

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File No. 724

8/31 Kohnstamm requested send readable copy of Notice of Hrg.

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 8/28
DATE FOR REVIEW 9/8
DATE DUE 9/17

Adopted w/a hearing _____
Adopted w/o a hearing _____
Temporary rule _____

Approved _____ Disapproved _____ Returned to Agency _____

Resubmitted _____ Due _____
Approved _____ Disapproved _____ Returned to Agency _____

Date filed w/Secretary of State _____ REVISOR approved _____ disapproved _____

✓ Rule as Adopted

✓ Rule as Proposed See SR.

✓ Order Adopting need copy

✓ Notice of Intent to Solicit Outside Opinion 10.27.80

✓ Order for rulemaking
1.14.81 Date of Hearing

N/A Certificate of Board's Authorizing Resolution

___ Notice of rulemaking
_____ Sufficiency See my note above - will check out when recd.

✓ Affidavit of Mailing Notice or rulemaking
12.9.81 At least 30 days prior to hearing/~~adoption~~

✓ Affidavit of additional mailing

✓ Mailing list Certificate

✓ Publication in State Register
12.15.80 At least 30/~~20~~ days prior to hearing/~~adoption~~

✓ Hearing Examiner's Report 3.19.81

✓ Chief Hearing Examiner's Report(s)
3.27.81 Approving H.E.'s Report
8.28.81 Approving agency action

✓ Agency's Findings of Fact included in Order Adopting

N/A LCRAR Report or agency Affidavit

N/A Certificate of Board's Resolution Adopting Rules

___ Order Approving Incorporation by Reference Revisor must approve.

✓ Statement of Need and Reasonableness

N/A Petition for Adoption of a Rule

✓ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

✓ Certificate of Compliance w/Rulemaking Procedures

✓ Affidavit of Mailing Notice of Submission to Attorney General

✓ Notice of Submission to the Attorney General

✓ Agency-prepared Review of HE report indicating changes made pursuant to the report.

SF-00006-02

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

TO : ARTHUR E. NOOT
Commissioner of Public Welfare

DATE: September 9, 1981

ATTN : Larry Woods

FROM : H. Theodore Grindal by HTG
Special Assistant
Attorney General

PHONE: 6-1288

SUBJECT: In the Matter of the Proposed Adoption of a Rule of the Department of Public Welfare Governing the Surveillance and Utilization Review Program, 12 MCAR 2.064 (Rule 64).

Enclosed herewith are the rules you submitted for approval. These rules have been approved by this office and filed with the Secretary of State.

Upon receipt, however, it is important that you recheck these rules as to:

1. Affixation of stamps of the Attorney General and Secretary of State to the last page of the rules;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages to the rules in the approved set.

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

Supplementary attachment of suggested amendments (drafted to agency's copy unless otherwise indicated)

Page 2, line 11 (of the initial attachment of suggested amendments accompanying Revisor's certificate of disapproval should read in part). "after 'recipient' insert a stricken comma, after"

Page 4, line 5, reinstate the stricken period and insert the underscored language in lines 5 to 7, except the period

Page 8, line 15, delete "entrees" and insert "entries"

Page 12, line 19, underscore the period

Page 13, line 9, underscore the period

Page 13, line 11, underscore the period

Page 15, line 15, before "medical" delete "of"

Page 21, line 19, after "F" insert a period

Page 24, line 21, remove the underscoring from the comma

Page 25, line 7, delete "~~random~~," and insert "~~random~~,"

✓ The changes requested by the revisor are approved by the agency

_____ The changes requested by the revisor are not approved by the agency

Phennett Hohnstenn

Agency Representative

Special Assistant Attorney General

(Please return to revisor after completion)

BARTSH, McINTOSH, TRIPP & WILDFANG
PROFESSIONAL ASSOCIATION
ATTORNEYS AT LAW
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AREA CODE 612
338-5636

OF COUNSEL
PAUL SIMONSON
DAVID GRONBECK

September 21, 1981

RECEIVED
SEP 29 198
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

Mr. Ted Grindal
Special Ass't Attorney General
50 Sherburne Avenue
St. Paul, Minnesota 55155

Re: In the matter of the proposed adoption of a rule of the Department of Public Welfare governing the Surveillance and Utilization Review Program, 12 MCAR §2.064 (Rule 64).

Dear Ted:

Enclosed herewith please find my letter to Duane Harves, Chief Hearing Examiner, in regard to the above-captioned matter, which I discussed with you last week. I think the letter sets forth adequately the reasons why the Rule should not have been approved by the Chief Hearing Examiner nor by the office of the Attorney General. I am providing this copy of the letter to you for your files. If you have any questions in regard to this matter, please give me a call.

Very truly yours,

BARTSH, MC INTOSH, TRIPP & WILDFANG
Professional Association

K. Craig Wildfang

KCW:pc

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OF COUNSEL
PAUL SIMONSON
DAVID GRONBECK

September 21, 1981

Mr. Duane Harves
Chief Hearing Examiner
Office of Administrative Hearings
1745 University Avenue
St. Paul, Minnesota 55104

Re: In the Matter of the Proposed Adoption of a Rule of the Department of Public Welfare Governing the Surveillance and Utilization Review Program, 12 MCAR §2.064 (Rule 64).
OAH Docket No. DPW-81-010-JL

Dear Mr. Harves:

The purpose of this letter is to call to your attention a couple serious errors which I believe were made in the adoption of the above-captioned rules, in which matter I represented the Minnesota Association of Health Care Facilities. The rules have been filed with the Secretary of State and will be published shortly, so any further challenge to them will lie only in the courts, however, I know that you have always been a strong advocate for an open and fair administrative process and, in addition, you have always been persistent in requiring state agencies to adhere to the requirements of Chapter 15. In the case of these rules, however, I believe you and/or your office made at least two serious errors in your review of the Department's proposed Order for the adoption of these rules pursuant to §15.0412, Subd. 4e. You determined that the rules, with changes proposed by DPW, resulted in a rule which was not "substantially different" from that originally proposed at the public hearing, and that DPW could submit the rule to the Attorney General for his review.

This determination should not have been made for two reasons. First, the rule was modified by DPW in a manner which was not consistent with the suggested actions of the hearing examiner. The Department's proposed changes in the "sampling procedure," contained in 12 MCAR §2.064.D.3.c. of the modified rule, were not the actions suggested by the hearing examiner. In the Report of the Hearing Examiner, dated March 19, 1981, in Finding No. 80, at page 37, the Hearing Examiner, after a long discussion of the many deficiencies of the Department's proposal for recovery by sampling, makes the following unambiguous finding

> "Consequently it is concluded that the reasonableness of this Part has not been established by an affirmative presentation of facts as required by Minn. Stat. §15.0412, Subd. 4c (1980). To correct this defect this Part must be deleted." (Emphasis supplied.)

The Part was, in fact, not deleted, but rather it was amplified, expanded, and defined by DPW. The action suggested by the Hearing Examiner was specifically not followed. The result of this is that DPW should have been required to submit the proposed rule to the Legislative Commission to Review Administrative Rules pursuant to §15.0412, Subd. 4d. That section provides, inter alia,

> "If the chief hearing examiner determines that the need for and reasonableness of the rule has not been established pursuant to subdivision 4, clause (c), and if the agency does not elect to follow the suggested actions of the hearing examiner to correct that defect, then the agency shall submit the proposed rule to the legislative commission to review administrative rules for the commission's advice and comment. The agency shall not proceed to adopt the rule until it has received and considered the advice of the commission; provided, that the agency is not required to delay adoption longer than 30 days after the commission's receipt of the agency's submission."

To proceed with the adoption of this rule without the review by the LCRAR is in blatant disregard of the statutory requirement.

Even if we ignore this disregard of the mandated LCRAR review, the rule as modified by DPW still should not have been approved by the Chief Hearing Examiner because the rule is substantially different from that originally proposed. It is obvious that the purpose of the review of a rule for substantial difference is to further the overriding goal of the A.P.A. of providing reasonable notice to affected persons and a meaningful opportunity to comment on a proposed rule. To the extent that a rule has been modified so as to make it different from that originally proposed, that rule has not been "tested" by the kind of public scrutiny envisioned by the A.P.A. because affected persons have not been given reasonable notice and a meaningful opportunity to comment. In the case of DPW Rule 64, the sampling procedure to be utilized was very broad and vague. The provision, as originally proposed, stated

> "For the purpose of D.3.b. of this rule, the commissioner shall be authorized to make monetary recovery from providers of monies erroneously paid, based upon extrapolation from a random, unbiased sample of claims billed to the programs by a provider, for a specific procedure code. The sampling method shall adhere to generally accepted statistical procedures regarding sample size, sample selection, and extrapolation from the results of the sample."

This provision, as modified, takes up almost three full pages (see attached) and adopts many important "triggering" devices, statistical standards, procedural remedies, etc. None of these important provisions were subject to public comment, none of these provisions were supported by even a single item of evidence or argument in the record, and none of these provisions were shown, or found, to be necessary or reasonable. None of this happened because these provisions were only added to the rule after the Report of the Hearing Examiner was issued. Under these circumstances I am really very perplexed as to how you could determine that the rule as modified was not substantially different from the rule as proposed.

Although I recognize that the rule is no longer within the jurisdiction of the Office of Administrative Hearings, I would be interested in hearing your thoughts on the issues I have raised in this letter. Hopefully, by an airing of issues like this, we can all contribute to a more open, fair and efficient administrative procedure in Minnesota.

Very truly yours,

BARTSH, McINTOSH, TRIPP & WILDFANG
Professional Association

K. Craig Wildfang

KCW/mm

Attachment

cc: Jon Lunde (w/ attachment)
Ted Grindal (w/ attachment)

RECEIVED
AUG 27 1981
ADMINISTRATIVE
HEARINGS

RULES AS PROPOSED (All New Material)

12 MCAR § 2.064 Surveillance and Utilization Review Program.

A. Introduction.

1. This rule governs procedures to be used by the Surveillance and Utilization Review (SUR) Section, Minnesota Department of Public Welfare in the identification and investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by a provider or recipient of health care in the Minnesota Medical Assistance. General Assistance Medical Care and/or Catastrophic Health Expense Protection Programs.

2. The provisions of this rule are to be read in conjunction with Titles XVIII and XIX of the Federal Social Security Act: Title 42 of the Code of Federal Regulations; Minn. Stat., ch. 62E, 256, 256B, 256D and 609; Minnesota Laws of 1980, ch. 349; and other rules of the Minnesota Department of Public Welfare.

3. The Minnesota Department of Public Welfare, as the state agency responsible for the administration of the Minnesota Medical Assistance, General Assistance Medical Care and Catastrophic Health Expense Protection programs, will issue instructional bulletins, manual materials and forms, to assist others in complying with this rule.

4. The provisions of this rule are binding on all county welfare boards (hereinafter referred to as local welfare agencies) in the State of Minnesota administering the programs, on all

providers of health care participating in the programs, on all recipients under the programs, and on the state agency.

B. Definitions. For the purposes of this rule, the following terms shall be defined as indicated.

1. "Abuse." A pattern of practice by a provider, or a pattern of health care utilization by a recipient which is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to the programs, or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse is characterized by, but not limited to, the presence of one of the following:

a. The repeated submission of claims by a provider from which required material data is missing or incorrect. Examples include but are not limited to: incorrect or missing procedure or diagnosis codes, incorrect mathematical entries, incorrect third party liability information, incorrect use of procedure code modifiers.

b. The repeated submission of claims by a provider presenting procedure codes which overstate the level or amount of health care provided.

c. The repeated submission of claims by a provider for health care which is not reimbursable under the programs, or the repeated submission of duplicate claims.

d. Failure of a provider to develop and maintain patient care records which document the nature, extent and evidence of the medical necessity of health care provided.

e. Failure of a provider to use generally accepted accounting principles,or other accounting methods which relate entries on the medical or health care record to corresponding entries on the billing invoice, unless otherwise indicated by federal or state law or rule.

f. The repeated submission of claims by a provider for health care which is not medically necessary, or which is of an unacceptable quality.

g. The repeated submission of claims by a provider for health care which exceeds that requested or agreed to by the recipient or his responsible relative or guardian or that otherwise required by federal or state law or rule; services, prescriptions or devices deemed unnecessary or excessive under the generally accepted practice of providers of such services, prescriptions or devices is abusive.

h. The recipient permitting the use of his/her medical identification card by any unauthorized individual for the purpose of obtaining health care through any of the programs.

i. Obtaining unneeded equipment, supplies, or pharmaceuticals by a recipient for the purpose of resale or the disposal of equipment, supplies or pharmaceuticals obtained with program monies without authorization of the local welfare agency.

j. Obtaining duplicate services by a recipient from a multiple number of providers, for the same health care condition excluding confirmation for diagnosis, evaluation or assessment.

2. "Commissioner." The Commissioner of Public Welfare or his designee.

3. "Health care." Services, equipment, or supplies provided by any individual, organization or entity that participates in the Medical Assistance, General Assistance Medical Care and/or Catastrophic Health Protection programs.

4. "Health care record." Written or diagrammed documentation of the nature, extent and evidence of the medical necessity of health care provided to the program recipients by a provider other than a medical doctor and billed to the programs.

5. "Medicaid Management Information System." (MMIS) A centralized automated processing and payment system certified by the United States Department of Health and Human Services and implemented in Minnesota to administer the Title XIX program.

6. Medical record." Written documentation of the nature, extent and evidence of the medical necessity of health care provided to program recipients by or under the authority of a medical doctor and billed to the programs.

7. "Medically necessary." Health care which is rendered pursuant to the provider's authority under state law and within the scope of his/her license, if any, and is:

a. Provided in response to life threatening conditions, or

b. Provided in response to pain, or

c. Provided to treat injuries, illness, or infections, or

d. Provided in compliance with the provisions of 12 MCAR §§ 2.047, 2.058 or 2.060 regarding services reimbursable under the programs.

8. "Pattern." An identifiable series of events, or activities.

9. "Programs." The Minnesota Medical Assistance program, the General Assistance Medical Care program and/or Catastrophic Health Expense Protection program.

10. "Provider." An individual, organization, or entity that has entered into an agreement with the state agency to be reimbursed by Minnesota Medical Assistance, General Assistance Medical Care and/or Catastrophic Health Expense Protection programs for health care provided to a recipient(s).

11. "Recipient." An individual who has established eligibility to receive health care paid by Minnesota Medical Assistance, General Assistance Medical Care and/or Catastrophic Health Expense Protection programs.

12. "Records." Medical, health care and financial records pertaining to health care provided program recipients and billed to the programs.

13. "State agency." The Minnesota Department of Public Welfare.

14. "Surveillance and Utilization Review." (SUR) The section of the Department of Public Welfare responsible for the identification and investigation of suspected fraud and abuse by providers and recipients participating in the programs. For the purpose of this rule, this definition specifically excludes the utilization control activity of the SUR section.

15. "Suspending participation." Making a provider ineligible for reimbursement by the programs for a stated period of time.

16. "Suspension of payments." Stoppage of any or all program payments for services billed by a provider pending resolution of the matter(s) in dispute between the provider and the stage agency.

17. "Terminating participation." Making a provider ineligible for reimbursement by the programs.

18. "Utilization control." The activity within the state agency responsible for the ongoing evaluation of the necessity for and the quality and timeliness of services provided in long term care facilities not under the responsibility of a Professional Standards Review Organization.

19. "Withholding of payments." A reduction or adjustment of the amounts paid to a provider for purposes of offsetting overpayments previously made to the provider, or of recovering payments made to a provider for services not documented in the recipient's medical or health care record.

C. Records.

1. Medical and health care records.

a. Medical and health care records must be developed and maintained as a condition for reimbursement by the programs. Program funds paid for health care not documented in the medical and health care record shall be subject to monetary recovery.

b. Medical and health care records shall be legible throughout to at least the individuals providing care.

c. Medical and health care records shall contain the following information:

(1) Each page of the record shall name or otherwise identify the patient.

(2) Each entry in the record shall be signed and dated by the individual providing health care. Record entries for health care provided by an individual under the supervision of an individual licensed provider, and which is billed directly to the programs by the provider, shall be countersigned by the provider. Institutional providers shall not be required to countersign record

entrees for health care provided in the facility by an individual provider; however, the institutional providers shall be responsible for monitoring the provision of such health care.

(3) Diagnoses, assessments or evaluations.

(4) The patient case history and results of oral or physical examination.

(5) The plan of treatment or patient care plan shall be entered in the physical record or shall be otherwise available on-site.

(6) Quantities and dosages of any prescribed drugs ordered and/or administered shall be entered in the record.

(7) The results of all diagnostic tests and examinations.

(8) The record shall indicate the patient's progress, response to treatment, any change in treatment, and any change in diagnosis.

(9) Copies of consultation reports relating to a particular recipient.

(10) Dates of hospitalization relating to service provided by a particular provider.

(11) A copy of the summary of surgical procedures billed to the programs by the provider.

d. The requirements of C.1.c. of this rule shall not apply to pharmacies, laboratories, ambulance services and medical transportation providers, or suppliers of medical equipment and nondurable supplies. For the purpose of this rule provider groups mentioned in this section shall develop and maintain the following records:

(1) Pharmacies.

(a) Prescriptions or equivalent computer record.

(b) This rule shall not require the development and maintenance of a recipient drug profile; however, if available, the state agency shall be authorized to review such a record.

(2) Laboratories.

(a) Documentation of provider orders for laboratory tests or procedures.

(b) Documentation of test results.

(3) Ambulance service and medical transportation providers.

(a) Documentation of physician authorization for non-emergency medical transportation.

(b) Trip tickets.

(c) Documentation of durable and nondurable supplies expended on a recipient.

(4) Suppliers of medical equipment and nondurable supplies.

(a) Prescriptions.

(b) Documentation of physician orders related to the provision of equipment and supplies.

2. Financial records.

a. Financial records, pertaining to the provider's costs (if the provider is reimbursed on a cost basis) and charges for health care provided to program recipients shall be developed and maintained.

b. Financial records for all providers, other than nursing homes and board and care homes certified by the Minnesota Department of Health shall include:

(1) Purchase invoices.

(2) All accounting records including, but not limited to, payroll ledgers, cancelled checks, and bank deposit slips.

(3) All contracts for supplies and services which relate to the providers cost and charges for health care billed to the program.

(4) Evidence of the providers usual and customary charges and written evidence of charges to non-recipient patients without violating non-recipient patient rights to confidentiality.

(5) Evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to other third party payers of health care. For the purposes of this rule, third parties shall include other governmental programs, insurance companies, no-fault auto insurers and other payers of health care who may be financially responsible for services rendered a recipient.

c. Financial records for nursing homes and board and care homes certified by the Minnesota Department of Health, shall include:

(1) All records identified in C.2.b. of this rule.

(2) Records of deposits and expenditures for patient personal needs allowance accounts.

3. For the purposes of this rule, as set forth in A.1., providers shall grant the state agency access during regular business hours to examine medical, health care and financial records related to health care billed to the programs. Access to a recipient's personal medical and health care record shall be for the purpose of investigating whether or not a provider has submitted a

claim for reimbursement, a cost report or a rate application which may be false in whole or in part or whether or not the health care was medically necessary. The SUR section shall notify the provider at least 24 hours before gaining access to such records. Upon the request of the provider, the SUR section shall present a copy of the recipient's written authorization to examine personal medical records unless the provider already has received written authorization from the recipient. A provider's refusal to grant the state agency access to examine records when authorized shall be grounds for sanction.

4. The state agency, at its own expense, is authorized to photocopy or otherwise duplicate any medical or financial record which it is authorized to examine. Photocopying shall be limited to the provider's premises unless removal is specifically permitted by the provider.

5. Providers shall retain all records for at least five (5) years. Records may be microfilmed after the third year.

6. In the event of a change of ownership of a facility or practice the seller, unless otherwise provided by law or by written agreement, shall be responsible for maintaining and preserving all records generated prior to the date of sale. Responsibility for making records available for inspection after the date of sale is on the seller and the seller must take reasonable steps by contract or otherwise to maintain a right of access to

those records which is necessary to substantiate his billings, cost reports, or rate applications.

7. In the event a provider withdraws or is terminated from the programs, all records developed during participation in the programs, and not subject to the provisions of item 6 of this section, shall be retained by the provider for a period of five (5) years and shall be available for review by the state agency. Providers must retain records for at least 5 years after the date of billing.

8. A recipient's consent to the state agency's review of his or her medical or health care records shall be presumed competent if given in conjunction with an application for coverage under the programs. This presumption shall be rebuttable, and and shall exist regardless of whether the application was signed by a recipient or a guardian.

D. Provider Surveillance and Utilization Review.

1. Identification of suspected fraud and abuse.

a. SUR shall be responsible for the detection and identification of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by providers who have billed the programs for health care rendered to a recipient.

b. For the purposes of this rule, SUR shall be authorized to utilize information from sources which shall include, but not be limited to:

(1) Computer reports generated by MMIS, using claim data to develop profiles on the provision and utilization of health care reimbursed by the programs. The profiles compare data on a peer group basis, and identify providers and recipients who appear exceptional when compared to group norms.

(2) Units of local, state and federal government.

(3) Other third-party payers including health insurance carriers.

(4) Professional Standards Review Organizations.

(5) Citizens, including recipients.

(6) Providers, professional associations, and health care professionals.

c. In assessing questions of abuse or of medical necessity, SUR shall consult with a review organization as defined in Minn. Stat. § 145.61 or other provider advisory committees as appointed by the Commissioner.

2. Investigation of suspected fraud or abuse.

a. SUR shall be responsible for the investigation of suspected fraud and abuse identified pursuant to D.1. of this rule. An investigation shall be conducted for the purposes of determining one or more of the following:

(1) Whether the suspected aberrant activity of a provider is the result of a legitimate condition of practice.

(2) Whether suspected fraud and abuse exists and can be documented.

(3) Whether sufficient evidence can be developed to support administrative, civil or criminal action as to such fraud and abuse.

b. A SUR investigation may include, but is not limited to:

(1) Examination of records pursuant to C. of this rule.

(2) Interviews of providers, their associates and employees.

(3) Interviews of program recipients.

(4) Verification of the professional credentials of providers, their associates and employees.

(5) Examination of any equipment, stock, materials or other items used in or for the treatment of program recipients.

(6) Examination of prescriptions written for program recipients.

(7) Determination of whether the health care provided was medically necessary.

c. Following the completion of an investigation SUR shall take one or more of the following actions:

(1) Determine that no further action is warranted and so notify the provider.

(2) Impose administrative sanctions against a provider in accordance with D.3. of this rule.

(3) Seek monetary recovery from a provider as set forth in D.3. of this rule.

(4) Refer the case in writing to the Attorney General for possible civil or criminal legal action.

3. Monetary recovery and sanctions. The commissioner shall be authorized to seek monetary recovery or impose administrative sanctions to protect the public welfare and the interests of the program. Monetary recovery and sanctions implemented by the commissioner shall be based upon documentation of fraud and abuse as set forth in D.1. and D.2 of this rule.

a. Grounds for monetary recovery and sanctions.

(1) The commissioner may seek monetary recovery against providers for any of the following:

(a) Fraud, theft, or abuse in connection with health care services billed to the programs.

(b) Presentment of false or duplicate claims for services not medically necessary.

(c) False statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

(2) The commissioner may impose administrative sanctions against providers for any of the following:

(a) Fraud, theft, or abuse in connection with health care services billed to the program.

(b) A pattern of presentment of false or duplicate claims or claims for services not medically necessary.

(c) A pattern of making false statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

(d) Refusal to grant the state agency access to records pursuant to C.3. of this rule.

(3) The commissioner shall suspend or terminate any provider who has been suspended or terminated from participation in the Medicare program because of fraud or abuse in connection with the Title XVIII of the Social Security Act.

b. The commissioner shall make monetary recovery from providers of monies erroneously paid due to violations described in D.3.a.(1) of this rule by the following means:

(1) Permitting voluntary repayment by the provider of monies erroneously paid, either in lump sum payments or installment payments.

(2) Withholding of payments.

(3) Debiting from program payments, monies determined to have been erroneously paid.

(4) Using any legal process to collect such monies.

c. For the purpose of D.3.b. of this rule, the Commissioner shall be authorized to make monetary recovery from providers of monies erroneously paid, based upon extrapolation from systematic random samples of claims submitted by a provider and paid by the programs.

(1) The decision to use sampling and extrapolation in calculating a monetary recovery shall be at the discretion of the Director of the SUR Section. The following criteria shall apply in determining whether the sampling technique will be used:

(a) The claims to be sampled represent services to 50 or more recipients; or

(b) There are more than 1,000 claims to be sampled; or

(c) The claims to be sampled constitute charges to the Department of more than $2,000.

(2) The following factors shall apply in determining recovery by sampling and extrapolation:

(a) Samples shall be selected such that every claim to be sampled has an equal and independent chance of being chosen for the sample;

(b) Samples shall only be selected from claims within a time period which coincides with the duration of the violations for which recovery will be made;

(c) The sampling method, to include sample size, sample selection and extrapolation from the results of the sample, shall be in accordance with statistical procedures published in the following texts: L. Kish, Survey Sampling, John Wiley and Sons, New York (1965), or W. Cochran, Sampling Techniques, John Wiley and Sons, New York 3rd Ed. (1977).

(d) Samples shall be selected at the 95% confidence level, such that, the overall monetary recovery amount determined by extrapolation from the sample recovery amount will be within 5% of the amount which would be recovered by a complete audit, 95% of the time. The department will recover the extrapolated amount less the 5% factor.

(3) The department shall notify the provider of its intent to use sampling and extrapolation. The notice shall state:

(a) the nature of claims to be sampled;

(b) the sample size;

(c) the sample selection method; and

(d) the formulas and calculators to be used in extrapolation.

(4) The monetary recovery proposed by the department, based upon the use of sampling and extrapolation is rebuttable. The provider may present, at a conference with the SUR director, material to rebut the sample size and design, the facts and conclusions drawn from each sample used, and the calculations used to extrapolate the sample findings to all services furnished for the period of time reviewed. The costs of gathering and presenting the information will be met by the provider. Alternatively, the provider, at his expense, may conduct a complete audit and use the results to rebut the Department's findings.

(5) If the department does not accept the provider's rebuttal, the provider may appeal under procedures cited at F of this rule.

d. The commissioner may impose any of the following sanctions for the conduct described in D.3.a.(2) of this rule:

(1) Referral to the appropriate state regulatory agency.

(2) Referral to the appropriate peer review mechanism.

(3) Transrer to a provider agreement of limited duration not to exceed 12 months.

(4) Transfer to a provider agreement which stipulates specific conditions of participation.

(5) Suspending or termianting participation.

e. Notice to providers.

(1) The state agency shall notify providers in writing of any recovery of money or sanction it intends to impose.

(2) The notice shall state:

(a) The factual basis for alleging discrepancies or violations;

(b) The dollar value to such discrepancies or violations;

(c) How such dollar value was computed;

(d) What actions the state agency intends to take;

(e) The provider's right to dispute the state agency's factual allegations and to provide evidence to support the provider's position; and

(f) The provider's right to appeal the state agency's proposed action pursuant to F. of this rule.

(3) The effective date of the proposed monetary recovery or sanction shall be at least 20 calendar days following receipt of certified mail notifying the provider of the proposed action. If the provider appeals pursuant to F. of this rule, the action shall not be implemented until the commissioner's order is issued following the hearing on appeal, provided that the suspending or withholding of payment shall be effective on the date the notice is received, if in the commissioner's opinion such action is necessary to protect the public welfare and interests of the program. However, the commissioner shall not order a prehearing suspension or withholding of payments to a nursing home or board and care home. Implementation of a proposed action following the hearing on appeal may be postponed if in the opinion of the commissioner the delayed action is necessary to protect the welfare or interests of program recipients.

f. The decision as to the sanction to be imposed against a provider, pursuant to subsection D.3.a.(2) of this rule, shall be at the discretion of the commissioner. The following factors shall be considered in determining the sanctions to be imposed:

(1) Nature and extent of offenses or violations;

(2) History of prior violations;

(3) Provider's willingness to obey program rules; and

(4) Actions taken or recommended by other state regulatory agencies.

g. Suspension or termination from participation shall preclude a provider from submitting any claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association for any health care provided under the programs, except for health care provided prior to the suspension or termination.

h. No clinic, group, corporation, or other association which is a provider of services shall submit any claim for payment for any health care provided by an individual provider within such organization who has been suspended or terminated from participation in the programs, except for health care provided prior to the suspension or termination. The state agency shall seek monetary recovery of such claims. Knowing submission of such claims shall be a ground for administrative sanction.

i. When a provider has been sanctioned in accordance with subsection D.3.c. of this rule, after all appeals have been exhausted or the time in which to file an appeal has

elapsed, the state agency shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made, sanctions imposed, appeals made and the results of any subsequent appeal.

4. Nothing in this rule shall prevent the commissioner from simultaneously seeking monetary recovery and imposing sanction against a provider.

5. Nothing in this rule shall prohibit SUR from conducting routine audits of providers in order to monitor compliance with program requirements.

6. The commissioner is authorized to suspend or withhold payments to a provider prior to a hearing, as provided in Part D.3.e.(3), if:

a. There is a substantial likelihood of prevailing in an action pursuant to D.3. of this rule, or

b. There is a substantial likelihood that the provider's pattern of practice which prompted a SUR investigation, will continue in the future, or

c. There is reasonable cause to doubt a provider's financial ability to refund any amounts determined to be due the program.

7. To the extent that federal law or regulation mandates sanctions against providers or recipients which conflict with provisions of this rule, such federal law or regulation shall prevail.

E. Identification of suspected fraud and abuse.

1. Identification of suspected fraud and abuse.

a. SUR shall be responsible for the detection and investigation of suspected fraud, theft or abuse by recipients of the programs.

b. For the purpose of this rule, SUR shall be authorized to utilize at least the sources of information identified in D.1.b. of this rule.

c. In assessing the question of medical necessity, SUR shall consult with a review organization as defined in Minn. Stat. § 145.61 or other provider advisory committees as appointed by the Commissioner.

2. Investigation of suspected fraud and abuse.

a. SUR shall be responsible for the investigation of suspected fraud and abuse identified pursuant to E.1. of this rule. A SUR investigation shall be conducted for the purpose of determining:

(1) Whether suspected fraud, theft, or abuse exists and can be documented.

(2) Whether sufficient evidence can be developed to support restricting recipient participation in the programs in accordance with E.3. of this rule.

(3) Whether sufficient evidence exists to support the imposition of other sanctions in accordance with E.3 of this rule.

3. Sanctions.

a. Grounds for sanctions. SUR may impose administrative sanctions against program recipients for any of the following:

(1) Altering or duplicating the identification card in any manner.

(2) Permitting the use of his or her medical identification by any unauthorized individual for the purpose of obtaining health care through the programs.

(3) Using a medical identification card that belongs to another person.

(4) Using the medical identification card to assist any unauthorized individual in obtaining health care for which the programs are billed.

(5) Duplicating or altering prescriptions.

(6) Knowingly misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, or drugs.

(7) Knowingly furnishing incorrect eligibility status or information to a provider.

(8) Knowingly furnishing false information to a provider in connection with health care previously rendered which the recipient has obtained and for which the programs have been billed.

(9) Knowingly obtaining health care in excess of established program limitations, or knowingly obtaining health care which is clearly not medically necessary.

(10) Knowingly obtaining duplicate services from a multiple number of providers for the same health care condition, excluding confirmation of diagnosis.

(11) Otherwise obtaining health care by false pretenses.

b. Sanctions against program recipients. SUR may impose any of the following sanctions for the conduct described in E.3.a. of this rule:

(1) Referring the recipient for appropriate health counseling in order to correct inappropriate or dangerous utilization of health care.

(2) Restricting the recipients participation in a program to receiving health care from a provider(s) whom the recipient has had the opportunity to select. The restriction shall be for a specified period of time and all changes in the designation of a provider(s) during the restriction period shall be approved by the state agency. Reimbursement for non-emergency health care shall be limited to the designated provider(s).

(3) Recovery from recipients, to the extent permitted by law all amounts incorrectly paid by the programs.

(4) Terminating participation for that period during which a potential recipient refuses to sign a consent for release of records.

(5) Referring the recipient to the Attorney General for possible criminal or civil legal action.

c. Notice to recipients.

(1) The state agency shall cause the recipients to be notifed in writing of any sanction it intends to impose.

(2) The notice shall state:

(a) The factual basis for alleging discrepancies or violations;

(b) The dollar value to such discrepancies or violations;

(c) How such dollar amount was computed.

(d) What actions the state agency intends to take;

(e) The recipient's right to dispute the state agency's factual allegations; and

(f) The recipient's right to appeal the state agency's proposed action pursuant to F. of this rule.

d. Emergency health care provided a restricted recipient by any provider shall be eligible for reimbursement by the programs if the claim for reimbursement is accompanied by a full explanation of the emergency circumstances.

e. The programs shall pay for specialized health care provided a restricted recipient if a copy of the written referral by the recipient's chosen provider is sent to the SUR section.

f. The fact that a recipient is restricted shall be clearly indicated on the medical card.

F. Appeal

1. A provider may appeal the state agency's proposed administrative sanction, proposed suspension or withholding of payment, or demand for monetary recovery against a provider pursuant to the provisions of Minn. Stat. § 15.0418 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner with 20 days of the date notice is received pursuant to D.3.d. of this rule.

2. A recipient may appeal any sanction proposed by the state agency pursuant to the provisions of Minn. Stat. § 256.045.

3. Nothing in this rule shall prevent a provider or recipient, upon receipt of a notice of intended sanction, from meeting with the commissioner to informally discuss the matter in dispute, so long as an appeal has not been commenced.

DPW-81-010-JL

3:32 pm
mmc

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF A RULE OF THE DEPARTMENT OF PUBLIC WELFARE GOVERNING THE SURVEILLANCE AND UTILIZATION REVIEW PROGRAM, 12 MCAR § 2064 (RULE 64).

REPORT OF THE CHIEF HEARING EXAMINER

The above-entitled matter came on for review by the Chief Hearing Examiner pursuant to the provisions of Minn. Stat. § 15.0412, subd. 4d (1980) which provides in part:

> If the [hearing examiner's] report contains a finding that the proposed rule is substantially different from that which was proposed at the public hearing, or that the agency has not met the requirements of section 15.0412, subdivisions 4 through 4f, it shall be submitted to the chief hearing examiner for approval. If the chief hearing examiner approves the finding of the hearing examiner, he shall advise the agency of actions which will correct the defects, and the agency shall not adopt the rule until the chief hearing examiner determines that the defects have been corrected. If the chief hearing examiner determines that the need for and reasonableness of the rule has not been established pursuant to subdivision 4, clause (c), and if the agency does not elect to follow the suggested actions of the hearing examiner to correct that defect, then the agency shall submit the proposed rule to the legislative commission to review administrative rules for the commission's advice and comment. The agency shall not proceed to adopt the rule until it has received and considered the advice of the commission; provided, that the agency is not required to delay adoption longer than 30 days after the commission's receipt of the agency's submission.

Based upon a review of the record in this proceeding, the Chief Hearing Examiner hereby approves the Report of the Hearing Examiner in all respects and specifically as to any finding of substantial change or of failure to comply with Minn. Stat. § 15.0412, subd. 4-4f (1980) or of failure to establish need for and reasonableness of the proposed rule.

In order to correct the defects enumerated by the Hearing Examiner, the agency shall either take the action recommended by the Hearing Examiner or reconvene the rule hearing if appropriate. If the agency chooses to reconvene the rule hearing, it shall do so as if it is initiating a new rule hearing, complying with all substantive and procedural requirements imposed on the agency by law or rule.

If the agency chooses to take the action recommended by the Hearing Examiner, it shall, prior to submitting the rules to the Attorney General for review, submit to the Chief Hearing Examiner a copy of the rules as initially published in the State Register, a copy of the rules as proposed for final adoption in the form required by the State Register for final publication, and a copy of the agency's Findings of Fact and Order Adopting Rules. The Chief Hearing Examiner will then make a determination as to whether the defect in regard to substantial change and the requirements of Minn. Stat. § 15.0412, subd. 4-4f (1980) have been corrected.

Should the agency make changes in the rules other than those recommended by the Hearing Examiner, it shall also, prior to submitting the rule to the Attorney General, submit the complete record to the Chief Hearing Examiner for a review in regard to substantial changes.

Dated: March 27th, 1981.

DUANE R. HARVES
Chief Hearing Examiner

DPW-81-010-JL

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of a Rule of the Department of Public Welfare Governing the Surveillance and Utilization Review Program, 12 MCAR § 2.064 (Rule 64).

REPORT OF THE HEARING EXAMINER

The above-entitled matter came on for hearing before Jon L. Lunde, duly appointed Hearing Examiner, on Wednesday, January 14, 1981, at 9:10 a.m. in the Chapel Auditorium, Building 15, Minnesota Veterans Home, East 51st Street and Minnehaha Avenue, Minneapolis, Minnesota, pursuant to an Order for Hearing dated November 21, 1980. This is a rulemaking proceeding conducted pursuant to Minn. Stat. Ch. 15 to determine whether the Department of Public Welfare has authority to adopt the rules proposed and whether they are necessary and reasonable and may be adopted.

Ken Kohnstamm, Special Assistant Attorney General, 515 Transportation Building, St. Paul, Minnesota, 55155, appeared as counsel on behalf of the Minnesota Department of Public Welfare (hereinafter the "Department" or "DPW"). The Department's primary witnesses were Robert C. Baird, Assistant Commissioner for Income Maintenance; Thomas A. Gaylord, Director of the Surveillance and Utilization Review Division (SUR), and Larry Woods, head of the SUR Provider Section. In addition, eight SUP staff members were available for testimony and questioning by the public.

Approximately 33 persons, excluding departmental staff, appeared at the hearing, and 30 of them signed the hearing register. The hearing continued throughout the day and until all persons present had had an opportunity to be heard. Subsequent to the close of the hearing, but before the expiration of the 20-day comment period ordered by the Hearing Examiner, eight public comments and one departmental comment were submitted to the Hearing Examiner and made a part of the record.

The Commissioner of the Department of Public Welfare must wait at least five working days before taking any final action on the rules; during that period, this Report must be made available to all interested persons upon request.

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 4d (1980), this Report has been submitted to the Chief Hearing Examiner for his approval. If the Chief Hearing Examiner approves the findings of this Report, he will advise the Commissioner of actions which will correct the defects and the Commissioner may not adopt the rule until the Chief Hearing Examiner determines that the defects have been corrected. However, in those instances where the Chief Hearing Examiner identifies defects which relate to the issues of need or reasonableness, the Commissioner may either adopt the Hearing Examiner's recommendations to cure the defects or, in the alternative, if the Commissioner does not elect to adopt the recommendations, he may submit the proposed rule to the Legislative Commission to Review Administrative Rules for

the Commission's advice and comment. Provisions relating to this submission to the Commission may be found in Minn. Stat. § 15.0412, subd. 4d (1980).

If the Commissioner elects to adopt the recommendations of the Hearing Examiner and makes no other changes and the Chief Hearing Examiner determines that the defects have been corrected, then the Commissioner shall submit the rule to the Attorney General for review of form and legality. If the Commissioner makes changes in the rule other than those recommended by the Hearing Examiner, then he shall submit the rule, with the complete record, to the Chief Hearing Examiner for a review of the changes before adopting it and submitting it to the Attorney General. Procedures relating to this subsequent review by the Chief Hearing Examiner are set forth in Minn. Stat. § 15.0412, subd. 4e (1980).

When the Commissioner submits the rule to the Attorney General, he shall give notice on the day of submission to all persons who requested that they be informed of the submission to the Attorney General.

Based upon all the testimony, exhibits and written comments, the Hearing Examiner makes the following:

FINDINGS OF FACT

Procedural Requirements

1. On November 24, 1980, the Department filed the following documents with the Chief Hearing Examiner:

(a) A copy of the proposed rules.
(b) The Order for Hearing.
(c) The Notice of Hearing proposed to be issued.
(d) A Statement of the number of persons expected to attend the hearing and estimated length of the Agency's presentation.

2. On December 15, 1980, more than 30 days prior to hearing, a Notice of Hearing and a copy of the proposed rules were published at 5 State Register 974-982.

3. On December 9, 1980, more than 30 days prior to hearing, the Department mailed the Notice of Hearing to all persons and associations who had registered their names with the Department for the purpose of receiving such notice.

4. On December 19, 1980, more than 25 days prior to hearing, the Department filed the following documents:

(a) The Notice of Hearing as mailed.
(b) The Agency's certification that its mailing list was accurate and complete.
(c) The Affidavit of Mailing the Notice to all persons on the Agency's list.
(d) The Statement of Need and Reasonableness.
(e) The names of Departmental personnel who will represent the Agency at the hearing together with the names of any other witnesses solicited by the Agency to appear on its behalf.
(f) A copy of the State Register containing the proposed rules.
(g) An Affidavit of Additional Notice.
(h) All materials received following a Notice of Intent to Solicit Outside Opinion published at 5 State Register 657 on October 27, 1980.

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

5. The record remained open through February 3, 1981 for the receipt of written comments and statements, the period having been extended by order of the Hearing Examiner to 20 calendar days following the hearing. At the

Hearing Examiner's request, the 30-day period for issuance of this Report was extended to March 19, 1981, by the Chief Hearing Examiner pursuant to Minn. Stat. § 15.0412, subd. 4d (1980)at the Hearing Examiner's request.

6. K. Craig Wildfang, staff counsel for the Minnesota Association of Health Care Facilities (MAHCF) criticized the Department for two alleged procedural irregularities. First, he challenged the propriety of ex parte communications between the Department and interested parties[1] after the rules were published; and second, he challenged the Department's proposed rule amendments presented the very day the public hearing was held.[2]

Minn. Stat. § 15.0412, subd. 6 (1980), which pertains to the solicitation of outside opinion from the public provides as follows:

> When an agency seeks to obtain information or opinions in preparing to propose the adoption, amendment, suspension or repeal of a rule from sources outside of the agency, the agency shall publish notice of its action in the state register and shall afford all interested persons an opportunity to submit data or views on the subject of concern in writing or orally. Such notice and any written material received by the agency shall become a part of the hearing record to be submitted to the attorney general under subdivision 4 (Emphasis added).

7. Nothing in the statute prohibits ex parte communications. On the contrary, the statute merely requires published notice before such communications are received and the inclusion of written comments submitted into the hearing record. Ex parte comments are not, therefore, prohibited under Chapter 15, and if made orally, need not be made part of the hearing record. Professor Davis has noted that such ex parte communications should be encouraged. Speaking about the federal notice and comment procedure for rule adoption, he stated:

> Communications of all sorts are the life of a notice and comment proceeding. The more the better. They should not be prohibited. They should be invited and encouraged. If commissioners and staff have time to talk with interested persons, they should do so as far as their time permits; of course, they should try to do so fairly. All kinds of communications, including written materials, oral arguments at a proceeding, and informal consultations should be allowed to whatever extent practical considerations permit. Although a cut-off point for presentations is necessary, the only restriction required either by fairness or by the needs of judicial review is that the essence of all significant communications should go into the public record [italics present].
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> * * *
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> The law of the future is unlikely to condemn ex parte contacts in the making of rules of general applicability, but it is likely to require that all significant communications be made a part of the public record.

1 Davis, Administrative Law Treatise, § 6:18 (2d Ed. 1979).

8. With respect to the ex parte communications that occurred in this case, there was no showing that they were made in an untimely manner, that

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[1]The specific ex parte contacts were with two state representatives and with members of the Minnesota Medical Association.

[2] These amendments appear as Exhibit 9.

they were significant, or that they were in writing but not included in the record, and it cannot be concluded, therefore, that they were either improper or prejudicial. Nothing in Chapter 15 requires all comments to be made a part of the record and an agency may not, apart from its affirmative presentation at the hearing, including its Statement of Need and Reasonableness, rely upon facts presented by others which do not appear of record. See, 15.0412, subd. 4c pertaining to the reliance on facts presented by others which are made on the record. Since an agency's rules must be supported by facts contained in the Statement of Need and Reasonableness or on such additional facts as are presented at the hearing, ex parte comments would not normally prejudice any party. If such comments are not of record, they may not be used to support the need or reasonableness of a rule, and if a rule is necessary or reasonable apart from such comments or facts, the fact that they were made would normally not be prejudicial. However, to the extent that such ex parte communications persuade an agency to adopt a policy position, it would be advisable for such oral comments to be summarized by the Department in a proper case and made a part of the hearing record. This would permit the public to respond. In this case, the Agency's failure to do so was, as was previously stated, not shown to have been prejudicial to any party or that the ex parte communications had any substantive impact on the rules proposed. Consequently, those contacts do not invalidate the rules.

9. MAHCF also challenged the propriety of the Department's proposal of amendments to the rule as published on the day of the hearing. The proposal of rule amendments at rule hearings is a common agency practice in this state which is neither directly permitted nor precluded by Chapter 15. In fact, the subject of amendments to a proposed rule after publication but prior to or at the hearing is not specifically addressed. Amendments after the hearing are specifically mentioned, however, in § 15.0412, subd. 4e. It provides:

> If the agency [after the hearing examiner's report] makes changes in the rule other than those recommended by the hearing examiner, it shall submit the rule with the complete hearing record to the chief hearing examiner for a review of the changes prior to adopting it and submitting it to the attorney general for review. If the chief hearing examiner determines that the proposed final rule of the agency is substantially different from that which was proposed at the public hearing, he shall advise the agency of actions which will correct the defects, and the agency shall not adopt the rule until the chief hearing examiner determines that the defects have been corrected. (Emphasis added)

Chapter 15, as a whole, sets out detailed notice requirements for the adoption of a rule and the "full text" of the rule (§ 15.0412, subd. 4) and the "exact wording" (§ 15.0412, subd. 4b) must be published and made available to the public. This procedure does not contemplate amendments to the rules prior to or at the hearing. However, such amendments should not be prohibited where they would be permissible after the hearing. It simply makes no sense to preclude an agency from stating at the hearing changes it intends to make so that the public can comment on them rather than to require no changes until after the hearing where no such comments can be made. However, any such changes cannot substantially change the rules but are limited as are posthearing amendments to insubstantial amendments otherwise permissible under 9 MCAR § 2.111 and subdivision 4e. If any agency could substantially change

rules at the hearing, the notice provisions of the Act would be rendered a nullity and while subdivision 4e refers to changes "from that which was proposed at the public hearing", that subdivision does not authorize substantial amendments at the hearing which were not included in the original publication. Any other construction of the provisions of Chapter 15 would lead to absurd results.

While parties have no right to insist that a rule remain frozen in its "vestigial form", they do have a right to insist on the notice contemplated by Chapter 15. That means that no substantial amendments to the rules as originally published can be made at the hearing where parties have no notice of such amendments. It is not enough that the parties attending the hearing have notice of the amendments where other parties who do not attend the hearing do not have such notice. This does not mean that the amendments may not be substantive in nature, it merely means that the amendments may not be substantial under 9 MCAR § 2.111. The amendments proposed by the Department in this case are considered infra and are considered proper and permissible except where they effect a substantial change in the rules.

The additional facts necessary to justify the proposed amendments were presented by the Department and no one requested a continuance of the hearing to respond to that additional evidence although such continuances are authorized under 9 MCAR § 2.104. In addition, with respect to those amendments, it is noted that all parties present at the hearing had an opportunity to comment on the amendments in writing after the close of the hearing, itself, and did so. The Hearing Examiner can find no prejudice under the circumstances.

Statutory Authority

10. The Department relies, inter alia, upon Minn. Laws 1980, Chapter 349, §§ 2, 3, 7 and 9 (codified as Minn. Stat. §§ 62E.54, subd. 1(d); 256B.04, subd. 10; 256B.27, subd. 3, and 256D.03, subd. 3(e) (1980)) as authority for the rules proposed. As amended, those statutes provide as follows:

Minnesota Statutes, Section 62E.54, subd. 1, dealing with CHEPP, provides in part as follows:

The commissioner shall:

* * *

> (d) Promulgate rules establishing general criteria and procedures for the identification and prompt investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, and false statements or representations of material facts by a vendor of health services, and for the imposition of sanctions against a vendor. The rules relating to sanctions shall be consistent with the provisions of section 256B.064, subdivision 2, and section 6 [Minn. Laws 1980, Ch. 349 § 6, codified as Minn. Stat. § 256B.04, subd. 1a.]

Minnesota Statutes, Section 256B.04, subd. 10, provides as follows:

> [The state agency shall] establish by rule general criteria and procedures for the identification and prompt investigation of suspected medical assistance fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by a vendor of medical care, and for the imposition of sanctions against a vendor of medical care. If it

appears to the state agency that a vendor of medical care may have acted in a manner warranting civil or criminal proceedings, it shall so inform the attorney general in writing.

Minnesota Statutes, Section 256B.27, subd. 3, provides as follows:

> The commissioner of public welfare, with the written consent of the recipient, shall be allowed access to all personal medical records of medical assistance recipients solely for the purposes of investigating whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which the vendor knows to be false in whole or in part; or (b) the medical care was medically necessary. The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records. To the extent feasible, the commissioner shall contract with a review organization, as defined in section 145.61, in determining whether or not the medical care provided was medically necessary. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of public welfare pursuant to this section.

Minnesota Statutes, Section 256D.03, subd. 3, reads in part as follows:

> (e) [The commissioner's rules may include] general criteria and procedures for the identification and prompt investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statements or representations of material facts by a vendor of general assistance medical care, and for the imposition of sanctions against such vendor of medical care. The rules relating to sanctions shall be consistent with the provisions of section 256B.064, subdivision 2, and section 6.

Except as is specifically noted to the contrary elsewhere in this Report, these provisions provide statutory authority for the adoption of legislative rules by the Department.

Although the Department cited Federal regulations as a possible source of authority to adopt the rules proposed, Federal statutes or regulations do not constitute authority for the adoption of rules by an agency of state government under Chapter 15. Agencies have only those powers given to them by the Constitution or the Legislature and no others. 3B Dun.Dig.2d, Constitutional Law, § 4:00 et seq. (3d Ed. 1979). Consequently, authority for rules may not be predicated on Federal laws or regulations. However, the requirements of Federal law in effect at the time the 1980 amendments were adopted are relevant for purposes of determining the scope of the authority the Legislature intended to delegate to the Department and for the purpose of determining a proposed rule's need and reasonableness.

Rule Provisions

11. The purpose of these rules is to set out the procedures to be used by the SUR unit in the identification and investigation of fraud or abuse in the Medical Assistance (MA) or Medicaid program, the General Assistance Medical Care (GAMC) and the Catastrophic Health Expense Protection Program (CHEPP), all of which are administered by the Department in conjunction with various local welfare agencies. These programs provide health care services for approximately 280,000 eligible recipients in the State through 14,000 health care providers, and result in daily expenditures of $1.5 million, the highest per capita cost in the nation. Prudent fiscal management, a shortage of funds

in the state, and the existence of fraud and abuse in these programs,[3] make it necessary for the Department to adopt rules for the identification, investigation and correction of improper activities under these programs and the rules are, for that reason, generally needed.[4]

The rules are generally arranged into the areas of purpose, definitions, record-retention, copying and access, the investigation and identification of fraud and abuse in the programs, sanctions and appeals. Generally speaking, the rules incorporate practices which have been followed in the SUR Unit over the past five years.

Part A - Introduction.

12. Part A.1.-4. is the introduction to 12 MCAR § 2.064. It states the purpose of the rules, cites the relevant laws, rules and regulations applicable to the subject matter (and which are to be read in conjunction with the proposed rules) and advises that future publications of instructional bulletins and manuals to be used in conjunction with the rules will be issued by DPW and that the rules are binding. This Part was not subject to adverse public comment and, with the exceptions noted in Finding 13, is a helpful, necessary and reasonable introduction.

13. Part A.3. provides that DPW "will issue instructional bulletins, manual materials and forms as necessary to assist others in the interpretation of this rule. Such publications do not have the force and effect of law; however, they do contain the state agency's interpretation of this rule." This language does create some problems under Chapter 15. In Minnesota-Dakotas Retail Hardware Association v. State, 279 N.W.2d 360 (Minn. 1979), the Minnesota Supreme Court held that interpretative rules, while not having the force and effect of law, are subject to the procedural requirements for adoption of rules under Chapter 15. The thrust of that decision is that any agency interpretation of the statutes or rules under which it is acting must be adopted as rules under the procedures of the Administrative Procedures Act where they are made to implement or "make specific" the law enforced or administered by the agency. Minn. Stat. § 15.0411, subd. 3. (1980). Thus, any manuals, handbooks, or other interpretations of its own rules may well be rules, themselves, which may not be adopted unless the procedures of Chapter 15 are followed. Thus, in Burke v. Public Welfare Div., 31 Or. App. 161, 570 P.2d 87, 90 (1977), the Oregon court held that the interpretative amplification or refinement of a rule is a new rule and must itself be properly adopted. In that case, the court held that where the "Indian benefits" provision of a food-stamp manual represented a policy choice among alternatives allowed by the terms of a general rule and was a policy-based interpretation of an income rule and not merely an application of that rule, the Indian benefits provision was itself a rule which had to be formally adopted. While it is true that an agency's interpretations of its own rules

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[3]Since 1975, the SUR Unit has recovered $800,000 in fines and improper payments.

[4]Nationally, the cost of fraud and abuse has been estimated to exceed one billion dollars annually. See, e.g., Pies, Control of Fraud and Abuse in Medicare and Medicaid, 3 J. Law & Med. 323 (1977); Lee, Fraud and Abuse in Medicare and Medicaid, 30 Ad. L. Rev. 1 (1978).

may not have the force and effect of law, their binding effect does not determine the procedure which must be followed for their promulgation. Consequently, it is concluded that Part A.3., violates Minn. Stat. § 15.0411, subd. 3 (1980) and therefore constitutes a substantive violation of law within the meaning of § 15.052, subd. 3. (1980). To correct this defect, the cited material must be deleted. It could be replaced with a simple statement that the Department "will issue instructional bulletins, manual materials and forms to assist others in complying with this rule." The language indicating that such materials will contain the agency's interpretation of their own rules is not proper where that interpretation represents policy choices among alternatives and not merely a result mandated by § 2.064 itself. It is improper in a duly promulgated rule to indicate that other rules may be adopted without compliance with Chapter 15. That problem is not cured by stating that such interpretations will not have the force and effect of law since the legal effect of a rule or interpretation thereof is immaterial in determining the procedures which must be followed for adoption.

so replaced p.1

Part B. - Definitions.

14. Part B. contains the definitions of words used throughout § 2.064. Some of the proposed definitions were subject to a great deal of public comment, however, the definitions of "commissioner, health care, health care record, medical management information system, medical record, programs, provider, state agency, suspending participation, suspension of payments, utilization control, and withholding of payments" were not the subject of adverse public comment or inquiry, and are found to be necessary and reasonable in their entirety.

15. Part B.1., as originally published, defined "abuse" as a pattern or practice characterized by, but not limited to, one of ten "conditions" being B.1.a. through B.1.j., respectively. At the hearing, the Department proposed to amend Part B.1.a. to read as follows:

> "Abuse." A pattern of practice by a provider, or a pattern of health care utilization by a recipient which is inconsistent with sound fiscal, business, or medical practices, and result [sic] in an unnecessary cost to the programs, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of health care. Abuse is characterized by, but not limited to, the presence of one of the following conditions: [Underlineation is new material][5]

added p.2.

* * *

DPW proposed this change in order to add a generic definition of abuse as suggested by the Minnesota Medical Association (MMA) prior to the hearing. MMA correctly noted that the definition originally proposed was too broad and too vague to give fair notice of what was prohibited and sanctionable by the Department. In fact, the original definition was not a definition at all but merely an example of some kinds of abuse without any limitation whatsoever as to what other practices were prohibited. For that reason, the proffered

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[5]The word "result" in the fourth line of the proposed definition should be made plural, and the word "an" should be deleted and both "cost" and "reimbursement" should be made plural. The Hearing Examiner also suggests that the word "conditions" be deleted. It is not necessary in order to understand the rule, and the examples of abuse cited are not technically speaking "conditions."

deleted p.2

amendment is necessary and reasonable. Furthermore, it is not a substantial change for purposes of 9 MCAR § 2.111 because it does not affect classes of persons who were not represented at the hearing, does not go to a new subject matter, does not make a major substantive change and does not result in a rule that is fundamentally different from that contained in the Notice. In fact, the amendment is a necessary and logical outgrowth of the subject matter noticed for hearing.

16. One of the primary criticisms of the proposed definition of abuse is that it fails to incorporate the concept of intent or knowledge into the definition or the various examples cited. In his posthearing comment, Brian F. McInerney, vice president of the Minnesota Association of Homes for the Aging, and the Minnesota Hospital Association (MAHA/MHA), stated:

> Our members are concerned that agency staff should have some guidelines in assessing the difference between mistakes and abuse. Institutional problems (e.g., loss of key personnel, extended absences, etc.) might result in a series of incorrect claims submissions; in working with such cases, agency staff would best serve their obligation to assess abuse if the rule specifies (even judgmentally) some determination of intent.

As noted in its Statement of Need and Reasonableness (hereinafter the "Statement"), DPW's failure to make abuse intentional or knowledgeable is consistent with Federal law and quite deliberate. DPW believes that a pattern of improper billing and other practices which result in unnecessary, unreasonable or improper costs to the various programs cannot be tolerated even if no specific intent exists. The various statutory provisions requiring the adoption of this rule do not require that abuse be intentionally or knowingly done. The Department, in administering those laws, has a considerable amount of discretion in determining what conduct is abusive and what intent, if any, is needed.

17. The word "abuse" is not a term of art in the law and must be assigned its popular or ordinary meaning which depends upon the context in which it is used and the subject matter under consideration. See, 1 C.J.S., Abuse. The common meaning of abuse includes "everything which is contrary to good order established by usage" or a "departure from use; immoderate or improper use." Black's Law Dict., p. 24 (Rev. 4th Ed., 1968). It also means "a corrupt practice or custom; improper use or treatment." Webster's New Collegiate Dict., p. 5 (1975 Ed.). Nothing in these definitions require an improper use to be intentional or knowing conduct.

The absence of an element of knowledge or intent from the rule is consistent with Federal law[6] and is a necessary and reasonable approach for sanctioning those providers who engage in a pattern of improper actions. While errors can and do routinely occur in the billing practices of health care providers, isolated or occasional errors or irregularities are not sanctionable as the Department pointed out in its Statement (p.4). The Department's decision to sanction patterns of improper activities is within its power and enables it to impose sanctions without the necessity of showing a specific intent, the pattern, itself, being evidence either of an improper

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[6]See the proposed definition of the Department of Health and Human Services, 45 Fed. Reg. 83772 (1980) which is nearly identical to that proposed here.

intent, or an inexcusable and impermissible pattern of indifference or negligence on the part of the provider. Such indifference or negligence in terms of the objectives to be accomplished by the rule, should be no less sanctionable than willful and deliberate improprieties. For that reason, it is found that the proposed definition of abuse to be necessary and reasonable. Although there may be reasons for reaching an opposite conclusion, it is the Department who ultimately has the discretion to choose between reasonable alternatives and the Hearing Examiner concludes that its choice in this case is reasonable and proper.

18. DPW proposes to amend Part B.l.a. to read as follows:

> a. The repeated submission of claims by a provider from which required material data is missing or incorrect. Examples include but are not limited to: incorrect or missing procedure or diagnosis codes, false mathematical entries, incorrect or missing third-party liability information, incorrect use of procedure code modifiers [underlineation indicates new material and strike marks indicate deletions].[7]

The words "or missing" are to be deleted from the rule because DPW does not require third-party liability information and feels that it would be inappropriate to consider it an abuse if that information is missing (T.-32, 33). The word "material" was added as a result of MMA's suggestion. The purpose is to make it clear that an abusive practice should only be found where the missing or incorrect data is material, that is, where it actually induces payment. As to materiality, DPW cited U. S. v. Adler, 623 F.2d 1287, 1291 (8th Cir. 1980). In that case, involving prosecution for Medicare fraud, the Court held that a statement is material if it has a tendency to induce government to act, even though the statement may relate to services which are not compensable under the program involved. So long as the statement or other act put the claimant in a position to receive benefits, whether rightfully or wrongfully, the statement would be material even though the benefits claimed were not properly compensable under the particular program. The addition of the word "material" in the rule as proposed by the Department is a necessary, reasonable and insubstantial amendment to the rule. While the Department's Statement impliedly limits materiality to a statement which "induces payment", it probably is not that restrictive and actual payment may not be necessary before a finding of abuse could be made. Thus, repeated submittals of duplicate claims, even if not paid, would constitute an abuse.

19. The Hearing Examiner is concerned with the rule insofar as it predicates abuse on a provider's reporting of incorrect third-party liability information. If it is true that DPW does not require third-party liability information and does not think it is appropriate to sanction providers who fail to supply that information, the Hearing Examiner does not understand why it is abusive if the information supplied is incorrect. Consequently, the Hearing Examiner feels that the Department should consider deletion of the third-party liablity abuse example.

It is noted that, except for mathematical entries, abusive practices under Part B.l.a. relate to incorrect information while mathematical entries

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[7]The words "or missing" were proposed for deletion at the hearing on these rules while the addition of the word "material" was proposed in the Department's posthearing comments.

are abusive if "false". The word "false" may connote some intentional falsehood or knowing falsehood which appears to be at odds with the Department's intention, and it is suggested, therefore, that the word "false" be deleted and replaced with the word "incorrect" since this apparently reflects the Department's intention and is more consistent with the other parts of the rule.

deleted + replaced p. 2

20. Both MAHCF and MAHA/MHA argued that the abuses set out in Part B.1.a. should be limited to intentional or knowing ones and not to those which occur innocently. MAHCF pointed out that the billing systems are complex and change regularly (T. 56, 57), and MAHA/MHA noted that studies previously conducted show that proper diagnosis codes are frequently in dispute. As McInerney noted in his posthearing comment:

> National studies of diagnosis coding indicate that physicians and medical records personnel may, upon second reading or review of the medical record, assign a different diagnosis or code in as many as 10-15 percent of all cases. We strongly urge the Department to consider some language that recognizes this occurrence. The determination of an appropriate diagnosis is, in the final analysis, judgmental. With the current language, it is impossible for our members to determine what normative criteria may be employed by the Department and whether those criteria are practical.

This comment was nearly identical to that submitted by Anne Voss Tegen, president of the Minnesota Medical Record Association (MMRA). In her posthearing comments, she noted that in a recent study by the Institute of Medicine, it was found that only 63.4% of the four-digit codes utilized agreed with the diagnosis and that the reliability of coding is only 86% when grouped in a broad categorization (19 categories) by body function. These comments raise a question as to the appropriateness of a system which characterizes as abusive inaccuracies which commonly occur and which are based on individual judgment. On the other hand, such common occurrences indicate the need for some rule and the very adoption of rules with some sanctions may provide the necessary incentive to reduce their frequency. While reasonable minds may disagree as to the point at which so-called innocent "mistakes" constitute an abuse, the Hearing Examiner reiterates his prior conclusion that the approach adopted by DPW is necessary and reasonable. While there may be other persuasive reasons for not adopting the precise approach proposed by DPW, its position is not arbitrary or unreasonable. This is especially true since the sanctions which will be ultimately proposed in a particular case can be resolved in a contested case proceeding where all relevant evidence can be weighed in determining the sanction that is appropriate. In imposing a sanction, it would no doubt be proper to determine whether similar practices or abuses had previously occurred, the complexity or newness of the procedures involved and other relevant circumstances. The opportunity for such a hearing should provide necessary protections to the individuals subject to the rule without making it impossible or unduly burdensome for the Department to properly identify and sanction improper and unnecessary expenditures.

21. Part B.1.b. makes the repeated submission of claims with codes which overstate the level or amount of health care provided a sanctionable abuse. For the reasons previously discussed, this is a necessary and reasonable provision. While MMA suggested that the rules should be redrafted to cover only procedure codes which "materially" overstate the level or amount of

health are provided, the Department properly rejected this suggestion. Improper procedure codes, by their very nature, are material and the amendment suggested by MMA only leads to confusion since the word "materially" could, if added as they propose, be equated with the word "substantially" or "excessive". That is clearly not the intent of the rule and no amendment to this section is necessary. Furthermore, it is the belief of the Hearing Examiner that only material abuses are sanctionable whether the rule specifically includes the word "material" or not. See, U.S. v. Adler, supra. Where the word is not specifically included in the rule, it must be implied in the proper case. Pein v. Cooper, 211 Minn. 517, 1 N.W.2d 847 (1941).

22. Part B.1.c. makes the repeated submission of unreimbursable claims an abuse. MAHCF, MMA, and the Minnesota Dental Association (MDA) also challenge this rule suggesting that it was either unreasonably oppressive or unnecessary. The crux of those challenges is that it is not always clear what is reimbursable and the time it takes to make that determination is too great a burden to place on providers. MAHCF argued that this kind of abuse should be limited to submissions known not to be reimbursable, and MDA suggested that the provision be deleted altogether. The Hearing Examiner is not persuaded that individuals who want to take advantage of monies made available by the Department do not have an obligation to determine their entitlement or that the Department is required to shoulder the administrative burden of processing improper or unreimbursable claims. Consequently, it is concluded that this provision is necessary and reasonable.

It is noted, however, that the proposed definition of abuse nowhere specifically deals with duplicate claims which are specifically mentioned in the authorizing statutes. So that the rule clearly incorporates such duplicate claims, the Hearing Examiner recommends that Part B.1.c. be amended to read as follows: "The repeated submission of claims by a provider for health care which is not reimbursable under the programs, or the repeated submission of duplicate claims." so amended p.3

23. Part B.1.e. makes the provider's failure to use "generally accepted accounting principles" unless otherwise indicated by Federal or state law an abuse. Several groups question the meaning of generally accepted accounting principles for purposes of the rule, and MMA argued that it was both unnecessary and unreasonable. In response to those comments, the Department proposes to amend Part B.1.e. to read as follows:

> e. Failure of a provider to use generally accepted accounting principles, or other accounting methods which relate entries on the medical or health care record to corresponding entries on the billing invoice, unless otherwise indicated by federal or state law or rule [underlineation indicates new material].

While the words "generally accepted accounting principles" may lead to some ambiguities, it is, of course, impossible for the Department to define every phrase used in its rules. The precise meaning of some terms must be developed over a period of time through contested case procedures and will depend, in some instances, on the facts of a particular case. Nonetheless, the Department has now proposed to further clarify the meaning of this rule and it is found that the proposed rule, as clarified, is necessary and reasonable in its entirety. Since this Report is in some respects a "legislative history" so clarified p.3

of the rules, the Hearing Examiner believes that the Department's explanation of the purpose of Part B.1.e. should be included here. In its posthearing comments regarding this Part, DPW stated: (p.3.):

> The Department's intent in requiring generally accepted accounting principles is to ensure that a reasonable audit trail is available in the event of an investigation. In order to determinine if health care services reimbursed by DPW where actually provided, some basic accounting documents are needed to relate the medical record to the billing invoice. Other basic documents are needed to verify the validity and reasonableness of charges billed to the programs. A minimum set of records is essential for DPW to fulfill the mandate of Minn. Stat. § 256B.27, subd. 3 which requires the agency to investigate whether a vendor has submitted a claim for reimbursement, a cost report, or a rate application which is false in whole or in part.

It is, of course, essential, as DPW noted, that providers have and maintain the documentation necessary to support their claims for benefits under the various programs. That is the essence of the rule and as such, it is necessary and reasonable.

24. Part B.1.f. makes the following an abuse:

> The repeated submission of claims by a provider for health care that is contrary to the generally accepted standards of practice of a provider's field of practice or specialty.

While this definition would arguably cover negligently performed services, that is not the expressed intent of DPW. Rather, the justification for this provision, according to the Department's Statement (p. 5) is that it is "inappropriate and abusive" to bill services which "the provider is not qualified to provide." MMA objected to this provision as unauthorized, unreasonable and unnecessary because it fails to implement the Agency's intent and because DPW has no authority to limit the kinds of services a licensed physician can perform. The Hearing Examiner concurs with MMA's objection to this rule as written and concludes that it is confusing and that its stated purpose is unauthorized. The general purpose of the rules proposed by DPW is to eliminate unnecessary costs to the various programs or the payment for services not medically necessary or which fail to meet recognized standards of health care. The provision of services by a physician outside of his specialty does not, however, mean that those services are medically unnecessary. Consequently, the proposed rule, rather than addressing unnecessary costs, addresses the issue of who can provide necessary services. Even assuming that a medical specialist might not normally perform services outside of his specialty does not mean that those services, if performed, are medically unnecessary or that they result in unnecessary costs to the programs. There is nothing in the authorizing statutes which empower DPW to regulate the scope of a physician's practice. On the contrary, as to physicians, surgeons and osteopaths, that authority is governed by Minn. Stat. § 147.01 et seq. and the Board of Medical Examiners. "Abuses" if any, which arise in that area simply are not within the scope of DPW's authority in detecting theft, fraud or abuse under the three programs covered by the rule.

Furthermore, the proposed definition of abuse only covers the repeated submission of claims. If a specialist repeatedly performs work outside of his specialty, it is confusing and inconsistent to conclude that he should limit his practice to his specialty when he repeatedly does not do so. In such cases, it would appear that the individual would be more than a mere

specialist and should not, for any reason, be confined to his specialty.

If the intent of the rule is to cover services a provider is not authorized by law to perform, or services which are unnecessary because not generally performed under the standards of the relevant provider group (such as unnecessary laboratory tests), those matters should be sanctionable as abuse. However, where the services are otherwise legally performed and medically necessary, the law does not contemplate that DPW may impose further restrictions on those who may provide such services. Any rule which attempts to do so is unauthorized (See Finding No. 30). To clarify this and to reflect the proper scope of such an abuse, Part B.1.f. could be rewritten to provide as follows:

> The repeated submission of claims by a provider for health care which is not medically necessary.

this language used p. 3.

The provision of legally unauthorized services under state law can be included by rewriting the definition of medically necessary under Part B.7. as is discussed infra. Or, Part B.1.f. could be written to state:

> The repeated submission of claims by a provider for health care that such provider is not legally authorized to perform under state law or which is not medically necessary.

On the other hand, DPW could retain the current definition but it must be understood that it cannot be used to restrict the scope of services which can be provided by a licensed doctor or dentist consistent with other state laws or rules. In this connection it is noted that proposed regulations of the Department of Health and Human Services specifically authorize the non-payment or recovery of medical services of an "unacceptable quality". (See proposed § 453.202, 45 Fed. Reg. 83772, et seq. (1980). This concept seems implicit in the language of Part B.1.f. but not in DPW's statements as to its purpose. If unacceptable quality is what is intended the proposed language should be retained with further language necessary to cover the concepts of unauthorized services or medically unnecessary services as discussed. With these considerations in mind the proposed Part is found necessary, reasonable and authorized within the limits stated.

added p. 3

25. Part B.1.g. makes the repeated submission of claims for health care which exceed that requested or agreed to by the recipient or required by law an abuse. This rule is subject, of course, to the limitation contained in Minn. Stat. § 256B.04, subd. 1a (1980) that no vendor of nursing home or convalescent care can be sanctioned for services ordered by a licensed health professional who is not an employee of the vendor. This Part is necessary and reasonable in its entirety. However, the stated purpose is not implemented by the language adopted. The Department's Statement (p. 6) provides:

> [This Part] defines as abusive the practice of inflating the quantity of services necessary to adequately treat the presenting condition. . . . The rule is more reasonably concerned with all services which are in excess of generally accepted practice for a particular health care condition.

The rule as written does not cover its stated purpose and should be clarified to give fair notice to the public of the abuses for which it may be sanctioned. This could be accomplished by adopting the Hearing Examiner's suggested amendment to Part B.1.f. or the Part could be redrafted to provide as follows:

The repeated submission of claims by a provider for health care which exceeds that requested or agreed to by the recipient or his responsible relative or guardian or that otherwise required or permitted by federal or state law or rule; services, prescriptions or devices deemed unnecessary or excessive under the generally accepted practice of providers of such services, prescriptions or devices is abusive.

adopted p. 3

Such an amendment clearly covers the practice of inflating the quantity of services necessary to adequately treat a specific medical condition, which is the primary purpose of the rule. Without such an amendment DPW may not be able to sanction all the abuses intended to be covered.

26. Parts B.1.h.-j. identify various recipient practices which are deemed abusive. These practices are consistent with those declared to be illegal under Minn. Stat. § 256.98 (1980) and are, therefore, necessary and reasonable in their entirety. However, that Part B.1.i. does not cover the actual disposal or resale where not obtained specifically for the purpose of resale. Section 256.98 makes any disposal of property obtained with program monies without authorization of a local agency wrongful. To spcifically cover that situation, it is recommended that subpart i. be amended to read:

"Obtaining unneeded equipment, supplies or pharmaceuticals by a recipient for the purpose of resale or the disposal of equipment, supplies or pharmaceuticals obtained with program monies without authorization of the local welfare agency.

amended p. 4

Part B.1.j. includes the obtaining of duplicate services by a recipient for the same health care condition as an abuse. It excludes duplication for purposes of confirming a diagnosis, evaluation or assessment. One commentator objected to this language because of the need for referral. However, because of the exclusion contained in the subpart, this concern does not seem to be palpable. MDA argued that certain treatment could be construed as duplicative services, such as the replacement of a filling that had been previously installed; however, the Rule clearly does not prohibit necessary duplicative services or replacement services which are medically necessary. Consequently, that concern does require further clarification.

? may be "not" means

The other specific types of abuse cited in Part B.1. were not subject to any substantial adverse comment and are found to be necessary and reasonable in their entirety.

27. There are other kinds of abuse which Part B.1. does not describe by example. One such abuse, commonly known as "ping-ponging", while not specifically mentioned is no doubt abusive. Ping-ponging is the practice of health care entities of referring patients from one practitioner to another within a facility where such referrals are not medically necessary. Similarly, "ganging", the billing for multiple services to relatives who accompany family members to a facility, and "steering", the directing of a patient to a particular pharmacy, may also come within the generic definition of abuse. Other improper activities such as kickbacks, bribes and rebates, while not specifically mentioned, may constitute fraud or abuse in a proper case. DPW may wish to address these matters more specifically in future rule-making proceedings.

28. Based on a comment by MDA, DPW proposed to amend the definition of "health care record" at Part B.4. to read as follows:

Written or diagrammed documentation of the nature, extent and evidence of the medical necessity of health care provided to the

amended p. 4

program recipients by a provider other than a medical doctor and billed to the programs.

This amendment specifically recognizes the fact that dental records are unique and are often diagrammatic and should be specifically addressed in the rule. While the Department did not adopt MDA's proposal to exclude dentists from keeping health care records, the proposed rule, as amended, is necessary and reasonable and does not constitute a substantial change for purposes of 9 MCAP § 2.111.

29. Part B.7. which pertains to the definition of "medically necessary" was amended, both at the hearing, and by DPW's posthearing comments. In its final form, that part will read as follows:

> "Medically necessary." Health care that is within the generally accepted standards of practice of a provider's field of practice or specialty and is:
>
> a. Provided in response to life threatening (sic) conditions, or
> b. Provided in response to pain, or
> c. Provided to treat injuries, illness, or infections, or
> d. Provided in compliance with the provisions of 12 MCAP §§ 2.047, 2.058 or 2.060 regarding services reimbursable under the programs.

MMA strongly protested that part of the proposed definition which stated that health care must be "within the generally accepted standards of a practice of a provider's field of practice or specialty." It stated:

> This language should not be used to restrict the professional judgment of a physician in determining the course of treatment best suited for his patient, or to prevent a physician who specializes from providing reimbursable services in an area outside of his specialty. A state license to practice medicine does not impose such a limitation, and this rule should not be more restrictive.

As is explained supra regarding Part B.1.f., the Department takes the position that an abuse occurs when a provider operates outside his field of practice or specialty or when the care billed is not within the generally accepted scope of that practice or specialty. Stated there is the conclusion that DPW is not authorized to restrict the practice of a specialist to the area of his specialty when the services he provides can be lawfully provided under the scope of his license and are not unnecessary and which do not result in unnecessary costs to the programs involved.

30. While the Department cites 42 C.F.R. § 440.50 and 12 MCAP § 2.047 F.1. as authority to impose such limitations, those sections neither imply nor authorize such a construction. As MMA pointed out, 42 C.F.R. § 440.50, in defining a physician's services, limits them to services provided: "(a) within the scope of practice of medicine or osteopathy as defined by state law . . . ." Similarly, 12 MCAP § 2.047 F.1. generally states that such providers will be directly paid for providing medical care or services rendered within their scope of practice under federal and state law and regulations. Furthermore, other parts of Rule 47 specifically provide for reimbursement of services rendered within the scope of one's license. Thus, 12 MCAR § 2.047 E.2.c. provides: "Physicians' services are those services provided by or under the personal supervision of a licensed physician or osteopath within the scope of his profession as defined by state law." Similarly, 12 MCAR § 2.047 E.2.k.(3)(a) defines medical services for rehabilitation purposes as those "provided to a patient within the scope and

practice of medicine as defined by Minnesota law and performed by a currently licensed physician."

For these reasons, and for the reasons previously mentioned (See, Finding No. 13), DPW has no authority to label as abusive the practice of medicine otherwise authorized by state law and rules of the relevant boards with specific jurisdiction to establish the bounds of a particular provider's practice. Such restrictions were not shown to have been contemplated under federal regulations and are inconsistent with other state rules such as those cited above. Therefore, Part B.7. as written is unauthorized for purposes of Minn. Stat. § 15.0412, subd. 1. (1980) and constitutes a violation of a substantive provision of law for purposes of Minn. Stat. § 15.052, subd. 3. (1980).

To correct this defect DPW must amend the first paragraph of Part B.7. to provide that:

> Health care which is rendered pursuant to the provider's authority under state law and within the scope of its license, if any, and is:
>
> * * *

It is further recommended that DPW consider a further subpart to the definition of medically necessary which incorporates the idea that medically necessary services must be of an "acceptable quality" as discussed infra. at Finding 24.

31. The other concerns and criticisms of Part B.7. have been addressed in the Department's posthearing amendment and the Hearing Examiner finds the final proposed version of this Part to be necessary and reasonable and not to be substantially different from the rule that was initially proposed. For that reason, it may be adopted with the change required (Finding No. 30.).

32. Part B.8. clarifies the term "abuse" by defining a "pattern" as "an identifiable series of events or activities." While MMA suggested amendments to this definition, it is necessary and reasonable as proposed. As DPW noted in its Statement (p. 9), a series means "a group or number of related things or events." While all instances of abuse are not characterized by repeated improprieties, those which are not so characterized involve, by their very nature, an element of repetitive or consistent activity. Since a specific or knowing intent to work a fraud on the various programs is not required, the adoption of a pattern or repetitive criteria for determining abuse is eminently reasonable and excludes single or occasional incorrect claims or mistakes and isolated instances from sanctions, except, of course, where theft or fraud is involved.

Although the Statement refers to the definition of series as involving the concept of "relatedness", it does not appear that the rule intends to exclude from sanction those improprieties which are not of a similar nature but which, even though dissimilar, are of such a magnitude that it can be reasonably concluded that they constitute a pattern. If this is not the intention of the Department, it should clarify the relatedness contemplated by this Part in its Order Adopting Rules.

33. Part B.11. defines "recipient" as an individual who has established eligibility for one of the programs. As noted in the Department's Statement (p. 9.), the definition includes individuals who have submitted an application, those currently eligible and those previously eligible but no

longer participating in the particular program. Although MAHCF argued that the rule should specifically provide for those individuals made retroactively eligible, those individuals are covered by the definition and that no amendment is necessary. Consequently, the definition proposed is necessary and reasonable.

34. Part B.12. defines "records" as including financial records pertaining to health care provided to recipients and billed to the programs. As explained by DPW at the hearing, the concept of financial records does not include the income tax records of the various providers involved. The rule is necessary and reasonable even though the rule, itself, does not exclude such tax records from the definition as MAHCF suggested.

35. Part B.16. defines "suspension of payments" as the stoppage of any or all program payments for services billed by a provider pending resolution of the matters in dispute between the provider and the state agency. MDA suggested that the word "for" in this definition should be replaced with the word "undisputed" to make it clear that the stoppage of payments was not authorized for all services but could only be stoppage of those services which are in dispute. MDA's proposal ignores the fact that it is impossible to withhold payments for disputed services which have already been paid. Where recovery is based on a pattern of imporper practices many previously paid claims may later become disputed and their aggregate value could be substantial. For that reason DPW's proposal to withhold any or all payments for services billed is necessary and reasonable. Of course, as is implied in Part D.3.b. and Minn. Stat. § 256B.064, subd. 1.c. (1980), which reference "erroneously" paid claims and "recovery", payments would not be withheld in an amount exceeding the amount in dispute.

36. In response to comments submitted by MAHCF, the DPW proposes to amend the definition of "terminating participation" to read as follows:

Making a provider ineligible for reimbursement by the programs.

This amendment was made because DPW believed that permanent termination rendering one forever ineligible from participation in these programs is inconsistent with the concept of rehabilitation. Under the rule as redrafted, it is intended that a provider once terminated can be allowed to reapply for participation. The section, as amended, is necessary, reasonable and not substantially changed.

amended p.7.

37. The other definitions in Part B. were not subject to public comment or criticism or were not subjected to any substantial objections, and the Hearing Examiner finds the other definitions to be necessary and reasonable in their entirety. While several parties requested that additional definitions be included in the rules, such as definitions for fraud, theft and the meaning of the word "repeated", the Hearing Examiner concurs with DPW, that with respect to fraud and theft, the meanings are sufficiently clear in the law and that further redefinition of those concepts does not render the statute vague or unfair and does not constitute a denial of proper notice of those fraudulent or felonious activities which are impermissible and sanctionable. Furthermore, defining those terms might only thwart DPW in imposing sanctions

against one who contrives a scheme which is outside the letter of the definition adopted.[8]

For that reason, the failure to include definitions of these additional terms is necessary and reasonable and within the agency's discretion. Further elaboration can properly be left to contested case proceedings or other judicial proceedings which might arise. It should be noted that Mr. Kohnstamm did state at the hearing, that DPW's basic notion of fraud is the intentional misstatement of material fact to induce someone to part with money or property (T. 204).

38. Dr. Dennis Brandstetter, Chairman of MDA's legislative committee, was concerned with the definition of "withholding of payments" at Part B.19. He felt that reimbursement should not be denied merely because the services performed were not found on a medical record or health record if the provider could show that the services were, in fact, performed. To that end, he suggested that the words "not documented in the recipient's medical or health record" in that definition, be replaced with the words "which have not been documented or cannot otherwise be proven to have been provided." DPW did not respond to this comment but the Hearing Examiner believes that this would be a reasonable and insubstantial amendment to that definition and suggests that it be adopted where no pattern of incomplete entries exist. There may be isolated cases when a medical record or health care record might not reflect services actually performed or isolated cases where the medical or health care record has been lost or destroyed. In those isolated cases, where a provider can establish that they were provided, the provider should not be sanctioned or denied reimbursement. On the other hand, where there are patterns of records not verifying the care given, there are good reasons for denying payments and imposing sanctions. Whether the Part should be amended is one best left to DPW's discretion. Either way, the Part is necessary and reasonable.

no change p.7.

Part C. - Records.

39. Part C. deals generally with medical records, health care records and financial records, what those records must contain, access which must be provided to the Department, and their retention. Special rules have been adopted in some respects for pharmacies, laboratories, ambulance services and

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8 In Johnson v. Mc Donald, 197 Okla. 117, 39 P.2d 150, 154 (1934), the court noted that fraud is:

> "A generic term, embracing all multifarious means which human ingenuity can devise, and which are resorted to by one individual to get advantage over another by false suggestions or by suppression of the truth, and includes all surprise, trick, cunning, dissembling, and any unfair way by which another is cheated."

In Minnesota the elements of fraud have been described as a false representation of a material fact, knowledge of the person making the representation of its falsity or with no knowledge of its truth or falsity, an intention that the other party act on the misrepresentation, or circumstances justifying the other in so acting, and the other person being induced to act on the representation, relying on it, and suffering damage. 8A Dunnell Minn. Digest 2d Fraud § 2.00 (3d ed. 1979). This definition may be too narrow for purposes of the rule.

suppliers of medical equipment and non-durable supplies. The two fundamental issues raised by public comments on this section pertain to DPW's authority to authorize the keeping of specific kinds of records and the scope of DPW's authority to examine records maintained by the various providers given their confidential nature. In addition, several parties expressed concern with the failure of the rules to distinguish between the various kinds of providers involved and their different record-keeping practices. All these objections, including other more specific objections to the rules, will be discussed.

40. Part C.1.b. requires that medical and health care records be legible to the individuals providing care. MAHCF, in its posthearing comments, objected to this requirement and suggested that the rule be amended to provide that those records be legible at least to the person making the record. MAHCF felt that in determining what had been ordered by a particular individual, DPW would question the person who made the notes and not just anyone. In addition, it stated:

> If persons providing care become responsible for another person's penmanship, nursing homes, as well as other institutional providers, may be placed in the position of requiring all medical doctors to either take courses in penmanship or purchase expensive dictation equipment along with additional personnel to transcribe any notes which are to be inserted into the record.

This objection has some merit and DPW could consider making the legiblity requirement applicable only to records maintained by the provider and its employees, if any. In the example cited by MAHCF, it doesn't appear that the provider should be responsible for medical records maintained by physicians or others who are not their employees. However, providers should be responsible for the legibility of records upon which they base reimbursement for themselves. If only the person making the record is able to read it, which is usually the case, it does others no good at all in providing health care. The purpose of requiring legible records, apart from creating an audit trail, is to document the needs of recipients, what has been done and what is needed. If this cannot be determined from the record unnecessary or duplicative care could be provided. However, regardless of the Department's ultimate decision as to the scope of the legibility requirement, the Hearing Examiner concludes that it is a necessary, reasonable and authorized requirement under the rules. If records are not legible, the Department simply cannot perform an adequate or effective audit or make reasoned determinations of incorrectness or fraud.

41. Part C.1.c.(1) through (11) contains the information required of every medical and health care record. MMA objected to this part as an unnecessary and unreasonable requirement and one that the Department was not authorized by law to adopt.

The Hearing Examiner is persuaded that DPW does have authority to require the keeping of specified records. Such authority is implicit in Minn. Stat. § 62E.54, subd. 1.(d) (1980) and Minn. Stat. § 256B.04, subd. 10 (1978) which authorize DPW to establish general criteria for the identification of fraud, theft and abuse. The power to identify fraud, theft and abuse necessarily encompasses the power to define those matters, and to the extent that specified records are necessary to identify fraud or abuse, or the failure to maintain them constitutes an abuse, those records must necessarily

be maintained. The failure to maintain them has been defined as an abuse and they must, of necessity, therefore, be maintained because it is abusive not to do so. In addition, even apart from those specific statutory provisions, DPW has other ample authority to specify what medical records must be maintained under its general rulemaking authority in Minn. Stat. §§ 62E.54(a) and 256B.04, subd. 2 (1980) and under Minn. Stat. § 256B.27, subd. 1 (1980), which permits DPW to require any reports, information or audits deemed necessary for the approval of rates and charges. It has adopted, consistent with federal requirements, other rules pertaining to the maintenance of adequate records and has included adequate record-keeping responsibilities in its contracts with the various providers. Given these circumstances, the Hearing Examiner concludes that DPW has authority to adopt this Part.

Noting the differences in the record-keeping practices of institutional providers, physicians and dentists, both MMA and MDA suggested that they be deleted from the requirements of Part C.1.c. MMA noted that recordkeeping habits of physicians in this state vary significantly with the nature of the patient's illness and the locality of the practice and that to apply these requirements uniformly to all physicians was not shown to be necessary and reasonable. MDA also argued for exemption from this Part and suggested that the record-keeping requirements for dentists be included in Part C.1.d. and suggested what those requirements should be. The Department did not specifically respond to the suggestion of MDA but it is suggested that it consider its comments to determine whether or not MDA should be separately considered as suggested. With respect to MMA, the Hearing Examiner is persuaded, as DPW argued, that the requirements of Part C.1.c. reflect the "normally available data which fully disclose the extent of service provided and the medical necessity for such service" and that "the minimum components of health care records are the same" for all providers. Consequently, the Hearing Examiner finds these provisions to be necessary and reasonable in their entirety.

42. Part C.1.c.(2) requires that each entry in a medical or health care record shall be signed by the individual providing care and that entries for care provided by an individual under the supervision of a licensed provider and which is billed directly to the program by the provider must be countersigned by the provider. The Minnesota Chiropractic Association (MCA) objected to this since it is not standard practice for chiropractors to sign each entry made in their patients' medical care records and that it would be a worthless procedure in a one-doctor office. While the Department can consider this objection for such one-doctor offices, the Hearing Examiner is not persuaded that the rule as written is unnecessary or unreasonable and there is no evidence that records, even in such offices, would be maintained only by one person.

43. In its Statement (p. 14), DPW stated that records must be countersigned by a licensed provider where the services involved are billed to the Department on the provider's number, and the provider was required to have direct on-site supervision of those services. For this reason, the Department feels that the countersignature requirement is necessary and reasonable. The Phoenix Residence, Inc., in its posthearing comment, objected to this requirement and its accountability for other professionals with whom it has

contracted, and it argued that the countersignature requirement would merely create an additional demand on facility time and result in little more than paperwork compliance, signatures for signatures' sake, rather than in a meaningful documentation of services provided. The Hearing Examiner is persuaded that abuse could occur if a facility does not monitor the services for which they must countersign, but the real evil is not that they don't countersign a document but that they don't properly monitor such services. Consequently, it is not unreasonable to suggest that the countersignature be deleted and that the rule merely make providers in such instances responsible for the care supposedly given, or make it an abuse if they repeatedly fail to properly monitor or supervise that care. This would eliminate the necessity to countersign every document. On the other hand, the requirement of countersigning does serve some purpose in that the provider doing so should know, verify or be able to determine if such services were, in fact, provided. The agency is, however, in the best position to make a final determination on this matter as the Hearing Examiner believes that there are reasonable arguments on both sides of the proposition.

See added language p. 8

It is clear, however, that the countersignature requirement does not apply to long-term care facilities, such as nursing homes (T. 75) because these institutions' costs are not billed directly to the various programs.

44. In response to comments from the public, the Department in its posthearing submittals proposes to amend Part C.1.c.(3) to read as follows:

(3) Diagnoses, assessments or evaluations.

This amendment deleted the words "initial and final" which previously preceded the word "diagnoses". Since there are many types of diagnoses, the words "initial and final" were not deemed accurate and merely led to confusion. This amendment is necessary, reasonable and insubstantial.

deleted p. 8

45. In response to the suggestion of MAHA/MHA, the Department proposed in its posthearing comments to amend Part C.1.d.(3)(a) to read as follows:

(a) Documentation of physician authorization for non-emergency medical transportation.

The words "non-emergency" were added because DPW does not require written authorization for emergency transportation and the rule, as initially proposed, did not reflect that policy. The amendment to this Part is necessary, reasonable and insubstantial.

added p. 10

46. In response to comments from the MMA, DPW proposed, in its posthearing comments, to amend Part C.2.a. to read as follows:

a. Financial records, pertaining to the providers' costs (<u>if the provider is reimbursed on a cost basis</u>) and charges for health care provided to program recipients shall be developed and maintained [new language underlined].

This amendment was made to clarify the fact that the data needed by the Department with respect to costs will vary according to the provider's basis for reimbursement. The purpose of the amendment is to make it clear that cost information is only required from cost-based providers and that charge information is required from other providers. This is a necessary, reasonable and insubstantial amendment.

amended p. 11

47. Part C.2.b.(1)-(3) specifies the financial records that must be kept by providers such as physicians. MMA challenged DPW's authority to impose

specific financial record-keeping requirements on all providers under this rule. The Hearing Examiner disagrees and finds the provisions to be authorized, necessary and reasonable.

Minn. Stat. §§ 62E.54(d) and 256B.04, subd. 10 (1980) both authorize the Department to establish the criteria (standards) for the identification of fraud, theft and abuse in these programs. Those provisions necessarily authorize and require providers to keep specified records where the failure to keep such records would constitute an abuse of the system because it would render DPW unable to conduct an audit for purposes of verifying the basis for costs incurred in those programs. Furthermore, such authority can be predicated on the Commissioner's general rulemaking authority under Minn. Stat. §§ 62E.54, subd. 1(a) and 256B.04, subd. 2 (1980), and under Minn. Stat. § 256B.27, which provides as follows:

> In the interests of efficient administration of the medical assistance to the needy program, and incident to the approval of rates and charges therefor, the commissioner of public welfare may require any reports, information, and audits of medical vendors which he deems necessary. (Emphasis added)

In addition, under Minn. Stat. § 256B.064, subd. 1a (1980), monetary recovery and sanctions may be imposed against the vendors of medical care for inter alia "refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients (Emphasis added)." In view of these various statutory provisions, and the general purpose of the statutes involved, the Department necessarily must possess authority to permit SUR to investigate financial records and determine what financial records must be maintained by providers. Any other result would make a meaningful audit impossible and would severely restrict the Department's ability to define abuses in these programs contrary to the purposes for which the rules were authorized.

48. Part C.2.b.(2) requires providers, other than nursing homes and board and care homes, to develop and maintain "all accounting records including, but not limited to, payroll ledgers, cancelled checks, and bank deposit slips." While the Department has authority to require the maintenance of certain records which are necessary to effectively determine whether the programs are properly billed for appropriate charges, it does not have authority to require general bookkeeping or accounting requirements upon anyone. Consequently, this Part must be read as including only those accounting records "necessary to disclose the extent of services provided to program recipients" (256B.064, subd. 1a), or those which it is abusive not to keep because it prevents the Department from effectively monitoring the providers and vendors involved. This is clear from DPW's comments on Part B.1.e. to the effect that only those records need be maintained which will enable the Department to effectively and reasonably audit the provider. Where particular documents are not necessary for purposes of an audit, they need not be maintained under these rules and would not be available for examination by SUR. The documents that need be retained and the scope of the Department's ability to examine them may not extend any further than is necessary to ascertain the facts necessary to make a determination of fraud, theft or abuse. The documents which can be examined would not be identical for all providers and the Department is not required in its rules to specify which records specifically must be maintained or which

can be examined in every possible factual circumstance. Thus the Part is necessary and reasonable as proposed and within the scope of DPW's authority.

49. Part C.2.b.(5) requires all providers except nursing homes and board and care homes to keep "records of other third-party claims, charges and payments." According to the Statement (p. 17), this Part is necessitated by 42 U.S.C. § 1396(a)(25) and 12 MCAR § 2.047 D.5. MHA challenged this provision as vague and incomprehensible. The Department did not respond to these allegations and the Hearing Examiner is unable to determine the purpose or scope of this Part. Consequently, if this section isn't clarified as to specifically what kind of records are intended to be covered, it should be deleted because it is impermissibly vague and offers absolutely no guidance to the parties supposedly regulated by it. In its present form it fails to meet the requirements of Minn. Stat. § 15.0412, subd. 3. (1980) and constitutes violation of a substantive provision of law. To correct this defect the scope of the Part must be clarified. see new clarifying language p. 91

50. Part C.3. sets forth DPW's right of access to records the various providers are required to keep. Access for examination of all medical health care and financial records related to health care billed to a program is permitted upon 24-hours' notice if DPW presents signed consent forms pertaining to the records of the individual sought to be examined.

MMA challenged this Part in its entirety in a detailed comment submitted at the hearing. It argues that DPW has authority to examine medical records only, that the rule is overbroad and that it violates the Fourth Amendment because no warrants are provided for in the authorizing statutes or the proposed rule, itself.

51. As authority for its inspection of the records specified in this Part, DPW cited Minn. Stat. §§ 62E.53, subd. 4, 256B.27, subds. 3-4, and 256D.05, subd. 4 (1980). None of these provisions authorize access to records other than "medical records"of program recipients and then only for the purpose of determining whether a vendor has submitted reports, claims or applications it "knows" to be false or in order to determine if the care provided is medically necessary. Contrary to those provisions, the proposed Part permits inspection of more than "medical records" and for purposes of determining more than knowingly false submittals or unnecessary care, but permits an examination for any fraud, theft or abuse covered in Part A.1. However, the statutory provisions cited by the Department are not the only pertinent provisions applicable. DPW also has general statutory authority to establish procedures for the investigation of fraud, theft and abuse. Minn. Stat. §§ 256B.04, subd. 10, and 62E.54, subd. 1(d) (1980) and has power to require any reports, information and audits of medical vendors deemed necessary. Minn. Stat. § 256B.27 (1980). In addition, while some statutory provisions indicate that the examination is limited to "medical records", §§ 256B.064, subd. 1a (1980), permits sanctions against vendors who refuse to grant DPW access during regular business hours to "examine all records necessary to disclose the extent of services provided to program recipients." Furthermore, regarding CHEPP, DPW has general rulemaking power under Minn. Stat. § 62E.54, subd. 1(a) to promulgate rules, inter alia, to implement Section 62E.53, subd. 3., which requires rules for procedures to determine the reasonableness of charges. The latter provision also permits the rules for

reviewing those charges to be consistent with Ch. 256B. which, as noted above, permits any audits deemed necessary.

52. These various provisions apparently mean that DPW may audit any records pertaining to the programs except that audits of personal medical records can only be made for the purpose of determining whether a provider has submitted a claim for reimbursement or cost report or rate application which the vendor knows to be false in whole or in part (fraud or theft) or for the purpose of determining whether the medical care was medically necessary. The limitation on the use of medical records is obvious in the use of the word "solely" in Minn. Stat. § 256B.27, subd. 3 (1980) and the word "only" in Section 62E.53, subd. 4. Since the rule is not limited to an inspection of medical reports for those limited purposes, it is, to that extent, inconsistent with the statutory provision and unauthorized. As such it violates a substantive provision of law. To correct this defect, the rule must be rewritten to specify that the examination of medical reports can only be made for the purposes noted in the statutes.

see new language p. 12

However, as to other records, DPW has general authority to examine them under its power to adopt rules for the investigation and identification of fraud, theft and abuse. This is consistent with its power to sanction providers for refusing access to examine "all records necessary to disclose the extent of services provided to recipients".

53. MMA also challenges Part C.3. and the underlying statutory provision, Minn. Stat. § 256B.27, subd. 3, as violative of the Fourth Amendment because both allegedly permit the search and seizure of various records without any provision for a warrant or a determination of probable cause. While the Hearing Examiner is without authority to find the statute or the rule which incorporates its terms, unconstitutional, as a practical matter, the constitutionality of a rule is not immaterial for purposes of rulemaking hearings, especially where, as here, the Agency is not required to implement the statute as written in its rules or follow its terms as written without any modifications or elaborations. On the contrary, DPW has obvious authority to add procedural protections and, with respect to sanctions, has discretion whether or not to impose them. Consequently, where important constitutional rights and principles are involved, DPW should consider them in preparing its rules and add administrative devices designated to safeguard precious constitutional rights, privileges and principles. This is certainly appropriate and agencies have, on occasion, fashioned their rules to avoid unconstitutional results which would otherwise flow from a rigid application of statutory provisions. See, e.g., State v. Minnesota Federal Savings & Loan Ass'n., 218 Minn. 229, 15 N.W.2d 568 (1944). Agencies are also free to grant procedural rights not required by statute in the exercise of their discretion. Vermont Yankee Nuclear Power Corp. v. N.R.D.C., Inc., 435 U.S.519, 524 (1978). For that reason, the Hearing Examiner feels that the constitutional issues raised by MMA should be considered and dealt with in its rules.

see Order Adopting Findings of Fact #1

+ new language p. 12.

54. MMA cited Marshall v. Barlow's, Inc., 436 U.S. 307 (1978) which held that administrative searches are subject to the Fourth Amendment prohibition of unreasonable searches and seizures and against warrantless intrusions of

commercial premises during civil or criminal investigations.[9] The Court distinguished its earlier holdings in Colonnade Catering Corp. v. United States, and United States v. Biswell,[10] and held that industries under OSHA have not impliedly consented to inspections.

Between Colonnade and Biswell, the Supreme Court, in Wyman v. James, 400 U.S.309 (1971), held that a welfare recipient has no Fourth Amendment right to receive AFDC benefits and refuse consent to a home visit by a caseworker because such searches were not unreasonable given the purposes for it (the protection of children and the assurance of proper use of tax funds). While some administrative searches are clearly subject to the Fourth Amendment prohibitions, current case law has left the status of administrative searches in some doubt and no readily ascertainable standard has been adopted for application to various other industries or programs.[11] The first issue raised with respect to the Fourth Amendment problem noted by MMA is whether Part C.3. actually permits a warrantless inspection or whether it merely authorizes an inspection if consented to and imposes a sanction for a vendor's failure to consent to such an inspection (this assumes there may be some ground for distinguishing between the two). In Wyman, the Supreme Court held that the law which required the consent of AFDC recipients did not authorize warrants and that the recipient had a right to refuse home visits but would lose benefits as a result. Similarly, in Colonnade, the Court found that the statute in question did not permit warrantless inspections, and the inspection was found unauthorized for that reason, the Court merely noting that the statute could have authorized warrantless searches. Also, in United States v. Litvin, 353 F.Supp. 1333 (D.D.C. 1973), the Court held that Congress could provide for warrantless searches of industries under parts of the Food, Drug & Cosmetics Act of 1970, but in that case, noted that the provision for a penalty for refusal of entry was the Agency's exclusive remedy. Minn. Stat. § 256B.064, subd. 1a and 256B.27, subd. 3 (1980) do not provide for a warrant and apparently means that inspections can be refused by providers, and if refused, the sole remedy for such refusal is the imposition of the sanction authorized.

55. Assuming that the provisions are read as authorizing a warrantless search or are found to be tantamount to such a search because of the sanctions

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[9]In Barlow's, the Supreme Court struck down the warrantless inspection of businesses authorized under the Occupational Safety and Health Act of 1970 (OSHA).

[10]397 U.S.72 (1970), and 406 U.S.311 (1972), respectively. In Colonnade, the Court held that warrants are not necessary for administrative inspections involving the liquor industry because the long history of regulation in that industry obviated the need for Fourth Amendment protections. Similarly, in Biswell, which has been called the "implied consent" exception to the Fourth Amendment, the Court held that no warrant was required for the search of businesses engaged in the firearms trade, even though the history of regulation of that trade was not as deeply rooted as in the liquor industry, because individuals in that business, which is significantly regulated, may be deemed to have consented to concomitant administrative inspections.

[11]Note, Camara, See, and Their Progeny: Another Look at Administrative Inspections Under the Fourth Amendment, 15 Col. J.L. & Soc. Prob. 60 (1979).

available, the Court, as noted in Colonnade and Biswell, may sustain that practice on the grounds that such searches are expressly or impliedly consented to by the various providers involved. Of course, the constitutionality of the provision in any particular case might very well depend on the type of provider involved and the history of the regulation of that provider's business, the types of records involved and contractual provisions which exist. Nursing homes, for instance, may be deemed to have impliedly consented where doctors, psychiatrists and dentists have not. Thus, the provision is not clearly unconstitutional on its face, but may only be invalid in its application to certain providers or as to certain records.

56. The Department has not undertaken to administratively implement the purposes of the Fourth Amendment by adopting criteria as to which providers will be examined under this Part and what administrative criteria, if any, the SUF section must meet prior to invoking it. While this would not be a simple endeavor, the Department has an obligation to make every attempt to comply with constitutional mandates and should not merely engage in a course of action where there are grounds to believe that course of action is repugnant to the Constitution simply because the authorizing statute has not been found repugnant in a particular case.

DPW did not discuss the constitional issues or to state whether it would pursue the inspections authorized and impose sanctions or demand a search where the particular provider refused access to them. For that reason it is difficult to comment on this Part. However, it is strongly recommended that this inspection provision be thoroughly reviewed and that inspection standards be adopted, where necessary, covering those providers who have not consented to searches, what constitutes a valid consent, what records will be examined, alternatives to a search, special provisions for the examination of confidential medical records that may be necessary or alternatives that may be available, and administrative criteria for the search of particular records for particular providers that establish, neutral administrative criteria of probable cause, where appropriate, or a higher standard of suspicion, where necessary. In the latter respect, for example, the agency could use its sampling results under Parts D.1.b.(1) as probable cause for certain inspections and could make a finding of "exceptionality" a necessary prerequisite to inspection in a proper case. DPW could also seek warrants, where necessary, from the District Courts so that evidence gathered is not rendered inadmissible in subsequent proceedings resulting in DPW's inability to obtain monetary recovery or impose sanctions. While no law was cited by the parties which authorizes administrative warrants, the Attorney General has determined that they are available from the District Courts. Op. Att'y Gen. 59a-9 (July 28, 1967). It has been held that specific statutory authority is not required to obtain such warrants. Owens v. City of Las Vegas, 55 Nev. 105,450 P.2d 754 (1968). See also, Note, Administrative Search Warrants, 58 Minn. L. Rev. 607 (1974).

57. The Department could gain needed flexibility and avoid some of the Fourth Amendment problems raised by the existing procedure by obtaining and/or implementing a subpoena power, to be used as an alternative to visitation, to aquire the pertinent records. DPW has suboena power under Minn. Stat. § 256B.13 (1980) which it could use instead of actual visitation and

inspection. Unlike the power to search and seize under the Fourth Amendment, the subpoena power is much broader, and the Fourth Amendment requires only that the subpoena be limited in scope, relevant in purpose and specific in directive so that compliance will not be unreasonably burdensome. As such, particularly as to corporations, the subpoena power permits inspections of records that might not be available in a search and seizure situation. See, e.g., Oklahoma Press Pub. Co. v. Walling, 327 U.S. 186 (1946); United States v. Morton Salt Co., 338 U.S. 632 (1950); See v. City of Seattle, 387 U.S. 541 (1967). See, also, State v. Mees, 235 Minn. 42, 49 N.W.2d 386 (1951). The Department could also seek legislation to eliminate constitutional problems raised by the public.

58. As to physicians and psychologists, the Court's decision in Hawaii Psychiatric Society v. Ariyosha, 381 F.Supp. 1028 (D. Hawaii 1979), is important. In that case, the Court enjoined enforcement of a warrant to inspect medical providers' records where the warrant was issued on a "valid public interest" standard of probable cause. The Court required either actual consent or a showing of some quantum of individualized suspicion before such a warrant could be issued. In order to legitimize the inspection of the records contemplated under the rule in light of this case, DPW should consider adding a consent to inspection clause in all provider contracts. Further, it could administratively develop standards of individualized suspicion which would have to be met prior to implementation of any search or the imposition of any sanction against the particular provider who refuses to give consent for an inspection.

Where consent is given the rule in Ariyosha is different. In United States v. Griffin, 555 F.2d 1323 (5th Cir. 1977), the Court upheld a warrantless search of pharmaceutical records where consent was given in the pharmacist's contract with the State. Warrantless inspections have also been upheld for the inspection of coal mines, food companies and massage parlors. See, Youghiogheny and Ohio Coal Co v. Morton, 364 F.Supp. 45 (S.D. Ohio, 1973; United States v. Del Campo Baking Mfg. Co., 345 F.Supp. 1371 (D.Del. 1972); and Pollard v. Cockrell, 578 F.2d 1002 (5th Cir. 1978). There is authority to the contrary, however, in each of these situations. See, Annots. 19 ALF Fed. 736, 18 ALF Fed 734.

59. MMA also challenged Part C.3. as violative of the privacy interests of providers and recipients under the due process clause of the 14th Amendment. It noted that in Whalen v. Poe, 429 U.S. 589 (1977), the Supreme Court implied that medical care decisions fall within the protective zone of autonomy and are protected. In Ariyosha, the Court reasoned that access by state officials to medical records of psychiatrists burdened privacy interests and that search warrants should not be issued to examine those records where there is no suspicion (probable cause) that the provider has defrauded the state or failed to maintain records. This decision applies the concept of probable cause, previously applied only in the area of criminal law, to administrative procedure. In view of this case, DPW should strictly comply to the scope of the examinations specifically authorized by § 256B.27, subd. 3, and limit its inspection of personal medical records only for the two purposes specified therein.

Further, Ariyoshi held that individual Medicaid recipients did not

waive privacy rights by signing application forms which contained a waiver permitting the Agency to examine them because such waivers by indigent persons could not be considered knowing waivers under the 14th Amendment. This holding raises the issue whether the consent forms authorized in Minnesota law are constitutionally adequate and may be used to predicate or authorize the investigations currently permitted. This issue is discussed in further detail below.

60. MHACF challenged Part C.3. in conjunction with B.14., C.8., D.3.a.(2)(d) as they related to signed authorizations by medical care recipients. Their basic argument is that the so-called U.C. Unit is not authorized to have access to medical records without presenting written authorizations for access to medical records. The purpose for excluding the U.C. Unit from Part C.3. was not stated, but that Unit is not granted authority for access to medical records or to have access to those records under § 256B.27, subd. 3, for any purposes other than those listed therein. DPW's attempt to excuse that Unit from compliance with those provisions is not authorized. To correct that defect, the last sentence of Part C.3. must be deleted because DPW has simply failed to establish any authority for such a provision which, on its face, is contrary to the provisions of § 256B.27. deleted p. 12

61. Part C.4., which authorizes the Agency to photocopy or duplicate any medical or financial records it is authorized to examine was challenged by MAHCF and MMA. MMA suggested the rule be limited to copying on the provider's premises, with the Agency's equipment and at the Agency's expense, while MAHCF requested compensation if the provider's equipment is used and a receipt if any material is removed from the provider's premises.

In response to those comments, DPW now proposes to amend the Rule to provide that all photocopying or duplicating will be at Agency expense. The new rule merely adds the words "at its own expense" after the words "The State Agency. . ." As far as it goes, this is a necessary, reasonable and insubstantial amendment. While MAHCF was concerned with the actual seizure of those records by the Department and their removal from the premises for photocopying or otherwise, such seizure or removal is not authorized under the statute or the rule and cannot be implied. Since seizure is nowhere permitted, the Hearing Examiner recommends to DPW that the rule be clarified to provide that copying be limited to the provider's premises unless removal is specifically permitted by the provider. clarified p. 13

62. Part C.5. requires providers to retain all records for at least five years. Despite some objections to the five-year period adopted, some parties suggesting three years as an alterative, the Hearing Examiner finds this five-year requirement to be consistent with 12 MCAR § 2.047 D.4.c. and with the Department's discretion in this area. However, the Hearing Examiner recommends that DPW consider the suggestion of MMRA that original records only be maintained for a minimum of three years after which time, they could be maintained on microfilm. Since audits of nursing homes take place at least every three years, and since record retention of original documents might impose some hardships, the Department should consider permitting microfilming after three years. OK. p. 13

63. At the hearing, DPW proposed to amend Part C.6. to read as follows:

In the event of a change of ownership of a facility or practice, the selling provider shall be responsible for all records generated prior to the change. Nothing in this provision shall have the effect of making either party involved in the change of ownership liable for the actions of the other party.

The purpose of this change, as noted in DPW's posthearing comments (p.9) is to put the seller on notice that he has the responsibility for making records available to DPW even if he sells his business. The Department made it clear that it was not concerned with mandating retention of these records by either party. MMA and MAHCF both pointed out problems with this section as drafted. Part of the confusion results from the use of the word "responsible." There seems to be two kinds of responsibility. Responsibility for the preservation of the records, and responsibility for making the records available to the Department. Apparently, DPW is concerned only with access and not to preservation. Such an approach ignores the realities of the situation, especially with respect to nursing homes which, when sold, require the selling provider to surrender those records to the purchasing provider. At the time of sale and the surrender of these records, it would seem that the selling provider loses all control over the records and cannot guarantee access to DPW except by some contractual provision. It appears that the rule should be redrafted to clarify DPW's intent. The following language is suggested:

In the event of the change of ownership of a facility or practice, the seller, unless otherwise provided by law or by written agreement, shall be responsible for maintaining and preserving all records generated prior to the date of sale. Responsibility for making records available for inspection after the date of sale is on the seller and the seller must take reasonable steps by contract or otherwise to maintain a right of access to those records which is necessary to substantiate his billings, cost reports and otherwise.

adopted p.13

As noted in the current rule, nothing in this provision has the effect of making either party involved in the change of ownership liable for the actions of the other party; that is, as clarified in the Department's Statement (p. 19), that the buyer is not liable for any conduct reflected by the seller's record." This latter provision should, of course, be retained. The Hearing Examiner finds that the amendment to Part C.6. is necessary, reasonable and insubstantial but still suggests that it be clarified as to its purpose and as to the selling and purchasing provider's obligations.

no other clarifying change p.13

64. Part C.7. makes the provider responsible for maintaining all records "developed during participation in the programs" for five years if the provider withdraws or is terminated from program participation. This provision is necessary and reasonable as proposed, but when read in conjunction with Part C.5. is confusing. Under Part C.5., records only have to be kept for five years. If one terminates his participation in the programs, only five-years' records are required to be in his possession, and with each succeeding year, one year's records would be dropped. Part C.7. is inconsistent with Part C.5. to that extent. This Part should, for that reason, be clarified with respect to Part C.5.

see new language p.14

With respect to this provision, MAHCF argued that it is very burdensome to retain records for five years if one retires from practice and suggested that this provision be waived where the retiree requests and is granted an audit. The Department should consider waiver of this provision

where an audit is requested and performed. Such a waiver could be made conditional on the seller's agreement to reimburse the Department for the costs of that audit. As an alternative, the retiree could be permitted to retain his records on microfilm as that could substantially reduce the burden imposed in storing the original documents for a long period of time.

65. Part C.8. provides that a recipient's consent shall be presumed competent if given in conjunction with an application for program coverage and that the presumption exists regardless of whether the application was signed by the recipient, a guardian, next of kin, friend or other person. In its posthearing comment, DPW indicated that this Part C.8. should be amended to make it clear that the presumption created is "rebuttable". However, it proposed no specific amending language. An amendment to the rule in any language DPW desires to utilize, making it clear that the presumption is rebuttable, would be a necessary, reasonable and insubstantial change.

66. As noted in Ariyosha, consents given by recipients in connection with applications for medical benefits do not necessarily waive privacy rights under the Fourteenth amendment. In light of that case, DPW should take great care to make the waiver provisions specific and knowingly signed. MMRA submitted detailed comments regarding the contents of an appropriate consent form and it is recommended that the Agency review the Ariyosha case and the recommendations of MMRA so that the consent form used does not raise unnecessary constitutional problems or unnecessarily infringe upon protected Fourteenth Amendment rights.

Finally, the Hearing Examiner agrees with those parties who objected to the Department's proposal to treat waivers signed by a "next of kin, friend or other person" as necessary, reasonable or authorized. The Department cited absolutely no law which permits them to authorize a stranger or an acquaintance or even a relative to waive important constitutionally recognized rights to privacy. This provision is not authorized by statute and constitutes a substantive violation of law which cannot be retained in the Rule. The defect can be cured only by eliminating the words "next of kin, friend or other person". See, Edelman, Search Warrants and Sanitation Inspections - The New Look in Enforcement, 45 Denver L. J. 296, 303 (1968).

Part D. - Provider Surveillance and Utilization Review.

67. Part D. deals generally with the identification of prospective fraud and abuse, its investigation, the recovery of monies improperly paid, and the imposition of sanctions upon providers.

68. Part D.1.b. specifies the informational sources which SUR is authorized to use. MMA suggested that the first paragraph be amended to provide that the authorization be coupled with the limitation that it is subject to "applicable principles of confidentiality." This suggested amendment is a reasonable one which the Hearing Examiner recommends be adopted. However, Departmental compliance with applicable principles of confidentiality contained in the laws of this state or the Constitution is required apart from any language in this rule, and it can be assumed that the Department will comply with those principles. As such, while the amended language is recommended, the rule in its present form is necessary and reasonable.

69. MAHCF challenged the proposed use by the SUR Unit of computer reports

generated by the Medicaid Management Information System (MMIS) implemented in cooperation with the U. S. Department of Health and Human Services. This program develops profiles on the provision and utilization of health care and compares data on peer group basis to identify providers and recipients who appear "exceptional" when compared to group norms. MAHCF felt that the kinds of peer groups and the criteria for normative behavior was not sufficiently defined, as in the previous hearing, so that the meaning of "exceptional" utilization is unclear, and that the specifics of these profiles must be promulgated by rule so that arbitrary and possibly discriminatory comparisons or investigations are not made. The Hearing Examiner disagrees that the specifics of the program or the profiles and standards for "exceptional" utilization need to be developed and set forth in the Rule. The provision, as written, is necessary and reasonable and fulfills a legitimate purpose of attempting to identify which providers, costs or billings and other matters are suspicious. The Internal Revenue Service uses a similar procedure in its administration of federal tax laws. See, 34 Am. J. 4 R. 2d. Federal Taxation § 9005. By using this technique, the Department does have a device for establishing some "quantum of suspicion" as referenced in Ariyosha for making an on-site investigation. Indeed, the use of this procedure is encouraged and it is recommended that DPW consider this as one of the necessary prerequisites for implementing on-site investigation of a provider.

70. DPW proposed at the hearing to amend D.1.c. to read as follows:

> In assessing questions of abuse or of medical necessity, SUR shall consult with a review organization as defined in Minn. Stat. § 145.61 or other provider advisory committees as appointed by the Commissioner.

amended p. 15.

This amendment makes the Pule consistent with Minn. Stat. § 256B.064, subd. 1a and is necessary, reasonable and insubstantial. MMRA suggested, in a similar vein, that so long as DPW insists on considering the submission of incorrect codes as abuse that it employ medical record professionals (RPA or ART) who have proven experience in diagnostic and procedural coding for the investigation of data reliability. This suggestion is simply called to the Department's attention for its consideration and in no way renders the proposed rule improper.

71. Part B.2.c.(1) provides that following the completion of an investigation, SUR shall take one or more of several specified actions, including the determination that no further action was warranted and to notify the provider of that determination. MDA suggested that such a determination and notification be made within 90 days or that the provider be notified of the reasons for an extension. While it is beneficial to have a speedy determination after investigations are completed, the time limit specified is not required to be set forth in the Rule. However, the suggestion does have merit and should be considered by the Department so that some final action is taken on investigations which have been completed by the SUR section.

no change p. 17

72. Part D.3.a.(1) provides that the Commissioner may seek monetary recovery against providers for fraud, theft or abuse in connection with services billed to the various programs, presentment of false or duplicate claims or claims for services not medically necessary, or false statements of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled. This is a necessary and reasonable

provision consistent with Minn. Stat. § 256B.064, subds. 1a and 1c (1980). MAHCF suggested that subpart (a) be amended to make it clear that recovery will only be made where the erroneous bill has actually been paid to the provider. The subpart is reasonable without that amendment. Since the very concept of a "recovery" implies a payment such a clarification is not necessary. If the Department is inclined to clarify the section, the Hearing Examiner also refers it to MDA's recommended language.

no change - p. 18

73. Part D.3.a.(2) authorizes the imposition of administrative sanctions against providers for fraud, theft or abuse in connection with health care services billed to the programs or a pattern of presentment of false or duplicate claims or claims for services not medically necessary or a pattern of making false statements of material facts for the purpose of obtaining greater compensation than to which the provider is legally entitled or the refusal of a provider to grant the state agency access to records pursuant to Part C.3. This language reiterates and is consistent with the provisions of Minn. Stat. § 256B.064, subd. 1a. MMA objected, however, to the Part as written, stating as follows:

> While it sometimes may be appropriate to seek monetary recovery when a provider acts in an intentionally abusive manner, MMA does not believe that sanctions are appropriate for unintentional actions. This conclusion is supported by the underlying statutes, which authorize examination of medical records to determine whether a provider "has submitted a claim for reimbursement, a cost report or rate application which the [provider] knows to be false in whole or in part. . . ." Minn. Stat. § 256B.27, subd. 3 (Emphasis added). However, Part D.3.a.(2) would permit the imposition of sanctions for several acts which would not necessarily be done intentionally.

It is quite different to recover money for unintentional abuses than to impose sanctions for unintentional abuses. Normally, sanctions or punishments are imposed for an evil intent or a deliberate and knowing failure to abide by proper procedures. However, the imposition of sanctions for unintentional abuses as defined by DPW is authorized. While the statutes, themselves, utilize some inconsistent language, they do generally sanction only that conduct which is more improper than the conduct for which monetary recovery may be had. Thus, while monetary recovery can be had for the presentment of false or duplicate claims or claims for services not medically necessary, sanctions can be imposed only when a pattern of presentment of false or duplicate claims or claims for services not medically necessary exists. It is the pattern that justifies the imposition of sanctions whether the pattern occurred as the result of carelessness, incompetence, intentional deception, improper practice or other causes. According to DPW, such patterns cannot be tolerated consistent with the purposes of the Act. It is true that Minn. Stat. § 256B.27, subd. 3, limits examination of records for purposes of determining whether certain claims, reports or applications known to be false were made. However, the same section authorizes investigations to determine whether medical care provided was medically necessary without any limitation to the provider's knowledge. So, also, it is clear that false or duplicate claims are sanctionable without any limitation to those which are knowingly false or knowingly duplicitous. While the word "false" sometimes connotes an intentional deception, the statute taken as a whole indicates that the word "false" in § 256B.064 is synonymous with incorrect and does not mean

intentionally or knowingly false. If the latter construction were placed on the word "false", it would be tantamount to redefining fraud. The Part is necessary and reasonable as proposed.

74. Part D.3.c. was criticized in detail in Mr. Wildfang's comments on behalf of MAHCF. That Part provides as follows:

> For the purpose of D.3.b. of this rule, the commissioner shall be authorized to make monetary recovery from providers of monies erroneously paid, based upon extrapolation from a random, unbiased sample of claims billed to the programs by a provider, for a specific procedure code. The sampling method shall adhere to generally accepted statistical procedures regarding sample size, sample selection, and extrapolation from the results of the sample.

see p. 19-21 for new sections on sampling

Both MAHCF and MMA challenged the need and reasonableness of such a statistical approach to the determination of abuse and the Department's authority to utilize such an approach. As noted by MAHCF, this sampling procedure would work substantially as follows:

> The Department, based upon some independent indication of erroneous payments (e.g., under D.1.b.(1), computer reports which showed a provider to be "exceptional when compared to group norms"), would select a sample of all the cases involving a particular procedure code, and if the sample indicates a certain percentage of such procedures resulted in an overpayment, then the Department would extrapolate the percentage in the sample to the entire universe of claims and recover that amount of money. For example, if a provider had billed for 1,000 cases of a given procedure, the Department might sample 100 cases or 10%, and if the sample contained 10 cases or 10% which resulted in an average overpayment of $5.00, then the Department would recoup $500 (10% x 1,000 cases x $5.00 per case) from the provider.

75. This procedure has been used by the U. S. Department of Health and Human Services in recovering money from states and has recently been adopted for use by state agencies in Pennsylvania, California and Illinois. In State of Georgia v. Califano, 446 F.Supp. 404 (N.D.Ga. 1977), a Federal District Court upheld the use of statistical sampling in establishing erroneous overpayments of federal funds to the state on the grounds that statistical sampling was the only feasible method of audit available to the federal department. That case, as noted by MMA, is not entirely applicable to DPW's proposed use of statistical sampling because the record does not reflect that such a procedure in Minnesota is the only feasible method of audit available to DPW and DPW intends to use that procedure not against a state but against individual or corporate providers. In Daytona Beach General Hospital, Inc. v. Weinberger, 435 F.Supp. 891 (M.D.Fla. 1977), the Court referred to its order in that proceeding finding that the sampling methodology utilized by HEW whereby less than 10% of some 3,500 Medicare cases during the years at issue were selected for review, in applying statistical results of determinations of medically unnecessary hospital stays, drawn from such sample, to all Medicare patients cared for by the hospital during the relevant period, denied the hospital due process of law under the Fourteenth Amendment. The rationale for the Court's order was not set forth in the Court's published decision but does not hold that all sampling techniques would result in a denial of Due Process under the Fourteenth Amendment, but only that the particular sampling technique involved in that case was repugnant. In Illinois Physicians' Union v. Jeffrey Miller, ___F.Supp.___ (N.D.Ill. December 17, 1980) the Court held

that sampling and extrapolation methods do not necessarily deprive individual providers of property without due process of law and held that the State of Illinois could, in recovering overpayments of monies paid to physicians, utilize a sampling and extrapolation method for determining the amount of the overpayments made as long as the physicians participating in the Medicaid program were given adequate notice in a duly promulgated regulation of when sampling and extrapolation would be used, and so long as the providers have an opportunity to rebut conclusions drawn as a result of the sample, either by challenging the statistical techniques used in selecting the sample and extrapolation, or in producing all of its own billings as an alternative to reliance on sampling and extrapolation or other reasonable means. In reaching this conclusion, the Court rejected the proposition that only a 100% audit in each case can support a departmental determination of overcharges and further stated:

> Department's employment of a random sampling of physicians to be audited, coupled with a statistically sound sampling approach to those physicians' records, is a reasonable way to deal with the enormous logistical problems of Medicaid-enforcement if the methods used and the results reached are not treated as irrefutable.

The Court further noted that whatever method of proof is used by the physician to rebut the Department's overcharge determination, it is plain that the burden of demonstrating the unreliability of Department's figures rests on the physician.

76. These cases support the notion that a sampling technique for purposes of determining overpayments under the programs covered in the Department's proposed rule are not per se violative of the Fourteenth Amendment but that in the adoption or implementation of any particular plan, certain fundamental procedural rights cannot be ignored. Therefore, Part D.3.c. is not unauthorized or unconstitutional on its face. However, as noted in the Illinois Physicians' Union case, Part D.3.c. should state when the Department proposes to use the sampling technique authorized in that section. If it is to be used routinely, the rule should so state, or if it is to be used only in special circumstances, the rule should identify the circumstances when it is to be used.

S (77. In that respect, MMA suggested, based upon the Court's decision in State of Georgia v. Califano, that the Agency should demonstrate, and the Commissioner determine, that unique factors make it infeasible or unduly burdensome for the Agency to establish abuse by actual proof of a suspected violation or violations on a claim-by-claim basis. In its posthearing comments, the Department stated that the magnitude and logistics of policing the programs required them to use methods such as sampling which promote efficiency and effectiveness whenever they are available because of the relatively small size of their staff. While MMA argued that DPW had not established the necessity for use of a statistical approach to the determination of erroneous payments, the Hearing Examiner believes that such a rule is a necessary part of the investigatory tools which should be available to the Department and that provision for such procedure is necessary. However, the Department must still indicate in its rule when the statistical approach will be used. If it is only to be used in special cases, the rule

must indicate which circumstances will result in its use. Or in the alternative, that its use be authorized specifically by the Commissioner as suggested by MMA, when necessary because workload, volume, efficiency or other factors. Without stating when this approach is to be used the Part violates the Due Process Clause under Illinois Physicians Union. This is a substantive violation of law and a defect that must be corrected in DPW's final rule.

78. MAHCF challenged DPW's authority to adopt a sampling methodology for determining erroneous payments since such a methodology is not specifically authorized in the relevant statutes. The Hearing Examiner disagrees with the position of MAHCF in this respect and finds that DPW's authority to adopt rules establishing procedures for the identification and investigation of fraud, theft and abuse to be adequate authority for the adoption of the sampling technique. It is a procedure for the identification of fraud, theft and abuse and is plainly within the terms of the authorizing statutes.

79. DPW proposes to amend Part D.3.c. to make it clear that the conclusions drawn from the sampling and extrapolation made by it may be disputed by the various providers and proposed the addition of the following sentence at the very end of that Part:

> The Department's determinations regarding monetary recovery based upon sampling and extrapolation may be disputed as provided in section D.3.e.(2) of this Rule.

This is a necessary, reasonable and insubstantial amendment, but the words "section" should be changed to "Part" because D.3.e.(2) is not itself a section but merely a part of a section.

80. The most serious objection to Part D.3.c. as proposed is that the Department has failed to establish its reasonableness in that the words "generally accepted statistical procedures" are too vague and ambiguous and fail to provide any guidelines as to what kinds of statistical methodologies are acceptable. Rules under the APA must "make specific" the laws enforced or administered by each agency. Minn. Stat. § 15.0411, subd. 3. In this case, however, there is no evidence that the words "generally accepted statistical procedures" have any commonly understood meaning with respect to sampling techniques and the rule fails to provide any guidelines as to which samples or sampling techniques are acceptable. Thus, with respect to the confidence factor and the margin for error involved in any particular statistical model, no evidence was presented showing that there is a generally accepted confidence factor (percentage) that a particular statistical model must have to be fair or reliable or whether there is a minimally acceptable margin for error which is generally recognized or what that margin of error should be under the terms of this Rule. It is not possible to determine from the record whether the Department in a particular case might not propose to recoup monies based on a confidence factor of only 60%, or 70%, or what minimum margin for error, if any, should apply in administrative proceedings. Nor is there any evidence nor any way to determine from the record what the minimally acceptable confidence factor (whether 90% or 95%) or margin for error (whether plus or minus 10% is acceptable, or some other percentage) should be. Since contested case hearings may arise concerning these issues, and since rules should be specific and uniform in application, it is concluded that the Department has failed to establish, by an affirmative presentation of facts,

that it is reasonable not to state the criteria that any specific sampling model must meet with respect to the size of the sample, the margin for error, and the confidence factors involved. Without a more detailed or even expert explanation of these factors, and without even knowing if the words "generally accepted statistical practices" have any meaning at all among statisticians, it cannot be concluded that the rule is reasonable as written. There must be some minimally acceptable criteria of reliability expressed in the margin for error or the confidence factor or the sampling size or otherwise, or an explanation why such criteria are unnecessary. Consequently, it is concluded that the reasonableness of this Part has not been established by an affirmative presentation of facts as required by Minn. Stat. § 15.0412, subd. 4c (1980). To correct this defect this Part must be deleted.

see p. 19-21 for new language

81. Part D.3.e.(3) specifies when proposed monetary recovery or sanctions shall be made. The first sentence permits monetary recovery or sanctions at least 20 calendar days following receipt of certified mail notifying the provider of the proposed action. MDA suggested that this is an insufficient period of time and recommended that the time period be extended to at least 30 calendar days following receipt and that mailing be made by registered mail, return receipt, restricted delivery, and MAHCF suggested that the word "of" in the first sentence be changed to the word "by." These technical amendments are better directed to the Department's informed discretion and the rule, as proposed, is necessary and reasonable in its entirety.

no change p. 23

82. At the hearing, DPW proposed to amend Part D.3.i. to add the words "after all appeals have been exhausted or the time in which to file an appeal has elapsed", after the first phrase in the rule as originally published. This is a necessary, reasonable and insubstantial amendment to which no parties offered comment.

amended p. 24

83. Parts D.3.g. and D.3.h. preclude a provider suspended or terminated from participation to submit any claims for payment, either directly or indirectly through a clinic, or group, or corporation. MMA suggested that these provisions be waived with respect to physicians who provide services on an emergency basis. MMA feels this is particularly important in rural areas where no other medical help may be available and argues that it would be consistent with Part E.3.d. which permits the restricted recipient to receive emergency health care. This amendment is addressed to the sound discretion of the Department. It seems reasonable to permit those suspended to submit claims for payment if performed on a genuinely emergency basis where no other medical help is available, so long as consistent with federal requirements.

no change p. 24

84. At the hearing, the Department proposed to amend Part D.5. by deleting the word "random" to avoid any possible confusion with the use of that word in other parts of the rule. This deletion is necessary, reasonable and insubstantial.

deleted p. 25

Part D.5. states that nothing in this rule prohibits SUR from conducting routine audits of providers in order to monitor compliance with program requirements. MDA suggested that this Part should specifically cite its authority to conduct routine audits of providers apart from the purposes of detecting fraud, theft or abuse. DPW cited several federal requirements imposing such an obligation on them but did not cite any specific state statutory authority authorizing routine audits of that nature. However, DPW's

authority to undermake other audits under other rules or statutes is not an issue within the scope of this proceeding and will not be decided. It should be sufficient to note that this Part does not itself authorize audits for any purposes other than those set forth in this Rule. Furthermore, the Department is not required to specify in this Rule its other authority to engage in other audit or investigatory activities. This Part merely clarifies that the Department might have other rights or responsibilities with respect to audits for other purposes under other provisions and that providers should be aware that they may exist.

85. The Department proposed a minor technical amendment to Part D.6. at the hearing which would add the word "or" to the end of subparts a. and b. This is a necessary, reasonable and insubstantial amendment and may be adopted. MMA objected to putting the three situations (when suspension or withholding of payments prior to hearing could be made) in the disjunctive "or" and suggested that all of the conditions should be met before prehearing suspension or withholding would take place. The Hearing Examiner is not persuaded that suspension or withholding for any one of the three is always unreasonable or unnecessary to protect the public welfare and the interests of the program for purposes of Minn. Stat. § 256B.064, subd. 2 (1980). The Commissioner has considerable discretion in that respect and may adopt the rule as proposed.

MAHCF suggested, however, that the Rule be further amended by adding the words "except as provided in Part D.3.e.(3)" immediately after the word "hearing". The Hearing Examiner believes that this is advisable clarifying language and recommends that it be adopted. adopted p.25

86. At the hearing, the Department proposed to amend Part E.1.c. to read as follows:

> In assessing questions of abuse or medical necessity, SUR shall consult with a review organization as defined in Minn. Stat. § 145.61 or other provider advisory committees as appointed by the Commissioner.

So amended p.26

This is a necessary, reasonable and insubstantial provision that brings the rule into actual compliance with Minn. Stat. § 256B.064, subd. 1a (1980).

87. At the hearing, the Department also proposed to amend Part F.3. by deleting the words "A Chapter 15 contested case" and replacing them with the words "An appeal". This is a necessary, reasonable and insubstantial amendment. replaced p. 30

88. Part F.4., which was vigorously opposed by several parties, provides as follows:

> Generally, the state agency shall have the burden of proving the facts in dispute by a preponderance of the evidence. However, when the state agency only seeks to make a monetary recovery, the burden of proof shall shift to the provider or recipient after the state agency has established a prima facie case.

deleted in entirety p. 31

With respect to contested case hearings, Minn. Stat. § 15.052, subd. 4 provides that the Chief Hearing Examiner shall adopt rules "to govern the procedural conduct of all hearings... and contested case hearings. Such procedural rules for hearings shall be binding upon all agencies and shall supercede any other agency procedural rules with which they may be in conflict". Pursuant to that authority 9 MCAR § 2.217 C.5. was duly adopted. It provides:

> 5. The burden of and standard of proof. The party proposing that certain action be taken must prove the facts at issue by a preponderance of the evidence, unless the substantive law provides a different burden or standard.

This rule is substantially the same as that contained in 5 USC § 1006(c). Section 7(c) of the Federal Administrative Procedure Act that places the burden of proof on the proponent of an order "except as statutes otherwise provide".

The issue raised by proposed Part F.4 is whether DPW has authority to adopt a burden of proof rule placing the ultimate burden of proof on providers in cases where monetary recovery is sought by DPW. The Hearing Examiner agrees with MAHCF that it does not.

89. The Office of Administrative Hearings has, under the statutory provisions cited, been given the exclusive authority to adopt rules pertaining to procedural matters. Matters of evidence, including burden of proof, are part of the law of remedy. 15A CJS Conflict of Laws §§ 22(1) and 22(9). The law of remedy is the same as procedural law or adjective law. Thus, adjective law is defined in 1 CJS, Adjective Law, P. 1468 as follows:

> The law which pertains to practice or procedure, or the legal machinery by which substantive law is made effective; the law which prescribes the method of enforcing rights or obtaining redress for their invasion; or which relates to those legal rules which direct the course of proceedings to bring the parties into court and the course of the court after they are brought in; the means whereby rights and duties are enforced; a method provided by law for aiding and protecting defined legal rights; procedure; also referred to as the "law of remedy", "procedural law", and "remedial law", the terms being used in contradistinction to "substantive law".

Accord. Meager v. Kavli, 251 Minn. 477. 88 N.W.2d 871, 880 (1958).

Since the Office of Administrative Hearings has been given the authority to adopt procedural rules and has done so, DPW may not adopt any rule inconsistent therewith in the absence of a specific delegation of authority to do so. DPW cited no such authority in this case and the second sentence of Part F.4. which adopts a rule at variance with 9 MCAR § 2.217 C.5. is unauthorized. To correct that defect the second sentence must be deleted.

90. The first sentence of Part F.4. is redundant to the extent that it reiterates 9 MCAR § 2.217, which pertains to the standard of proof in contested case proceedings and which is controlling. Furthermore, the first sentence is unauthorized because DPW has no authority to establish the standard of proof in its rules and failed to show that the preponderance standard is the proper standard to apply in all contested cases that might arise under existing statutes and court decisions. Those determinations must be made on a case-by-case basis. Since this sentence is unauthorized it constitutes a violation of Minn. Stat. §§ 15.0412, subd. 1 and 15.052, subd. 4 (1980) and is a substantive violation of the law. To correct this defect that sentence must be deleted.

The reasonableness of a rule which places the burden of proof on a provider to show that a given statistical conclusion, with no limit on reliability, need not be decided because it is unauthorized in this case.

91. The other Parts of the Rule not specifically addressed in this Report

were not subject to comment or did not raise substantial questions of necessity, reasonableness or authority; the proper exercise of the Department's discretion; or did not raise issues of vagueness or other incidental clarifications. As to those other Parts or amendments not specifically addressed in the Rule, the Hearing Examiner finds them to be necessary, reasonable and authorized; that no such amendments constitute a substantial change; and that the repetition of statutory language is in all cases essential for an understanding of the rule.

Based on the foregoing Findings of Fact, the Hearing Examiner makes the following

CONCLUSIONS

1. That the Commissioner of Public Welfare gave proper notice of the hearing in this matter.

2. That the Department has fulfilled the procedural requirements of Minn. Stat. § 15.0412, subd. 4-4f (1980) and all other procedural requirements of law or rule.

3. That the Department has demonstrated its statutory authority to adopt the proposed rules and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. §§ 15.0412, subd. 4e and 15.052, subd. 3(4)(i) and (ii) (1980), except as noted at Findings 13, 30, 49, 52, 60, 66, 77, 89 and 90.

4. That the Department has documented the need for and reasonableness of its proposed rules with an affirmative presentation of facts in the record within the meaning of Minn. Stat. § 15.0412, subd. 4c (1980), except as noted at Finding 80.

5. That the amendments and additions to the proposed rules which were suggested by the Department after publication of the proposed rules in the State Register do not result in rules which are substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. § 15.0412, subd. 4d (1980) and 9 MCAR §§ 2.110 A. and 2.111 (1980 Ed.).

6. That the Hearing Examiner has suggested action to correct the defects cited in Conclusions 3 and 4 as noted at Findings 13, 30, 49, 52, 60, 66, 77, 80, 89 and 90.

7. That due to Conclusions 3 and 4, this Report has been submitted to the Chief Hearing Examiner for his approval pursuant to Minn. Stat. § 15.0412, subd. 4d (1980).

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

9. That a finding or conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the Department from further modification of the proposed rules based upon an examination of the public comments, provided that no substantial change is made from the proposed rules as originally published, and provided that the rule finally adopted is based upon facts appearing in this rule hearing record.

Based upon the foregoing Conclusions, the Hearing Examiner makes the following:

RECOMMENDATION

It is hereby recommended that the proposed rules be adopted except where specifically otherwise noted above.

Dated this 19 day of March, 1981.

JON L. LUNDE
Hearing Examiner

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of a Rule of the Department of Public Welfare Governing the Surveillance and Utilization Review Program, 12 MCAR 2.064 (DPW Rule 64)

ORDER FOR HEARING

IT IS ORDERED this 21st day of November 1980, that a public hearing on the proposed rules captioned above be held in the Minnesota Veterans Home, East 51st Street and Minnehaha, Building 15, Chapel Auditorium Building, Minneapolis, Minnesota on January 14, 1981, commencing at 9:00 a.m., and continuing until all representatives of associations or other interested groups or persons have had an opportunity to be heard.

IT IS FURTHER ORDERED that notice of said hearing be given to all persons who have registered their names with the State Department of Public Welfare for that purpose and be published in the State Register.

STATE OF MINNESOTA

Judith Ehlers

Commissioner of Public Welfare

Agency Exh. No. 1
File No. DPW-81-010-JL
Date 1-14-81

3

Agency Exh. No. 3
File No. DPW-81-010-JL
Date 1-14-81

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the matter of the proposed adoption of a rule of the Department of Public Welfare governing the Surveillance and Utilization Program, 12 MCAR 2.064 (Rule 64).

AFFIDAVIT OF MAILING

LINDA M. NELSON, being first duly sworn, deposes and says:

That on the 9th day of December, 1980, at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Notice of Hearing by depositing in the State of Minnesota Central Mail System for first class mailing (or) in the United States mail at said City of St. Paul, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who have requested that their names be placed on file with the Department of Public Welfare for the purpose of receiving notice of the proposed adoption of rules by this Department.

Linda M. Nelson

Subscribed and sworn to before me

this 10 day of December, 1980.

Margaret Holt

JW/cmc

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires Sept 22, 1984

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

Agency Exh. No. 4
File No. DPW-81-010-JL
Date 1-14-81

In the matter of the proposed adoption of a rule of the Department of Public Welfare governing the Surveillance and Utilization Review Program, 12 MCAR 2.064 (Rule 64).

AFFIDAVIT OF ADDITIONAL MAILING

LINDA M. NELSON, being first duly sworn, deposes and says:

That on the 9th day of December, 1980, at the City of St. Paul, County of Ramsey, State of Minnesota, in addition to serving the attached Notice of Hearing to all persons and associations who have requested that their names be placed on file for the purpose of receiving notice of the proposed adoption of rules by this Department, she also served the attached Notice by depositing in the State of Minnesota Central Mail System for first class mailing (or) in the United States mail at said City of St. Paul, a copy thereof, properly enveloped, with postage prepaid to the following agencies:

Professional Associations representing Medical Assistance Providers and Recipients
All County Social Service Agencies
Human Service Boards
Mental Health Centers
State Hospitals

Linda M Nelson

Subscribed and sworn to before me

this 10 day of December, 1980.

Margaret Holt

JT/clw

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires Sept. 22, 1984

RECEIVED
JAN 5 1981
ATTORNEY GENERAL'S OFFICE
615 TRANSPORTATION BLDG.
ST PAUL, MN. 55155

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STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the matter of the proposed adoption of a rule of the Department of Public Welfare governing the Surveillance and Utilization Review Program, 12 MCAR 2.064 (Rule 64)

CERTIFICATE

I hereby certify that the list of persons, associations, and other interested groups who have requested, pursuant to Minn. Stat. §15.0412, subd. 4, that their names be placed on file with and maintained by the Department of Public Welfare for the purpose of receiving notice of the proposed adoption of rules by this Department is accurate and complete as of 10:00, A.M., this 9th day of December, 1980.

Linda M. Nelson

JW/cmb

Agency Exh. No. 5
File No. DPW-81-010-JL
Date 1-14-81

DPW-81-010-JL

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of a Rule of the Department of Public Welfare Governing the Surveillance and Utilization Review Program, 12 MCAR § 2.064 (Rule 64).

ORDER OF THE CHIEF HEARING EXAMINER

WHEREAS, a hearing was held on January 14, 1981, before Jon L. Lunde, a Hearing Examiner of the State Office of Administrative Hearings, on the above-entitled matter in compliance with Minn. Stat. § 15.0412, subd. 4; and

WHEREAS, the Report of the Hearing Examiner made pursuant to Minn. Stat. § 15.052, subd. 3, was issued to the Department of Public Welfare and;

WHEREAS, the Department of Public Welfare has now determined to adopt rules pursuant to Minn. Stat. § 15.0412, subd. 4-4f; and

WHEREAS, the Department of Public Welfare has submitted said rules to the Chief Hearing Examiner for review pursuant to Minn. Stat. §§ 15.0412, subd. 4e, and 15.052, subd. 4, and 9 MCAR § 2.111; and

WHEREAS, the Chief Hearing Examiner finds that the final proposed rules are not substantially different from those proposed at the public hearing and that the Department of Public Welfare has cured the defects in the rules as required.

NOW, THEREFORE, upon receipt of this Order, the Department of Public Welfare has the responsibility of submitting the complete hearing record and the rules as adopted by it to the Attorney General and to publish in the State Register, all pursuant to Minn. Stat. § 15.0412, subd. 4e and 4f, and to obtain approval of the Revisor of Statutes for the incorporation by reference pursuant to Minn. Stat. § 15.0412, subd. 4a.

Dated this 28th day of August, 1981.

DUANE R. HARVES
Chief Hearing Examiner

Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minn. Stat. § 10A.01, subd. 11 (1979 Supp.), as any individual:

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

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

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

November 19, 1980

Agency Exh. No. 7 Arthur E. Noot
File No. DPW-81-010-JL Commissioner of Public Welfare
Date 1-14-81

Rules as Proposed (all new material)

12 MCAR § 2.064 Surveillance and Utilization Review Program.

A. Introduction.

1. This rule governs procedures to be used by the Surveillance and Utilization Review (SUR) Section, Minnesota Department of Public Welfare in the identification and investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by a provider or recipient of health care in the Minnesota Medical Assistance, General Assistance Medical Care and/or Catastrophic Health Expense Protection Programs.

2. The provisions of this rule are to be read in conjunction with Titles XVIII and XIX of the Federal Social Security Act; Title 42 of the Code of Federal Regulations; Minn. Stat., ch. 62E, 256, 256B, 256D and 609; Minnesota Laws of 1980, ch. 349; and other rules of the Minnesota Department of Public Welfare.

3. The Minnesota Department of Public Welfare, as the state agency responsible for the administration of the Minnesota Medical Assistance, General Assistance Medical Care and Catastrophic Health Expense Protection programs, will issue instructional bulletins, manual materials and forms as necessary to assist others in the interpretation of this rule. Such publications do not have the force and effect of law; however, they do contain the state agency's interpretation of this rule.

4. The provisions of this rule are binding on all county welfare boards (hereinafter referred to as local welfare agencies) in the State of Minnesota administering the programs, on all providers of health care participating in the programs, on all recipients under the programs, and on the state agency.

B. Definitions. For the purposes of this rule, the following terms shall be defined as indicated.

1. "Abuse." A pattern of practice by a provider, or a pattern of health care utilization by a recipient which is characterized by, but not limited to, the presence of one of the following conditions:

a. The repeated submission of claims by a provider from which required data is missing or incorrect. Examples include but are not limited to: incorrect or missing procedure or diagnosis codes, false mathematical entries, incorrect or missing third party liability information, incorrect use of procedure code modifiers.

b. The repeated submission of claims by a provider presenting procedure codes which overstate the level or amount of health care provided.

c. The repeated submission of claims by a provider for health care which is not reimbursable under the programs.

d. Failure of a provider to develop and maintain patient care records which document the nature, extent, and evidence of the medical necessity of health care provided.

e. Failure of a provider to use generally accepted accounting principles unless otherwise indicated by federal or state law or rule.

f. The repeated submission of claims by a provider for health care that is contrary to the generally accepted standards of practice of a provider's field of practice or specialty.

g. The repeated submission of claims by a provider for health care which exceeds that requested or agreed to by the recipient or his responsible relative or guardian or that otherwise required by federal or state law or rule.

h. The recipient permitting the use of his/her medical identification card by any unauthorized individual for the purpose of obtaining health care through any of the programs.

i. Obtaining unneeded equipment, supplies or pharmaceuticals by a recipient for the purpose of resale.

j. Obtaining duplicate services by a recipient, from a multiple number of providers, for the same health care condition excluding confirmation for diagnosis, evaluation or assessment.

2. "Commissioner." The Commissioner of Public Welfare or his designee.

3. "Health care." Services, equipment, or supplies provided by any individual, organization or entity that participates in the Medical Assistance, General Assistance Medical Care and/or Catastrophic Health Expense Protection programs.

4. "Health care record." Written documentation of the nature, extent and evidence of the medical necessity of health care provided to the program recipients by a provider other than a medical doctor and billed to the programs.

5. "Medicaid Management Information System." (MMIS) A centralized automated processing and payment system certified by the United States Department of Health and Human Services and implemented in Minnesota to administer the Title XIX program.

6. "Medical record." Written documentation of the nature, extent and evidence of the medical necessity of health care provided to program recipients by or under the authority of a medical doctor and billed to the programs.

7. "Medically necessary." Health care that is within the generally accepted standards of practice of a provider's field of practice or specialty and is:

a. Provided to maintain at least the minimum level of care required for certification and licensure of a long term care facility by the Minnesota Department of Health, or

b. Provided in response to life threatening conditions, or

c. Provided in response to pain, or

d. Provided to treat injuries, illness, or infections, or

e. Provided as periodic examination and diagnosis, or

f. Provided as preventive health care.

8. "Pattern." An identifiable series of events or activities.

9. "Programs." The Minnesota Medical Assistance program, the General Assistance Medical Care program and/or Catastrophic Health Expense Protection program.

10. "Provider." An individual, organization, or entity that has entered into an agreement with the state agency to be reimbursed by Minnesota Medical Assistance, General Assistance Medical Care and/or Catastrophic Health Expense Protection programs for health care provided to a recipient(s).

11. "Recipient." An individual who has established eligibility to receive health care paid by Minnesota Medical Assistance, General Assistance Medical Care and/or Catastrophic Health Expense Protection programs.

12. "Records." Medical, health care and financial records pertaining to health care provided program recipients and billed to the programs.

13. "State agency." The Minnesota Department of Public Welfare.

14. "Surveillance and Utilization Review." (SUR) The section of the Department of Public Welfare responsible for the identification and investigation of suspected fraud and abuse by providers and recipients participating in the programs. For the purpose of this rule, this definition specifically excludes the utilization control activity of the SUR section.

15. "Suspending participation." Making a provider ineligible for reimbursement by the programs for a stated period of time.

16. "Suspension of payments." Stoppage of any or all program payments for services billed by a provider pending resolution of the matter(s) in dispute between the provider and the state agency.

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17. "Terminating participation." Making a provider permanently ineligible for reimbursement by the programs.

18. "Utilization control." The activity within the state agency responsible for the ongoing evaluation of the necessity for and the quality and timeliness of services provided in long term care facilities not under the responsibility of a Professional Standards Review Organization.

19. "Withholding of payments." A reduction or adjustment of the amounts paid to a provider for purposes of offsetting overpayments previously made to the provider, or of recovering payments made to a provider for services not documented in the recipient's medical or health care record.

C. Records.

1. Medical and health care records.

a. Medical and health care records must be developed and maintained as a condition for reimbursement by the programs. Program funds paid for health care not documented in the medical and health care record shall be subject to monetary recovery.

b. Medical and health care records shall be legible throughout to at least the individuals providing care.

c. Medical and health care records shall contain the following information:

(1) Each page of the record shall name or otherwise identify the patient.

(2) Each entry in the record shall be signed and dated by the individual providing health care. Record entries for health care provided by an individual under the supervision of a licensed provider, and which is billed directly to the programs by the provider, shall be countersigned by the provider.

(3) Initial and final diagnoses, assessments or evaluations.

(4) The patient case history and results of oral or physical examination.

(5) The plan of treatment or patient care plan shall be entered in the physical record or shall be otherwise available on-site.

(6) Quantities and dosages of any prescribed drugs ordered and/or administered shall be entered in the record.

(7) The results of all diagnostic tests and examinations.

(8) The record shall indicate the patient's progress, response to treatment, any change in treatment, and any change in diagnosis.

(9) Copies of consultation reports relating to a particular recipient.

(10) Dates of hospitalization relating to service provided by a particular provider.

(11) A copy of the summary of surgical procedures billed to the programs by the provider.

d. The requirements of C.1.c. of this rule shall not apply to pharmacies, laboratories, ambulance services and medical transportation providers, or suppliers of medical equipment and nondurable supplies. For the purpose of this rule provider groups mentioned in this section shall develop and maintain the following records:

(1) Pharmacies.

(a) Prescriptions or equivalent computer record.

(b) This rule shall not require the development and maintenance of a recipient drug profile; however, if available, the state agency shall be authorized to review such a record.

(2) Laboratories.

(a) Documentation of provider orders for laboratory tests or procedures.

(b) Documentation of test results.

(3) Ambulance service and medical transportation providers.

(a) Documentation of physician authorization for medical transportation.

(b) Trip tickets.

(c) Documentation of durable and nondurable supplies expended on a recipient.

(4) Suppliers of medical equipment and nondurable supplies.

(a) Prescriptions.

(b) Documentation of physician orders related to the provision of equipment and supplies.

2. Financial records.

a. Financial records pertaining to the provider's costs and charges for health care provided to program recipients shall be developed and maintained.

b. Financial records for all providers, other than nursing homes and board and care homes certified by the Minnesota Department of Health, shall include:

(1) Purchase invoices.

(2) All accounting records including, but not limited to, payroll ledgers, cancelled checks, and bank deposit slips.

(3) All contracts for supplies and services which relate to the providers cost and charges for health care billed to the programs.

(4) Evidence of the providers usual and customary charges and written evidence of charges to non-recipient patients without violating non-recipient patient rights to confidentiality.

(5) Records of other third-party claims, charges and payments.

c. Financial records for nursing homes and board and care homes certified by the Minnesota Department of Health, shall include:

(1) All records identified in C.2.b. of this rule.

(2) Records of deposits and expenditures for patient personal needs allowance accounts.

3. For the purposes of this rule, as set forth in A.1., providers shall grant the state agency access during regular business hours to examine medical, health care and financial records related to health care billed to the programs. The SUR section shall notify the provider at least 24 hours before gaining access to such records. Upon the request of the provider, the SUR section shall present a copy of the recipient's written authorization to examine personal medical records unless the provider already has received written authorization from the recipient. A provider's refusal to grant the state agency access to examine records when authorized shall be grounds for sanction. Nothing in this section shall be construed as applying to the Utilization Control Unit of the SUR section of the state agency.

4. The state agency is authorized to photocopy or otherwise duplicate any medical or financial record which it is authorized to examine.

5. Providers shall retain all records for at least five (5) years.

6. In the event of a change of ownership of a facility or practice all records generated prior to the change shall be retained by the provider assuming responsibility for the health care of recipients. Nothing in this provision shall have the effect of making either party involved in a change of ownership liable for the actions of the other party.

7. In the event a provider withdraws or is terminated from the programs, all records developed during participation in the programs, and not subject to the provisions of item 6 of this section, shall be retained by the provider for a period of five (5) years and shall be available for review by the state agency.

8. A recipient's consent to the state agency's review of his or her medical or health care records shall be presumed competent if given in conjunction with an application for coverage under the programs. This presumption shall exist regardless of whether the application was signed by a recipient, a guardian, next of kin, friend, or other person.

D. Provider Surveillance and Utilization Review.

1. Identification of suspected fraud and abuse.

a. SUR shall be responsible for the detection and identification of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by providers who have billed the programs for health care rendered to a recipient.

b. For the purposes of this rule, SUR shall be authorized to utilize information from sources which shall include, but not be limited to:

(1) Computer reports generated by MMIS, using claim data to develop profiles on the provision and utilization of

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health care reimbursed by the programs. The profiles compare data on a peer group basis, and identify providers and recipients who appear exceptional when compared to group norms.

(2) Units of local, state and federal government.

(3) Other third-party payers including health insurance carriers.

(4) Professional Standards Review Organizations.

(5) Citizens, including recipients.

(6) Providers, professional associations, and health care professionals.

c. In assessing questions of medical necessity, SUR shall utilize health care professionals either employed by or serving as consultants to the state agency.

2. Investigation of suspected fraud or abuse.

a. SUR shall be responsible for the investigation of suspected fraud and abuse identified pursuant to D.1. of this rule. An investigation shall be conducted for the purposes of determining one or more of the following:

(1) Whether the suspected aberrant activity of a provider is the result of a legitimate condition of practice.

(2) Whether suspected fraud and abuse exists and can be documented.

(3) Whether sufficient evidence can be developed to support administrative, civil or criminal action as to such fraud and abuse.

b. A SUR investigation may include, but is not limited to:

(1) Examination of records pursuant to C. of this rule.

(2) Interviews of providers, their associates and employees.

(3) Interviews of program recipients.

(4) Verification of the professional credentials of providers, their associates and employees.

(5) Examination of any equipment, stock, materials or other items used in or for the treatment of program recipients.

(6) Examination of prescriptions written for program recipients.

(7) Determination of whether the health care provided was medically necessary.

c. Following the completion of an investigation SUR shall take one or more of the following actions:

(1) Determine that no further action is warranted and so notify the provider.

(2) Impose administrative sanctions against a provider in accordance with D.3. of this rule.

(3) Seek monetary recovery from a provider as set forth in D.3. of this rule.

(4) Refer the case in writing to the Attorney General for possible civil or criminal legal action.

3. Monetary recovery and sanctions. The commissioner shall be authorized to seek monetary recovery or impose administrative sanctions to protect the public welfare and the interests of the program. Monetary recovery and sanctions implemented by the commissioner shall be based upon documentation of fraud and abuse as set forth in D.1. and D.2. of this rule.

a. Grounds for monetary recovery and sanctions.

(1) The commissioner may seek monetary recovery against providers for any of the following:

(a) Fraud, theft, or abuse in connection with health care services billed to the programs.

(b) Presentment of false or duplicate claims, or claims for services not medically necessary.

(c) False statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

(2) The commissioner may impose administrative sanctions against providers for any of the following:

(a) Fraud, theft, or abuse in connection with health care services billed to the program.

(b) A pattern of presentment of false or duplicate claims or claims for services not medically necessary.

(c) A pattern of making false statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

(d) Refusal to grant the state agency access to records pursuant to C.3. of this rule.

(3) The commissioner shall suspend or terminate any provider who has been suspended or terminated from participation in the Medicare program because of fraud or abuse in connection with the Title XVIII of the Social Security Act.

b. The commissioner shall make monetary recovery from providers of monies erroneously paid due to violations described in D.3.a.(1) of this rule by the following means:

(1) Permitting voluntary repayment by the provider of monies erroneously paid, either in lump sum payment or installment payments.

(2) Withholding of payments.

(3) Debiting from program payments, monies determined to have been erroneously paid.

(4) Using any legal process to collect such monies.

c. For the purpose of D.3.b. of this rule, the commissioner shall be authorized to make monetary recovery from providers of monies erroneously paid, based upon extrapolation from a random, unbiased sample of claims billed to the programs by a provider, for a specific procedure code. The sampling method shall adhere to generally accepted statistical procedures regarding sample size, sample selection, and extrapolation from the results of the sample.

d. The commissioner may impose any of the following sanctions for the conduct described in D.3.a.(2) of this rule:

(1) Referral to the appropriate state regulatory agency.

(2) Referral to the appropriate peer review mechanism.

(3) Transfer to a provider agreement of limited duration not to exceed 12 months.

(4) Transfer to a provider agreement which stipulates specific conditions of participation.

(5) Suspending or terminating participation.

e. Notice to providers.

(1) The state agency shall notify providers in writing of any recovery of money or sanction it intends to impose.

(2) The notice shall state:

(a) The factual basis for alleging discrepancies or violations;

(b) The dollar value to such discrepancies or violations;

(c) How such dollar value was computed;

(d) What actions the state agency intends to take;

(e) The provider's right to dispute the state agency's factual allegations and to provide evidence to support the provider's position; and

(f) The provider's right to appeal the state agency's proposed action pursuant to F. of this rule.

(3) The effective date of the proposed monetary recovery or sanction shall be at least 20 calendar days following receipt of certified mail notifying the provider of the proposed action. If the provider appeals pursuant to F. of this rule, the action shall not be implemented until the commissioner's order is issued following the hearing on appeal, provided that the suspending or withholding of payment shall be effective on the date the notice is received, if in the commissioner's opinion such action is necessary to protect the public welfare and interests of the program. However, the commissioner shall not order a prehearing suspension or withholding of payments to a nursing home or board and care home. Implementation of a proposed action following the hearing on appeal may be postponed if in the opinion of the commissioner the delayed action is necessary to protect the welfare or interests of program recipients.

f. The decision as to the sanction to be imposed against a provider, pursuant to subsection D.3.a.(2) of this rule, shall be at the discretion of the commissioner. The following factors shall be considered in determining the sanctions to be imposed:

(1) Nature and extent of offenses or violations;

(2) History of prior violations;

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(3) Provider's willingness to obey program rules; and

(4) Actions taken or recommended by other state regulatory agencies.

g. Suspension or termination from participation shall preclude a provider from submitting any claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association for any health care provided under the programs, except for health care provided prior to the suspension or termination.

h. No clinic, group, corporation, or other association which is a provider of services shall submit any claim for payment for any health care provided by an individual provider within such organization who has been suspended or terminated from participation in the programs, except for health care provided prior to the suspension or termination. The state agency shall seek monetary recovery of such claims. Knowing submission of such claims shall be a ground for administrative sanction.

i. When a provider has been sanctioned in accordance with subsection D.3.c. of this rule, the state agency shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made, sanctions imposed, appeals made and the results of any subsequent appeal.

4. Nothing in this rule shall prevent the commissioner from simultaneously seeking monetary recovery and imposing sanction against a provider.

5. Nothing in this rule shall prohibit SUR from conducting random, routine audits of providers in order to monitor compliance with program requirements.

6. The commissioner is authorized to suspend or withhold payments to a provider prior to a hearing, if:

a. There is a substantial likelihood of prevailing in an action pursuant to D.3. of this rule.

b. There is a substantial likelihood that the provider's pattern of practice which prompted a SUR investigation, will continue in the future.

c. There is reasonable cause to doubt a provider's financial ability to refund any amounts determined to be due the program.

7. To the extent that federal law or regulation mandates sanctions against providers or recipients which conflict with provisions of this rule, such federal law or regulation shall prevail.

E. Recipient Surveillance and Utilization Review.

1. Identification of suspected fraud and abuse.

a. SUR shall be responsible for the detection and investigation of suspected fraud, theft or abuse by recipients of the programs.

b. For the purpose of this rule, SUR shall be authorized to utilize at least the sources of information identified in D.1.b. of this rule.

c. In assessing the question of medical necessity, SUR shall utilize health care professionals either employed by or serving as consultants to the state agency.

2. Investigation of suspected fraud and abuse.

a. SUR shall be responsible for the investigation of suspected fraud and abuse identified pursuant to E.1. of this rule. A SUR investigation shall be conducted for the purpose of determining:

(1) Whether suspected fraud, theft, or abuse exists and can be documented.

(2) Whether sufficient evidence can be developed to support restricting recipient participation in the programs in accordance with E.3. of this rule.

(3) Whether sufficient evidence exists to support the imposition of other sanctions in accordance with E.3. of this rule.

3. Sanctions.

a. Grounds for sanctions. SUR may impose administrative sanctions against program recipients for any of the following:

(1) Altering or duplicating the medical identification card in any manner.

(2) Permitting the use of his or her medical identification card by any unauthorized individual for the purpose of obtaining health care through the programs.

(3) Using a medical identification card that belongs to another person.

(4) Using the medical identification card to assist any unauthorized individual in obtaining health care for which the programs are billed.

(5) Duplicating or altering prescriptions.

(6) Knowingly misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, or drugs.

(7) Knowingly furnishing incorrect eligibility status or information to a provider.

(8) Knowingly furnishing false information to a provider in connection with health care previously rendered which the recipient has obtained and for which the programs have been billed.

(9) Knowingly obtaining health care in excess of established program limitations, or knowingly obtaining health care which is clearly not medically necessary.

(10) Knowingly obtaining duplicate services from a multiple number of providers for the same health care condition, excluding confirmation of diagnosis.

(11) Otherwise obtaining health care by false pretenses.

b. Sanctions against program recipients. SUR may impose any of the following sanctions for the conduct described in E.3.a. of this rule:

(1) Referring the recipient for appropriate health counseling in order to correct inappropriate or dangerous utilization of health care.

(2) Restricting the recipients participation in a program to receiving health care from a provider(s) whom the recipient has had the opportunity to select. The restriction shall be for a specified period of time and all changes in the designation of a provider(s) during the restriction period shall be approved by the state agency. Reimbursement for non-emergency health care shall be limited to the designated provider(s).

(3) Recovery from recipients, to the extent permitted by law all amounts incorrectly paid by the programs.

(4) Terminating participation for that period during which a potential recipient refuses to sign a consent for release of records.

(5) Referring the recipient to the Attorney General for possible criminal or civil legal action.

c. Notice to recipients.

(1) The state agency shall cause the recipients to be notified in writing of any sanction it intends to impose.

(2) The notice shall state:

(a) The factual basis for alleging discrepancies or violations;

(b) The dollar value to such discrepancies or violations:

(c) How such dollar amount was computed;

(d) What actions the state agency intends to take;

(e) The recipient's right to dispute the state agency's factual allegations; and

(f) The recipient's right to appeal the state agency's proposed action pursuant to F. of this rule.

d. Emergency health care provided a restricted recipient by any provider shall be eligible for reimbursement by the programs if the claim for reimbursement is accompanied by a full explanation of the emergency circumstances.

e. The programs shall pay for specialized health care provided a restricted recipient if a copy of the written referral by the recipient's chosen provider is sent to the SUR section.

f. The fact that a recipient is restricted shall be clearly indicated on the medical card.

F. Appeal.

1. A provider may appeal the state agency's proposed administrative sanction, proposed suspension or withholding of

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payment, or demand for monetary recovery against a provider pursuant to the provisions of Minn. Stat. § 15.0418 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of the date notice is received pursuant to D.3.e. of this rule.

2. A recipient may appeal any sanction proposed by the state agency pursuant to the provisions of Minn. Stat. § 256.045.

3. Nothing in this rule shall prevent a provider or recipient, upon receipt of a notice of intended sanction, from meeting with the commissioner to informally discuss the matter in dispute, so long as a Chapter 15 contested case has not been commenced.

4. Generally, the state agency shall have the burden of proving the facts in dispute by a preponderance of the evidence. However, when the state agency only seeks to make a monetary recovery, the burden of proof shall shift to the provider or recipient after the state agency has established a prima facie case.

ADOPTED RULES

The adoption of a rule becomes effective after the requirements of Minn. Stat. § 15.0412, subd. 4, have been met and five working days after the rule is published in the *State Register*, unless a later date is required by statutes or specified in the rule.

If an adopted rule is identical to its proposed form as previously published, a notice of adoption and a citation to its previous *State Register* publication will be printed.

If an adopted rule differs from its proposed form, language which has been deleted will be printed with strike outs and new language will be underlined, and the rule's previous *State Register* publication will be cited.

A temporary rule becomes effective upon the approval of the Attorney General as specified in Minn. Stat. § 15.0412, subd. 5. Notice of his decision will be published as soon as practicable, and the adopted temporary rule will be published in the manner provided for adopted rules under subd. 4.

Department of Natural Resources

Adopted Amendments to the Boat and Water Safety Rules

The rules proposed and published at *State Register*, Volume 5, Number 8, pp. 271-277, August 25, 1980 (5 S.R. 271) are now adopted with the following amendments:

Amendments as Adopted

NR 200 Licensing of watercraft.

(b) Display of license certificate. No person shall operate or use a watercraft, except a non-motorized canoe, kayak, sailboat, sailboard or rowing shell required to be licensed unless the license certificate for such watercraft is on board and available for inspection by authorized enforcement officers. Owners of non-motorized canoes, kayaks, sailboats, sailboards, or rowing shells shall produce the license certificate for such watercraft within a reasonable time upon request of authorized enforcement officers. The owner of rental watercraft may keep the license certificate available for inspection on the premises from which the watercraft is rented, provided that the owner's business is legibly printed on the rear half and on both sides of the watercraft in the same size and manner as required for the license number in NR 200, Section (c).

(c) Display of license number & validation decal on motorized watercraft. The license number, on all watercraft, except non-motorized canoes, kayaks, sailboats, sailboards and rowing shells shall be securely affixed on each side of the forward half of the watercraft for which it was issued in such a position as to provide clear and legible identification. The letters and numerals must be of a color that contrasts with the background and may be reflectorized decals or metal or may be painted. The letters and numerals shall read from left to right and shall not be less than 3 inches in height, of block type, of a stroke not less than ½ inch or more than ¾ inch in width, not including a border. The license number shall be maintained so that it is clearly visible and legible, and the letter groups must be separated from the numeral groups by a space of not less than 3 inches nor more than 4 inches. Adjacent letters and numerals within each group must be spaced not less than ½ inch nor more than ¾ inch apart. A state validation decal for the current license period must be affixed toward the stern of the boat and not more than 4 inches from the first or last letter of the license number on each side of the boat.

(e) Marking of non-motorized sailboats and sailboards. All non-motorized sailboats and sailboards shall display the decals furnished by the Department of Natural Resources for such watercraft. These decals shall be securely affixed on each side of the forward half of the watercraft for which it was issued, in such a position as to provide clear and legible identification. If it is

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STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED RULE OF THE DEPARTMENT OF PUBLIC WELFARE GOVERNING THE SURVEILLANCE AND UTILIZATION REVIEW PROGRAM, 12 MCAR § 2.064 (RULE 64)

STATEMENT OF NEED AND REASONABLENESS

The above captioned rule is a newly proposed rule of the Department of Public Welfare ("DPW" or "the state agency"). The statutory authority of DPW to promulgate this rule is contained in Minn. Laws 1980 § 2, 3, 9 which specify that the Commissioner establish by rule general criteria and procedures for the identification and investigation of suspected fraud, theft, and abuse by vendors of medical care (providers) and by eligible individuals receiving medical care (recipients) in the Minnesota Medical Assistance program (MA), the General Assistance Medical Care program (GAMC), and the Catastrophic Health Expense Protection Program (CHEPP).

The need to initiate the administrative rule-making process for the State's Surveillance and Utilization Review activity is not limited solely to the above noted legislative directives. It is through proposing these rules, and the holding of the public hearing thereon, that the public, all interested parties, and all affected parties are afforded the opportunity to comment upon the procedures and requirements used by the state agency in carrying out the legislative mandates.

The proposed rules, designated as 12 MCAR 2.064, are hereby affirmatively presented by DPW in accordance with the provisions of the Minnesota Administrative Procedures Act. Minn. Stat. § 15.0412 and state Rule Hearing Procedures 9 MCAR § 2.101.

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A. INTRODUCTION

Sections 2.064 A.1 and 2. set forth the scope and purpose of the proposed rule and give cross references to related laws regarding the State's fraud and abuse control activities in publically funded health care programs, i.e., Medical AssistanceA (medicaid), General Assistance Medical Care - GAMC, and Catastrophic Health Expense Protection Program - CHEPP. The reasonableness and necessity of the proposed rule should be viewed in light of both federal and state mandate for the detection of suspected fraud and abuse, and the determination of medical necessity of health care reimbursed by the programs. See [1977] U.S. Code Cong. & Ad. News 3039, Minn. Laws 1980, ch. 349.

The Medical Assistance program in Minnesota is a joint federal-state program to implement the provisions of Title XIX of the Social Security Act by providing for the medical needs of low income or disabled persons (42 U.S.C. § 1396a). The statutory authority for rule is thus derived from both federal and state law. Specifically, federal regulation at 42 C.F.R. § 456.3 requires that the state medicaid agency (DPW) must implement a statewide surveillance program to "safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments". See also 42 C.F.R. § 455.10. Correspondingly, state law requires the Commissioner to establish rules for the identification and investigation of suspected medical assistance fraud, theft, or abuse (Minn. Laws 1980, ch. 349, § 3.) and to investigate whether or not the medical care was medically necessary (Minn. Laws 1980, ch. 349, § 7.).

Justification for the proposed rule is further supported by the provisions of Minn. Stat. § 256B.04 subd. 4, which states, in part, that the state agency shall cooperate with the federal government "in any reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program". Given that

continued federal financial participation is contingent upon an effective surveillance and utilization review activity (42 U.S.C. 1396a) it is reasonable for the state agency to promulgate a rule which will achieve compliance with federal and state law.

The statutory authority to promulgate rules governing the identification and investigation of suspected fraud, theft or abuse in the CHEPP and GAMC programs are contained in Minn. Laws 1980, ch. 349, § 2, 9 respectively. Moreover, 12 M.C.A.R. § 2.0581, which governs administration of the GAMC program specifies that local agencies choosing to have the centralized disbursement system process their GAMC claims agree to "accept all reimbursement standards and audits of the system which are applied to Title XIX payments" (12 MCAR § 2.058 E.5.b.(1)), and to "not allow payments of medical provider claims which exceed the fee schedules established by the Commissioner for the Medical Assistance Program" (12 MCAR § 2.058.E.8.). Similarly, the CHEPP rule requires use of MA enrollment forms and provider agreements for CHEPP providers and specifies that a provider's acceptance of CHEPP payments "shall be deemed to extend the provider's agreement with the Medical Assistance Program to cover services to CHEPP beneficiaries" (12 MCAR § 2.060 D.5.). The CHEPP rule further provides that "procedures used by the Minnesota Medical Assistance Program for review of the appropriateness or medical necessity of health services shall be used for the review of claims for CHEPP payments" (12 MCAR § 2.060 D.9.).

Section 2.064 A.3. sets forth that DPW will issue instructional material to assist in the interpretation of this rule, as well as other program requirements related publically funded health care. It is acknowledged that policy material does not have the force of law.

Section 2.064. A.4 states that the provisions of the rule are binding on all providers, recipients, and state and local welfare agencies participating in, or administering the programs.

B. DEFINITIONS

The agency will affirmatively present the need for and reasonableness of proposed definitions, except that definitions which are solely for the purpose of identification, e.g., "Commissioner", shall be presumed both needed and reasonable without further justification.

1. The term "abuse" is defined as to distinguish it from fraud and theft. The latter terms are defined by case law and statutes, and are characterized by intentional wrongdoings. The definition of abuse as proposed is both needed and reasonable in that it specifies practices which are unacceptable or inappropriate under the programs even if they are committed unintentionally. The House report on the Medicare-Medicaid Antifraud and Abuse Amendments recognizes the need to regulate such abuse. "Program abuse is less clearly defined [than fraud] and includes activity wherein providers, practitioners, and suppliers of services operate in a manner inconsistent with accepted, sound medical or business practices resulting in excessive and unreasonable financial cost to either medicare or medicaid." [1977] U.S. Code Cong. & Ad. News 3039, 3050. Errors can and do routinely occur in the billing practices of health care providers. However, isolated or occasional errors or irregularities will not be sanctionable; abuse is defined as repeated conduct.

The rule sets forth ten conditions or practices which represent a departure from acceptable billing practices for medicaid services. Items (a.)-(c). represent billing procedures which are counter to billing procedures set forth in the handbook and materials supplied to each provider. The handbooks clearly detail the necessary data for a billing invoice, the reference source which contains the appropriate procedure codes to be used and any service limitations applicable to a particular provider category. An identifiable series of claims with such repeated inconsistencies is reasonably considered inappropriate use of the medicaid services.

Item (d.) establishes that failure to develop and maintain records as provided by 12 MCAR § 2.047D.4.c., 42 C.F.R. § 431.107, and the provider agreement is in direct conflict with the conditions of participation for health care providers. Failure to document health care in the record has the effect of negating the agency's responsibility to determine the extent of services actually provided program recipients.

Item (e.) indicates that generally accepted accounting principles must be used unless otherwise provided. This provision is in keeping with the requirements established for nursing home providers under the Medical Assistance program, as set forth at 12 MCAR § 2.049C.1.b., and is reasonably extended to other health care providers.

Item (f.) establishes that health care billed to the programs that is not within the generally accepted scope of the providers' practice or specialty is abusive. Federal regulations at 42 C.F.R. §§ 440.50 and 440.60 clearly indicate that services paid by the programs must be within the scope of practice of the provider. It is reasonable that the state agency considers as inappropriate and abusive, the billing of service which the provider is not qualified to provide.

Item (g.) defines as abusive the practice of inflating the quantity of services necessary to adequately treat the presenting condition. The agency acknowledges that health care requested by a recipient may not fully treat the underlying health problem, and it is not the intent of this rule to address that situation. The rule is more reasonably concerned with all services which are in excess of generally accepted practice for a particular health care condition. The medicare system treats such unnecessary services as abusive. 2 CCH Medicare-Medicaid Guide ¶ 13,895.23.

Items (h.) - (j) identify as abusive recipient practices which result in the programs paying for health care to which the recipient is not entitled or which is greater than that to which he/she is entitled. This interpretation is consistent with the provisions of statute at Minn. Stat. § 256.98 governing assistance wrongfully obtained by a recipient.

2. The term "Commissioner" refers to the Commissioner of Public Welfare or his designated agent.

3. For the purpose of the rule, the term "health care" has been broadly defined so as to encompass all services,equipment, and supplies provided for a program recipient and paid for by the programs. The term "health" has been used rather than "medical" to acknowledge the participation of the wide range of vendors as defined by Minn. Stat. § 256B.02, subd. 7.

4. The phrase "health care record" is used to describe those documents reasonably related to the care or services provided for a program recipient, by a provider other than a medical doctor (M.D.). The distinction between "health care record" and "medical record" is again made to acknowledge those providers whose services are not medical in the restrictive, non-generic sense of the word. The concept of a record to document the nature, extent, and evidence of the medical necessity of care is consistent with the provision of

12 MCAR § 2.047 D.4.c. which states that providers participating in the MA program shall "maintain for at least five (5) years, in the manner prescribed by DPW in accordance with applicable federal regulations, medical and financial records fully disclosing the extent of services provided, the medical necessity for such service and payment claimed under the MA program". Specifying that the health care record must document the nature, extent, and evidence of the medical necessity of health care is consistent with Minn. Laws 1980, ch. 349, §§ 2, 3, 9. These statutes place upon the state agency the burden of identifying and investigating the "presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts". It is only through documentation in the health care record that the agency can determine if the claim for reimbursement submitted by a provider is indeed legitimate.

5. The phrase "Medicaid Management Information System" or MMIS represents a computer system implemented in Minnesota to administer the centralized disbursement system within DPW. Minn. Stat. § 256B.041. This system is an internal management tool which enables the state agency to receive, process, pay and monitor all invoices submitted for reimbursement by eligible providers. Utilization of a centralized, automated, processing system enables Minnesota to qualify for enhanced federal financial participation for costs related to the administration of the Medicaid program.

6. The phraise "medical record" is used to describe those documents reasonably related to the care or services provided by a program recipient by a medical doctor (M.D.) or by ancillary personnel under the authority of the M.D. The distinction between "medical record" vs. "health care record" is made in this rule to avoid semantic conflict and to ensure that the records of all providers are encompassed within the scope of this rule. The need and reasonableness of the definition follows the justification presented above for "health care records".

7. DPW is authorized to review medical necessity by Minn. Laws 1980, ch. 349, §§ 2, 3, 9 which all state in part that the Commissioner shall investigate the "presentment of false claims for services not medically necessary". The requirement that "medically necessary" care be within the generally accepted standards of practice of the provider is consistent with the concept of care as set forth in federal and state regulations. Specifically, at 42 C.F.R. §§ 440.50, 440.60 and 12 MCAR § 2.047 F.1., care and services eligible for reimbursement under the MA program are those provided "within the scope of practice" of the particular vendor of care. The categories of medically necessary care, set forth in items a. - f. of the definition, can be separated into two functional classifications. Items b., c. and d. are representative of those conditions for which care is necessary and essential to maintain the health and well-being of the recipient. These items represent care which is provided in response to a condition or ailment about which the provider must make a professional judgment regarding the course of that condition. The second classification of items a, e, and f are representative of services which are considered to be medically necessary for surveillance and utilization review purposes, but not in the literal, medical sense. Items a., e. and f. do however, represent services, along with items b., c. and d., which are reimbursable under the programs as set forth at 42 C.F.R. § 440, subpart A and 12 MCAR § 2.047 E., and as such are within the scope of the agency's investigatory responsibility. Inclusion of item a., e., and f are therefore reasonable in this definition to enable the agency to investigate claims which are not medically necessary, i.e. not covered.

8. The term "pattern" is reasonably defined as an "identifiable series of events or activities" relating to the presentment of claims and to the making of false statements of material facts by providers. In the rule, the term is used in the definition of abuse and in the section dealing with grounds for

administrative sanctions. In both instances, the term places upon the agency the burden of proving that a particular event or activity is one of a series of occurrences. Series means a "group or number of related or smaller. . .things or events (Webster's New World Dictionary, 2nd edition). This distinction of related group occurrences is important in that a single or occasional false claim should not be considered in terms of abuse or grounds for administrative sanction, but rather as a separate, isolated incidence. The burden of proving a relationship between false claims or false statements of material facts is consistent with the provisions of Minn. Laws 1980, ch. 349, §§ 3, 6. The former authorizes the Commissioner to establish procedures for identification and investigation of the presentment of false claims or material facts, while the latter requires that a pattern of such conduct be shown prior to imposition of an administrative sanction. The proposed definition of the term "pattern" reasonably describes the concept of relatedness and thereby affords the appropriate degree of protection under the law.

9. "Programs" identifies the publically funded health care systems, i.e. MA, GAMC, and CHEPP, which are within the purview of the state agency's fraud and abuse control activity.

10. The term "provider" relates specifically to all vendors of services, equipment, or supplies who have entered into agreement with, and accept payment from, any of the programs. Minn. Stat. § 256B.02, subd. 7.

11. "Recipient" identifies individuals who have applied to and established their eligibility to receive health care paid for by the programs. This definition includes individuals who have submitted an application, those currently eligible and those previously eligible but no longer participating in the programs. The condition of eligibility for MA, GAMC and CHEPP are those set forth in 12 MCAR §§2.047, 2.058 and 2.060 respectively.

12. The term "records" as used in the rule references all medical, health care, and financial records which reflect costs billed to the programs. DPW is authorized to review such records in order to verify the propriety of the claim and the medical necessity of care provided. Minn. Laws 1980, ch. 349, §§ 1, 7, 10. Each provider has signed a "provider agreement" with DPW agreeing to furnish DPW information concerning submitted claims. 42 C.F.R. § 431.107.

13. "State agency" identifies the Minnesota Department of Public Welfare as the designated agency responsible for the administration of the programs.

14. The phrase "Surveillance and Utilization Review" or SUR identifies that activity of the state agency responsible for the control of fraud and abuse in Minnesota's publically funded health care program. Specifically, 42 C.F.R. § 455.13 provides that "the Medicaid agency must have (a) methods and criteria for identifying suspected fraud cases; (b) methods for investigating these cases. . .". In addition, 42 C.F.R. § 456.23, require that the state Medicaid agency "have a post payment review process that -

(a) allows state personnel to develop and review -

(1) recipient utilization profiles;

(2) provider service profiles; and

(3) exception criteria; and

(b) identifies exceptions so that the agency can correct practices of recipients and providers."

DPW is permitted to review medical records for the purpose of identifying or investigating suspected fraud and abuse. Minn. Laws 1980, ch. 349, §§ 2, 7, 10. Similarly, 12 MCAR § 2.047D.10.a(2) establishes a post-payment review process responsible for activities cited above from 42. C.F.R. § 456.23.

The definition of "Surveillance and Utilization Review", as well as later provisions of the rule, specifically exclude the activities of the utilization control unit (defined in #19.) of the state agency. The utilization control (UC) unit, while organizationally related to SUR is functionally distinct and should not fall within the scope of the rule. The utilization control program monitors the effectiveness of the state health agency (Minnesota Department of Health) in its efforts to review the appropriateness and effectiveness of Medicaid services provided in long term care facilities. It is required by federal and state regulations. 42 C.F.R. § 456, 12 MCAR § 2.047 D.10. The UC program has separate line staff from the SUR unit and does not investigate fraud and abuse. Information gathered by UC staff is not used to seek monetary recoveries or administrative sanctions and therefore Minn. Laws 1980, ch. 349, § 7 does not apply to UC functions.

15. "Suspending participation" as a form of sanction is authorized by Minn. Laws 1980, ch. 349, § 6. The concept of suspension for a stated period of time is consistent with common usage of the term, i.e., stop temporarily.

16. The phrase "suspension of payments" can reasonably be defined as stoppage of any or all payments based upon the statutory authorization noted in Minn. Laws 1980, ch. 349, § 5. This statute allows the Commissioner to "suspend or reduce payment to a vendor of medical care, . . .prior to a hearing if in the Commissioner's opinion that action is necessary to protect the public welfare and the interests of the program". Further, the Commissioner is authorized by Minn. Laws 1980, ch. 349, § 6 to suspend or withhold payments based upon the outcome of an investigation. Given common usage of the term suspension, defined in Webster's New World Dictionary 2nd edition as "temporary stoppage of payments", and the Commissioner's statutory authority to suspend payments, this definition is reasonable.

17. Terminating participation" as a form of sanction is authorized by Minn. Laws 1980, ch. 349, § 6. The concept of permanent exclusion is consistent with common usage of the term, "terminate", i.e., to bring to an end.

18. Utilization control" refers to the UC program described in the definition of Surveillance and Utilization Review above. It is organizationally related to SUR, but functionally distinct.

19. The withholding of payments as another form of monetary recovery is authorized in the provision of Minn. Laws 1980, ch. 349, § 6. The act of reducing or adjusting payments for the purpose of offsetting overpayments is implicit in the language which allows the Commissioner to assess and recover monies erroneously paid.

C. RECORDS

1. The provisions of this section are intended to set forth the record keeping requirements of providers participating in the programs, as well as the state agency's responsibilities regarding the use and access of such records.

a. The state agency is permitted access to records related to the health care provided program recipients. Minn. Laws 1980, ch. 349, § 1, 8, 10. Providers are required to develope and maintain records to fully disclose the extent of service provided. 42 C.F.R. § 431.107 and 12 MCAR § 2.047D.4.C.(1). Further, at Minn. Stat. § 256B.27 Subd. 1 the Commissioner may require any reports, information and audits of medical vendors which he deems necessary. There is a contractual, as well as statutory, basis for providers to to maintain records. The contract which all providers sign obligates them "to keep such records as are necessary fully to disclose the extent of the services provided. . .".

b. The requirement that a medical or health care record be legible to at least those individuals providing care is inherent in the concept of the medical or health care record as a dynamic, as well as historical, account of health care. The significance of a

legible record is at least two- fold. The record is first and foremost the document which contains information specific to the health of the recipient and should be legible to ensure continuity of care. Second, a legible record must be available if the agency is to interpret record content pursuant to Minn. Laws 1980, Ch. 349, § 7 to determine if the vendor has submitted a claim which the vendor knows is false in whole or in part or if the health care was medically necessary. The concept of legibility in the medical record is not unprecedented in regulations regarding health care paid by the programs. Federal regulations at 42 C.F.R § 442.499(b) require that any individual who makes an entry into the record of an ICF/MR resident "must make it legibly, date it, and sign it". In addition, at least one other state, Pennsylvania, has the condition of legibility established in rule at § 1101.43e. of the Pennsylvania Medical Assistance Regulations.

c. This provision of the rule designates those items which must be entered into the medical or health care record if program funds are paid for health care.

(1) It is not unreasonable to assume that each page of a record should identify the patient to ensure that all information pertains to recipient in question. This requirement is appropriate both for the continuity of care of the patient and for the agency's investigatory needs. Federal regulations at 42 C.F.R. § 442.202 require that skilled nursing facilities meet the medical standards at 405.1132 which require that the record contain sufficient information as to identify the patient clearly.

(2) All entries into the record represent segments of information, which, when combined, form a descriptive account of the patient's health condition. To require the date a particular service is provided and the signature of the person providing care, validates the legitimacy of the record as a health care document. This concept of documentation is supported by the requirement at 42 C.F.R. § 405.1132 which requires entries into the record of a

skilled nursing facility by a physician to be signed and dated, and by the requirement at 42 C.F.R. § 442.499 which requires that all entries into the record of an ICF/MR resident be legible, dated, and signed. This requirement does not mandate countersignature by a licensed provider for all entries made by personnel under the supervision and authority of that provider, such as, entries made by the nursing staff of a hospital in response to a physician's order. However, the rule does reasonably require that the licensed provider countersign record entries for health care provided by ancillary personnel under the supervision of the licensed provider and billed directly to the program using the providers number. This provision stems from the fact that the programs will pay, at a reduced rate, for services provided by a non-entrolled vendor under the direct, on-site supervision of the licensed provider. An example of this billing situation would be the psychiatrist or psychologist who employs a non-enrolled counselor or therapist to provide psycho-therapy services for the licensed provider's clients. The enrolled provider may bill the programs directly for the counselor services at one-half (1/2) the allowed rate and must have provided direct on-site supervision of the services provided by the counselor. Since this service is billed using the provider's number, even though the provider did not physically provide the service, it is reasonable that the provider be aware of the care provided and accept professional responsibility for that care.
(3) - (11) Rule requirements contained in items (3) - (11) essentially spell out the components of a medical and health care record necessary to reveal the care provided, the reasonableness of costs incurred by the programs, and the medical necessity of the health care. The initial and final diagnoses, patient care history, plan of treatment, quantities of dosages of drugs ordered and/or administered, results of diagnostic tests, indication of patient's progress, consultation reports, dates of hospitalization and surgical summaries are all data which reflect the medical necessity

of care provided and as such are reasonable. In support of these rule requirements, federal regulations for hospitals, at 42 C.F.R 405.1026 require a standard record content of identification data, chief complaint, present illness, past history, family history, physical examination, provisional diagnosis, clinical laboratory reports, X-ray reports, consultations, medical and surgical treatment, final diagnosis, progress rate, discharge summaries, and autopsy findings. In addition, federal requlations for skilled nursing facilities at 42 C.F.R § 442.202 require a standard record content which essentially duplicates the record keeping perameters outlined in the rule and in the federal regulations for hospitals. The existence of a nearly uniform record data set for the two provider groups cited can be extrapolated to other providers. See also Stoffan v. Pennsylvania Department of Public Welfare, (1977). CCH Medicare-Medicaid Guide ¶ 28,548. (Disqualification of Physician from Program due in part to inadequate medical records.)

d. The medical or health care record is not an appropriate record to be required of several vendors of services and supplies, notably pharmacies, laboratories, ambulance services and medical transportation providers and suppliers of medical equipment and non-durable supplies. For this particular group of providers, the rule requests specific records or documentation needed to determine if claims submitted were false in whole or in part or if care was medically necessary. Unless otherwise noted, records required by this rule are already required by the provision of 12 MCAR § 2.047.

(1) Prescriptions are maintained in accordance with 12 MCAR § 2.047.E.2.n. which requires pharmacists to maintain prescriptions for 5 years, subject to audit at any reasonable time. While recipient drug profiles are not required to be maintained it is reasonable for the agency to access such records to support tHe validity of provider claims.

(2) Laboratories' services are paid for by the program in accordance with the provision of 12 MCAR, § 2.047E.2.m. which requires that the service was provided by or under the direction of a physician or licensed provider. The requirements for documentation of provider orders and of test results are reasonable to substantiate billing claims.

(3) In accordance with the provision of 12 MCAR § 2.047E.2.r., the programs will not pay for medical transportation which is routine and determined not to be medically necessary, and which was provided when other transportation would suffice. The rule requirement for the physician's authorization for medical transportation and the trip ticket are reasonable documents to access in determining compliance with state regulations. The agency is further justified in requesting documentation of supplies and equipment expended on a recipient and billed to the programs.

(4) The provisions of 12 MCAR § 2.047E.2.i require that supplies prescribed by a physician or licensed provider must be within the scope of his profession and that they must be medically necessary. It is therefore reasonable for the agency to require access to documentation which validates that order or prescription.

2. The authority to require the development and maintenance of financial records pertaining to the provider's costs and charges for health care provided follows from the Commissioner's authority to examine records for the purpose of "investigating whether or not a health service vendor has submitted a claim for reimbursement, a cost report or a rate application which the vendor knows to be false in whole or in part". Minn. Laws 1980, ch. 349, §§ 1, 7, 10.

Further, at Minn. Stat. § 256B.27 Subd. 1 the Commissioner may "require any reports or information and audits of medical vendors which he deems necessary". In addition, providers are under a contractual obligation to provide such information. 42 U.S.C. § 1396a(a)(27), 42 C.F.R. § 431.107, 12 MCAR § 2.047D.7. The

specific items listed in this section, i.e., purchase invoices, accounting records, contracts for supplies and service, evidence of usual and customary charges, records of third party claims, charges and payments, and (for long term care facilities) records of deposits and expenditures from patient personal needs allowance accounts are integral elements of the claims for reimbursement, cost reports or rate applications the state agency is empowered to investigate. The evidence of third party claims is necessitated by 42 USC § 1396a(a)(25), 12 MCAR § 2.047 D.5.

The provision of rule which requires "written evidence of charges to non-recipient patients" has been written so as to prevent violation of non-recipient patient rights to confidentiality. This can be accomplished in several ways which will protect that right, e.g. having the provider display a ledger or a copy of a ledger with all identifying characteristics covered. This random review of a non-recipient patient charge is necessary to ensure that the usual and customary charges provided by the provider are indeed factual and not manufactured. Access to evidence of the usual and customary charges is necessitated by 12 MCAR § 2047 F.2.

3. The authority of the state agency to access records related to health care billed to the programs is set forth in Minn. Laws 1980, ch. 349, § 1, 7, 10. The requirements that the agency provide 24 hours notice prior to access and to provide written consent forms as requested is contained in the same statutes which also make recipient consent to the Department's access to their medical records a precondition of eligibility. Courts have upheld access to records without search warrants or subpoenas. CCH Medicare-Medicaid Guide ¶ 28,634,29050.

Any privilege to keep the records private belongs to the recipient and once waived by the recipient cannot be raised on his behalf by the provider. (Even if a recipient refused to consent it can be argued that the state agency is entitled to access. "The statutory

provision which prohibits a physician from releasing treatment information without the consent of his patient, does not apply to agency compliance audits of medical records of Medicaid recipients." Department of Social and Health Services v. Letta, 92 Wash.2d 812, 601 P.2d 520 (1979) as cited in CCH Medicare-Medicaid Guide ¶ 30.386. Accord Matter of Hayes, CCH Guide ¶ 30,607 (1980)).

The Minnesota Government Data Practices Act does not prohibit DPW's access to recipient medical records. This law primarily concerns the dissemination of data wich state agencies have collected. Minn. Stat. § 15.162 et. seq. However, certain disclosures must be made to the subjects of the data prior to its collection. Minn.Stat. § 15.165. The application forms used by the state agency in conjunction with all three programs (MA, GAMC, CHEPP) contain the required disclosures.

In addition, state law concerning the Patient's Bill of Rights, Minn. Stat. § 144.651(15), cannot be construed as conflicting with this rule since it allows the patient to approve or refuse release of their records "except as otherwise provided by law".

A provider's refusal to grant the state agency access, during regular business hours, to examine all necessary records is grounds for sanctions as provided in Minn. Laws 1980, ch. 349, § 6.

4. In seeking the authority to duplicate recipient records, the state agency hopes to facilitate the investigation process and to minimize the inconvenience associated with an audit. During the course of an investigation, a large number of records may be examined over an extended period of time. Since this may prove to be disruptive and make records unavailable to a provider, photocopying is proposed as a reasonable course of action.

5. The requirement that records be retained for five years is consistent with provisions at 12 MCAR § 2.047 D.4.c.

6.-7. In the event of a change of ownership or of termination or withdrawl of a provider, the records must be maintained and available for review. That the record is to be maintained by the party assuming responsibility for care is reasonable for continuity of health care. The rule does not specify the contractual relationship which might develop between parties, but rather, is concerned only with the relative availability of all documents necessary to support the determinations required by law. The rule makes clear that the buyer is not liable for any of the conduct reflected by the seller's record.

8. As noted above, Minnesota law specifically states that no persons shall be eligible for assistance under the programs, unless he or she has authorized the Commissioner of Public Welfare in writing to examine all personal medical records developed while the recipient received publically funded health care. The fact that eligibility is established and that the recipient or responsible guardian has applied for and accepts health care under the programs implies that participation and all that it entails was knowingly sought. This means that expressed written consent for release of records was made; that the recipient waives any right to approve or refuse release of records as afforded by the patient Bill of Rights; and that the provider is released from all liability attendant upon release of records to the state agency.

D. PROVIDER SURVEILLANCE AND UTILIZATION REVIEW

The provisions of Section D set forth the scope and purpose of SUR activities relating specifically to providers of health care participating in the programs.

1. The statutory authority to promulgate rules regarding identification of suspected fraud and abuse is clearly cited at Minn. Laws 1980, ch. 349, § 2, 3, 9.

a. Rule language describing the responsibilities of the state agency in the identification of suspected fraud and abuse is essentially taken from the above statutory citations. Language of the statutes has been quoted so that the state agency's authority in this area is clear and unambiguous.

b. The provisions of this section identify the sources of information the Commissioner may use to identify inappropriate activity by health care providers. The use of MMIS computer reports to identify exceptional provider activity is embodied in the requirements of the federal regulations at 41 C.F.R. § 456.23 which states that the state Medicaid agency "must have a postpayment review process that - (a) allows state personnel to develop and review - (1) recipient utilization profiles; (2) provider service profiles; and () exceptions criteria. . .". The use of computer generated profiles which compare groupings of providers having similar characteristics (peer groups) forms the basis for determining what may be exceptional system utilization.

c. In determining the necessity of care provided it is required that the state agency utilize health care professionals in the review process. Minn. Laws 1980, ch. 349, §§ 6, 7.

2. The statutory authority to promulgate rules regarding the investigation of suspected fraud and abuse is contained in the same citations given for the identification process in D.1. above.

a. The purposes of an investigation follow directly from federal regulation. Specifically, at 42 C.F.R. § 455.15 the state "agency must conduct a full investigation to determine if (a) the allegation is true; and (b) there is sufficient evidence that can be developed to support a civil or criminal fraud or abuse action under state law".

b. In conducting an investigation, the state agency must necessarily be authorized to utilize all sources of information which confirm or refute the suspected fraud or abuse. The state agency acknowledges that this authority must be tempered by the

requirements of due process and data privacy, but that the items listed at b. (1) - (7) are ordinary and reasonable investigative activities.

c. Federal regulations regarding the agency's fraud investigation program specifically require at 42 C.F.R. § 455.16 that an investigation, once started

> "must continue until -
>
> (a) Appropriate legal action is initiated;
>
> (b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or
>
> (c) The matter is resolved between the agency and the provider. This resolution may include but is not limited to -
>
> (1) Sending a warning letter to the provider giving notice that continuation of the activity in question will result in further action;
>
> (2) Suspending the provider from participation in the Medicaid program.
>
> (3) Terminating the provider from participation in the Medicaid program; or
>
> (4) Seeking recovery of payments made to the provider."

The above cited provisions encompass and fully justify the items contained at section D.2.c., namely:

> (1) a determination that no further action is warranted corresponds with the closing or dropping of a case because of insufficient evidence;
>
> (2)-(3) imposing administrative sanctions and recovery of money is drawn directly from 42 C.F.R. § 455.16 (c); and
>
> (4) referral of the case to the Attorney General is required by state law which provides that "if it appears to the state agency that a vendor of medical care may have acted in a manner warranting civil or criminal proceedings, it shall so inform the Attorney General in writing." Minn. Laws 1980, ch. 349, § 3. See also Minn. Stat. §§ 609.466, 609.52, subd. 2(d).

3.a. The authority to impose administrative sanctions and to seek monetary recovery and the grounds upon which to do so are clearly and unambiguously provided at Minn. Laws 1980, ch. 349,

§ 6. The statutory language was essentially duplicated in the rule to avoid any confusion. For the purpose of monetary recovery, DPW is specifically exempted from the requirement to establish a pattern of improper billing which is a precondition to sanctioning for false claims, duplicate claims, claims for services not medically necessary, or false statements. The state agency is also authorized to sanction a provider for refusal to grant the state agency access to examine rules, when authorized. Minn. Laws 1980, ch. 349, § 6. The authority to sanction providers who have been suspended or terminated from the Medicare (Title XVIII) program is taken from 42 C.F.R. § 455.212 which prohibits the state from expending Medicaid program dollars for any service by, or under the direct supervision of a provider suspended from the Medicare program. See also 42 U.S.C. § 1396a(a)(39).

b. The methods by which the state agency may seek monetary recovery of monies erroneously paid are drawn from Minn. Laws 1980, ch. 349, § 6. This statute which permits the Commissioner to assess and recover monies, and debit from future accounts, clearly encompasses the proposed methods of recovery. In actual practice, the state agency has historically given providers the option of voluntary payback by means of a provider initiated payment or by automatically debiting the providers' future payments to recover the monies. In the event that voluntary payback or account debiting is not possible, the agency is justified in recovering monies by any legal process.

c. The provisions of this section permit the Commissioner to recover monies erroneously paid a provider by use of statistical sample rather than by an individual claim by claim review. Recovery on the basis of statistical sample permits the state agency to sample a specific, defined group of claims (specified by procedure code), to determine the percentage of program monies inappropriately paid in the sample and then to extrapolate or apply that percentage to the entire population of all similar claims. The rule requires

the use of generally accepted statistical procedures to ensure that the sample is truly random, hence representative of the general population. Given the costly and time consuming nature of a claim by claim review, it is reasonable for DPW to use a more efficient, economical method of audit.

The validity of statistical sampling as a method of recovering overpayments is supported by the decision resulting from the State of Georgia's challenge to the Department of H.E.W. for use of sampling as a valid audit technique. State of Georgia v. Joseph A. Califano, Jr., 446 F. Supp. 404 (N.D. Ga., (1977). In this case, the State of Georgia sued H.E.W. for reimbursement of some $3.5 million which was paid by Georgia for services provided Medicaid recipients by health care providers. Georgia brought suit to cause the release of federal financial participation funds withheld by H.E.W. on the grounds that state payments to physicians exceeded amounts determined by application of federal regulations. The audit which was performed by H.E.W. to determine if federal dollars had been used to pay excessively high claims was conducted on the basis of random statistical samples of claims paid. Georgia asserted that to determine overpayment based upon extrapolation from a random sample was arbitrary and capricious. The court concluded that the use of statistical sample was not improper and that projection of the nature of a large population through review of a relatively small number of its components has been recognized as a valid audit technique.

Sampling and extrapolation technique is currently used by several states in the administration of their Medicaid programs. Pennsylvania established in statute, Article XIV, Section 1407 (c)(1) of the Public Welfare Code, that "the department shall have the authority to use statistical sampling methods to determine the appropriate amount of restitution due from the provider". Similarly, California establishes in rule at Title 22, § 51488.2 of

California Code that a "probability sample may be used in auditing to determine the recoverable amount due from a pharmacy provider".

d. The sanctions which the Commissioner is empowered to impose are stated in Minn. Laws 1980, ch. 349, § 6 which authorizes: "referral to the appropriate state licensing board, suspension or withholding of payments to a vendor, and suspending or terminating participation in the program". The proposed rule further provides lesser sanctions which limit the provider agreement without accomplishing full exclusion from the programs. Establishment in rule of lesser sanctions which permit the provider to conditionally participate in the programs is a reasonable interpretation of the Commissioner's authority in administration of the Medicaid program.

e.(1) - (2) The agency's responsibility to provide notice of intent to recover monies or impose sanction established by the provisions of Minn. Laws 1980, ch. 349, § 5. The content of the notice, as established by this section of the rule, complies with notice requirements applicable to contested case hearings as set forth in Minn. Stat. § 15.0418.

(3) Providers have 20 days to notify the agency that they wish to contest proposed action. This is the same time period that defendants have to serve their answers in civil proceedings. Minn. R. Civ. P. 12.01. Further, to circumvent problems assiciated with delay of mail delivery, the agency accepts the burden of notification by certified mail. The agency feels that a full 20-day notice period affords ample time for providers to consider a future course of action, i.e. compliance or appeal. It should be noted that the 20-day appeal period for providers is well in excess of the 10-day notice period afforded recipients according to the federal regulations at 42 C.F.R. § 431.211. The Commissioner's authority to impose a pre-hearing suspension or reduction of payments is clearly set forth at Minn. Laws 1980, ch. 349, § 5 as is the exemption from this provision for nursing homes or board and care homes. The determination of when such a pre-hearing action might be imposed is addressed in section D.6 of the rule.

Following a hearing on appeal in which the state agency's position is upheld, it is reasonable to grant the Commissioner the discretion to delay imposition of the sanction based upon the interests of program recipients. Notably, in the case of nursing homes, in-patient hospitals and individual providers in isolated rural areas, a period of time may be needed to facilitate patient transfers, discharges, etc. Federal regulations at 42 C.F.R. §§ 455.202, 455.212 provide for delayed implementation dates which is directly compatible with the provisions proposed in this section of the rule.

f. The determination of sanctions to be imposed must necessarily be a discretionary power of the Commissioner. This discretion must take into consideration the gravity of the misconduct, the providers past conduct, and the likelihood of future compliance. It has been the experience of the state agency in five years of operation that circumstances may differ greatly between two participants determined to have committed the same offense. What may be an appropriate sanction to impose against a multi-specialty metro area clinic, for example, may be entirely inappropriate to impose against an individual practioner in a rural practice. To determine sanctions in advance without investing discretionary power in the Commissioner will likely produce inequitable results and unintended hardships.

g.-h. Federal regulations at 42 C.F.R. § 455.212(d) specifically provide that "the agency may not make Medicaid payments for any service furnished directly by, or under the supervision of, the suspended practitioner during the period of suspension". This provision is applicable to the individual providers, as well as clinics or hospitals who may attempt to bill the programs for services performed by the suspended or terminated provider while in their employ. Given the specific prohibition against billing for an ineligible provider, it is reasonable for the agency to recover monies and to consider imposition of sanction for such false claims.

3. Federal regulations at 42 C.F.R. § 455.17 set forth specific reporting requirements for the state agency regarding sanctions imposed against a provider. In addition, the state agency considers it within the public interest to inform appropriate agencies or associations concerned with the professional conduct of health care providers of any sanctions imposed.

4. The simultaneous imposition of a sanction along with monetary recovery is implicitly authorized by Minn. Laws 1980, ch. 349, § 6 which states that "the Commissioner may seek monetary recovery and impose sanctions against vendors of medical care.

5. The authority of the state agency to conduct random, routine audits, a generally accepted method of ascertaining program compliance, is drawn from the agency's overall responsibility to "safeguard against unnecessary utiliztion of [MA] and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy and quality of care." 42 U.S.C. 1396a(a)(30), 42 C.F.R. § 456.3, 42 C.F.R. 456.22 (requiring state agency to do ongoing evaluation on a sample basis of the need for and quality of Medicaid services). See also CCH Medicare-Medicaid Guide ¶ 30,113 (federal requirement of random recipient audits to ascerain whether providers are supplying services for which the agency is billed).

6. As stated previously in this statement, the Commissioner is authorized by statute to suspend or withhold payments to a provider prior to a hearing if it is necessary to protect the public welfare and the interests of the program. Given the complexity and individuality of each case it is reasonable for the Commissioner to exercise discretionary judgment regarding the implementation of this provision. The rule does however provide guidelines which limit the degree of discretion which may be exercised.

7. In keeping with the provision of Minn. Stat. § 256B.04 Subd. 4, the rule resolves conflicts regarding sanctions in favor of Federal law.

E. RECIPIENT SURVEILLANCE AND UTILIZATION REVIEW

1. a.-c. The state agency has general authority to develop rules regarding recipient utilization of the programs. Minn. Laws 1980, ch. 349, § 1, 8, 10. In addition federal regulation at 42 C.F.R. §§ 456.3 and 456.23 provide for a surveillance system and post payment review process which will address inappropiate use by recipients of Medicaid services, and will profile recipient activity in the Medicaid System. The Commissioner's authority to utilize specific sources of information in the identification of suspected fraud and abuse, and to utilize health care professionals for the determination of medical necessity is similar to that established for provider surveillance and has already been addressed in the statement.

2.a. The investigation of suspected fraud and abuse by a recipient in the programs is authorized by the same citations presented in the preceding section. An investigation is conducted to confirm the existence of a fraudulent condition and to support the application of the appropriate corrective action.

3.a. The imposition of sanctions against recipients of the programs is taken from federal regulation at 42 C.F.R. § 456.3 which requires the state agency to implement a program which, among other things, will provide for the control of the utilization of all services provided by the Medicaid program. Grounds 3a(1)-(4) implement DPW's authority to restrict the use of MA identification cards "to prevent duplication or documented abuse of service, to prevent violations of prior authorization requirements or to assure continuity of care." 12 MCAR § 2047 D.6. The grounds for imposing sanctions upon a recipient for fraud are detailed in sections 3a(5)-(11). These find a legal basis in the provisions governing theft and wrongful attainment of assistance. Specifically, Minn. Stat. § 256.98 provides that:

"whoever obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, or by impersonation or other fraudulent device, assistance to which he is not entitled, or assistance greater than that to which he is entitled. . . shall be guilty of theft. . ." Grounds for sanction proposed in the rule at E.3.a. (1) - (11) are reasonable in that each item represents an event or activity which results in the recipient obtaining, or aiding others to obtain, assistance to which they are not entitled.

3.b. The sanctions proposed in rule at E.3.b. are reasonable actions to correct misutilization by recipients. 42 C.F.R. § 456.3 (c), 42 C.F.R. § 456.23 (b) and 12 MCAR § 2.047 D.6. Health counseling E.3.b.(1) as a form of sanction enables the agency to correct inappropriate health care utilization by the recipient, e.g. visiting multiple providers and obtaining multiple prescriptions for potentially incompatible drugs. However, it is possible that counseling alone may be ineffective or perhaps the recipients's pattern of abuse is so dangerous as to require more direct control. The proposed rule would enable the state agency to restrict the recipient to obtaining his or her health care from a core of designated providers. The recipient may choose a physician, dentist, pharmacy or other enrolled provider to provide all non-emergency health care. The purpose of the restriction program is to change the recipient's pattern of health care utilization by limiting program payment to care provided by those few providers. The restriction is imposed for a limited period of time and is removed if the recipient's pattern of utilization improves during this time period. Program payment remains available for emergency health care and services provided upon referral by the primary providers. The fact that a recipient is under restriction is indicated on the medical identification card so that providers will know that the programs will not pay for any care provided this individual unless it is emergency or by referral. The Department

believes that the restriction program is a reasonable way to control abuse of the program by recipients while assuring that medically necessary care remains available to them.

Recovery of monies E.3.b.(2), from a recipient for assistance wrongfully obtained is authorized by Minn. Stat. § 256.98 which indicates that assistance incorrectly paid and established by judicial determination "shall be recoverable from the recipient". In addition, referral of the recipient's case to the Attorney General is permitted by the same citation, i.e. the Attorney General. . . may institute a criminal or civil action.

A recipient may be terminated from participation for that period for which he refuses to sign a consent for release of records. Minn. Laws 1980, ch. 349 § 1, 8, 10. (No person shall be eligible for assistance for health care unless he has authorized the Commissioner in writing to examine all records developed while receiving publically funded health care).

c. Federal regulations at 42 C.F.R. §§ 431.206 and 431.211 require that the state agency provide notice of its proposed action at least 10 days before the date of action. In addition, at 42 C.F.R. § 431.210 the regulations address the content of the notice. The rule provisions at E.3.c. regarding notice to recipients complies with federal regulation in both the content, which explains reason for the intended action and the right of the recipient to dispute and appeal the action.

d. The intent of the programs restriction activity is to control abuse of the programs by recipients and to afford the recipient consistent, coordinated health care. Obviously, emergency situations can and do exist which would require that health care be provided by other than the designated provider(s). The agency is aware of the need for an emergency exemption in its restriction program, but is justified in requiring documentation to confirm an emergency condition.

e. In addition to emergency care, the agency is aware that health care may be needed which is not within the scope of practice or specialty of the designated provider of a restricted recipient. However, it is reasonable that the care be contingent upon referral from the designated provider to ensure that consistent and coordinated care is provided.

F. APPEAL

1. The provider's right to appeal an agency determination is fully protected by incorporation of the contested case provisions cited at Minn. Stat. § 15.0418.

2. The recipient's right to appeal an agency determination is protected by the incorporation of Minn. Stat. § 256.045, subds. 2-3. Further authority is found at 42 C.F.R. § 431.206.

3. The purpose of this section is to provide for an informal dispute resolution process by which a provider or recipient may discuss the agency's proposed action. If the matter is not resolved, the provider or recipient may institute the formal appeal process.

4. Generally, in contesed cases the party proposing that certain action be taken must prove the facts at issue by a preponderance of the evidence. 9 MCAR § 2.217 C.S. (as amended in 4 S.R. 1814). However, when the matter in dispute is a monetary one in which the provider or recipient has possession or control of the records and information that best determines questions of fact, the burden shifts to them after the agency has established a prima facie case. In the Matter of the Contested Case of Anoka Nursing Home, et al., DPW-80-036-JL, "Order on Motion for Determination of Burden of Proof." Oct. 28, 1980, Hospital Ass'n. of New York State v. Tora, 473 F. Supp. 917, 935-36 (S.D. N.Y. 1979).

The standard of proof for the suspension or revocation of a providers license may be the "clear and convincing" standard. However, a proceeding under this rule would be more analogous to a contract dispute.

In assessing a constitutional attack on 42 U.S.C. 1320c of the medicaid act a federal court noted that the provision concerned "conditions of compensation" not "criminal sanctions" or "severance from the medical profession" and should be scrutinized by the courts accordingly. Ass'n. of American Physicians and Surgeons v. Weinberger, 395 F. Supp. 125, 138 (N.D. Ill. 1975), aff'd., 423 U.S. 975 (1975).

The state agency will not call any outside expert witnesses.

Dated:

ARTHUR E. NOOT
Commissioner of Public Welfare

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the matter of the proposed adoption of a rule of the Department of Public Welfare governing the Surveillance and Utilization Review Program, 12 MCAR 2.064 (Rule 64).

STATEMENT OF COMPLIANCE WITH RULEMAKING PROCEDURES

I, Special Assistant Attorney General Ken Kohnstamm do hereby declare that I have examined the rule and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedure Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed. Any exceptions are noted below.

Special Assistant Attorney General

Dated: August 28, 1981

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the matter of the proposed adoption of a rule of the Department of Public Welfare governing the Surveillance and Utilization Review Program, 12 MCAR 2.064 (Rule 64).

AFFIDAVIT OF MAILING NOTICE OF SUBMISSION TO THE ATTORNEY GENERAL

STATE OF MINNESOTA)
)ss.
COUNTY OF RAMSEY)

Larry L. Woods, being first duly sworn, deposes and says:

That on the 28 th day of August, 19 81, in the City of St. Paul, County of Ramsey, State of Minnesota, he served the attached Notice of Submission to the Attorney General by depositing in the State of Minnesota Central Mail System for United States mailing or United States mail at said City of St. Paul, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who requested notice that the rules in the above-entitled matter have been submitted to the Attorney General.

Larry Woods

Subscribed and sworn to before me this 28th day of August, 1981.

Jean D. Storm

JEAN D. STORM
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires Feb. 3, 1983

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the matter of the proposed adoption of a rule of the Department of Public Welfare governing the Surveillance and Utilization Review Program, 12 MCAR 2.064 (Rule 64).

NOTICE OF SUBMISSION TO THE ATTORNEY GENERAL

Pursuant to your request and in accordance with Minnesota Statutes, section 15.0412:

PLEASE TAKE NOTICE that the above-captioned rules have been submitted to the Office of the Attorney General on this date, August 28, 1981, for review as to form and legality. Pursuant to 1 MCAR § 1.206 B., the Attorney General will not approve the rules for at least ten (10) calendar days after receipt to allow any person or association time to comment on the legality of the above-captioned rules, you should direct your comments to the Office of the Attorney General, G-25 State Administration Building, 50 Sherburne Avenue, Saint Paul, Minnesota 55155, telephone (612) 296-7030. Please note that the above-cited rule of the Attorney General also provides that a copy of any written comments submitted to the Attorney General must be submitted simultaneously to this agency.

If you are interested in determining what changes, if any, were made in the proposed rules after [the hearing/publication in the State Register] and before submission to the Attorney General, you may contact Larry Woods, Department of Public Welfare, Surveillance and Utilization Review Section, P.O. Box 43208, St. Paul, Minnesota 55164

Larry Woods

RECEIVED
AUG 27 1981
ADMINISTRATIVE
HEARINGS

Report of the Hearing Examiner on Rule 64

The Hearing Examiner referred the report to the Chief Hearing Examiner for review pursuant to the provisions of Minn. Stat. § 15.0412, Subd. 4d. Review was required because the Hearing Examiner had determined the following:

- the need for and reasonableness of one part of the rule was not established by the agency; or
- several parts of the rule were found to substantively violate provisions of the administrative procedures act.

The Hearing Examiner has made specific recommendations to correct the defects and those recommendations have been upheld by the Chief Hearing Examiner. The agency has the option of either taking actions recommended by the Hearing Examiner or reconvening a rule hearing to establish the need and reasonableness of the contested provision. The alternative to a rule hearing on issues which relate to need and reasonableness would be to submit the rule to the Legislative Commission to Review Administrative Rules for the Commission's advice and comment. The rule cannot be promulgated until substantive defects have been corrected. Recommendations of the Hearing Examiner which are non-substantive can be changed or adapted at the discretion of the Commissioner.

A review of the findings of the Hearing Examiner on substantive issues and his recommendations follow. References to rule 64 relate to the rule and rule changes proposed at public hearing.

SUBSTANTIVE

Rule Part: A.3. - authority to issue bulletins which represent the agency's interpretation of rule.
Finding 13: An agency's interpretation of their own rule represents policy choices among alternatives and should, therefore, be promulgated.
CHANGED PER H.E.
Proposed: Delete current wording and replace with wording which indicates the bulletins are to assist others in complying with rule.

Rule Part: B.7. - the definition of "medically necessary" care is care within the generally accepted standards of practice of a provider's practice.
Finding 30: DPW cannot limit or restrict the scope of practice of practitioners beyond that otherwise authorized by state laws.
CHANGED PER H.E.
Proposed: Amend first paragraph to read "Health care which is rendered pursuant to the provider's authority under state law and within the scope of the license, if any, and is: (in response to pain, etc.). The Hearing Examiner recommended that a statement be added to further define "medically necessary" as care of "acceptable quality".

Rule Part: C.2.b.(5) - the requirement that nursing homes keep "records of other third party claims, charges and payments".
CHANGED/H.E.
Finding 49: Impermissibly vague in that it does not specify what records are potentially invalued.
Proposed: Clarify the records to specify which records are needed to investigate third party claims, charges and payments.

Rule Part: C.3. - relating to DPW access to review health care (medical) records.
Finding 52: Statutory authority permits access to medical records "solely" to determine if a claim for reimbursement is false in whole or in part and to determine if care was medically necessary. (This does not apply to financial records.)
Proposed: Amend rule language to indicate that medical records can be reviewed solely for the purposes stated above.

CHANGED/HE

Rule Part: C.3. - exempting utilization control from the requirement of presenting consent forms to access medical records.
Finding 60: Exemption of utilization control from presenting consent forms not authorized by statute.
Proposed: Delete language which authorizes exemption. (This does not necessarily mandate that consent forms be presented, only that we could not exempt utilization control in rule.)

CHANGED/H.E.

Rule Part: C.8. - permits the use of consent forms signed by "next of kin, friend, or other person" to access medical records.
Finding 66: Signature of above named parties inadequate to waive constitutional rights to privacy.
Proposed: Delete reference to above parties.

CHANGED/H.E.

Rule Part: D.3.c. - permits use of sampling methodology to recover program dollars.
Finding 77: Failure of rule to state <u>when</u> this methodology would be used in a violation of due process.
Proposed: Amend rule to clarify under what circumstances, sampling methodology may be used.

Rule Part: D.3.C. - see above.
Finding 80: The agency has not established the need for and reasonableness of sampling as a form of monetary recovery in Minnesota.
Proposed: Delete part D.3.c.

Rule Part: F.4. - places on the agency the burden of proving the facts in dispute by a preponderance of the evidence, and shifts the burden of proof to the provider once a prima facie case is established.
Finding 89: DPW does not have the authority to adopt procedural rules of this nature since the office of administration has that responsibility and DPW cannot promulgate a rule which is counter to that exclusive authority, specifically by shifting the burden of proof after a prima facie case.
Proposed: Delete that wording which would shift the burden of proof.

CHANGED/HE

Rule Part: F.4. - established that the standard of proof for contested cases will be by a preponderance of the evidence.
Finding 90: The agency does not have the authority to adopt as standard of proof. (See above.)
Proposed: Delete F.4.

NONSUBSTANTIVE

Rule Part: B.1. - the definition of "abuse" with specific examples of what might characterize abuse.
Finding 15 - 27: That the generic definition is needed and reasonable, that the Department need not incorporate the element of intent. Specific wording changes suggested for elements of abuse definition.

NO Suggestion: B.1.a. - delete reference to incorrect TPL information since missing TPL information has already been deleted.

YES B.1.c. - amend element dealing with submission of non reimbursable claims to cover submission of duplicate claims.

YES B.1.f. - existing wording would have the effect of placing DPW in the position of defining the standards of practice of a provider's practice or specialty rather than addressing the medical necessity of the case.
Proposed rewording "The repeated submission of claims by a provider for health care which is not medically necessary".

YES Consider adding concept of unacceptable quality.

B.1.g. - existing wording regarding inflating the quantity of service necessary

YES should be clarified by adding the following wording: .... or rule;"
Services, prescriptions or device deemed unnecessary or excessive under the generally accepted practice of providers of such service, prescriptions or devices is abusive.

B.1.i. - does not address recipient disposal of property not obtained specifically

YES for the purpose of resale. Suggested rewording: "Obtaining unneeded equipment, supplies or pharmaceuticals by a recipient for the purpose of resale or the disposal of equipment, supplies or pharmaceuticals obtained with program monies without authorization of the local welfare agency."

Rule Part: B-19. - definition of "withholding of payments" which includes recovery for services not documented in the medical record.
Finding 38: Restriction on "documented" in record be loosened to include

NO services which can otherwise be proven to have been provided (suggested by MDA).
Suggestion: At discretion of agency adopt language which is flexible enough to allow providers to provide evidence of service.

NO Rule Part: C.1.b. - medical records be legible to individuals providing care.
Finding 40: MAHCF suggests that record be legible to person making record to reduce liability of institutional provider.
Suggestion: Change at agency discretion.

Rule Part: C.1.c. (1)-(11) - minimum information necessary in medical or health care record.
Finding 41: MMA & MDA requested exclusion from specific requirements on the grounds they were not in keeping with record keeping requirements of

NO practitioners.
Suggestion: Exclude group at agency discretion.

Rule Part: C.1.c. (2) - requires signature of provider for each entry in

NO medical record.
Finding 42: MCA objected to requirement in the single doctor office.
Suggestion: Modify at agency discretion.

Rule Part: C.1.c.(2) - requires countersignature of services by non-enrolled practitioners by supervisive provider.
YES Finding 43: Institutional providers object to countersignature in form of a statement which clarifies their responsibility to monitor or supervise such care.
Suggestion: Modify at agency discretion.

Rule Part: C.3. - access to records.
NA Finding 58: To legitimize inspection of records, DPW should consider a consent clause in the provider contract.
Suggestion: Action at agency discretion.

Rule Part: C.3. - access to records.
YES Finding 59: Access should be limited to that stated in statute.
Suggestion: Action at agency discretion.

Rule Part: C.4. - photocopying.
YES Finding 61: Removal of records from premises for purposes of photocopying would constitute seizure unless specifically permitted by provider.
Suggestion: Amend wording to indicate photocopying on premises or provider's permission to remove.

Rule Part: C.5. - record retention, 5 years.
YES Finding 62: Record retention creates a logistical problem and DPW should permit microfilming after 3 years.
Suggestion: Amend wording to allow microfilming after 3 years.

Rule Part: C.6. - establishes responsibility for maintaining records, in the event of a change of ownership, on the selling provider.
YES Finding 63: Existing language does not fully establish obligation of selling and purchasing providers.
Suggestion: Amend wording to indicate that the responsibility for record maintenance and record availability rests with the seller unless contractual arrangements are made.

Rule Part: C.7. - mandates 5 year record retention for providers who withdraw or are terminated from the program.
YES Finding 64: Record retention for terminated provider is not consistent with main record retention provisions, i.e., do retirees maintain 5 years records for 5 years or can they drop off 1 year's records as each year passes? Further, the section does not address recommendations that retiring providers may request an audit, at their expense, to negate the need for record retention.
Suggestion: Amend wording at agency discretion to clarify record retention and options for retention, i.e. audit, microfilm, etc.

Rule Part: C.8. - recipient consent presumed competent if given in conjunction
YES with an application.
Finding 65: Presumption of competence should be rebuttable.
Suggestion: Amend wording to include concept of rebuttable presumption.

Rule Part: D.1.b. - identifies sources of information which may be utilized by SUR.
YES Finding 68: Principles of confidentiality regarding information sources are already contained in state law; however, re-statement in the SUR rule is recommended.

Suggestion: Adopt a confidentiality statement.

Rule Part: D.2.c.(1) - provides for notification of provider following SUR investigation if no further action is contemplated.
NO
Finding 71: While not required a time limit on the determination and notification has merit.
Suggestion: Amend wording to require a time limit on SUR action.

Rule Part: D.3.e.(3) - establishes the effective date of monetary recovery at 20 days after receipt of certified mail.
NO
Finding 81: Associations suggest 30 days.
Suggestion: Change at agency discretion.

Rule Part: D.6. - prehearing suspension of payments.
YES
Finding 85: Following the Ward "hearing" add - except as provided in Part D.3.e.(3).
Suggestion: Amend at agency discretion.

STATE OF MINNESOTA

COUNTY OF RAMSEY

BEFORE ARTHUR E. NOOT

COMMISSIONER OF PUBLIC WELFARE

In the Matter of the Proposed
Adoption of a Rule of the
Department of Public Welfare
Governing the Surveillance and Utilization
Review Program,
12 MCAR § 2.064 (Rule 64).

ORDER ADOPTING
THE RULE

RECEIVED
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HEARINGS

The above entitled matter came on for hearing before Hearing Examiner Jon Lunde, of the State Office of Administrative Hearings, on January 14, 1981, in the Chapel Auditorium, Building 15, Minnesota Veterans Home, East 51st Street and Minnehaha Avenue, Minneapolis, Minnesota, after proper notice as required by Minn. Stat. § 15.0412, subd. 4 (1980), was served upon all persons, associations and other interested groups registered with the Department for that purpose.

At the hearing the proposed Rule 64 as published at 5 State Register 974 (December 15, 1980) was considered. The following persons testified for the Department of Public Welfare: Robert C. Baird, Assistant Commissioner for Income Maintenance, Thomas A. Gaylord, Director of the Surveillance and Utilization Review Division (SUR) and Larry Woods, head of the SUR Provider Section. In addition, eight SUR staff members were available for testimony and questioning by the public. The hearing continued until all interested groups and persons had an opportunity to be heard. Pursuant to the Order of the Hearing Examiner, the record remained open for twenty (20) days for the submission of written material.

Based upon all the records and proceedings, the Hearing Examiner made Findings of Fact, Conclusions and Recommendations which are contained in the Report of the Hearing Examiner, dated March 19, 1981. The Report is attached hereto as Exhibit A. Pursuant to the requirements of Minn. Stat. § 15.0412, subd. 4 (1980), the Report was available to all affected persons for at least five (5) days. In a report dated March 27, 1981, the Chief Hearing Examiner approved the report of the Hearing Examiner in all respects.

Having considered all of the evidence adduced and upon the records, files and proceedings herein, and applicable statutory standards and criteria, and having confirmed the need for the above-captioned Rule and the reasonableness thereof,

NOW, THEREFORE, IT IS ORDERED,

That the Findings and Conclusions of the Hearing Examiner, as contained in the Report of the Hearing Examiner, are, with the exceptions made below, hereby adopted and incorporated herein.

The Findings of Fact of the Hearing Examiner are enumerated 1 through 91 in his Report. The Commissioner does not accept the Hearing Examiner's Findings 53-59, 80, and 88-90. The Commissioner accepts but makes additional comments to the Hearing Examiner's Findings 49, 74-77, and 84. The Commissioner has also adopted the large majority of the Examiner's recommendations pertaining to discretionary changes. Among recommendations which have been rejected, the Commissioner explains his reasoning in regard to Hearing Examiner Findings 19, 38, and 40-43. The remaining Findings of the Hearing Examiner are accepted by the Commissioner and are incorporated herein. The Commissioner accepts the Hearing Examiner's Conclusions except insofar as they relate to Findings 53-59, and 80.

The Commissioner of Welfare, based upon all the records and proceedings herein, makes the following:

FINDINGS OF FACT

A. Findings Not Adopted.[1/]

1. (Paragraphs 53-59; C.3) Minnesota law provides that the Department "shall be allowed access to all personal medical records of medical assistance recipients" upon 24 hours notice to the vendor. Minn. Stat. § 256B.27, subd. 3. The Hearing Examiner made extensive Findings as to the constitutionality of this statute and allegations that it permits warrantless searches. Neither the

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1/ The Commissioner's Findings will identify the related Findings from the Hearing Examiner's Report and the section of the proposed rule.

Commissioner nor the Hearing Examiner have the authority to decide the constitutionality of state statutes and accordingly the Hearing Examiner's Findings in this regard are rejected.[2/]

It should be noted, however, that the Department takes the position that its recourse to denial of access under the 24 hour notice provision is to sanction the provider under this rule and/or seek a subpoena or search warrant. The Department does not view the 24 hour notice statute as authority to conduct a warrantless search.

The 24 hour notice and access provision of C.3. parallels the statutory language. The Commissioner therefore finds it necessary and reasonable.

2. (Paragraph 80; D.3.c.) This provision permits the Department to compute monetary recoveries based upon statistical samplings. The Hearing Examiner found that this procedure was unreasonable due to the failure of the rule to specify "minimally acceptable criteria of relability." Therefore, the Examiner felt that the provision had to be deleted. The Department has amended the provision to state the criteria of reliability. This provides the vendor a more concrete standard than the more general language of the rule as originally proposed ("generally accepted statistical procedure").

The Department's amended D.3.c. is reasonable because it specifies that the sampling be based on nationally recognized standards (Kish and Cochran), that a 95% confidence factor be used, and that the sample would be applied only to the time period in controversy. The provider would receive prior notice that sampling is to be used. After the sampling, the results are rebuttable and, of course, appealable.

The Department's post-hearing changes to D.3.c. significantly clarify the procedure to be used and reduce the likelihood that a monetary recovery would be sought based upon an arbitrary or unfair method. The Commissioner finds that the

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2/ The Hearing Examiner acknowledged that "the Hearing Examiner is without authority to find the statute or the rule which incorporates its terms unconstitutional." (Finding 52)

post-hearing changes to the sampling provision are reasonable and do not constitute a substantial change. (See paragraph 5 below for additional Commissioner Findings relevant to the Hearing Examiner's Finding that the sampling procedure is necessary.)

3. (Paragraphs 88-90; F.4) The proposed rule set forth the burden and standard of proof for contested cases arising under the rule. However, there was considerable public criticism of the Department's proposal and for that reason it has been withdrawn. The law concerning burden of proof in Medicaid fraud and abuse cases is unclear and therefore, to avoid adopting any position, the Hearing Examiner's rationale is not adopted. The Commissioner finds that deletion of F.4 is not a substantial change.

B. Additional Comments to Hearing Examiner Findings Which Are Adopted.

4. (Paragraph 49; C.2.b.(5)) The rule as proposed required providers to keep certain financial records. This provision originally specified this to include records of third party claims. The Hearing Examiner found that the scope of this requirement needed to be clarified. Accordingly, the Department's post-hearing amendment defines "third parties" and specifies what third party records must be maintained. The provision, as amended, is necessary in part due to the Department's subrogation interests in private insurance policies. Minn. Stat. § 256B.37. Providers increasingly deal with third party payers and, given the post-hearing amendment, C.2.b(5) is clear as to what records must be maintained. The Commissioner finds the amendment not to be a substantial change.

5. (Paragraphs 74-77; D.3.c.) The Department's proposal to compute monetary recoveries based on samplings was critized as unnecessary. The Hearing Examiner found that it was necessary, but indicated that the rule must indicate when the statistical approach will be used. (Paragraph 77). The Department's post-hearing amendment specifies that sampling may be used to compute monetary recoveries under any of three circumstances: 1) the claims to be sampled reflect services rendered to 50 or more recipients, 2) there

are more than 1,000 claims to be sampled, or 3) the charges to the Department exceed $2,000.

These criteria insure that the sampling method of computing recoveries will be used when a manual audit would be inefficient. They also eliminate the possibility of arbitrary use of sampling. Sampling, as restricted by the post-hearing amendment, will primarily be used in connection with providers who service substantial numbers of recipients and/or bill the Department substantial amounts under one procedure code.

The Commissioner finds the amendment to D.3.c. necessary and not a substantial change. (See paragraph 2 above for the Commissioner's finding that D.3.c. is reasonable.)

6. (Paragraph 84; D.5.) This provision states that SUR is not prohibited from conducting "routine audits." The Hearing Examiner found that the deletion of the word "random," in order to avoid confusion with the use of that term elsewhere in the rule, was appropriate. The purpose of D.5 is to codify existing practice in regard to routine audits. The SUR division, after giving providers notice and the appropriate recipient consent forms, conducts audits of certain classes of providers (e.g., pharmacists, large dollar providers) without any allegation of wrongdoing or erroneous billings. Such routine audits are occasionally required by the federal government.

The Hearing Examiner properly found that the change to D.5. is necessary, reasonable and insubstantial.

C. Recommendations not Adopted.

The Hearing Examiner, in addition to his Findings, made many recommendations as to choices within the Commissioner's discretion. The majority have been adopted and incorporated. Here, the Commissioner indicates the reasoning for rejecting a few of the recommendations.

7. (Paragraph 19; B.1.a.) This provision gives as an example of abuse the repeated submission of incorrect third party liability information. This example has been retained even though

providers are not required to submit third party liability information. There are two reasons for this. First, Minnesota's payment system is premised on the assumption that information submitted is accurate. Inaccurate information is more burdensome and cost inefficient than no information. Second, the Department is aware of instances in which providers have falsely indicated that there is no third party liability. This enables the provider to recover from two parties for the same service.

The Commissioner finds B.1.a. to be necessary and reasonable, and its amendment to be an insubstantial change.

8. (Paragraphs 38; B.19.) Payments are withheld as an offset for services not documented. The Hearing Examiner recommended that the Department consider amending this provision to indicate that services could be reimbused if they were documented or otherwise proven to have been provided. The Commissioner rejects this suggestion. Properly administered health care services are documented. In addition, the SUR division is essentially an auditing unit; it does not have the personnel or resources to make the additional determination that non-documented services were actually provided. The Hearing Examiner properly found this provision necessary and reasonable as proposed.

9. (Paragraphs 40-43; C.1.b. and C.1.c.) The Hearing Examiner recommended some minor changes in the provisions concerning record keeping. He suggested the Department consider the following: that medical records need only be legible to a provider and its employees (paragraph 40); that dentists be excluded from certain record keeping requirements (paragraph 41); that one-doctor offices not be required to sign medical record entries (paragraph 42); and that supervising providers need not countersign services billed under their name (paragraph 43).

The Commissioner finds that in order to monitor the validity and medical necessity of services provided, the records must be legible. The rule has been amended to enable dentists to meet documentation requirements by presentation of drawings or

x-rays. (B.4.) The signature of the provider or supervisor of services after the chart entry is commonly accepted not only as a good health care practice but it establishes the individual responsibility for the service rendered.

The Commissioner finds that the rule as proposed in these respects reasonable and necessary and does not find the rejection of these suggestions to be an abuse of discretion.

IT IS FURTHER ORDERED that this Rule, identified as Rule 64 of the Minnesota Department of Public Welfare, is adopted this 27 day of August, 1981, and after this day Rule 64 shall read in its entirety as set forth in the attached Exhibit B, pursuant to the authority vested in me, and pursuant to Minn. Stat. Chapters 15 and 256.

Dated: This 27 day of August, 1981.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

By: Francis Moriarty, for
COMMISSIONER

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File No. DPW-81-010-JL
Date 1-14-81

program, and/or the Catastrophic Health Expense Protection Program. The statutory authority for the rule is Minn. Stat. § 62 E.54, subd. 1 as amended by Minn. Laws of 1980, ch. 349, § 256B.04, subd. 10 as amended by Minn Law of 1980, ch. 349, § 256D.03, subd. 3 as amended by Minn. Law of 1980, ch. 349.

All interested or affected persons or groups are requested to participate. Statements of information and comment may be made orally or in writing. Written statements of information and comment may be made addressed to:

Larry Woods
Department of Public Welfare
Surveillance and Utilization Review Section
P.O. Box 43208
St. Paul, Minnesota 55164

Oral statements of information and comment will be received during regular business hours over the telephone at (612) 296-9943.

All statements of information and comment must be received by November 21, 1980. Any written material received by the department shall become part of the hearing record.

Department of Public Welfare
Mental Health Bureau

Notice of Intent to Solicit Outside Opinion Concerning Approval of Mental Health Centers and Clinics for Insurance Reimbursement

Notice is hereby given that the Minnesota Department of Public Welfare is considering temporary rule 12 MCAR § 2.029 and, subsequently, permanent rule 12 MCAR § 2.029, governing conditions or approval of mental health centers and clinics insurance reimbursement.

These rules authorized by Minn. Stat. § 245.69 (amended 1980) govern the conditions under which the commissioner will approve mental health centers and clinics for insurance reimbursement.

The proposed rules will set forth the minimum requirements to qualify for approval such as staffing, peer review of clinical work, and continuing education standards.

All interested or affected persons or groups are requested to participate. Statements of information and comment may be made orally or in writing. Written statements of information and comment may be made to:

Trudy Dunham, Insurance Reimbursement Specialist
Mental Illness Program Division
Fourth Floor, Centennial Building
St. Paul, MN 55155

Oral statements of information and comment will be received during regular business hours over the telephone at (612) 296-4503.

All statements of information and comment must be received by November 14, 1980. Any written material received by the Department shall become part of the hearing record.

Department of Public Welfare
Mental Health Bureau

Notice of Intent To Solicit Outside Opinion Concerning Chemical Abuse and Dependency (C.D.) Services

Notice is hereby given that the Minnesota Department of Public Welfare is considering a draft rule, 12 MCAR § 2.033, Standards for Provision of Comprehensive C.D. Services. This rule will govern and set standards for the planning and providing of comprehensive chemical abuse and dependency services by the county boards.

Authority for this rule is contained in Minn. Stat. § 254.07, subd. 2; Minn. Stat. § 256E.06; and Minn. Stat. § 254A.10.

All interested or affected persons or groups are requested to participate. Statements of information and comment may be made orally or in writing. Written statements of information and comment may be made addressed to:

RECEIVED
DEC 19 1980
ADMINISTRATIVE HEARINGS

47-97 : Unnamed	27,34	121	30
47-143: Mary Lake	16,21	120	31
47-162: Unnamed	4	118	32
47-245: Unnamed	27	120	31

2. Watercourses

Name	Section	Township	Range	Section	Township	Range

None

B. Wetlands

Number and Name	Section	Township	Range
47-305: Unnamed	8	121	31
*47-349: Unnamed	14	119	31
*47-350: Unnamed	28, 29	119	31
*47-351: Unnamed	2	117	31
86-294: Unnamed	19, 30; 24, 25	118	28; 29

*These wetlands were petitioned to be added.

Within 60 days following completion of the hearing, the hearings unit shall issue its findings of fact, conclusions and an order, which shall be considered the decision of an agency in a contested case for purposes of judicial review pursuant to Minnesota Statutes, Sections 15.0424 and 15.0425.

Any activity that would change the course, current or cross-section of public waters or wetlands requires a permit from the Commissioner of Natural Resources. Minnesota Statutes, Section 105.42, subd. 1 (1979). Designation as public waters or wetlands does not transfer ownership of the bed or shore, does not grant the public any greater right of access to those waters than was available prior to designation and does not prevent a landowner from utilizing the bed of those waters for pasture or cropland during periods of drought. Minnesota Statutes, Section 105.391, Subdivisions 10 and 12 (1979).

All petitioners may be represented by counsel or anyone else of their choosing and shall be given an opportunity to be heard orally, to present and cross-examine witnesses and to submit written data, statements or arguments. Petitioners should bring all evidence bearing on these matters including maps, records or other documents.

Failure to attend may result in the challenged waters being designated public waters or wetlands and may prejudice your rights in this and subsequent proceedings.

Questions concerning this Notice and Order may be directed to any member of the hearings unit or to

David B. Milles
DNR—Division of Waters
Third Floor, Space Center Building
444 Lafayette Road
Saint Paul, MN 55101
Telephone: 612/297-2835

October 17, 1980

Joseph N. Alexander, Commissioner
Department of Natural Resources

Department of Public Welfare
Income Maintenance Bureau

Notice of Intent to Solicit Outside Opinion Concerning Surveillance and Utilization Review

Notice is hereby given that the Minnesota Department of Public Welfare is considering a draft rule 12 MCAR § 2.064 (DPW Rule 64), Surveillance and Utilization Review. This rule governs procedures to be used by the Surveillance and Utilization Review Section, Minnesota Department of Public Welfare, in the identification and investigation of exceptional utilization, suspected fraud, or abuse by participants in the Minnesota Medical Assistance program, the General Assistance Medical Care

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF A RULE OF THE DEPARTMENT OF PUBLIC WELFARE GOVERNING THE SURVEILLANCE AND UTILIZATION REVIEW PROGRAM, 12 MCAR 2.064 (RULE 64).

NOTICE OF HEARING

A public hearing concerning the above-entitled matter will be held at the Minnesota Veterans Home, East 51st Street and Minnehaha, Building 15, Chapel Auditorium Building, Minneapolis, Minnesota, on January 14, 1981, commencing at 9:00 a.m. and continuing until all persons have had an opprotunity to be heard. The proposed rule may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rule, you are urged to participate in the rule hearing process.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to ask questions and make comments. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted to Jon L. Lunde, Hearing Examiner, Room 300, 1745 University Avenue, St. Paul, Minnesota 55104, telephone 612/296-5938, either before the hearing or within five working days after the public hearing ends. The hearing examiner may, at the hearing, order that the record be kept open for a longer period not to exceed 20 calendar days. The rule hearing procedure is governed by Minn. Stat. §§ 15.0411-15.0417 and 15.052, and by 9 MCAR §§ 2.101-2.113 (Minnesota Code of Agency Rules). If you have any questions about the procedure, call or write the hearing examiner.

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

Proposed Rule 64 sets standards for the Surveillance and Utilization Review (SUR) program. The Surveillance and Utilization Review Division is responsible for identifying and investigating suspected fraud, theft, abuse and inappropriate utilization of services by eligible recipients and enrolled providers in the Medical Assistance, General Assistance Medical Care, and Catastrophic Health Expense Protection Program programs of the Department of Public Welfare. Through its computer generated exception reports and referrals, SUR identifies patterns of provision and utilization of medical services, equipment and supplies which may be indicative of fraud and abuse. SUR then conducts investigations to verify this information and determine if corrective actions are required. SUR is authorized to sanction providers

Ken Kohnstamm

and recipients as appropriate for documented abuse, misutilization, fraud, and violation of federal regulations, state law, or agency rules. SUR has a range of possible sanctions which may be imposed, including recovery of overpayments, suspension, termination, referral for peer review, restriction, and civil or criminal actions.

Proposed Rule 64 is divided into several subsections. Subsection A contains the introduction which explains the scope of the rule and its statutory basis. Subsection B contains several definitions of terms used throughout the rule. Subsection C explains the purposes for which and the methods whereby records are examined by authorized state agency personnel. Subsection D describes the process of identification and investigation of suspected fraud, theft or abuse of the programs by enrolled health care providers. This section further describes the grounds for monetary recovery and sanctions, as well as the range of corrective actions, which may be imposed against an abberant provider. Subsection E describes the process of identification and investigation of suspected fraud, theft or abuse of the programs by eligible recipients. This section further describes grounds for monetary recovery and sanctions, as well as the range of corrective actions, which may be imposed against a recipient. Subsection F outlines the appeal process available to recipients and providers in the event that a corrective action is imposed by the Department.

The agency's authority to promulgate the proposed rule is contained in Minn. Stat. §256B.04 Subd. 10 as amended by Minn. Law 1980, Chap 349, Minn. Stat. §256D.03 Subd. 3 as amended by Minn. Law 1980, Chap. 349, and Minn. Stat. §62E.53 Subd. 3 as amended by Minn. Law 1980, Chap. 349.

The Department of Public Welfare estimates that there will be no cost to local public bodies in the State to implement the rule for the two years immediately following its adoption within the meaning of Minn. Stat. §15.0412, Subd. 7 (1978).

Copies of the proposed rule are now available and at least one free copy may be obtained by writing to Larry Woods, Department of Public Welfare, Centennial Building, St. Paul, MN 55155, telephone (612) 296-9943. Additional copies will be available at the hearing. If you have any questions on the content of the proposed rule, contact Larry Woods at (612) 296-9943.

Any person may request notification of the date on which the hearing examiner's report will be available, after which date the agency may not take any final action on the rule for a period of five working days. Any person may request notification of the date on which the hearing record has been submitted or resubmitted to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the hearing examiner, in the case of the hearing examiner's report, or to the agency, in the case of the agency's submission or resubmission to the Attorney General.

Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minn. Stat. §10A.01, Subd. 11, 1979 Supp., as any individual:

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

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

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

Dated: November 19, 1980

Arthur E. Noot
Commissioner of Public Welfare

JT/clhh

September 2, 1981

OFFICE OF THE REVISOR OF STATUTES
Disapproval of Form of Rules

__X__ The form of the attached rules is not approved. The revisor requests the changes described below before the rules will be approved.

See Attached

Steven C. Cross
Revisor of Statutes

Name: Paul M. Marinac

Title: Assistant Revisor

Phone: 296-0948

- -

_____ The changes requested by the revisor are approved by the agency.

_____ The changes requested by the revisor are not approved by the agency

_____
Agency's Representative

- -

_____ The attorney general agrees that the changes requested by the revisor are form changes, not substantive changes.

_____
Assistant Attorney General

Page 1, line 10, delete the period and insert a comma

Page 1, line 15, delete the colon and insert a semicolon

Page 1, line 22, delete the second comma

Page 1, line 25, delete the stricken period

Page 2, line 15, after "following" insert "conditions"

Page 2, line 19, delete "incorrect" and after "~~false~~" reinsert it

Page 3, line 2, underscore the comma

Page 3, line 5, after "extent" insert a comma

Page 3, line 14, reinstate the stricken period and insert the underscored language before it

Page 3, line 15, delete the period

Page 3, line 19, underscore the semicolon

Page 4, line 8, after "recipient" insert a comma

Page 4, line 16, after "Health" insert "Expense"

Page 5, line 7, delete the stricken colon

Page 5, line 10, reinstate "~~a~~"

Page 5, line 13, delete "a."

Page 5, line 15, delete "b." and after "~~c.~~" insert "b."

Page 5, line 16, delete "c." and after "~~d.~~" insert "c."

Page 6, line 10, strike "recipient(s)" and insert "recipient"

Page 7, line 6, strike "matter(s)" and insert "matter"

Page 8, line 12, delete "an individual" and reinsert it

after " a"

Page 8, line 19, do not show the change from a lower case to a capitol letter by strikeouts and underlining

Page 11, lines 14 and 16, strike "providers" and insert " provider's"

Page 11, line 21, reinstate the old period and insert the underscored text, except the period

Page 13, lines 13 to 20 delete the underscored language

Page 13, line 24, reinstate the old period and before it insert the underscored language in lines 13 to 20, except the period

Page 14, line 11, after ", and" delete "and"

Page 14, line 13, after "recipient" insert a comma, after "guardian" delete "." and insert ";"

Page 15, line 17, reinstate the stricken period and insert the underscored language in lines 17 to 20 before it

Page 15, line 20, delete the period

Page 17, line 23, after "claims" insert ", or claims"

Page 18, line 2, delete "purspose" and insert "purpose"

Page 19, line 13, reinstate the stricken period and insert the underscored language in lines 13 and 14 before it

Page 19, line 14, delete the period

Page 22, line 3, delete "Transrer" and insert "Transfer"

Page 22, line 7, delete "termianting" and insert "terminating"

Page 26, line 1, delete "Identification of suspected fraud and abuse" and insert "Recipient Surveillance and Utilization Review"

Page 26, line 11, reinstate the stricken period and before it insert the underscored language in lines 11 to 13

Page 26, line 13, delete the period

Page 27, line 2, after "3" insert a period without underscoring

Page 27, line 8, after "the" insert "medical"

Page 27, line 11, after "identification" insert "card"

Page 28, line 19, strike "recipients" and insert " recipient's"

Page 28, lines 20, 23, and 25 strike "provider(s)" and

insert " provider"

Page 30, line 11, after "Appeal" insert a period without underscoring