 21, 1992

Pam Zembal
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St Paul MN 55155-4316

Dear Ms. Zembal:

On behalf of the Minnesota Hospital Association, we appreciate the opportunity to comment on the proposed emergency rules governing Workers' Compensation managed care plan. During the legislative session, MHA supported the use of case management as a way to control medical costs by ensuring appropriate utilization of health care services.

In general, the new rule does not appear to break with present practices. Providers will continue to be reimbursed for performing procedures as opposed to being rewarded for providing effective case management. A new system should address expenses associated with case management and reward providers for effective case management.

Without addressing these issues, it is possible that case management will just add another administrative layer that adds costs to the system and does not improve the quality of care.

More specifically, we would like to comment on certain sections of the rule.

5218.1000 Application for Certification D(2b) & D(3b)

This section requires that a managed care plan may not discriminate against or exclude from participation any category of health care providers and workers must be able to choose health care providers from the plan, provided the treatment is medically appropriate. The rules, however, do not address who decides what is medically appropriate.

This section also allows the initial evaluation by a participating chiropractor. How will the issue be dealt with if the injury to be evaluated is outside the scope of chiropractic practice?

5218.200 Coverage Responsibility of Managed Care Plan (Subp 4 - Restrictions)

2221 UNIVERSITY AVENUE SE, SUITE 425 • MINNEAPOLIS, MINNESOTA 55414-3085 • PHONE (612) 331-5571 • FAX (612) 331-1001

This section prohibits, in cases where there is a single managed care plan, the plan from being administered by the employer. While this restriction was part of the Workers' Compensation law, MHA believes that it should not apply to hospitals. Obviously, hospitals are in a unique position to provide services and many already coordinate services for their own employees. This section, however, does allow employers to administer plans when an insurer contracts with multiple managed-care plans. This is a step in the right direction.

5218.6000 Charges and Fees

This section requires that providers will be reimbursed according to the fee schedule. As the rule perpetuates the current system (i.e. no rewards for providers providing effective case management) MHA supports this section.

It is important that managed care organizations do not produce cost savings by simply "gauging" medical providers. The additional administrative costs added to the system because of managed care should not be borne by health care providers. The fee schedule already significantly discounts providers charges.

We appreciate the opportunity for responding to these proposed rules and look forward to working with the Department in assuring quality cost-effective health care services to injured workers.

Sincerely,

Linda Sandvig

Linda Sandvig
Legislative Consultant

LS:jf

MMA
MINNESOTA MEDICAL ASSOCIATION
612/378-1875
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800-999-1875

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VIA FACSIMILE

August 21, 1992

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Pam Zembal, MSN
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul, MN 55155-4316

Re: Proposed Emergency Rules Relating to Workers' Compensation; Managed Care

Dear Ms. Zembal:

Pursuant to the Notice of Intent to Adopt an Emergency Rule published in the State Register, Monday July 27, 1992, the Minnesota Medical Association (MMA) has the following comments:

1. Proposed Minnesota Rule 5218.0100, subpt. 3., [Emergency], (hereinafter "Proposed Minn. R.") defines emergency care as "professional health services necessary to preserve life or limb". This definition is somewhat restrictive. The MMA recommends adoption of the following definition of emergency care. This definition was adopted by the Health Care Financing Administration and has been endorsed by the American College of Emergency Physicians:

> [a] medical condition that is manifested by symptoms of sufficient severity (including severe pain) that, in the absence of immediate medical attention, could reasonably be expected to result in placing health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of a bodily organ or part.

2. Proposed Minn. R. 5218.1000, subpt. 1., states that "Any person or entity may make written application to the commissioner to provide managed care..." The MMA understands that this is interpreted to include independent groups of physicians who may wish to seek application.

3. Proposed Minn. R. 5218.1000, subpt. 1.C., establishes that each application for certification must be accompanied by a nonrefundable fee of $1500. A fee of $50 per physician with a **limit of $1500** would be less burdensome for small managed care groups.

4. Proposed Minn. R. 5218.1000, subpt. 2., sets forth that "If a certification is denied, the applicant will be provided with the reason for the denial. The commissioner must require an in-person meeting if necessary to determine compliance with parts 5218.0100 to 5218.9000 [Emergency]". This provision does not provide adequate due process review of denied certifications. Rather, the MMA recommends implementation of a contested case proceeding.

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Proposed Minn. R. 5218.2000, subpt. 4., states as follows:

> When an insurer contracts with a single managed care plan for coverage for an employer, the plan may not be formed, operated, or administered by the same employer or insurer. When an insurer contracts with multiple managed care plans, one or more of the plans, but not all, may be operated, formed, or administered by the employer or insurer. No employee shall be required to obtain services under a managed care plan that is operated, formed, or administered by the employer or insurer liable for the services under Minnesota Statutes, chapter 176 (emphasis added).

Minn. Stat. 176.1351, subd. 1 states:

> Any person or entity, **other than a workers' compensation insurer** or an employer for its own employees, may make written application to the commissioner to have a plan certified...(emphasis added).

A review of the above provisions indicates that Proposed Minn. R. 5218.2000, subpt. 4., is inconsistent with Minn. Stat. 176.1351. Proposed Minn. R. 5218.2000, subpt. 4., implies that workers' compensation insurers will be allowed to obtain certification. The plain meaning of the law prohibits workers' compensation insurers from forming managed care plans.

The MMA is concerned that this interpretation of the law will not serve the legislative intent of reducing health care costs. This interpretation presents the old paradigm of the insurance carrier holding information and establishing a barrier between employer and providers who together can determine what is the best care and how it can be provided in the most cost effective manner. The MMA believes that this interpretation presents an inappropriate profit motivation for carriers to keep all services in a closed system in which they determine: compensability of a claim; level of reserve of the claim; how and when medical care is provided; limits of rehabilitation and retraining and ultimately, determine employer insurance premiums based on all of these factors which they control.

6. Proposed Minn. R. 5218.6000, establishes that the payment by the insurer or the managed care plan to participating and nonparticipating health care provider for medical services shall be the maximum amount allowed under Minn. Stat. section 176.136. The MMA understands that this provision means that no discounting will be allowed. The MMA requests that language be added to this provision to clarify this intent of the Department.

7. General Comments

The MMA has received comments from physicians concerning clarification of various rules. There is concern that it will be difficult to comply with the rules if they are vague. The following examples illustrate this concern:

1. Proposed Minn. R. 5218.1000, subpt. 1.D.(2)(a).
The definition of "all medical and health care services that may be required by Minnesota statutes" is vague. Standards do not exist for all services.

2. Proposed Minn. R. 5218.1000, subpt. 1.D.(7).

Requirements for peer review, utilization review, and internal dispute resolution need to be clarified.

3. Proposed Minn. R. 5218.3000 subpt. 2. E.
Reporting requirements need to be clarified.

4. Proposed Minn. R. 5218.8000 subpt. 1.
Periodic audits and special examinations needs to be clarified. Specifically, what is included in the periodic audits and special examinations - is it the records review mentioned in the following subpt. 2.?

The MMA appreciates the opportunity to comment on the Proposed Emergency Rules Relating to Workers' Compensation; Managed Care. Please do not hesitate to contact the undersigned if you should have any questions regarding the above comments. In addition, if necessary, we could meet to further discuss MMA comments.

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W. C. ADMINISTRATIVE OPERATIONS

Very truly yours,

S M Veenhuis
Suzanne M. Veenhuis
Associate Legal Counsel

Molly Sigel
Molly Sigel
Lobbyist

STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

November 23, 1992

HUBERT H. HUMPHREY III
ATTORNEY GENERAL

GOVERNMENT SERVICES SECTION
525 PARK STREET
SUITE 500
ST. PAUL, MN 55103-2106
TELEPHONE: (612) 297-2040
FACSIMILE: (612) 297-2576

Ms. Mary L. Goddard
Senior Consultant
Coopers & Lybrand
1000 TCF Tower, Suite 700
Minneapolis, Minnesota 55402

Re: Workers Compensation Managed Care Rules

Dear Ms. Goddard:

In response to your request of November 19, 1992, I am enclosing a copy of the decision approving the above-captioned emergency rules.

Please call me at the number below if you have any questions.

Very truly yours,

MARY JO MURRAY
Special Assistant
Attorney General

(612) 296-3258

Enclosure
MJM:murr.bs3

STATE OF MINNESOTA

Office of the Attorney General

TO : PAM ZEMBAL
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul

DATE : October 12, 1992

FROM : MARY JO MURRAY
Special Assistant
Attorney General

PHONE : 296-3258

SUBJECT : In the Matter of the Adopted Rule Relating to Workers' Compensation; Managed Care

The above-referenced rule has been approved as to its legality by the Attorney General on October 12, 1992.

Enclosed is your copy of the approved rule. This office has already filed two copies with the Secretary of State, who will forward one copy to the Revisor of Statutes. The fourth is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submissions or comments along with any extra copies of documents which you submitted to the Attorney General.

Your next step is to arrange for publication of the Notice of Adoption in the State Register. In a day or two, you should receive from the Revisor's Office three copies of the notice of adoption of your rule. You should submit two copies of the Notice of Adoption to the State Register for publication. A permanent rule without a hearing does not become effective until five days after a notice of adoption is published in the State Register in accordance with Minn. Stat. § 14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. § 14.34.

If you have any questions in this regard, please contact me.

Enclosures
cc: Gilbert S. Buffington
William Brown, Chief Judge
MaryAnn Hruby

MJM:jj.rules.bb7

Coopers
&Lybrand

certified public accountants

human resource
advisory group

1000 TCF Tower
Minneapolis, Minnesota 55402

telephone (612) 370-9300

in principal areas of the world

November 19, 1992

Dear Sir/Madam:

This letter is a request for a copy of the attorney general's decision regarding the Rule of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans. We understand that approval or disapproval of the rule as modified in a notice dated September 28, 1992 was to have been made on the tenth working day following date of receipt of this rule.

Please send a copy of the decision to:

Mary Lee Goddard
Senior Consultant
Coopers & Lybrand
1000 TCF Tower Suite 700
Minneapolis MN 55402

If there are any questions or problems with this request, please call me at 370-9360.

Thank you for your consideration.

Sincerely,

Mary

Mary L. Goddard
Senior Consultant

MLG/st

cc: Kathryn Berger, Legal Services

STATE OF MINNESOTA

OFFICE OF THE ATTORNEY GENERAL

HUBERT H. HUMPHREY III
ATTORNEY GENERAL

October 15, 1992

GOVERNMENT SERVICES SECTION
525 PARK STREET
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ST. PAUL, MN 55103-2106
TELEPHONE: (612) 297-2040
FACSIMILE: (612) 297-2576

Ms. Joanne Wardell
Occupational Health Coordinator
HealthCare COMPARE Corporation
2485 Natomas Park Drive
Sacramento, CA 95833-2937

Re: Proposed Adoption of the Rule of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

Dear Ms. Wardell:

The above-captioned rule was approved on October 12, 1992. Copies of the rule as adopted may be obtained from the Department of Labor and Industry. A copy of the memo approving the rule is enclosed.

Very truly yours,

MARY JO MURRAY
Special Assistant
Attorney General

(612) 296-3258

Enclosure
MJM:jj.murr.b19

STATE OF MINNESOTA

Office of the Attorney General

TO : PAM ZEMBAL
Rehabilitation and Medical Affairs
Department of Labor and Industry
443 Lafayette Road North
St. Paul

DATE : October 12, 1992

FROM : MARY JO MURRAY
Special Assistant
Attorney General

PHONE : 296-3258

SUBJECT : In the Matter of the Adopted Rule Relating to Workers' Compensation; Managed Care

The above-referenced rule has been approved as to its legality by the Attorney General on October 12, 1992.

Enclosed is your copy of the approved rule. This office has already filed two copies with the Secretary of State, who will forward one copy to the Revisor of Statutes. The fourth is being retained by this division of the Attorney General's Office for its records.

Also enclosed are any petitions, requests, submissions or comments along with any extra copies of documents which you submitted to the Attorney General.

Your next step is to arrange for publication of the Notice of Adoption in the State Register. In a day or two, you should receive from the Revisor's Office three copies of the notice of adoption of your rule. You should submit two copies of the Notice of Adoption to the State Register for publication. A permanent rule without a hearing does not become effective until five days after a notice of adoption is published in the State Register in accordance with Minn. Stat. § 14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. § 14.34.

If you have any questions in this regard, please contact me.

Enclosures
cc: Gilbert S. Buffington
William Brown, Chief Judge
MaryAnn Hruby

MJM:jj.rules.bb7

HealthCare COMPARE® AFFORDABLE℠ OUCH®
2485 Natomas Park Drive Sacramento, CA 95833-2937 (916) 925-7800

October 6, 1992

The Office of the Attorney General
Public Finance Division
525 Park Street - Suite 400
Saint paul, Minnesota 55103

Re: Proposed Adoption of the Rule of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

We have received notice of submission of emergency rule to the Attorney General, dated September 28, 1992. As advised in that document, we are submitting this written request for a copy of the Attorney General's decision on the legality issue and any further modifications to the rule.

Thank you.

Sincerely,

Joanne Wardell

Joanne Wardell
Occupational Health Coordinator

(916) 925-7900, Ext. 2659

STATE OF MINNESOTA
DEPARTMENT OF LABOR AND INDUSTRY

In the Matter of the Proposed Adoption of the Rule of the State Department of Labor and Industry, Governing Workers' Compensation Managed Care Plans

NOTICE OF SUBMISSION OF EMERGENCY RULE TO THE ATTORNEY GENERAL

Pursuant to your request and in accordance with Minnesota Statutes, section 14.32:

PLEASE TAKE NOTICE that the above-captioned emergency rule as adopted has been submitted to the Office of the Attorney General on the date of this notice, September 28, 1992, for review as to legality and form to the extent form relates to legality. The proposed emergency rule. the rule as adopted, all the notices, all written comments received and other required documents also have been submitted to the attorney general.

The proposed emergency rule which was published in the State Register and made available to the public on July 27, 1992, has been modified. A copy of the rule as modified is enclosed with this notice.

The rule must be approved or disapproved by the Attorney General on the tenth working day following date of receipt of the rule. You may submit written comments to the Attorney General. Any written comments must be submitted within seven working days of the date of this notice. Your comments must address only the issue of legality of the rule or the legality of the specific parts or subparts of the rule. The attorney general standards for review are set forth in Minnesota Rules, part 2010.1000. You may receive a copy of the attorney general decision upon written request to the attorney general. Your comments or requests for the decision must be directed to:

The Office of the Attorney General
Public Finance Division
525 Park Street - Suite 400
Saint Paul, Minnesota 55103
Telephone: (612) 297-2040

Any written comments submitted to the attorney general must be submitted simultaneously to:

Kathryn Berger
Legal Services
Department of Labor and Industry
443 Lafayette Road North
Saint Paul, Minnesota 55155-4301

September 28, 1992

John B. Lennes, Jr., Commissioner