

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
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ATTORNEY GENERAL

December 15, 1988

ARU SEAM
Department of Human Services

JACQUELYN B. ALBRIGHT
Special Assistant
Attorney General

6-9715

In the Matter of the Adopted Rule Relating to Physician and Hospital Certification for Payment of Medical Assistance and General Assistance Care for Inpatient Hospital Services

The above-referenced rule has been approved as to its legality by the Attorney General on December 14, 1988.

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

Also enclosed are any petitions, requests, submission or comments received by the agency and any extra copies of documents which the agency submitted to the Attorney General.

In order for a permanent rule without a hearing to become effective, your agency must publish a notice of adoption in the State Register in accordance with Minn. Stat. §14.27. An emergency rule becomes effective five working days after approval by the Attorney General; however, the agency must publish a notice in the State Register in accordance with Minn. Stat. §14.34.

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

JAL:rer

Enclosures

cc: Maryanne Hruby
Executive Director
Legislative Commission to Review
Administrative Rules

William Brown
Chief Administrative Law Judge
Office of Administrative Hearings

File No. 15-1-5 Docket No. 85.0009.0866

DATE RECEIVED 12/1/88 ADOPTED W/O HEARING 40

REVIEW DATE 12/10/88 EMERGENCY RULE _____

DUE DATE 12/15/88 REVISOR APPROVED _____

APPROVED 12/14/88 EA REVISOR DISAPPROVED _____

DISAPPROVED _____ FILED W/SEC. OF STATE _____

WITHDRAWN _____ RETURNED TO AGENCY _____

GA Rush if possible

✓ Rule as adopted (4 copies)

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

10/26/88 Date published in State Register

none Comments

_____ Petition for Adoption of a Rule (if applicable)

_____ Board's Authorizing Resolution

_____ Date adopted

✓ Proposed Rule

yes Revisor's Certificate

✓ Notice of Intent to Adopt Rule

256B.503, 256D.03 *

256B.04 Statutory Authority

no Small Business Statement

yes Expenditure of public money statement

yes Signature

✓ Statement of Need and Reasonableness (if applicable)

no Small Business Statement

N/A Fees - § 16A.128

✓ Affidavit of Mailing Notice of Intent to Adopt Rule

9/28/88 Date 30/25 days before adoption

yes Notice attached

_____ Copy of rule or summary attached

✓ Publication in State Register

10/3/88 Date 30/25 days before adoption

_____ 180-day deadline from:

11/3/88 end of comment period (§ 14.26) (rules without hearing)

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

_____ Resolution Adopting

_____ Date adopted

✓ Findings of Fact, Conclusions & Order Adopting

12/1/88 Date

✓ Written requests, submissions or comments (1)

✓ Declaration of attorney

N. Scott Name of SAAG representing agency

_____ Notice of Submission to Atty. Gen. (if applicable)

_____ Aff. of Mailing Notice to Atty. Gen. (if applicable)

Department of Human Services

Adopted Permanent Rules Relating to Physician and Hospital Certification for Payment of Medical Assistance and General Assistance Medical Care for Inpatient Hospital Services

Rules as Adopted

9505.0500 DEFINITIONS.

Subpart 1. and 2. [Unchanged.]

Subp. 3. **Admission certification.** "Admission certification" means the determination of the medical review agent that all or part of a recipient's inpatient hospital services are medically necessary and that medical assistance or general assistance medical care funds may be used to pay the admitting physician, hospital, and other vendors of inpatient hospital services for providing medically necessary services, subject to parts 9500.1070, subparts 1, 4, 6, 12 to 15, and 23; 9500.1090 to 9500.1155; 9505.0170 to 9505.0475; 9505.1000 to 9505.1040; and 9505.5000 to 9505.5105.

Subp. 3a. **Admitting diagnosis.** "Admitting diagnosis" means the physician's tentative or provisional diagnosis of the recipient's condition as a basis for examination and treatment when the physician requests admission certification.

Subp. 4. [Unchanged.]

Subp. 4a. **Authorization number.** "Authorization number" means the number issued by the medical review agent that establishes that the surgical procedure requiring a second surgical opinion is medically appropriate.

Subp. 5. **Certification number.** "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 6. to 8. [Unchanged.]

Subp. 9. **Continued stay review.** "Continued stay review" means a review and determination, after the admission

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certification and during a patient's hospitalization, of the medical necessity of continuing inpatient hospital services to the recipient.

Subp. 10. [Unchanged.]

Subp. 10a. **Diagnostic category.** "Diagnostic category" means the list of diagnosis-related groups in the diagnostic classification system established under Minnesota Statutes, section 256.969, subdivision 2, and defined in part 9500.1100, subpart 20.

Subp. 10b. **Diagnostic category validation or validate the diagnostic category.** "Diagnostic category validation" or "validate the diagnostic category" refers to the process of comparing the medical record to the information submitted on the inpatient hospital billing form required by the department to ascertain the accuracy of the information upon which the diagnostic category was assigned.

Subp. 11. to 13. [Unchanged.]

Subp. 14. **Inpatient hospital service.** "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital for the care and treatment of the recipient. The inpatient hospital service may be furnished by a hospital, physician, or a vendor of an ancillary service which is prescribed by a physician and which is eligible for medical assistance or general assistance medical care reimbursement.

Subp. 15. [Unchanged.]

Subp. 16. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B. For purposes of parts 9505.0500 to 9505.0540, "medical assistance" includes general assistance medical care unless otherwise specified.

Subp. 17. [Unchanged.]

Subp. 18. **Medical review agent.** "Medical review agent" means the representative of the commissioner who is authorized by the commissioner to make decisions about admission

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certifications, concurrent reviews, continued stay reviews, retrospective reviews, and second surgical opinions if such opinions are a term of the agent's contract with the department.

Subp. 19. [Unchanged.]

Subp. 19a. **Medically appropriate or medical appropriateness.** "Medically appropriate" or "medical appropriateness" refers to a determination, by a medical review agent or the department, that the recipient's need for a surgical procedure requiring a second surgical opinion meets the criteria in part 9505.0540 or that a third surgical opinion has substantiated the need for the procedure.

Subp. 20. and 21. [Unchanged.]

Subp. 22. **Physician adviser.** "Physician adviser" means a physician who practices in the specialty area of the recipient's admitting or principal diagnosis or a specialty area related to the admitting or principal diagnosis.

Subp. 23. [Unchanged.]

Subp. 23a. **Principal diagnosis.** "Principal diagnosis" means the condition established, after study, to be chiefly responsible for causing the admission of the recipient to the hospital for inpatient hospital services.

Subp. 23b. **Principal procedure.** "Principal procedure" means a procedure performed for definitive treatment of the recipient's principal diagnosis rather than one performed for diagnostic or exploratory purposes or a procedure necessary to take care of a complication. When multiple procedures are performed for definitive treatment, the principal procedure is the procedure most closely related to the principal diagnosis.

Subp. 23c. **Provider.** "Provider" means an individual or organization under an agreement with the department to furnish health services to persons eligible for the medical assistance or general assistance medical care programs. Providers include hospitals, admitting physicians, and vendors of other services.

Subp. 24. **Readmission.** "Readmission" means an admission that occurs within 15 days of a discharge of the same recipient. The 15-day period does not include the day of

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discharge or the day of readmission.

Subp. 25. and 26. [Unchanged.]

Subp. 27. **Retrospective review.** "Retrospective review" means a review conducted after inpatient hospital services are provided to a recipient. The review is focused on validating the diagnostic category and determining the medical necessity of the admission, the medical necessity of any inpatient hospital services provided, the medical appropriateness of a surgical procedure requiring a second opinion, and whether all medically necessary inpatient hospital services were provided.

Subp. 28. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the medical appropriateness of a proposed surgery as specified in parts 9505.5000 to 9505.5105.

Subp. 29. **Transfer.** "Transfer" means the movement of a recipient after admission from one hospital directly to another.

9505.0510 SCOPE.

Parts 9505.0500 to 9505.0540 establish the standards and procedures for admission certification to be followed by admitting physicians and hospitals seeking medical assistance or general assistance medical care payment under parts 9500.1090 to 9500.1155 for inpatient hospital services provided to medical assistance or general assistance medical care recipients under Minnesota Statutes, chapters 256B and 256D. Parts 9505.0500 to 9505.0540 are to be read in conjunction with Code of Federal Regulations, title 42, and titles XVIII and XIX of the Social Security Act. The department retains the authority to approve prior authorizations established under parts 9505.5000 to 9505.5030 and second surgical opinions established under parts 9505.5035 to 9505.5105. A hospital or admitting physician who seeks medical assistance or general assistance medical care payment for inpatient hospital services provided to a Minnesota recipient must comply with the requirements of parts 9505.0500 to 9505.0540 unless the hospital or admitting physician has received prior authorization for inpatient hospital services

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under parts 9505.0170 to 9505.0475. Admission certification must be obtained when a recipient moves from one hospital with a provider number to another hospital with a different provider number or from one unit within a hospital to another unit with a different provider number in the same hospital. For purposes of this part, "provider number" means a number issued by the department to a provider who has signed a provider agreement under part 9505.0195.

9505.0520 INPATIENT ADMISSION CERTIFICATION.

Subpart 1. [Unchanged.]

Subp. 2. **Exclusions from admission certification or prior admission certification.** Admission for inpatient hospital services under items A to C shall be excluded from the requirement in subpart 1.

A. Admission certification is not required before an emergency admission and shall be subject to subpart 4, item B.

B. Admission certification is not required for delivery of a newborn or a stillbirth, inpatient dental procedures, or inpatient hospital services for which a recipient has been approved under Medicare. However, if an inpatient hospital service is also covered under Medicare, then denial of ~~an inpatient hospital~~ the service under Medicare on grounds other than medical necessity shall also constitute sufficient grounds for denying admission certification for the service under medical assistance. The admission of a pregnant woman that does not result in the delivery of a newborn or a stillbirth within 24 hours of her admission shall be subject to retroactive admission certification.

C. Admission of a recipient who has been approved by the county for inpatient hospital services for chemical dependency as specified in parts 9530.6600 to 9530.6655 may occur without admission certification, provided that the inpatient hospital chemical dependency services to the recipient during the recipient's stay in the hospital are not to be billed to medical assistance under parts 9500.1090 to 9500.1155.

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Subp. 3. **Admitting physician responsibilities.** The admitting physician who seeks medical assistance or general assistance medical care program payment for an inpatient hospital service to be provided to a recipient shall:

A. [Unchanged.]

B. Request admission certification by contacting the medical review agent either by phone or in writing and providing the information in subitems (1) to (9):

(1) to (5) [Unchanged.]

(6) whether the admission is a readmission or a transfer;

(7) [Unchanged.]

(8) information from the plan of care and the reason for admission as necessary for the medical review agent to determine if admission is medically necessary or the procedure requiring a second surgical opinion is medically appropriate; or

(9) when applicable, information needed to prove that a procedure requiring a second surgical opinion meets the criteria for exemption from the requirement.

C. Provide the following information when applicable:

(1) surgeon's name and medical assistance provider number;

(2) expected date of surgery;

(3) affirmation that prior authorization has been received;

(4) affirmation that a procedure requiring a second surgical opinion that was denied by the medical review agent has been approved by a third physician; and

(5) when requested by the medical review agent, documentation that the procedure requiring a second surgical opinion meets the criteria for exemption from the requirement.

D. Inform the hospital of the certification number.

E. Provide the hospital documentation necessary for the verification required in subpart 4, item D.

F. For purposes of billing, enter the certification

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number, any required prior authorization number, and second surgical opinion authorization number on invoices submitted to the department for payment.

Subp. 4. **Hospital responsibilities.** A hospital that seeks medical assistance or general assistance medical care payment for inpatient hospital services provided to a recipient shall:

A. Obtain the certification number and the authorization number, if required under parts 9505.5000 to 9505.5105, from the admitting physician.

B. Within 48 hours after the occurrence of an event described in subitem (1) or (2), and within 72 hours of the event described in subitem (3), excluding weekends and holidays, inform, by phone, the medical review agent of the event and provide the information required in subpart 3, items B and C, if applicable.

(1) An admission that is an emergency admission as specified in subpart 2.

(2) A surgical procedure requiring a second surgical opinion that meets the requirements of part 9505.5040, item B or C, for exemption from the second opinion.

(3) The admission of a pregnant woman that does not result in the delivery of a newborn or a stillbirth within 24 hours of her admission, as specified in subpart 2, item B.

For purposes of this subitem, the time limit for notifying the medical review agent is calculated beginning with the time of the admission of the pregnant woman.

If the hospital fails to notify the medical review agent within the required time limit, the hospital shall submit, at its own expense, a copy of the complete medical record to the medical review agent within 30 days after the recipient's discharge. Failure to submit the record within the 30 days shall result in denial of the certification number.

C. For billing purposes, enter the certification number and any required prior authorization number and second surgical opinion authorization number on all invoices submitted to the department for payment.

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D. Within 20 days, exclusive of weekends and holidays, of the date of a written request by the medical review agent, obtain and submit to the medical review agent an admitting physician's verification that a procedure requiring a second surgical opinion has been approved by a third physician. The verification must include at least the signed form required by the department to approve a procedure requiring a second surgical opinion.

Subp. 5. [Unchanged.]

Subp. 6. **Medical review agent responsibilities.** The medical review agent shall:

A. [Unchanged.]

B. determine within 24 hours of receipt of the information, exclusive of weekends and holidays, whether admission is medically necessary, whether a surgical procedure requires a second surgical opinion or is exempt from the requirement, and whether a procedure requiring a second surgical opinion meets the criteria of appropriateness established in part 9505.0540 or requires the approval of a third physician;

C. [Unchanged.]

D. mail a written notice by certified letter of the admission certification determination to the admitting physician and the hospital, and a written notice to the recipient within five days of the determination, exclusive of weekends and holidays;

E. determine if admission of a retroactively eligible recipient was medically necessary and if the surgical procedure requiring a second opinion was medically appropriate;

F. conduct a concurrent, continued stay, or retrospective review of a recipient's medical record as specified in subpart 10;

G. provide for a reconsideration of a denial or withdrawal of admission certification, and of an authorization number denied or withdrawn under subpart 8, item C;

H. recruit and coordinate the work of the physician advisers;

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I. notify the admitting physician and the person responsible for the hospital's utilization review, by phone, of a reconsideration decision within 24 hours of the decision, exclusive of weekends and holidays;

J. mail a written notice by certified letter of the reconsideration decision to the admitting physician, the person responsible for the hospital's utilization review, and the department within ten days of the determination, exclusive of weekends and holidays;

K. provide for consideration of a request for retroactive admission certification;

L. validate the diagnostic category; and

M. perform other duties as specified in the contract between the medical review agent and the department.

Subp. 7. [Unchanged.]

Subp. 8. **Procedure for admission certification or authorization of surgical procedure requiring a second surgical opinion.** The procedure for admission certification or authorization of a surgical procedure requiring a second surgical opinion shall be as in items A to H.

A. Upon receipt of the information requested in subpart 3, items B and C, if applicable, the clinical evaluator shall review the information and determine whether the admission is medically necessary or whether a procedure requiring a second surgical opinion is appropriate or meets the criteria for exemption from the requirement.

B. If the clinical evaluator determines that one of the conditions in item A exists, the medical review agent shall issue a certification or authorization number.

C. If the clinical evaluator determines that a procedure requiring a second surgical opinion does not meet the criteria for exemption under part 9505.5040, except items B, C, and F, the medical review agent shall notify the admitting physician by phone and mail the admitting physician and the recipient a written notice within 20 days of the determination. If the exemption is denied, the recipient who wants the surgery

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may obtain a second or third surgical opinion. Exemptions from the second surgical opinion under part 9505.5040, items B and C, shall be subject to subpart 4, item B. Exemptions from the second surgical opinion under part 9505.5040, item F, shall be subject to part 9505.5096, subpart 4. If the medical review agent determines that the procedure requiring a second surgical opinion was not entitled to an exemption or that the surgical procedure was not medically appropriate under part 9505.5040, items B, C, and F, the medical review agent shall not issue or shall withdraw the authorization number and notify the admitting physician and the hospital of denial of the authorization number. The notice shall be in writing, mailed by certified letter within 20 days of the determination, and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

D. If the clinical evaluator is unable to determine that the admission is medically necessary or that a procedure requiring a second surgical opinion is appropriate, the evaluator shall contact a physician adviser.

E. If the physician adviser determines that the admission is medically necessary or that a procedure requiring a second surgical opinion is appropriate, the medical review agent shall issue a certification or authorization number.

F. If the physician adviser is unable to determine that the admission is medically necessary or that a procedure requiring a second surgical opinion is appropriate, the physician adviser shall notify the clinical evaluator by phone, the clinical evaluator shall notify the admitting physician by phone, and the admitting physician may request a second physician adviser's opinion, except in the case of a procedure requiring a second surgical opinion. In this case, the medical review agent shall notify the admitting physician that the recipient may obtain the opinion of a third physician as provided in parts 9505.5050 to 9505.5105.

G. If the admitting physician does not request a

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second physician adviser's opinion, the medical review agent shall deny the admission certification, shall not issue a certification number, and shall notify the admitting physician, the hospital, and the recipient of the denial. The notice to the recipient shall be in writing and shall state the reasons for the denial and the recipient's right to appeal under Minnesota Statutes, section 256.045, and part 9505.0522. The notices to the admitting physician and the hospital shall be in writing, shall state the reasons for the denial, and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

If the admitting physician requests a second physician adviser's opinion about an admission, the clinical evaluator shall contact a second physician adviser.

H. If the second physician adviser determines that the admission is medically necessary, the medical review agent shall issue a certification number.

I. If the second physician adviser is unable to determine that the admission is medically necessary, the medical review agent shall deny the admission certification, shall not issue a certification number, and shall notify the admitting physician, the hospital, and the recipient of the denial. The notice to the recipient shall be in writing and shall state the reasons for the denial and the recipient's right to appeal under Minnesota Statutes, section 256.045, and part 9505.0522. The notices to the admitting physician and the hospital shall be in writing and shall state the reasons for the denial and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

Subp. 9. **Reconsideration.** The admitting physician or the hospital may request reconsideration of a decision to deny or withdraw an admission certification or an authorization number under subpart 8, item C. The admitting physician or the hospital shall submit the request in writing to the medical

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review agent together with the recipient's medical record and any additional information within 30 days of the date of receipt of the certified letter denying or withdrawing admission certification or the authorization number. Upon receipt of the request, the medical record, and any additional information, the medical review agent shall appoint at least three physician advisers, none of whom shall have been involved previously in the procedure for the recipient's admission certification or authorization number, to hear the reconsideration. The reconsideration may be conducted by means of a telephone conference call. The physician advisers may seek additional facts and medical advice as necessary to decide whether the admission is medically necessary or whether the surgical procedure requiring a second surgical opinion meets the criteria of exemption or is medically appropriate under part 9505.5040, items B, C, and F. The reconsideration shall be completed within 45 days of the receipt of the information necessary to complete the reconsideration. The outcome of the reconsideration shall be the one chosen by the majority of the physician advisers appointed to consider the request. The admitting physician or the hospital may appeal the determination of the physician advisers according to the contested case provisions of Minnesota Statutes, chapter 14, by filing a written notice of appeal with the commissioner within 30 days of the date of receipt of the certified letter upholding the denial or withdrawal of admission certification or authorization number. However, an admitting physician or hospital that does not request reconsideration or appeal under the contested case procedures of Minnesota Statutes, chapter 14, within 30 days after the denial or withdrawal of admission certification or authorization number is not entitled to an appeal under Minnesota Statutes, chapter 14.

Subp. 9a. **Retention or withdrawal of certification number.** When a hospital discharges a recipient who is subsequently readmitted to the same or a different hospital or transfers a recipient to another hospital, the readmission or

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transfer is subject to the procedures in part 9505.0540, subparts 3 to 6. The hospital or admitting physician who disagrees with the medical review agent's determination under this subpart may request reconsideration as specified in subpart 9.

Subp. 10. **Medical record review and determination.** As specified in the contract between the department and the medical review agent, upon the request of the department, or upon the initiative of the medical review agent, the medical review agent shall conduct a concurrent, continued stay, or retrospective review of a recipient's medical record to validate the diagnostic category and to determine whether the admission was medically necessary, whether the inpatient hospital services were medically necessary, whether a continued stay will be medically necessary, whether all medically necessary services were provided, or whether a surgical procedure requiring a second opinion was medically appropriate. The procedure for concurrent, continued stay, and retrospective reviews shall be as in items A to G.

A. to C. [Unchanged.]

D. If a physician adviser determines that the recipient's admission was not medically necessary, that the recipient's continued stay will not be medically necessary, or that all medically necessary services were not provided, the medical review agent shall withdraw the previously issued certification number and shall notify the admitting physician and hospital by telephone within 24 hours of the determination and by certified letter mailed within five days, exclusive of weekends and holidays, of the determination. The notice shall state the right of the admitting physician and hospital to request a reconsideration or appeal under subpart 9.

E. If the diagnostic category validation shows that the diagnostic category was inaccurately assigned, the department shall adjust the reimbursement as applicable to the diagnostic category that is accurate for the recipient's condition.

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F. If the medical review agent conducting a retrospective review finds the recipient's medical record is inadequate to justify that a surgical procedure requiring a second opinion is medically appropriate, or that an exemption under part 9505.5040 was appropriate, the medical review agent may request a hospital to submit, at the hospital's expense, documentation substantiating the opinion of the third physician that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate. The hospital shall submit the documentation within 20 days, exclusive of weekends and holidays, of the date of the notice requesting the documentation.

G. If the clinical evaluator is unable to determine from the documentation in the recipient's medical records the reasons for the recipient's discharge and readmission, the clinical evaluator shall submit the medical records of the recipient's discharge and readmission to a physician adviser. The physician adviser shall review the records and determine the nature of the discharge and readmission according to the criteria in part 9505.0540, subparts 3 to 5, and if the determination of the medical review agent is different from that of the admitting physician or hospital, then the medical review agent shall notify the admitting physician or hospital by certified letter mailed within five days, exclusive of weekends and holidays, of the determination. The notice shall state the right of the admitting physician and hospital to request a reconsideration under subpart 9.

Subp. 11. **Consequences of withdrawal of admission certification or authorization number; general.** The department or the medical review agent shall withdraw the certification number or authorization number and may take action as specified in items A to F if the medical review agent determines any of the following: (1) that the admission was not medically necessary; (2) that all medically necessary inpatient hospital services were not provided; (3) that some or all of the inpatient hospital services were not medically necessary; (4)

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that within 20 days, exclusive of weekends and holidays, the hospital has failed to comply with the department's or the medical review agent's request to submit the medical record or other required information to support that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, or that some or all of the inpatient hospital services provided were medically necessary; or, that the information submitted by the hospital was inadequate to support that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, or that some or all of the inpatient hospital services provided were medically necessary; (5) that documentation submitted by the hospital at the request of the department or the medical review agent does not support that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate; or (6) that within 20 days, exclusive of weekends and holidays, the hospital has failed to comply with the medical review agent's request to submit documentation to substantiate the opinion of a third physician that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate.

A. For hospitals receiving payments under parts 9500.1090 to 9500.1155, if the admission was not medically necessary or the medical record does not adequately document that the admission was medically necessary, the entire payment shall be denied or recovered as provided in subpart 15. If the hospital failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

B. For hospitals receiving payments under parts 9500.1090 to 9500.1155, if the admission was medically necessary but some or all of the additional inpatient hospital services were not or will not be medically necessary, or the medical record does not adequately document that the additional inpatient hospital services were necessary, payment for the additional services shall be denied or recovered as provided in

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subpart 15. If the hospital failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

C. If the admission was not medically necessary or the medical record does not adequately document that the admission was medically necessary, payment shall be denied or recovered from the admitting physician and other vendors of inpatient hospital services as provided in subpart 15. If the admitting physician and other vendors failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

D. If additional inpatient hospital services were not or will not be medically necessary, or the medical record did not adequately document that the additional inpatient hospital services were medically necessary, payment for the additional services shall be denied or recovered from the admitting physician and other vendors of inpatient hospital services as provided in subpart 15. If the admission was medically necessary but some or all of the inpatient hospital services were not medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150. If the admitting physician and vendors failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

E. If within 20 days, exclusive of weekends and holidays, the hospital failed to comply with the department's or the medical review agent's request to submit the medical record or other required information to support (1) that the admission was medically necessary; (2) that all medically necessary inpatient hospital services were provided; or (3) that some or all of the inpatient hospital services provided were medically necessary; or, if the information submitted by the hospital was inadequate to support clauses (1) to (3) of this item, all or

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part of the payment shall be denied or recovered as provided in items A to D.

F. If the documentation does not support that the surgical procedure was medically appropriate or that the exemption under part 9505.5040 was appropriate, or if the hospital failed to comply with the medical review agent's request to submit documentation to substantiate the opinion of the third physician that the surgical procedure was medically appropriate or that the exemption under part 9505.5040 was appropriate, payment for the surgical procedure shall be denied or recovered from the hospital, admitting physician, or other vendors as provided in subpart 15.

Subp. 12. **Reconsideration of denial or withdrawal of admission certification or authorization number.** The denial or withdrawal of admission certification or authorization number may be reconsidered under subpart 9.

Subp. 13. and 14. [Unchanged.]

Subp. 15. **Recovery of payment after withdrawal of admission certification or denial of authorization of second surgical procedure.** An admitting physician or hospital that receives a notice of withdrawal of a certification number or authorization number and that does not request reconsideration under subpart 9 or appeal under Minnesota Statutes, chapter 14, shall be subject to recovery of payment without further notice or right to appeal. If a reconsideration results in the denial or withdrawal of a certification number or authorization number, and the admitting physician or hospital does not appeal within the time permitted pursuant to other remedies, the department shall recover payment without further notice to the admitting physician and hospital. If an appeal results in the denial or withdrawal of a certification number or authorization number, the department shall recover the payment without further notice to the admitting physician and the hospital.

Recovery of overpayments may be made by:

A. adjusting the provider's invoice to the difference between the billed amount and the correct amount;

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B. canceling the incorrect invoice and directing the provider to submit a correct invoice;

C. withholding or offsetting the payment due the provider for other medical assistance or general assistance medical care services; or

D. using any other remedy available under state or federal law or rules.

9505.0521 PROHIBITION OF RECOVERY FROM RECIPIENT.

The provider may not seek payment from the recipient for inpatient hospital services provided under parts 9505.0500 to 9505.0540 if the certification or authorization number is not issued or is withdrawn.

9505.0522 RECIPIENT'S RIGHT TO APPEAL.

A recipient who is denied inpatient hospital services because of the medical review agent's determination that the services are not medically necessary or who is denied a surgical procedure requiring a second surgical opinion because of the medical review agent's determination that the surgical procedure is not appropriate, may appeal the medical review agent's determination under Minnesota Statutes, section 256.045.

9505.0530 INCORPORATION BY REFERENCE OF CRITERIA TO DETERMINE MEDICAL NECESSITY.

The most recent edition of the Appropriateness Evaluation Protocol of the National Institutes of Health is incorporated by reference. The book is available at the Health Data Institute, 20 Maguire Road, Lexington, Massachusetts, 02173, and it is also available through the Minitex interlibrary loan system. The book is subject to change.

The Criteria for Inpatient Psychiatric Treatment, 1981 edition, published by Blue Cross and Blue Shield of Minnesota are incorporated by reference. The criteria are available at Blue Cross and Blue Shield of Minnesota, P.O. Box 64560, Saint Paul, Minnesota 55164, and at the state law library, Ford Building, Saint Paul, Minnesota 55155. The criteria are not

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subject to frequent change.

9505.0540 CRITERIA TO DETERMINE MEDICAL NECESSITY OR APPROPRIATENESS.

Subpart 1. **Determination for admission for purpose other than chemical dependency treatment.** The medical review agent shall follow the Appropriateness Evaluation Protocol and Criteria for Inpatient Psychiatric Treatment of Blue Cross and Blue Shield of Minnesota in determining whether a recipient's admission is medically necessary, whether the inpatient hospital services provided to the recipient were medically necessary, whether the recipient's continued stay will be medically necessary, and whether all medically necessary inpatient hospital services were provided to the recipient.

In determining whether a surgical procedure requiring a second surgical opinion is medically appropriate, the medical review agent shall follow the criteria published in the State Register pursuant to Minnesota Statutes, section 256B.02, subdivision 8, paragraph 21.

Subp. 2. **Determination for admission for chemical dependency treatment.** The assessment of a recipient's need for chemical dependency treatment in a hospital shall be made according to parts 9530.6600 to 9530.6655.

Subp. 3. **Readmission considered as a second admission.** The medical review agent shall issue a certification number for a readmission that meets the criteria for medical necessity specified in subpart 1 whether the admitting and readmitting hospitals are the same or different. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. Both the admission and the readmission shall be subject to a retrospective review as provided in part 9505.0520, subpart 10. If the reason for the discharge and the reason for the readmission meet one set of

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circumstances specified in items A to D, the medical review agent shall determine that both the admission and the readmission shall retain the certification number subject to the hospitals' and admitting physicians' compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The readmission results from the recipient leaving the hospital against medical advice.

B. The readmission results from the recipient being noncompliant with medical advice that is recorded on the recipient's medical record as being given to the recipient at the admitting hospital. For purposes of this part, "recipient being noncompliant with medical advice" means that the recipient, fully informed of his or her medical condition, and fully understanding the need for the treatment and the follow-up discharge instructions, if any, refuses to adhere to the treatment or to follow the discharge instructions.

C. The readmission results from a new episode of the same diagnosis of an episodic illness or condition.

D. The readmission results from the fact that the recipient's discharge from the admitting hospital and readmission are medically necessary according to prevailing medical standards, practice, and usage.

Subp. 4. **Readmission considered as continuous with admission.** The medical review agent shall determine that a readmission of a recipient is continuous with the recipient's admission whether the admitting and readmitting hospitals are the same or different if the circumstances requiring the recipient's readmission meet one set of the circumstances specified in items A to C. The medical review agent shall issue a certification number if the readmission meets the criteria for medical necessity specified in subpart 1. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. Both the admission and the

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readmission shall be subject to a retrospective review as provided in part 9505.0520, subpart 10. Upon completing the retrospective review and determining whether the readmission and admission are consistent with item A, B, or C, the medical review agent shall take the action specified in the item that applies. Medical assistance payment for the inpatient hospital services retaining the certification number after the determination resulting from the retrospective review shall be paid according to parts 9500.1090 to 9500.1155 for the diagnostic category assigned to the recipient's principal diagnosis of the admission and readmission. In each circumstance, retention of the certification number shall be subject to the hospital's and admitting physician's compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The recipient was discharged from the admitting hospital without receiving the procedure or treatment of the condition diagnosed during the admission because of the hospital's or physician's preference or because of a scheduling conflict. If the admitting and readmitting hospitals are the same, the medical review agent shall withdraw the certification number of the readmission and determine the admission eligible to retain the certification number. If the admitting and readmitting hospitals are not the same, the medical review agent shall apply the requirements under subpart 5, item C, regarding readmission eligible for a transfer payment.

B. The recipient's discharge was not appropriate according to prevailing medical standards, practice, and usage. If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admission eligible to retain the certification number and withdraw the certification number of the readmission. If the admitting and readmitting hospitals are different, the medical review agent shall withdraw the certification number of the admission and shall determine the readmission eligible to retain a certification number.

C. The recipient's discharge and readmission to the same hospital results from the preference of the recipient or

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the recipient's family that the recipient's treatment be delayed, that the recipient be discharged without receiving the necessary procedure or treatment, and that the recipient be readmitted for the necessary procedure or treatment. If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admission eligible to retain the certification number and withdraw the certification number of the readmission. If the admitting and readmitting hospitals are not the same, the medical review agent shall apply the requirements under subpart 5, item A, regarding readmission eligible for a transfer payment. For purposes of this part, "preference of the recipient or the recipient's family" means that the recipient or the recipient's family makes a choice to delay or change the location of inpatient hospital services, and the choice is compatible with prevailing medical standards, practices, and usage.

Subp. 5. **Readmission eligible for transfer payment.** The medical review agent shall issue a certification number for a readmission that is eligible for a transfer payment if the readmission meets the criteria for medical necessity specified in subpart 1 and a set of circumstances in item A, B, or C. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. The medical review agent shall conduct a retrospective review of the medical records, determine whether the readmission is consistent with the circumstances in item A, B, or C, and take the action specified in the item. Retention of the certification number by the hospital shall also be subject to the admitting physician's and hospital's compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The readmission results from the preference of the recipient or the recipient's family that the recipient be discharged from the admitting hospital without receiving the

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necessary procedure or treatment and that the recipient be readmitted to a different hospital to obtain the necessary procedure or treatment. In this case, both hospitals shall retain their certification numbers subject to the hospitals' and admitting physicians' compliance with all requirements of parts 9505.0500 to 9505.0540, and medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1130, subpart 7, item A, for the inpatient hospital services necessary for the recipient's diagnosis and treatment.

B. The readmission results from a referral from one hospital to a different hospital because the recipient's medically necessary treatment was outside the scope of the first hospital's available services. In this case, both hospitals shall retain their certification numbers, and medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1130, subpart 7, item A, for the inpatient hospital services necessary for the recipient's diagnosis and treatment. If, however, the admission to the first hospital is not due to an emergency and the first hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for the recipient's treatment or condition were outside the scope of the hospital's available services and the readmission to another hospital resulted because of the recipient's need for those services, the first hospital's certification number will be withdrawn.

C. The readmission results from a physician's or hospital's scheduling conflict at the admitting hospital. The medical review agent shall determine both hospitals eligible to retain their certification numbers. In this case, medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1130, subpart 7, item A, for the inpatient hospital services necessary for the recipient's diagnosis and treatment.

Subp. 6. **Physician adviser's review of readmission.** If

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the clinical evaluator is unable to determine from the documentation in the recipient's medical records the reasons for the recipient's discharge and readmission, the records shall be reviewed by the physician adviser, according to the procedure in part 9505.0520, subpart 10, item G.

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FILED

DEC 14 1988

Joan Anderson Growe
Secretary of State

2:55PM

APPROVED AS TO FORM AND LEGALITY

Dec 14 1988

HUBERT H. HUMPHREY, III
ATTORNEY GENERAL

BY Jacquelyn E. Albright
SPECIAL ASSISTANT ATTORNEY GENERAL

preparing to propose the amendment of the rule governing Program Rules for Vocational Education. The adoption of the rule is authorized by *Minnesota Statutes*, section 121.11 subd. 12, which permits the Board to promulgate rules concerning courses of study in elementary and secondary schools.

The State Board of Education requests information and opinions concerning the subject matter of the rule. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally. Written statements should be addressed to: J. Thomas Strom, 626 Capitol Square Building, 550 Cedar Street, St. Paul, MN 55101. Oral statements will be received during regular business hours over the telephone at 612/296-3306 and in person at the above address.

All statements of information and opinions shall be accepted until November 20, 1987. Any written material received by the State Board of Education shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that the rule is adopted.

Dated: 14 October 1987

Ruth E. Randall
Commissioner of Education

Minnesota Historical Society

State Review Board Regular Meeting

A meeting of the State Review Board will be held on Thursday, November 19, 1987 at 7:00 p.m. in the Auditorium, Fort Snelling History Center, Fort Snelling, Minnesota.

Department of Human Services

Hospital Reimbursement Section—Audits Division

Notice of Solicitation of Outside Information or Opinions Regarding Amendments to Rules Governing Hospital Admissions Certification as a Requirement of Medical Assistance and General Assistance Medical Care Reimbursement

Notice is hereby given that the State Department of Human Services is seeking information or opinions from sources outside the agency in preparing to propose amendments to the rules governing hospital admissions certification as a requirement of medical assistance and general assistance medical care reimbursement, *Minnesota Rules*, parts 9505.0500 to 9505.0540.

The adoption of the rule is authorized by *Minnesota Statutes*, sections 256B.503 and 256D.03, Subdivision 7(b) which requires the agency to establish standards for utilization review in the general assistance medical care program that conform to the procedures established for the medical assistance program.

The proposed amendments establish procedures to coordinate the hospital admissions certification requirements with the procedures related to the requirement of obtaining a second surgical opinion as set forth in *Minnesota Rules*, parts 9505.5000, 9505.5005, 9505.5035 to 9505.5105. (*Minnesota Rules*, parts 9505.5000, 9505.5005, 9505.5035 to 9505.5105 are being amended concurrently with the amendments to *Minnesota Rules*, parts 9505.0500 to 9505.0540.)

The State Department of Human Services requests information and opinions concerning the subject matter of the rule. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally. Written statements should be addressed to:

Eleanor Weber
Rules Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55101

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

Office of the Revisor of Statutes

Administrative Rules

TITLE: Proposed Permanent Rules Relating to Physician and Hospital Certification for Payment of Medical Assistance and General Assistance Medical Care for Inpatient Hospital Services

AGENCY: Department of Human Services

MINNESOTA RULES: Chapter 9505

The attached rules are approved for publication in the State Register

Kathleen M. Traxler

Kathleen M. Traxler
Assistant Revisor

Oral statements will be received during regular business hours over the telephone at (612) 297-4301 by Eleanor Weber and in person at the above address.

All statements of information and opinions shall be accepted until further notice. Any written material received by the State Department of Human Services shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that the rule is adopted.

Department of Human Services

Mental Health Division

Notice of Solicitation of Outside Information or Opinions Regarding Proposed Rules Governing Licensure of Residential Facilities for Persons with Mental Illness

Notice is hereby given that the State Department of Human Services is seeking information or opinions from sources outside the agency in preparing to propose the adoption of the rules governing the licensure of residential facilities for persons with mental illness.

The adoption of these rules is authorized by *Minnesota Statutes,* sections 245A.09, subdivision 1, and 245A.095, subdivision 2, which requires the commissioner to adopt rules for programs serving persons with mental illness who do not have a significant physical or medical problem that necessitates nursing home care. The rules must govern the operation, maintenance and licensure of programs serving persons with mental illness. Adopted parts 9520.0500 to 9520.0690 (Rule 36) and will be reviewed and revised rules proposed to make the rules consistent with 1987 changes to the Human Services Licensing Act (*Minnesota Statutes*, sections 245A.01 to 245.16) and the adopted Minnesota Comprehensive Mental Health Act (*Minnesota Statutes,* sections 245.461 to 245.486).

The State Department of Human Services requests information and opinions concerning the subject matter of the rule. Interested persons or groups may submit data or views on the subject matter of concern in writing or orally. Written statements should be addressed to: Jay Bambery, Mental Health Division, 4th Floor, Centennial Office Building, 658 Cedar St., St. Paul, MN 55155. Oral statements will be received during regular business hours over the telephone at (612) 296-3923 and in person at the above address.

All statements of information and opinions shall be accepted until further notice is published in the *State Register* or the Notice of Hearing or Notice of Intent to Adopt Rules Without a Hearing is published in the *State Register.* Any written material received by the State Department of Human Services shall become part of the rulemaking record to be submitted to the attorney general or administrative law judge in the event that the rule is adopted.

Dated: 19 October 1987

Jane Nelson

Department of Human Services

Notice of Surgical Procedures Performed on Inpatients Which Require a Second Opinion

Omphalocele repairs (CPT-4 codes 49600 through 49611) have been deleted from the list of surgeries for which a second opinion is required. This deletion applies to surgeries performed on or after April 1, 1987. Pursuant to *Minnesota Rules*, part 9505.5035, Subpart 1, this is the revised list of surgical procedures performed on inpatients for which a second surgical opinion is a condition of Medical Assistance or General Assistance Medical Care reimbursement.

Service Name	CPT-4 (1986 Version) Codes
1. Tonsillectomy and/or Adenoidectomy	42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836, 42860, 42870
2. Hysterectomy	58150, 58152, 58180, 58260, 58265, 58267, 58270, 58275, 58280, 58285
3. Hernia Repair	49505, 49510, 49515, 49520, 49525, 49540, 49550, 49552, 49555, 49560, 49565, 49570, 49575, 49581, 49590
4. Cholecystectomy	47600, 47605, 47610, 47610 with 47550, 47612, 47620

The requirements of the Medical Assistance and General Assistance Medical Care second surgical opinion program are outlined in *Minnesota Rules*, parts 9505.5000 to 9505.5105.

Department of Human Services

Proposed Permanent Rules Relating to Physician and Hospital Certification for Payment of Medical Assistance and General Assistance Medical Care for Inpatient Hospital Services

Rules as Proposed

9505.0500 DEFINITIONS.

Subpart 1. and 2. [Unchanged.]

Subp. 3. **Admission certification.** "Admission certification" means the determination of the medical review agent that all or part of a recipient's inpatient ~~hospitalization is~~ hospital services are medically necessary and that medical assistance or general assistance medical care funds may be used to pay the admitting physician, hospital, and other vendors of inpatient hospital services for providing medically necessary services, subject to parts ~~9500.0750 to 9500.1080,~~ 9500.1070, subparts 1, 4, 6, 12 to 15, and 23; 9500.1090 to 9500.1155; 9505.0170 to 9505.0475; 9505.1000 to 9505.1040~~,~~; and 9505.5000 to 9505.5105.

Subp. 3a. **Admitting diagnosis.** "Admitting diagnosis" means the physician's tentative or provisional diagnosis of the recipient's condition as a basis for examination and treatment when the physician requests admission certification.

Subp. 4. [Unchanged.]

Subp. 4a. **Authorization number.** "Authorization number" means the number issued by the medical review agent that establishes that the surgical procedure requiring a second surgical opinion is medically appropriate.

Subp. 5. **Certification number.** "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 6. to 8. [Unchanged.]

Subp. 9. **Continued stay review.** "Continued stay review"

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means a review and determination, after the admission certification and during a patient's hospitalization, of the medical necessity of continuing inpatient hospital services to the ~~recipient's stay at a hospital level of care~~ recipient.

Subp. 10. [Unchanged.]

Subp. 10a. **Diagnostic category.** "Diagnostic category" means the list of diagnosis-related groups in the diagnostic classification system established under Minnesota Statutes, section 256.969, subdivision 2, and defined in part 9500.1100, subpart 20.

Subp. 10b. **Diagnostic category validation or validate the diagnostic category.** "Diagnostic category validation" or "validate the diagnostic category" refers to the process of comparing the medical record to the information submitted on the inpatient hospital billing form required by the department to ascertain the accuracy of the information upon which the diagnostic category was assigned.

Subp. 11. to 13. [Unchanged.]

Subp. 14. **Inpatient hospital service.** "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in ~~a~~ the hospital for the care and treatment of ~~a~~ the recipient. The inpatient hospital service may be furnished by a hospital, physician, or a vendor of an ancillary service which is prescribed by a physician ~~that may be paid~~ and which is eligible for ~~under~~ medical assistance or general assistance medical care reimbursement.

Subp. 15. [Unchanged.]

Subp. 16. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B. For purposes of parts 9505.0500 to 9505.0540, "medical assistance" includes general assistance medical care unless otherwise specified.

Subp. 17. [Unchanged.]

Subp. 18. **Medical review agent.** "Medical review agent"

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means the representative of the commissioner who is authorized by the commissioner to make decisions about admission certifications, concurrent reviews, continued stay reviews, and retrospective reviews, and second surgical opinions if such opinions are a term of the agent's contract with the department.

Subp. 19. [Unchanged.]

Subp. 19a. **Medically appropriate or medical appropriateness.** "Medically appropriate" or "medical appropriateness" refers to a determination, by a medical review agent or the department, that the recipient's need for a surgical procedure requiring a second surgical opinion meets the criteria in part 9505.0540 or that a third surgical opinion has substantiated the need for the procedure.

Subp. 20. and 21. [Unchanged.]

Subp. 22. **Physician adviser.** "Physician adviser" means a physician who practices in the specialty area of the recipient's ~~primary~~ admitting or principal diagnosis or a specialty area related to the ~~primary~~ admitting or principal diagnosis.

Subp. 23. [Unchanged.]

Subp. 23a. **Principal diagnosis.** "Principal diagnosis" means the condition established, after study, to be chiefly responsible for causing the admission of the recipient to the hospital for inpatient hospital services.

Subp. 23b. **Principal procedure.** "Principal procedure" means a procedure performed for definitive treatment of the recipient's principal diagnosis rather than one performed for diagnostic or exploratory purposes or a procedure necessary to take care of a complication. When multiple procedures are performed for definitive treatment, the principal procedure is the procedure most closely related to the principal diagnosis.

Subp. 23c. **Provider.** "Provider" means an individual or organization under an agreement with the department to furnish health services to persons eligible for the medical assistance or general assistance medical care programs. Providers include hospitals, admitting physicians, and vendors of other services.

Subp. 24. **Readmission.** "Readmission" means an admission

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that occurs within ~~seven~~ 15 days of a discharge of the same recipient. The 15-day period does not include the day of discharge or the day of readmission.

Subp. 25. and 26. [Unchanged.]

Subp. 27. **Retrospective review.** "Retrospective review" means a review conducted after inpatient hospital services are provided to a recipient. The review is focused on validating the diagnostic category and determining the medical necessity of the admission, the medical necessity of any inpatient hospital services provided, the medical appropriateness of a surgical procedure requiring a second opinion, and whether all medically necessary inpatient hospital services were provided.

Subp. 28. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the medical appropriateness of a proposed surgery as specified in parts 9505.5000 to 9505.5105.

Subp. 29. **Transfer.** "Transfer" means the movement of a recipient after admission from one hospital directly to another.

9505.0510 ~~APPLICABILITY~~ SCOPE.

Parts 9505.0500 to 9505.0540 establish the standards and procedures for admission certification to be followed by admitting physicians and hospitals seeking medical assistance or general assistance medical care payment under parts 9500.1090 to 9500.1155 for inpatient hospital services provided to medical assistance or general assistance medical care recipients under Minnesota Statutes, chapters 256B and 256D. Parts 9505.0500 to 9505.0540 are to be read in conjunction with Code of Federal Regulations, title 42, and titles XVIII and XIX of the Social Security Act. The department retains the authority to approve prior authorizations established under parts 9505.5000 to ~~9505.5105~~ 9505.5030 and second surgical opinions established under parts 9505.5035 to 9505.5105. ~~Parts 9505.0500 to 9505.0540 do not apply to out-of-state hospitals and~~ A hospital or admitting ~~physicians~~ physician who ~~seek~~ seeks medical assistance or general assistance medical care ~~program~~ payment

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for inpatient hospital services provided to ~~recipients-who-are Minnesota-residents.--Instate-admitting-physicians-who-admit-a Minnesota-resident-who-is-a-recipient-to-an-out-of-state hospital-must-comply-with-parts-9505.0500-to-9505.0540. Out-of-state-admitting-physicians-who-admit-a-Minnesota-resident who-is-a-recipient-to-an-in-state-hospital-must-comply-with parts-9505.0500-to-9505.0540~~ a Minnesota recipient must comply with the requirements of parts 9505.0500 to 9505.0540 unless the hospital or admitting physician has received prior authorization for inpatient hospital services under parts 9505.0170 to 9505.0475. Admission certification must be obtained when a recipient moves from one hospital with a provider number to another hospital with a different provider number or from one unit within a hospital to another unit with a different provider number in the same hospital. For purposes of this part, "provider number" means a number issued by the department to a provider who has signed a provider agreement under part 9505.0195.

9505.0520 INPATIENT ADMISSION CERTIFICATION.

Subpart 1. [Unchanged.]

Subp. 2. **Exclusions from admission certification or prior admission certification.** Admission for inpatient hospital services under items A ~~and~~ B to C shall be excluded from the requirement in subpart 1.

A. Admission certification is not required before an emergency admission ~~may-occur-without-prior-admission certification~~ and shall be subject to subpart 4, item B.

B. Admission certification is not required for delivery of a newborn or a stillbirth, inpatient dental procedures, or inpatient hospital services for which a recipient has been approved under Medicare. However, denial of an inpatient hospital service under Medicare ~~because-the-service-is not-medically-necessary~~ shall also constitute sufficient grounds for denying ~~payment~~ admission certification for the service under medical assistance. The admission of a pregnant woman

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that does not result in the delivery of a newborn or a stillbirth within 24 hours of her admission shall be subject to retroactive admission certification.

C. Admission of a recipient who has been approved by the county for inpatient hospital services for chemical dependency as specified in parts 9530.6600 to 9530.6655 may occur without admission certification, provided that the inpatient hospital chemical dependency services to the recipient during the recipient's stay in the hospital are not to be billed to medical assistance under parts 9500.1090 to 9500.1155.

Subp. 3. **Admitting physician responsibilities.** The admitting physician who seeks medical assistance or general assistance medical care program payment for an inpatient hospital service to be provided to a recipient ~~for a purpose other than chemical dependency treatment~~ shall:

A. [Unchanged.]

B. Request admission certification by contacting the medical review agent either by phone or in writing and providing the information in subitems (1) to ~~(8)~~ (9):

(1) to (5) [Unchanged.]

(6) whether the admission is a readmission or a transfer;

(7) [Unchanged.]

(8) information from the plan of care and the reason for admission as necessary for the medical review agent to determine if admission is medically necessary or the procedure requiring a second surgical opinion is medically appropriate; or

(9) when applicable, information needed to prove that a procedure requiring a second surgical opinion meets the criteria for exemption from the requirement.

C. Provide the following information when applicable:

(1) surgeon's name and medical assistance provider number;

(2) expected date of surgery; ~~and~~

(3) affirmation that ~~a second surgical opinion~~

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and prior authorization have has been received;

(4) affirmation that a procedure requiring a second surgical opinion that was denied by the medical review agent has been approved by a third physician; and

(5) when requested by the medical review agent, documentation that the procedure requiring a second surgical opinion meets the criteria for exemption from the requirement.

D. Inform the hospital of the certification number.

E. Provide the hospital documentation necessary for the verification required in subpart 4, item D.

F. For purposes of billing, enter the certification number ~~on, and attach a copy of a necessary~~, any required prior authorization ~~form~~ number, and a second ~~or third~~ surgical opinion ~~to all~~ authorization number on invoices submitted to the department for payment.

Subp. 4. **Hospital responsibilities.** A hospital that seeks medical assistance or general assistance medical care ~~program~~ payment for inpatient hospital services provided to a recipient shall:

A. Obtain the certification number and the authorization number, if required under parts 9505.5000 to 9505.5105, from the admitting physician ~~or, for an admission for chemical dependency treatment, from the person who conducted the assessment of the recipient for chemical dependency treatment as specified in parts 9530.6600 to 9530.6655~~.

B. ~~In an emergency admission~~ Within 48 hours after the occurrence of an event described in subitem (1) or (2), and within 72 hours of the event described in subitem (3), excluding weekends and holidays, inform, by phone, the medical review agent of the ~~emergency admission~~ event and provide the information required in subpart 3, items B and C, if applicable, ~~within 48 hours of the emergency admission exclusive of weekends and holidays~~.

(1) An admission that is an emergency admission as specified in subpart 2.

(2) A surgical procedure requiring a second

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surgical opinion that meets the requirements of part 9505.5040, item B or C, for exemption from the second opinion.

(3) The admission of a pregnant woman that does not result in the delivery of a newborn or a stillbirth within 24 hours of her admission, as specified in subpart 2, item B.

For purposes of this subitem, the time limit for notifying the medical review agent is calculated beginning with the time of the admission of the pregnant woman.

If the hospital fails to notify the medical review agent within ~~48-hours-excluding-weekends-and-holidays~~ the required time limit, the hospital shall submit, at its own expense, a copy of the complete medical record to the medical review agent within 30 days after the recipient's discharge. Failure to submit the record within the 30 days shall result in denial of the certification number.

C. For billing purposes, enter the certification number and any required prior authorization number and second surgical opinion authorization number on all invoices submitted to the department for payment.

D. Within 20 days, exclusive of weekends and holidays, of the date of a written request by the medical review agent, obtain and submit to the medical review agent an admitting physician's verification that a procedure requiring a second surgical opinion has been approved by a third physician. The verification must include at least the signed form required by the department to approve a procedure requiring a second surgical opinion.

Subp. 5. [Unchanged.]

Subp. 6. **Medical review agent responsibilities.** The medical review agent shall:

A. [Unchanged.]

B. determine within 24 hours of receipt of the information, exclusive of weekends and holidays, whether admission is medically necessary, whether a surgical procedure requires a second surgical opinion or is exempt from the requirement, and whether a procedure requiring a second surgical

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opinion meets the criteria of appropriateness established in part 9505.0540 or requires the approval of a third physician;

C. [Unchanged.]

D. mail a written notice by certified letter of the admission certification determination to the admitting physician and the hospital, and a written notice to the recipient within five days of the determination, exclusive of weekends and holidays;

E. determine if admission of a retroactively eligible recipient was medically necessary and if the surgical procedure requiring a second opinion was medically appropriate;

F. conduct a concurrent, continued stay, or retrospective review of a recipient's medical record as specified in subpart 10;

G. provide for a reconsideration of a denial or withdrawal of admission certification, and of an authorization number denied or withdrawn under subpart 8, item C;

~~G.~~ H. recruit and coordinate the work of the physician advisers;

~~H.~~ I. notify the admitting physician and the person responsible for the hospital's utilization review, by phone, of a reconsideration decision within 24 hours of the decision, exclusive of weekends and holidays;

~~I.~~ J. mail a written notice by certified letter of the reconsideration decision to the admitting physician, the person responsible for the hospital's utilization review, and the department within ten days of the determination, exclusive of weekends and holidays;

~~J.~~ K. provide for consideration of a request for retroactive admission certification; ~~and~~

~~K.--issue-a-certification-number-for-a-recipient-whose condition-requires-chemical-dependency-treatment-in-a-hospital as-indicated-in-an-assessment-made-according-to-parts-9530.6600 to-9530.6655~~

L. validate the diagnostic category; and

M. perform other duties as specified in the contract

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between the medical review agent and the department.

Subp. 7. [Unchanged.]

Subp. 8. **Procedure for admission certification or authorization of surgical procedure requiring a second surgical opinion.** The procedure for admission certification or authorization of a surgical procedure requiring a second surgical opinion shall be as in items A to H.

A. Upon receipt of the information requested in subpart 3, items B and C, if applicable, the clinical evaluator shall review the information and determine whether the admission is medically necessary or whether a procedure requiring a second surgical opinion is appropriate or meets the criteria for exemption from the requirement.

B. If the clinical evaluator determines ~~the admission is medically necessary~~ that one of the conditions in item A exists, the medical review agent shall issue a certification or authorization number.

C. If the clinical evaluator determines that a procedure requiring a second surgical opinion does not meet the criteria for exemption under part 9505.5040, except items B, C, and F, the medical review agent shall notify the admitting physician by phone and mail the admitting physician and the recipient a written notice within 20 days of the determination. If the exemption is denied, the recipient who wants the surgery may obtain a second or third surgical opinion. Exemptions from the second surgical opinion under part 9505.5040, items B and C, shall be subject to subpart 4, item B. Exemptions from the second surgical opinion under part 9505.5040, item F, shall be subject to part 9505.5096, subpart 4. If the medical review agent determines that the procedure requiring a second surgical opinion was not entitled to an exemption or that the surgical procedure was not medically appropriate under part 9505.5040, items B, C, and F, the medical review agent shall not issue or shall withdraw the authorization number and notify the admitting physician and the hospital of denial of the authorization number. The notice shall be in writing, mailed by certified letter

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within 20 days of the determination, and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

D. If the clinical evaluator is unable to determine that the admission is medically necessary, or that a procedure requiring a second surgical opinion is appropriate, the evaluator shall contact a physician adviser.

~~D.~~ E. If the physician adviser determines that the admission is medically necessary, or that a procedure requiring a second surgical opinion is appropriate, the medical review agent shall issue a certification or authorization number.

~~E.~~ F. If the physician adviser is unable to determine that the admission is medically necessary, or that a procedure requiring a second surgical opinion is appropriate, the physician adviser shall notify the clinical evaluator by phone, the clinical evaluator shall notify the admitting physician by phone, and the admitting physician may request a second physician adviser's opinion, except in the case of a procedure requiring a second surgical opinion. In this case, the medical review agent shall notify the admitting physician that the recipient may obtain the opinion of a third physician as provided in parts 9505.5050 to 9505.5105.

~~F.~~ G. If the admitting physician does not request a second physician adviser's opinion, the medical review agent shall deny the admission certification, shall not issue a certification number, and shall notify the admitting physician, the hospital, and the recipient of the denial. The notice to the recipient shall be in writing and shall state the reasons for the denial and the recipient's right to appeal under Minnesota Statutes, section 256.045, and part 9505.0522. The notices to the admitting physician and the hospital shall be in writing, shall state the reasons for the denial, and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

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If the admitting physician requests a second physician adviser's opinion about an admission, the clinical evaluator shall contact a second physician adviser.

~~G.~~ H. If the second physician adviser determines that the admission is medically necessary, the medical review agent shall issue a certification number.

~~H.~~ I. If the second physician adviser is unable to determine that the admission is medically necessary, the medical review agent shall deny the admission certification ~~and~~, shall not issue a certification number, and shall notify the admitting physician, the hospital, and the recipient of the denial. The notice to the recipient shall be in writing and shall state the reasons for the denial and the recipient's right to appeal under Minnesota Statutes, section 256.045, and part 9505.0522. The notices to the admitting physician and the hospital shall be in writing and shall state the reasons for the denial and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

Subp. 9. **Reconsideration.** The admitting physician or the hospital may request reconsideration of a decision to deny or withdraw an admission certification or an authorization number under subpart 8, item C. The admitting physician or the hospital shall submit the request in writing to the medical review agent together with the recipient's medical record and any additional information within 30 days of the date of receipt of the certified letter denying or withdrawing admission certification or the authorization number. Upon receipt of the request, the medical record, and any additional information, the medical review agent shall appoint at least three physician advisers, none of whom shall have been involved previously in the procedure for the recipient's admission certification or authorization number, to hear the reconsideration. The reconsideration may be conducted by means of a telephone conference call. ~~The admitting physician or the hospital may submit additional facts at their own expense to support the~~

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~~request-for-admission-certification.~~ The physician advisers may seek additional facts and medical advice as necessary to decide whether the admission is medically necessary or whether the surgical procedure requiring a second surgical opinion meets the criteria of exemption or is medically appropriate under part 9505.5040, items B, C, and F. The reconsideration shall be completed within ~~30~~ 45 days of the receipt of the ~~request~~ information necessary to complete the reconsideration. The outcome of the reconsideration shall be the one chosen by the majority of the physician advisers appointed to consider the request. The admitting physician or the hospital may appeal the determination of the physician advisers according to the contested case provisions of Minnesota Statutes, chapter 14, by filing a written notice of appeal with the commissioner within ~~20~~ 30 days of the date of receipt of the ~~notice-of-the determination~~ certified letter upholding the denial or withdrawal of admission certification or authorization number. However, an admitting physician or hospital that does not request reconsideration or appeal under the contested case procedures of Minnesota Statutes, chapter 14, within 30 days after the denial or withdrawal of admission certification or authorization number is not entitled to an appeal under Minnesota Statutes, chapter 14.

Subp. 9a. **Retention or withdrawal of certification number.** When a hospital discharges a recipient who is subsequently readmitted to the same or a different hospital or transfers a recipient to another hospital, the readmission or transfer is subject to the procedures in part 9505.0540, subparts 3 to 6. The hospital or admitting physician who disagrees with the medical review agent's determination under this subpart may request reconsideration as specified in subpart 9.

Subp. 10. **Medical record review and determination.** As specified in the contract between the department and the medical review agent, upon the request of the department, or upon the initiative of the medical review agent, the medical review agent

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shall ~~be authorized to~~ conduct a concurrent, continued stay, or retrospective review of a recipient's medical record to validate the diagnostic category and to determine whether the admission was medically necessary, whether the inpatient hospital services were medically necessary, whether a continued stay will be medically necessary, ~~or~~ whether all medically necessary services were provided, or whether a surgical procedure requiring a second opinion was medically appropriate. The procedure for concurrent, continued stay, and retrospective reviews shall be as in items A to ~~D~~ G.

A. to C. [Unchanged.]

D. If a physician adviser determines that the recipient's admission was not medically necessary, that the recipient's continued stay will not be medically necessary, or that all medically necessary services were not provided, the medical review agent shall withdraw the previously issued certification number and shall notify the admitting physician and hospital by telephone within 24 hours of the determination and ~~by written notice~~ by certified letter mailed within ~~24 hours~~ five days, exclusive of weekends and holidays, of the determination. The notice shall state the right of the admitting physician and hospital to request a reconsideration or appeal under subpart 9.

E. If the diagnostic category validation shows that the diagnostic category was inaccurately assigned, the department shall adjust the reimbursement as applicable to the diagnostic category that is accurate for the recipient's condition.

F. If the medical review agent conducting a retrospective review finds the recipient's medical record is inadequate to justify that a surgical procedure requiring a second opinion is medically appropriate, or that an exemption under part 9505.5040 was appropriate, the medical review agent may request a hospital to submit, at the hospital's expense, documentation substantiating the opinion of the third physician that the surgical procedure was medically appropriate, or that

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the exemption under part 9505.5040 was appropriate. The hospital shall submit the documentation within 20 days, exclusive of weekends and holidays, of the date of the notice requesting the documentation.

G. If the clinical evaluator is unable to determine from the documentation in the recipient's medical records the reasons for the recipient's discharge and readmission, the clinical evaluator shall submit the medical records of the recipient's discharge and readmission to a physician adviser. The physician adviser shall review the records and determine the nature of the discharge and readmission according to the criteria in part 9505.0540, subparts 3 to 5, and if the determination of the medical review agent is different from that of the admitting physician or hospital, then the medical review agent shall notify the admitting physician or hospital by certified letter mailed within five days, exclusive of weekends and holidays, of the determination. The notice shall state the right of the admitting physician and hospital to request a reconsideration under subpart 9.

Subp. 11. **Consequences of withdrawal of admission certification or authorization number; general.** The department or the medical review agent shall withdraw the certification number or authorization number and may take action as specified in items A to F if the medical review agent determines any of the following: (1) that the admission was not medically necessary ~~or~~; (2) that all medically necessary inpatient hospital services were not provided ~~or~~; (3) that some or all of the inpatient hospital services were not medically necessary~~,~~ ~~the department shall withdraw the certification number and may take action as specified in items A to E~~; (4) that within 20 days, exclusive of weekends and holidays, the hospital has failed to comply with the department's or the medical review agent's request to submit the medical record or other required information to support that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, or that some or all of the inpatient

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hospital services provided were medically necessary; or, that the information submitted by the hospital was inadequate to support that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, or that some or all of the inpatient hospital services provided were medically necessary; (5) that documentation submitted by the hospital at the request of the department or the medical review agent does not support that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate; or (6) that within 20 days, exclusive of weekends and holidays, the hospital has failed to comply with the medical review agent's request to submit documentation to substantiate the opinion of a third physician that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate.

A. For hospitals receiving payments ~~on-a-per admission-basis~~ under parts 9500.1090 to 9500.1155, if the admission was not medically necessary or the medical record does not adequately document that the admission was medically necessary, the entire payment shall be ~~debited-for-an-admission that-was-not-medically-necessary.--If-the-admission-was medically-necessary-but-some-or-all-of-the-inpatient-hospital services-were-not-medically-necessary,-the-matter-shall-be referred-to-the-department-which-may-take-action-under-parts 9505.1750-to-9505.2150~~ denied or recovered as provided in subpart 15. If the hospital failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

B. ~~For-hospitals-receiving-per-diem-payment,-no payment-shall-be-made-if-the-admission-was-not-medically necessary.--If-the-stay-or-a-portion-of-the-stay-was-not medically-necessary,-no-payment-shall-be-made-for-the-portion-of the-stay-that-was-not-medically-necessary.~~ For hospitals receiving payments under parts 9500.1090 to 9500.1155, if the admission was medically necessary but some or all of the

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additional inpatient hospital services were not or will not be medically necessary, or the medical record does not adequately document that the additional inpatient hospital services were necessary, payment for the additional services shall be denied or recovered as provided in subpart 15. If the hospital failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

C. ~~If the medical review agent determines that additional inpatient hospital services will not be medically necessary, the medical review agent shall notify the hospital, admitting physician, and the recipient or the person designated by the recipient in the hospital record that no payment will be made for additional hospital services.~~

~~D.~~ If the admission was not medically necessary or the medical record does not adequately document that the admission was medically necessary, ~~the department may seek to recover payments made to physicians~~ payment shall be denied or recovered from the admitting physician and other vendors of inpatient hospital services as provided in subpart 15. If the admitting physician and other vendors failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

D. If additional inpatient hospital services were not or will not be medically necessary, or the medical record did not adequately document that the additional inpatient hospital services were medically necessary, payment for the additional services shall be denied or recovered from the admitting physician and other vendors of inpatient hospital services as provided in subpart 15. If the admission was medically necessary but some or all of the inpatient hospital services were not medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150. If the admitting physician and vendors failed to provide services that were medically necessary, the matter shall

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be referred to the department which may take action under parts 9505.1750 to 9505.2150.

E. ~~If an inpatient hospital service is not medically necessary, payment for a service not medically necessary shall be denied to the vendor of the service except as provided in items A and B.~~ If within 20 days, exclusive of weekends and holidays, the hospital failed to comply with the department's or the medical review agent's request to submit the medical record or other required information to support (1) that the admission was medically necessary; (2) that all medically necessary inpatient hospital services were provided; or (3) that some or all of the inpatient hospital services provided were medically necessary; or, if the information submitted by the hospital was inadequate to support clauses (1) to (3) of this item, all or part of the payment shall be denied or recovered as provided in items A to D.

F. If the documentation does not support that the surgical procedure was medically appropriate or that the exemption under part 9505.5040 was appropriate, or if the hospital failed to comply with the medical review agent's request to submit documentation to substantiate the opinion of the third physician that the surgical procedure was medically appropriate or that the exemption under part 9505.5040 was appropriate, payment for the surgical procedure shall be denied or recovered from the hospital, admitting physician, or other vendors as provided in subpart 15.

Subp. 12. **~~Appeal~~ Reconsideration of denial or withdrawal of admission certification or authorization number.** The denial or withdrawal of admission certification or authorization number may be ~~appealed to the medical review agent through the reconsideration process in~~ reconsidered under subpart 9.

Subp. 13. and 14. [Unchanged.]

Subp. 15. **Recovery of payment after withdrawal of admission certification or denial of authorization of second surgical procedure.** An admitting physician or hospital that receives a notice of withdrawal of a certification number or

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authorization number and that does not request reconsideration under subpart 9 or appeal under Minnesota Statutes, chapter 14, shall be subject to recovery of payment without further notice or right to appeal. If a reconsideration results in the denial or withdrawal of a certification number or authorization number, and the admitting physician or hospital does not appeal within the time permitted pursuant to other remedies, the department shall recover payment without further notice to the admitting physician and hospital. If an appeal results in the denial or withdrawal of a certification number or authorization number, the department shall recover the payment without further notice to the admitting physician and the hospital.

Recovery of overpayments may be made by:

A. adjusting the provider's invoice to the difference between the billed amount and the correct amount;

B. canceling the incorrect invoice and directing the provider to submit a correct invoice;

C. withholding or offsetting the payment due the provider for other medical assistance or general assistance medical care services; or

D. using any other remedy available under state or federal law or rules.

9505.0521 PROHIBITION OF RECOVERY FROM RECIPIENT.

The provider may not seek payment from the recipient for inpatient hospital services provided under parts 9505.0500 to 9505.0540 if the certification or authorization number is not issued or is withdrawn.

9505.0522 RECIPIENT'S RIGHT TO APPEAL.

A recipient who is denied inpatient hospital services because of the medical review agent's determination that the services are not medically necessary or who is denied a surgical procedure requiring a second surgical opinion because of the medical review agent's determination that the surgical procedure is not appropriate, may appeal the medical review agent's determination under Minnesota Statutes, section 256.045.

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9505.0530 INCORPORATION BY REFERENCE OF CRITERIA TO DETERMINE MEDICAL NECESSITY.

The most recent edition of the Appropriateness Evaluation Protocol of the National Institutes of Health is incorporated by reference. The book is available at the Health Data Institute, ~~7 Wells Avenue, Newton~~ 20 Maguire Road, Lexington, Massachusetts, ~~02159~~ 02173, and it is also available through the Minitex interlibrary loan system. The book is subject to change.

The Criteria for Inpatient Psychiatric Treatment, 1981 edition, published by Blue Cross and Blue Shield of Minnesota are incorporated by reference. The criteria are available at Blue Cross and Blue Shield of Minnesota, P.O. Box 64560, Saint Paul, Minnesota 55164, and at the state law library, Ford Building, Saint Paul, Minnesota 55155. The criteria are not subject to frequent change.

9505.0540 CRITERIA TO DETERMINE MEDICAL NECESSITY OR APPROPRIATENESS.

Subpart 1. **Determination for admission for purpose other than chemical dependency treatment.** The medical review agent shall follow the Appropriateness Evaluation Protocol and Criteria for Inpatient Psychiatric Treatment of Blue Cross and Blue Shield of Minnesota in determining whether a recipient's admission is medically necessary, whether the inpatient hospital services provided to the recipient were medically necessary, whether the recipient's continued stay will be medically necessary, and whether all medically necessary inpatient hospital services were provided to the recipient.

In determining whether a surgical procedure requiring a second surgical opinion is medically appropriate, the medical review agent shall follow the criteria published in the State Register pursuant to Minnesota Statutes, section 256B.02, subdivision 8, paragraph 21.

Subp. 2. **Determination for admission for chemical dependency treatment.** The assessment of a recipient's need for chemical dependency treatment in a hospital shall be made

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according to parts 9530.6600 to 9530.6655. ~~The-person-who conducted-the-assessment-shall-contact-the-medical-review-agent and-request-a-certification-number.--If-the-person-who-conducted the-assessment-reports-that-the-recipient-meets-the-criteria-for chemical-dependency-treatment-in-a-hospital,-the-medical-review agent-shall-issue-a-certification-number.~~

Subp. 3. **Readmission considered as a second admission.** The medical review agent shall issue a certification number for a readmission that meets the criteria for medical necessity specified in subpart 1 whether the admitting and readmitting hospitals are the same or different. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. Both the admission and the readmission shall be subject to a retrospective review as provided in part 9505.0520, subpart 10. If the reason for the discharge and the reason for the readmission meet one set of circumstances specified in items A to D, the medical review agent shall determine that both the admission and the readmission shall retain the certification number subject to the hospitals' and admitting physicians' compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The readmission results from the recipient leaving the hospital against medical advice.

B. The readmission results from the recipient being noncompliant with medical advice that is recorded on the recipient's medical record as being given to the recipient at the admitting hospital. For purposes of this part, "recipient being noncompliant with medical advice" means that the recipient, fully informed of his or her medical condition, and fully understanding the need for the treatment and the follow-up discharge instructions, if any, refuses to adhere to the treatment or to follow the discharge instructions.

C. The readmission results from a new episode of the

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same diagnosis of an episodic illness or condition.

D. The readmission results from the fact that the recipient's discharge from the admitting hospital and readmission are medically necessary according to prevailing medical standards, practice, and usage.

Subp. 4. **Readmission considered as continuous with admission.** The medical review agent shall determine that a readmission of a recipient is continuous with the recipient's admission whether the admitting and readmitting hospitals are the same or different if the circumstances requiring the recipient's readmission meet one set of the circumstances specified in items A to C. The medical review agent shall issue a certification number if the readmission meets the criteria for medical necessity specified in subpart 1. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. Both the admission and the readmission shall be subject to a retrospective review as provided in part 9505.0520, subpart 10. Upon completing the retrospective review and determining whether the readmission and admission are consistent with item A, B, or C, the medical review agent shall take the action specified in the item that applies. Medical assistance payment for the inpatient hospital services retaining the certification number after the determination resulting from the retrospective review shall be paid according to parts 9500.1090 to 9500.1155 for the diagnostic category assigned to the recipient's principal diagnosis of the admission and readmission. In each circumstance, retention of the certification number shall be subject to the hospital's and admitting physician's compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The recipient was discharged from the admitting hospital without receiving the procedure or treatment of the condition diagnosed during the admission because of the

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hospital's or physician's preference or because of a scheduling conflict. If the admitting and readmitting hospitals are the same, the medical review agent shall withdraw the certification number of the readmission and determine the admission eligible to retain the certification number. If the admitting and readmitting hospitals are not the same, the medical review agent shall apply the requirements under subpart 5, item C, regarding readmission eligible for a transfer payment.

B. The recipient's discharge was not appropriate according to prevailing medical standards, practice, and usage. If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admission eligible to retain the certification number and withdraw the certification number of the readmission. If the admitting and readmitting hospitals are different, the medical review agent shall withdraw the certification number of the admission and shall determine the readmission eligible to retain a certification number.

C. The recipient's discharge and readmission to the same hospital results from the preference of the recipient or the recipient's family that the recipient's treatment be delayed, that the recipient be discharged without receiving the necessary procedure or treatment, and that the recipient be readmitted for the necessary procedure or treatment. If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admission eligible to retain the certification number and withdraw the certification number of the readmission. If the admitting and readmitting hospitals are not the same, the medical review agent shall apply the requirements under subpart 5, item A, regarding readmission eligible for a transfer payment. For purposes of this part, "preference of the recipient or the recipient's family" means that the recipient or the recipient's family makes a choice to delay or change the location of inpatient hospital services, and the choice is compatible with prevailing medical standards, practices, and usage.

Subp. 5. **Readmission eligible for transfer payment.** The

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medical review agent shall issue a certification number for a readmission that is eligible for a transfer payment if the readmission meets the criteria for medical necessity specified in subpart 1 and a set of circumstances in item A, B, or C. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. The medical review agent shall conduct a retrospective review of the medical records, determine whether the readmission is consistent with the circumstances in item A, B, or C, and take the action specified in the item. Retention of the certification number by the hospital shall also be subject to the admitting physician's and hospital's compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The readmission results from the preference of the recipient or the recipient's family that the recipient be discharged from the admitting hospital without receiving the necessary procedure or treatment and that the recipient be readmitted to a different hospital to obtain the necessary procedure or treatment. In this case, both hospitals shall retain their certification numbers subject to the hospitals' and admitting physicians' compliance with all requirements of parts 9505.0500 to 9505.0540, and medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1130, subpart 7, item A, for the inpatient hospital services necessary for the recipient's diagnosis and treatment.

B. The readmission results from a referral from one hospital to a different hospital because the recipient's medically necessary treatment was outside the scope of the first hospital's available services. In this case, both hospitals shall retain their certification numbers, and medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1130, subpart 7, item A, for

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the inpatient hospital services necessary for the recipient's diagnosis and treatment. If, however, the admission to the first hospital is not due to an emergency and the first hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for the recipient's treatment were outside the scope of the hospital's available services and the readmission to another hospital resulted because of the recipient's need for those services, the first hospital's certification number will be withdrawn.

C. The readmission results from a physician's or hospital's scheduling conflict at the admitting hospital. The medical review agent shall determine both hospitals eligible to retain their certification numbers. In this case, medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1130, subpart 7, item A, for the inpatient hospital services necessary for the recipient's diagnosis and treatment.

Subp. 6. **Physician adviser's review of readmission.** If the clinical evaluator is unable to determine from the documentation in the recipient's medical records the reasons for the recipient's discharge and readmission, the records shall be reviewed by the physician adviser, according to the procedure in part 9505.0520, subpart 10, item G.

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STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Amendments to Rules of the Department of Human Services Governing Inpatient Hospital Admission Certification in the Medical Assistance and General Assistance Medical Care Programs Parts, 9505.0500 to 9505.0540

NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING AND NOTICE OF INTENT TO ADOPT A RULE WITH A PUBLIC HEARING IF TWENTY-FIVE OR MORE PERSONS REQUEST A HEARING

Notice is hereby given that the State Department of Human Services proposes to adopt the above-entitled rule without a public hearing following the procedures set forth in Minnesota Statutes, section 14.22 to 14.28. The specific statutory authority to adopt the rule is Minnesota Statutes, section 256B.04, subdivisions 2 and 15, section 256B.503, and section 256D.03 subdivision 7(b).

Persons interested in this rule shall have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule and comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, section 14.131 to 14.20. PLEASE NOTE THAT IF TWENTY-FIVE OR MORE PERSONS SUBMIT WRITTEN REQUESTS FOR A PUBLIC HEARING WITHIN THE 30-DAY COMMENT PERIOD, A HEARING WILL BE HELD ON MONDAY, NOVEMBER 14, 1988, UNLESS A SUFFICIENT NUMBER WITHDRAW THEIR REQUEST, IN ACCORDANCE WITH THE NOTICE OF PUBLIC HEARING ON THESE SAME RULES PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between November 3, 1988 and November 13, 1988, at (612) 297-4997.

Persons who wish to submit comments or a written request for a public hearing must submit such comments or requests to: Anu Seam, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 297-4997.

Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on November 2, 1988.

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

A free copy of this rule is available upon request for your review from: Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854. A copy of the proposed amended rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

Minnesota Rules, parts 9505.0500 to 9505.0540, establish a system for reviewing the utilization of inpatient hospital services under the Medical Assistance and General Assistance Medical Care programs. These rules are designed to guard against excess payments and to reduce expenditures which result from unnecessary hospitalization of MA and GAMC recipients.

Besides persons receiving Medical Assistance and General Assistance Medical Care services, this rule affects providers of Medical Assistance and General Assistance Medical Care services who are responsible for following the procedures specified in the rule, and the medical review agent who is responsible for reviewing the necessity of admissions and the appropriateness of the surgical services provided.

The proposed amendments to these rules remove inconsistencies between this rule and Minnesota Rules, parts 9500.1090 to 9500.1155, which is a related medical assistance and general assistance medical care rule. Parts 9500.1090 to 9500.1155 govern the reimbursement for inpatient hospital services to be provided to Medical Assistance and General Assistance Medical Care recipients, and have to be read in conjunction with the present rule.

The amendments expand the time frame for readmissions and clarify the criteria for a readmission considered as a second admission, a readmission considered as continuous with the first admission, and a readmission considered as a transfer. The amendments also specify procedures to be followed by providers of Medical Assistance and General Assistance Medical Care to be eligible for reimbursement, and incorporate the second surgical opinion process into the admission certification process.

The amended rule contains definitions of terms used in the rule and amends existing definitions. It amends the scope of the rule, exclusions from admission certification requirements, and the time requirements for excluding obstetrical services from admission certification requirements.

The rule expands the responsibilities of the admitting physician, the medical review agent and the Department. It specifies the procedures to be followed by providers to obtain the authorization number or certification number. It contains changes to reconsideration procedures, procedures for retention or withdrawal of certification number, and medical record review and determination by the medical review agent.

The amended rule contains additional consequences of withdrawal of admission certification or authorization number, and provides for recovery of payment after withdrawal of admission certification or authorization number. It prohibits recovery from the recipient, provides the recipient with right to appeal if the recipient is denied inpatient hospital services, and provides for physician adviser's review of readmissions.

A Statement of Need and Reasonableness 12 that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854, upon request.

Adoption of these rules will not result 13 in additional spending by local public bodies in the excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854.

If no hearing is required upon adoption of the rule, the rule and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Anu Seam, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816.

State of Minnesota

for Julie Brunner
SANDRA S. GARDEBRING
Commissioner

Dated: 5/6/85

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Amendments to Department of Human Services Rules Governing Inpatient Hospital Admission Certification in the Medical Assistance and General Assistance Medical Care Programs, Parts, 9505.0500 to 9505.0540	NOTICE OF HEARING AND NOTICE OF INTENT TO CANCEL HEARING IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO NOTICE OF INTENT TO ADOPT RULES WITHOUT A PUBLIC HEARING

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in Rooms 2A and 2B, Human Services Building, 444 Lafayette Road, St.Paul, Minnesota, 55155, on November 14, 1988 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

PLEASE NOTE, HOWEVER, THAT THE HEARING WILL BE CANCELLED IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO THE NOTICE OF INTENT TO ADOPT THESE SAME RULES WITHOUT A PUBLIC HEARING PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between November 3, 1988 and November 13, 1988 at (612) 297-4997.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Howard Kaibel, Administrative Law Judge, Office of Administrative Hearings, 500 Flour Exchange Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341-7608, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge may at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the

agency is willing to adopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Law Judge will write a report as provided for in Minnesota Statutes, sections 14.15 and 14.50. The rule hearing is governed by Minnesota Statutes, sections 14.14 to 14.20 and by Minnesota Rules, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

Minnesota Rules, Parts 9505.0500 to 9505.0540, establish a system for reviewing the utilization of inpatient hospital services under the Medical Assistance and General Assistance Medical Care programs. These rules are designed to guard against excess payments and to reduce expenditures which result from inappropriate hospitalization of MA and GAMC recipients.

Besides persons receiving MA and GAMC services, this rule affects providers of MA/GAMC services who are responsible for following the procedures specified in the rule, and the medical review agent who is responsible for reviewing the necessity of admissions and the appropriateness of the surgical services provided.

The proposed amendments to these rules remove inconsistencies between this rule and Minnesota Rules, parts 9500.1090 to 9500.1155, which is a related medical assistance and general assistance medical care rule. Parts 9500.1090 to 9500.1155 govern the reimbursement for inpatient hospital services to be provided to Medical Assistance and General Assistance Medical Care recipients, and have to be read in conjunction with the present rule.

The amendments expand the time frame for readmissions and clarify the criteria for a readmission considered as a second admission, a readmission considered as continuous with the first admission, and a readmission considered as a transfer. The amendments also specify procedures to be followed by providers of Medical Assistance and General Assistance Medical Care to be eligible for reimbursement, and incorporate the second surgical opinion process into the admission certification process.

The amended rule contains definitions of terms used in the rule and amends existing definitions. It amends the scope of the rule, exclusions from admission certification requirements, and the time requirements for excluding obstetrical services from admission certification requirements. The rule expands the responsibilities of the admitting physician, the medical review agent and the Department. It specifies the procedures to be followed by providers to obtain the authorization number or certification number. It contains changes to reconsideration procedures, procedures for retention or withdrawal of certification number, and medical record review and determination by the medical review agent.

The amended rule contains additional consequences of withdrawal of admission certification or authorization number, and provides for recovery of payment after withdrawal of admission certification or authorization number. It prohibits recovery from the recipient, provides the recipient with right to appeal if the recipient is denied inpatient hospital services, and provides for physician adviser's review of readmissions.

The agency's authority to adopt the proposed rules is contained in Minnesota Statutes, section 256B.04, subdivisions 2 and 15, section 256B.503, and section 256D.03 subdivision 7(b). Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854. This rule is also available for viewing at each of the county welfare or human service agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule contact Anu Seam, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 297-4997.

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

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

Minnesota Statutes, chapter 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 Minnesota Statutes, section 10A.01, subdivision 11, as any individual:

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

(b) who spends more than $250, not including 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, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

for Julie Brunner
SANDRA S. GARDEBRING
Commissioner

Dated: 9/6/88

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO MINNESOTA RULES, PARTS 9505.0500 TO 9505.0540, GOVERNING INPATIENT HOSPITAL ADMISSION CERTIFICATION IN THE MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PROGRAMS.

STATEMENT OF NEED AND REASONABLENESS

Minnesota Rules, parts 9505.0500 to 9505.0540 establish a system for reviewing the utilization of inpatient hospital care services under the Medical Assistance (MA) and General Assistance Medical Care (GAMC) Programs. These rules are designed to guard against excess payments and to reduce expenditures which result from inappropriate hospitalization of MA and GAMC recipients.

Minnesota Statutes, Section 256B.04 subdivision 15, requires the department to establish a program to safeguard against the unnecessary or inappropriate use of medical assistance services, against unnecessary or inappropriate hospital admissions or lengths of stay, and against underutilization of services in any health care delivery system subject to fixed rate reimbursement. The department is directed, under Minnesota Statutes, section 256D.03, subdivision 7(b) to establish standards for utilization review in the GAMC program that conform to the procedures established for the Medical Assistance program.

The temporary rules were adopted on May 10, 1984, and the permanent rule on March 26, 1985. The rule was also amended on March 24, 1987.

Since adopting these rules and the amendments to them, the department has identified several additional areas of the rules that need to be amended. The need for these amendments arises from inconsistency with related rules, the need for incorporating a second surgical opinion process, and confusion over criteria for a readmission considered as a second admission or a readmission considered as continuous with the first admission.

The department solicited the opinion of an advisory committee before and during the preparation of the proposed amendments to the rule. The committee was composed of representatives from the Minnesota Medical Association, Minnesota Hospital Association, Council of Hospital Corporations, and individual hospitals. The committee also included the medical review agent and utilization review specialists. (See appendix A for committee membership.) The committee met on December 2, 1987, February 4, 1988, and March 4 1988, to review the amendments proposed by the department. Members of the committee supported the department's desire to address these concerns.

In addition the department established a task force of utilization review specialists to assist in the development of processes and criteria. (See appendix B for membership of the task force). The task force included members of the advisory committee who maintained a link between task force recommendations and the advisory committee's opinion.

The proposed amended rules, designated as Minnesota Rules, Parts 9505.0500 to 9505.0540 are hereby affirmatively presented by the Department as required by Minnesota Statutes,Section 256B.04, subdivisions 2 and 15, Section 256B.503, Section 256D.03 subdivision 7(b) and in accordance with the provisions of the Minnesota Administrative Procedures Act, Minnesota Statutes chapter 14, and the rules of the Office of Administrative Hearings.

Part 9505.0500 DEFINITIONS.

The proposed amendments to the definitions are necessary to clarify the meaning of terms which may be subject to multiple interpretations, and to be consistent with medical usage, statutes and other related rules.

Subp. 3. Admission certification. This amendment is necessary because it clarifies that the determination that it is medically necessary to admit a recipient as an inpatient to a hospital includes the determination that all or part of the inpatient services provided to the recipient are medically necessary. The amendment is reasonable because it covers the kind of cases where admission may be medically necessary but continued inpatient hospital services may not be medically necessary. The department should not be expected to pay for services that were not medically necessary, but at the same time providers (hospitals, admitting physicians and vendors of services) should be eligible for payment of services that were medically necessary.

The amendment deleting Minnesota Rules, Parts 9500.0750 to 9500.1080, and adding Minnesota Rules, Parts 9505.1070, subparts 1, 4, 6, 12 to 15, and 23; 9500.1090 to 9500.1155; 9505.0170 to 9505.0475 is necessary and reasonable because they bring the citations up to date with existing rules.

Subp. 3a. Admitting diagnosis. The amendment describes the initial diagnosis that is the basis for examination and treatment given by the admitting physician. It is necessary to define "admitting diagnosis" because the term can be subject to different interpretations unless it is clearly defined. It is also necessary to define this term to distinguish it from "principal diagnosis" which is the diagnosis determined by reviewing the recipient's medical record after discharge from hospital. The definition of admitting diagnosis is reasonable because it is universally accepted according to the American Medical Record Association (AMRA). The AMRA is an association of medical record professionals which has been in existence since 1939. The association organizes health care data and specifies universal definitions of medical terms to facilitate collection of uniform and comparable health information from all hospitals.

Subp. 4 (A). Authorization number. This definition is necessary to clarify a term used in this rule and in the associated second surgical opinion rule (Rule 68). It is also necessary to distinguish the term

authorization number from the term certification number. The authorization number is the number issued by the medical review agent that establishes that the recipient needs a surgical procedure requiring a second surgical opinion, i.e., that the surgical procedure is medically appropriate. The certification number is the number issued by the medical review agent that establishes that the recipient needs the inpatient hospital services, i.e., that inpatient hospital services are medically necessary.

The authorization number will be required for any surgical procedure requiring a second surgical opinion, regardless of whether the surgical service is to be provided on an inpatient or an outpatient basis. However, if the physician offering to provide the surgical service recommends that the surgical service should be provided on an inpatient basis, then the provider is required to obtain a certification number in addition to the authorization number, to establish the need of inpatient hospital services.

It is reasonable to ask providers to obtain an authorization number because the issuance of the authorization number reassures the department that the surgical procedure is medically appropriate and it assures providers that they will be paid for the surgical procedure performed by them.

Subp. 5. Certification number. This amendment is necessary and reasonable because it clarifies that the certification number is the number issued by the medical review agent to indicate that an admission is medically necessary. It is also necessary to amend the definition to distinguish it from the authorization number issued by the medical review agent, which establishes that the surgical procedure requiring a second surgical opinion is medically appropriate [refer to SNR for subpart 4(A)].

Subp. 9. Continued stay review. The amendment is necessary and reasonable to clarify that the review determines that all or part of the services provided in the hospital after a recipient's admission are medically necessary.

Subp. 10a Diagnostic category. The term "diagnostic category" is defined with reference to applicable rules promulgated by the commissioner. The diagnostic category may be modified with 30 days notice, and published in the State Register as permitted under Minnesota Statutes, section 256.969, subdivision 2. The definition is reasonable and necessary to distinguish and group the different types of inpatient hospital services that are clinically coherent and uniform with respect to cost.

Subp. 10b. Diagnostic category validation or validate the diagnostic category. This definition is necessary to inform providers of the process of comparing the medical record to the information submitted on the inpatient hospital billing form required by the Department. The diagnostic category determines reimbursement, and the department assigns the diagnostic category based on information given by the provider. The definition is reasonable because it allows a determination of the accuracy of the information upon which the diagnostic category was assigned.

Subp. 14. Inpatient hospital services. The amendment is necessary and reasonable to clarify that the inpatient hospital services are services that are provided after the recipient is admitted to the care of the

hospital, and hospital services are made available to the recipient on a continuous 24 hour-a-day basis. The amendment is necessary because it distinguishes inpatient services from outpatient services for which no admission certification is required. The amendment is reasonable because it is consistent with common medical usage and with the definition in parts 9500.1090 to 9500.1155 (Rule 54).

Subp. 16. Medical Assistance or MA. The amendment is necessary because it identifies the funding programs that come under the purview of this rule and clarifies that GAMC is one of the funding sources and is included in all references to MA throughout this rule. Minnesota Statutes, section 256D.03,subd.7(b) requires the department to establish standards for utilization review in the GAMC program that conform to procedures established for the Medical Assistance program. It is reasonable to use one term in order to delete unnecessary words in a reference frequently repeated in the rule.

Subp.18. Medical review agent. The amendment is necessary to clarify that the medical review agent's authority includes giving second surgical opinions whenever that is a term of the contract with the department. The amendment is reasonable because it is consistent with the authority given to the medical review agent in parts 9505.5000 to 9505.5105, a related medical assistance rule.

Subp.19a. Medically appropriate or medical appropriateness. The terms medically appropriate or medical appropriateness refer to the determination by the department, or by it's authorized representative, the medical review agent, that the recipient needs the surgical procedure. The determination is made by seeing if the recipient's needs meet the criteria in part 9505.0540 or if a third surgical opinion has determined the need of the surgical procedure.

This amendment is necessary because the term medical appropriateness can be subject to different interpretations if it is not clearly defined. It is also necessary to distinguish the term "medically appropriate" from the term "medically necessary" which means that the recipient's diagnosis and condition requires inpatient hospital services, and, under the criteria in part 9505.0540 cannot be provided on an outpatient basis. The determination of medical appropriateness is made independently of the determination of medical necessity. If the surgical procedure requiring a second surgical opinion is determined to be medically appropriate, and if the admitting physician recommends that the surgery be provided on an inpatient hospital basis, then a determination of medical necessity is required.

The term "medically appropriate" is also the term used in a related medical assistance rule, parts 9505.5000 to 9505.5105, and it is necessary to use the same term in these rule parts to ensure consistency between the rules. The amendment is reasonable because the department should be able to determine the appropriateness of the surgical procedure requiring a second surgical opinion before it pays out of MA and GAMC funds.

Subp.22. Physician adviser. The amendment is necessary to clarify the area of expertise required from the physician advisor. It is both reasonable and necessary to delete the word "primary diagnosis" because

there is no universally accepted definition of that term. In contrast, both the terms "admitting diagnosis" and "principal diagnosis" are consistent with the definitions used by the AMRA.

Subp.23a. Principal diagnosis. Principal diagnosis describes the condition that was the foremost basis for causing the admission of the recipient to the hospital. This diagnosis is determined after study of the medical records and upon discharge of the recipient from the hospital. The principal diagnosis provides information for use in the diagnostic category validation process. The amendment is necessary because it informs providers of the diagnosis that is used in the diagnostic category validation process, and on which their payment is based. It is also necessary because it eliminates any confusion between the principal diagnosis and the admitting diagnosis, which is the diagnosis determined before the patient is admitted to hospital. It is reasonable because this definition is universally accepted according to the AMRA.

Subp.23b. Principal procedure. Principal procedure refers to the procedure that is performed as a specific treatment of a recipient's principal diagnosis. The procedure also provides information to allow a determination of the medical necessity of inpatient hospital care and for use in the diagnostic category validation process.

The definition is necessary because it informs providers of the procedure that the department or medical review agent will consider in the diagnostic category validation process. It is reasonable because this definition is universally accepted according to the AMRA.

Subp.23c. Provider. "Provider" is a term used to refer to a person or institution who is eligible for medical assistance payment for providing covered services to a recipient. The definition is necessary to clarify it's meaning. It is also necessary to clarify that hospitals, admitting physicians and vendors of other services are included in the definition because those are terms used throughout the rule for persons who are eligible for payment. This definition is reasonable because it is consistent with Minnesota Rule parts 9505.0010 to 9505.0150, which rule governs eligibility for medical assistance.

Subp.24. Readmission. It is necessary to inform providers and recipients of the extended time frame for readmissions. The complexity of medical care and the potential for fragmented care make it reasonable to extend the time frame of review of readmissions from 7 to 15 days. The per admission prospective payment system causes an incentive to discharge and readmit recipients. The extended time frame serves as a safeguard against unnecessary, inappropriate or underutilization of services because it allows for more thorough detection of such occurences. The amendment is also reasonable because it is consistent with the Medicare prospective payment system which expanded the review of readmissions from 7 to 15 days.

Subp.27. Retrospective review. The amendment is necessary to indicate that other functions of the retrospective review process will be to gather the information necessary to validate the diagnostic category, and to determine the medical appropriateness of a surgical procedure requiring a second surgical opinion.

The diagnostic category can be validated only retrospectively, because it is determined after the department receives the billing form from the hospital. It is also reasonable to add this function to the retrospective review process because the information necessary to validate the diagnostic category is contained in the medical record which is also the document used for reviewing medical necessity.

It is reasonable to allow a retrospective review of the medical appropriateness of a surgical procedure requiring a second surgical opinion because the department has a responsibility to determine the need for the surgical procedure if the provider is eligible for reimbursement from MA funds. In most cases medical appropriateness will be determined before the surgical procedure. However, if there is an emergency or incidental surgery, or if the surgical procedure is performed before the recipient applies for MA or GAMC and the recipient is later determined to be eligible retroactively, then the provider has the option to perform the surgical procedure and obtain the determination of medical appropriateness through a retrospective review. This process ensures that the surgical procedure was necessary, but at the same time it ensures that urgent medical care is not delayed while the provider obtains the determination.

Subp.28. Second surgical opinion. Second surgical opinion refers to the confirmation or denial of the medical appropriateness of a proposed surgery by the medical review agent or, if there is no medical review agent, by the second physician. This definition is necessary to eliminate any confusion between the second surgical opinion, and the opinion of the admitting physician and the third surgical opinion.

Minnesota Rules, Parts 9505.5000 to 9505.5105 establish a system for requiring a second opinion for certain surgical procedures. The same rule parts also establish the procedures to be followed by hospitals while providing inpatient hospital services. However this procedure proved to be cumbersome, and it confused hospitals to have different procedures for a few elective surgeries. Therefore the department believes it is necessary and reasonable to incorporate the procedures for inpatient hospital admission for surgical procedures requiring a second surgical opinion into parts 9505.0500 to 9505.0540. These parts now describe admission certification procedures for inpatient hospital services including procedures for elective surgeries. It is thus reasonable to define second surgical opinion because the rule parts that follow deal with the term frequently.

Subp.29. Transfer. This definition is necessary to clarify that a transfer is a situation in which a recipient is transported directly from one hospital to another with no change in the level of care provided. The word "directly" has the meaning given to it in the American Heritage Dictionary (The American Heritage Dictionary, Second College Edition,1985), i.e. without intervening persons, conditions, or agencies ; immediate. A direct transfer occurs when the hospital codes the recipient's disposition status as "discharged to another hospital". This is reasonable because not all recipients treated for inpatient hospital services receive the entire treatment for an episode in one hospital or one service within a hospital.

Although direct transfers are technically readmissions, it is necessary to differentiate them from readmission situations in which there has been a change in the level of care between discharge and readmission. This is important for coding claims and retaining consistent data, and for record keeping within the hospital. This definition is also reasonable because it is consistent with the definition of "transfer" in part 9500.1100, subpart 50.

9505.0510 SCOPE

It is necessary and reasonable to emphasize that this rule must be read in conjunction with the Department's rules pertaining to inpatient hospital reimbursement and second surgical opinions. In addition, it is necessary to inform affected parties that this rule will apply to hospitals outside the state. This part is necessary in order to clarify that all out of state hospitals who have not received prior authorization for providing inpatient hospital services (as required under Minnesota Rules, parts 9505.0170 to 9505.0475) are required to follow the same admission certification procedures as Minnesota hospitals.

It is reasonable that out of state hospitals be subject to the same process as Minnesota hospitals because they receive funds from the same MA or GAMC programs as Minnesota hospitals. It is also reasonable to regulate admission certification procedures for out of state hospitals serving Minnesota recipients because Minnesota Statutes, section 256B.04, subdivision 15 directs the commissioner to safeguard against unnecessary or inappropriate use of medical assistance services, against excess payments, against unnecessary or inappropriate hospital admissions or lengths of stay, and against underutilization of services in <u>any</u> health care delivery system subject to fixed rate reimbursement.

It is necessary and reasonable to inform providers that admission certification must be obtained each time a recipient is admitted to a different hospital or unit with a different provider number because the information removes confusion about a procedure required to obtain payment. It is also necessary and reasonable to amend the rule by defining the term "provider number" to clarify its meaning and inform affected persons.

9505.0520 INPATIENT ADMISSION CERTIFICATION

Subp.2. Exclusions from admission certification or prior admission certification. The amendment is necessary and reasonable because it identifies situations that are not subject to admission certification prior to admission. Certain medical conditions either do not allow for the delay inherent in the pre-admission determination of medical necessity, or the medical necessity of the condition is beyond dispute. Therefore it is necessary and reasonable to exempt those conditions from the prior admission certification requirement.

Subp.2, item A. It is necessary to clarify that admission certification is not required before an emergency admission. Due to the nature of an emergency, it would be unreasonable to require certification prior to admission. However, it is reasonable to require certification within a given period of time retrospectively (subpart 4, item B), so that

the department can determine whether the admission was medically necessary. The new language, particularly the inclusion of the word "before," clarifies that admission certification is necessary, but not before the admission occurs which is usually the case.

Subp.2, item B. The amendment is necessary to identify situations that are not subject to the admission certification process prior to admission. Admission certification is not required for the delivery of a newborn or a stillbirth. If the admission of a woman does not result in a delivery within twenty four hours, the admission will be reviewed by the medical review agent to determine the medical necessity of the services provided. The hospital shall not be denied admission certification for medically necessary services. Admission certification will be denied only if the medical review agent determines that the admission was not medically necessary.

This provision is reasonable because the medical necessity of the hospitalization of a woman for the delivery of a child is beyond dispute. The average time between the onset of contractions and the birth of a child is approximately fourteen hours. The twenty four hour time frame is reasonable because it reflects the nature of the admission. Some admissions may result in a delivery, and no admission certification will be required. However, there may be other admissions relating to pregnancy or ante partum which do not result in a delivery, and which involve a determination of whether the inpatient hospital services were medically necessary. Those admissions may, for example, have been more appropriate for outpatient treatment. It is reasonable that such admissions should be subject to retroactive admission certification.

Subp.2, item C. It is necessary to inform providers that treatment for chemical dependency is no longer subject to the admission certification process of parts 9505.0500 to 9505.0540. This amendment is reasonable because of the implementation of Minnesota Statutes,section 254A.03 which creates an alcohol and other drug abuse section in the department of human services and directs the Commissioner to establish by rule, the criteria for chemical use assessment and for determining the appropriate level of chemical dependency care for each recipient. (See Minnesota Rules, parts 9530.6600 to 9530.6655 (Rule 25).

It is also necessary and reasonable to require that all MA and GAMC chemical dependency treatment be paid through the Consolidated Chemical Dependency Treatment Fund (CCDTF). Minnesota Statutes, section 254B.03 subdivision 5 gives the Commissioner authority to promulgate rules to operate the Chemical Dependency fund and Minnesota Rules, parts 9530.7000 to 9530.7030 (Rule 24) govern payments for chemical dependency treatment. Part

Subp.3. Admitting physician responsibilities. It is necessary and reasonable to delete this reference due to the implementation of the Consolidated Chemical Dependency Treatment Fund (refer to SNR part 9505.0520, subpart 2, item C).

Subp.3, item B, subitem 6. It is necessary to amend this subitem to clarify and emphasize that a readmission includes the situation in which a recipient is transferred directly to a different hospital (Refer to SNR for part 9505.0500, subpart 29).

It is reasonable that the admitting physician provide this information to the medical review agent upon request for admission certification as it is important for the medical review agent and the Department to collect data to identify patterns of readmission which may signal inappropriate care.

Subp.3, item B, subitem 8. The Medical Review Agent is authorized by the department to determine the medical appropriateness of a surgical procedure requiring a second surgical opinion. This amendment is necessary because it clarifies that the admitting physician also has to provide information regarding the appropriateness of a surgical procedure if the information provided in subitems 1 to 7 is insufficient for the medical review agent to determine whether the surgical procedure is medically appropriate or not. It is reasonable because the medical review agent should have the authority to request more information in order to make a fully informed decision about the medical appropriateness of a surgical procedure. Adoption of this amendment will require the deletion of the phrase "a second surgical opinion and" from item C, subitem (3).

Subp.3, item B, subitem 9. There are certain situations outlined in the associated medical assistance rule, part 9505.5040, when surgical procedures are exempt from the requirement of a second opinion. This provision is necessary to inform admitting physicians that if they claim exemption from the second surgical opinion, then they will have to provide the medical review agent with the information necessary to prove that the surgical procedure meets the criteria for exemption. This provision is reasonable because the medical review agent should be provided with the information necessary to make the determination of whether the surgical procedure is in fact exempt from a second opinion, and thus avoid unnecessary payments.

Subp.3, item C, subitems 4 and 5. Subpart 1 of the proposed amendment of part 9505.5090 provides that if the medical review agent denies a surgical procedure requiring a second surgical opinion but a third physician agrees with the admitting physician that such procedure is medically appropriate, then the medical review agent will issue an authorization number. It is necessary and reasonable that the admitting physician should be responsible for informing the medical review agent that the procedure has been approved by a third physician because the admitting physician or the physician who offers to provide the surgical procedure is responsible under part 9505.5055 to obtain the opinion of the third physician and will be reimbursed for the surgery if the medical review agent issues a certification number.

Subp.3, item E. This provision refers to the verification provided by the admitting physician to the hospital that the surgical procedure requiring a second surgical opinion has been approved by a third physician. The approval of a third physician is obtained on a form required by the department. It is necessary and reasonable that the

admitting physician should provide information to the hospital because under subpart 4 item D, the hospital is responsible for submitting the documentation to the medical review agent.

Subp.3, item F. It is necessary to amend this item to make the billing procedures for second surgical opinion consistent with those for inpatient hospital services. The amendment is reasonable because it is less cumbersome to enter authorization numbers on invoices rather than to attach separate authorization forms as is done at present.

Subp.4, item A. It is necessary and reasonable to delete this language due to the implementation of Consolidated Chemical Dependency Treatment Fund (refer to SNR part 9505.0520, subpart 2, item C).

It is also necessary to inform providers that in the case of a surgical procedure requiring a second surgical opinion, the hospital shall obtain an authorization number. This is reasonable because the issuance of the authorization number reassures the department that the surgical procedure is medically appropriate and it assures providers that they will be paid for the surgical procedure performed by them. It is also reasonable because the hospital is required to obtain an authorization number in order to be reimbursed for surgical services provided under rule parts 9505.5000 to 9505.5105 (Rule 68).

Subp.4, item B, subitems 1, 2 and 3. It is necessary and reasonable to delete "In an emergency admission" and replace it with "event" due to the inclusion of second surgical opinion and certain pregnancy situations as subitems which refer to situations other than emergencies. It is necessary to inform the provider of time restrictions for contacting the medical review agent to obtain a retroactive certification or authorization number for an emergency admission, surgical procedure which requires a second surgical opinion, and obstetric (relating to pregnancy and ante partum) admissions without delivery.

Forty-eight hours from the time of admission is a reasonable amount of time in which to require the provider to contact the medical review agent to obtain a certification number for an emergency admission, or an authorization number for a procedure requiring a second surgical opinion. This is the time frame in force at present and it has proved to be workable. Seventy-two hours from the time of admission is a reasonable amount of time to require the provider to contact the medical review agent and obtain a certification number for an obstetrics (relating to pregnancy and ante partum) admission that does not result in a delivery within 24 hours of admission. The 72 hours begins at the time of the recipient's admission, therefore, the provider has 48 hours to contact the medical review agent after the first 24 hours of the admission have elapsed without delivery.

Subp.4, item C. It is necessary to amend this provision to inform the hospital that it has to enter the prior authorization number and the second surgical opinion authorization number on all invoices to be eligible for payment of MA and GAMC funds. The amendment is reasonable because it makes the admission certification process easier and less cumbersome.

Subp.4, item D. This provision informs the hospital of the time frame within which it must submit a verification of approval of the surgical procedure by a third physician. It is necessary and reasonable because the medical review agent must be sure that approval has been obtained before issuing a certification number. The time frame is reasonable because twenty days is sufficient time for the hospital to contact the admitting physician and obtain the verification.

Subp.6, item B. Medical review agent responsibilities This amendment is necessary because it clarifies that the medical review agent's authority extends to the determination of medical appropriateness of a surgical procedure requiring a second surgical opinion. It is reasonable because the commissioner has been directed to establish methods and standards for determining inappropriate utilization of MA and GAMC services by Minnesota Statutes, section 256B.04,subdivisions 2 and 15 and section 256D.03 subdivision 7(b). The commissioner is also authorized by Health Care Financing Administration to contract out its authority to make the determination. (See section 1902(d) Social Security Act (42 U S C); 42 C F R 433.15; and 42 CFR 456.1 to 456.145).

The medical review agent ensures that the care that recipients receive is medically necessary, appropriate, and of a quality that meets professionally recognized standards of care.

Subp.6, item D. It is necessary and reasonable to send a notice by certified letter because the date of receipt of notice is required to set the time frame in which the admitting physician, hospital or recipient must ask for reconsideration or appeal. The medical review agent should inform the recipient of the determination because the recipient is the affected party and has a right to appeal the decision.

Subp.6, item E. It is necessary to inform providers and recipients that, in the case of surgical procedures requiring a second surgical opinion, the medical review agent will also determine whether the surgical procedure was medically appropriate. This is reasonable because it is consistent with the responsibilities of the department and the medical review agent under parts 9505.5000 to 9505.5105, which govern second surgical opinions. Since the medical review agent already has the responsibility to determine the medical necessity of the admission of retroactively eligible recipients, this amendment will ensure that procedures for admission certification and second surgical opinion cases are similar, and will reduce costs and minimize confusion.

Subp.6, item F. It is necessary to clarify all duties and responsibilities of the medical review agent in the admission certification process. This item specifies that the medical review agent may use several methods of medical record reviews depending on the circumstances of the case and the point at which it is reviewed. It is reasonable that the review process be performed by the medical review agent as a logical extension of the certification process. Concurrent and continued stay reviews ensure continued medical necessity of a hospitalization. Retrospective reviews verify medical appropriateness of surgical procedures, and medical necessity of admissions and of services provided.

Subp.6, item G. This amendment informs providers, recipients, and the medical review agent that the medical review agent has the responsibility to provide for a reconsideration of the determination that surgical procedures for which a provider requested exemption under part 9505.5040, items B, C, or F (emergencies, incidental surgeries, or surgeries provided before the recipient applied for MA/GAMC benefits), were not entitled to an exemption or were not medically appropriate. It is necessary and reasonable to provide for a reconsideration in such situations because the determination is often a medical decision and should be evaluated by independant physician advisers before the provider is denied reimbursement. This amendment is also reasonable because the provider has already performed the surgical procedure and should be allowed another opportunity to explain the case before reimbursement is denied.

Subp.6, item J. It is necessary and reasonable to provide that the medical review agent shall mail a certified letter because a certified letter sets the time frame within which the provider must request reconsideration or file an appeal.

Subp.6, item K. It is necessary and reasonable to delete this language and responsibility due to the implementation of Consolidated Chemical Dependency Treatment Fund (refer to SNR part 9505.0520, subpart 2, item C).

Subp.6, item L. It is necessary and reasonable to add the diagnostic category validation process to the duties and responsibilities of the medical review agent, because that is one of the functions performed by the medical review agent. It is necessary for the Department to take actions to ensure that payment is made for the correct diagnostic categories. It is reasonable for the medical review agent to compare the hospital medical record with the inpatient hospital billing form to ensure accuracy in billing.

Subp.6, item M. This provision is necessary and reasonable because it clarifies that the responsibilities and duties of the medical review agent are not necessarily limited to those listed in subpart 6. The contract between the Department and the medical review agent may include other responsibilities and duties mutually agreed upon by the parties. This provision is consistent with section 1902(d) of the Social Security Act; 42 C.F.R.433.15; and 42 C.F.R 456.1 to 456.145 which give the department the authority to contract out its responsibilities to the medical review agent. It is also more efficient and cost effective for the department to delegate the medical review functions rather than to develop the necessary expertise and technology required for an effective review.

Subp.8, items A and B. Procedure for admission certification or authorization of surgical procedure requiring a second surgical opinion. This subpart describes the procedure to be followed by the medical review agent for issuing a certification or an authorization number. It is necessary to inform providers, recipients and the medical review agent of the relevant procedures, and to specify the differences and similarities between the procedures for obtaining the certification number and those for obtaining the authorization number in order to inform affected parties and avoid confusion.

It is necessary and reasonable that as far as practical, the procedures for issuing a certification and an authorization number should be combined, so that a provider calling to obtain a certification number can, simultaneously, obtain an authorization number. This makes the system more efficient and cost effective, and eliminates much of the confusion which results from having separate procedures.

The amendment clarifies that the clinical evaluator shall determine whether the surgical procedure is medically appropriate or meets the criteria for exemption from the second surgical opinion. If one of the two conditions exists, the medical review agent shall issue the authorization number. This provision is necessary and reasonable because if the surgical procedure falls within the list of elective surgeries published under Minnesota Statutes, section 256B.02 subdivision 8, then it requires a second surgical opinion prior to reimbursement. Part 9505.5040 (promulgated under authority from Minnesota Statutes, section 256B.04 subdivisions 2 and 15) enumerates a list of circumstances in which the surgical procedure can get an exemption from the second surgical opinion requirement. The medical review agent has the authority and the necessary expertise to make the determination of medical appropriateness and exemptions.

Subp.8, item C. Item C specifies the procedure to be followed by the medical review agent if the clinical evaluator determines that a procedure does not meet the criteria for exemption under part 9505.5040. If the clinical evaluator determines that the surgical procedure has not been approved for reimbursement by Medicare, or that obtaining a second opinion does not require travel outside the local trade area, or that the recipient does not have good cause for not obtaining the second opinion, then the medical review agent shall notify the physician by phone, and also notify the admitting physician and the recipient by mail within twenty days of the determination.

It is necessary and reasonable to inform the admitting physician by phone and by mail, because if the exemption is denied, there will be no reimbursement for services provided. Timely notification will ensure that the admitting physician does not incur financial responsibility. Twenty days gives the medical review agent sufficient time to study the medical record without producing undue delay for the recipient. This is the time frame being used at present and it has proved to be workable.

If the provider requests exemption on the grounds of emergency or incidental surgery, then the provider is required to submit all relevant information (specified in subpart 3) to the medical review agent within forty eight hours of the incident. This provision is necessary and reasonable for the reasons explained in subpart 4 item B. If the provider requests exemption on the ground that the recipient had not applied for MA or GAMC when the surgical procedure was performed, then the provider may be required to submit the medical record of the recipient to the medical review agent within thirty days of the request.

This provision is reasonable because if the recipient is retroactively eligible for MA then the provider will be eligible for reimbursement. But the medical review agent still has a duty to ensure that the recipient was eligible for MA/GAMC at the time of surgery and that the surgical procedure was medically appropriate, before the department reimburses the provider. This determination can be made only if the medical record is provided to the medical review agent within a reasonable time. This requirement is consistent with the requirement for admission certification, provided in subpart 5.

If the medical review agent determines that the surgical procedure is not entitled to an exemption on any of the grounds mentioned above, or that the surgical procedure is not medically appropriate, the medical review agent shall deny the authorization number and notify by certified mail, within twenty days, the admitting physician and hospital of the denial and of their right to request reconsideration or to appeal.

This provision is necessary and reasonable because these exemptions are obtained after the surgery has been performed, and providers have to be notified that they will not be reimbursed for services delivered. It is reasonable to give providers an opportunity to prove their case in a reconsideration and to inform them of their right to appeal, because they have already incurred an expense for which they seek reimbursement. It is also reasonable that the notice be by certified mail because the date of receipt of notice is required to set the time frame within which the provider must ask for reconsideration or appeal. For reasons stated above, twenty days is a reasonable amount of time for the medical review agent to make the determination and send the notice.

Subp.8, items D and E. If the clinical evaluator is unable to determine that the surgical procedure is medically appropriate, the evaluator shall contact a physician adviser. This is both necessary and reasonable, because the clinical evaluator can be a registered nurse or a licensed physician who may not be a specialist in the area of diagnosis of the patient.

A determination that a surgical procedure is medically appropriate should be made only by a person who has expertise in the area of the recipient's diagnosis, or a related area. Therefore if the clinical evaluator is unable to make the determination, the request should be referred to a physician adviser, who by definition has the expertise necessary to make a determination regarding medical appropriateness. If the physician adviser believes that the surgical procedure is medically appropriate, it is necessary and reasonable for the medical review agent to issue an authorization number. This procedure is consistent with the procedure for obtaining an admission certification.

Subp.8, item F. This amendment informs recipients, providers, and the medical review agent of the procedure to be followed if the physician adviser is unable to determine that the surgical procedure is medically appropriate. This amendment is necessary because the process for obtaining an authorization number after the medical review agent's denial is different from the process used for the certification number.

If the physician adviser is unable to determine that the surgical procedure is medically appropriate, the medical review agent shall inform the admitting physician that the recipient may obtain the opinion of a third physician, as provided under the second surgical opinion rule (Rule 68). The third opinion in the case of surgical procedures is more comprehensive than the admission certification procedure. Under the admission certification process the second physician adviser reviews the same documentation provided by the admitting physician. Under the authorization process the recipient can have a face to face third opinion by a physician of the recipient's choice. This is reasonable because under the certification process the recipient is not denied the medical service - only the inpatient hospital environment. In the authorization process, the recipient is denied the surgical service. Therefore the recipient should have a more comprehensive review even at the third opinion stage.

Subp.8, item G. It is necessary to clarify that it is the admitting physician's responsibility to request admission certification, and this includes the responsibility to request a second physician adviser's opinion if the first physician adviser is unable to determine that the admission is medically necessary. If the admitting physician does not request a second physician adviser's opinion, the medical review agent shall deny the admission certification.

This is reasonable because the admitting physician is expected to know the procedures established by the department and to request a second physician adviser's opinion if it is needed. This is also reasonable because it is the admitting physician who will be reimbursed for services provided, and therefore, should be held responsible for following the procedures required for reimbursement. It is reasonable for the medical review agent to notify the recipient of the denial because the recipient will be denied inpatient hospital services because of this decision. It is also reasonable to notify the admitting physician and the hospital of the denial, because they will be denied admission certification if they do not take any further steps.

It is necessary and reasonable to clarify that the request for a second physician adviser's opinion pertains to a determination of medical necessity and whether an admission certification number should be issued, and not to the medical appropriateness of a surgical procedure.

Subp.8, item I. The amendment provides for a written notification of the denial to the admitting physician, the hospital and the recipient. It is necesssary that all affected parties be informed of the procedures to be followed and their recourse against the decision. It is reasonable to provide appeal for the recipient because Minnesota Statutes, section 256.045 requires it. It is reasonable that the notice to the admitting physician and the hospital inform them of their right to request reconsideration because they are directly affected by the denial of inpatient certification and should know that they have an opportunity to prove their case to the department.

Subp.9. Reconsideration. This amendment is necessary and reasonable as it clarifies that the medical review agent will also provide for a reconsideration of denial of an authorization number under some

circumstances (Refer to SNR of Subp.8, item C). It also clarifies the process and time frame of requesting a reconsideration. It is reasonable that the request for reconsideration should include the medical record and that the provider should have the option to submit additional information because that record and documentation will be the basis of the reconsideration decision by the medical review agent.

It is intended that the medical review agent will begin the reconsideration process upon receipt of the request and medical record. No further information will be accepted after that time except at the request of the medical review agent. In addition, it is reasonable and necessary that the reconsideration process be completed within 45 days of the receipt of the request and medical record with the final determination made by the majority of physicians involved in the reconsideration.

The change in time frame was selected in conjunction with the suggestions of the advisory committee, appointed for development of this rule. The change in days is to accommodate rescheduling due to medical emergencies and a review of the written determination by each physician involved in the reconsideration before the Medical Review agent notifies the provider. It is necessary to clarify that the reconsideration process will include three physician advisors. It is reasonable that a majority consensus will determine the outcome because it is possible to have different views on the same medical record.

It is necessary to inform affected parties and is reasonable that providers take advantage of established appeal processes when there is a denial of medical necessity. It is necessary to clarify providers' options to have a case reassessed if the certification number has been denied or withdrawn. The provider has the option of a medical review provided by the reconsideration process, or a contested case hearing provided by Minnesota Statutes, chapter 14. The provider is required to request a reconsideration or a chapter 14 contested case hearing within 30 days of written notification. If the provider allows the time to lapse without requesting a reconsideration or an appeal of denial or withdrawal of certification, the provider has relinquished those options.

It is reasonable that the two processes be available within an established time frame in order to ensure timely and meaningful review. If a provider requests a reconsideration within the required time and disagrees with the outcome, that provider may appeal through a chapter 14 contested case hearing if requested within 30 days of reconsideration notification. However, if the provider allows the 30 days to elapse without request, the provider has relinquished the option to appeal. The time limit is reasonable because it is consistent with Minnesota Statutes, section 256.045 sub 7 (1987).

Subp.9a. Retention or withdrawal of certification number. This section sets forth the situations that are subject to a retention or withdrawal of a certification number and the appeal process that is available. It is necessary and reasonable to inform affected parties of the process pertaining to readmissions or transfers and to allow a reconsideration or appeal in case of disagreement.

Subp.10, items A to E. Medical record review and determination. It is necessary and reasonable to clarify the role of the medical review agent under contract with the Department. These items specify that the review agent will validate the diagnostic category as part of the medical record review and will supply the Department with the necessary information to adjust the reimbursement as applicable (refer to SNR part 9505.0520, subpart 6, item L).

In addition, it is necessary and reasonable to inform the providers of a denial determination and of their right to appeal (refer to SNR part 9505.0520, subpart 9). Extension of the notice mailing time from 24 hours to five working days was accepted by the advisory committee and by the medical review agent as reasonable because it balances allowing sufficient time to complete a required procedure and the need of the hospital and admitting physician to receive a confirmation of the verbal determination as soon as possible in order to prevent a possible misunderstanding of the decision. The change in time frame is necessary to give extra working days to this procedure in order to accomodate a review of the written determination by the physician who made any of the decisions in subpart D.

Subp.10, item F. The medical review agent has the responsibility, under subpart 6, items B and F, to conduct a retrospective review to determine the medical appropriateness of a surgical procedure and to determine if the surgical procedure is exempt from the second surgical opinion requirement.

It is necessary for an effective retrospective review that the medical review agent should have access to all documentation supporting the opinion of the third physician that the surgical procedure was medically appropriate or that the surgical procedure was exempt from the second surgical opinion requirement. It is reasonable to give the medical review agent the authority to ask the hospital for additional documentation if the medical review agent finds that the medical record is inadequate to justify the opinion of the third or the admitting physician.

It is also necessary and reasonable that the documentation be submitted at the expense of the hospital, because the hospital is responsible for submitting all relevant information to the medical review agent and the hospital will be reimbursed for the surgical procedure if the medical review agent finds that it was medically appropriate, or that the surgical procedure was exempt from a second surgical opinion. Twenty working days is sufficient time for the hospital to comply with the request of the medical review agent. This provision is also reasonable because it is consistent with the provision for retrospective review of admission certification.

Subp.10, item G. This amendment is necessary in order to define and clarify the procedure for medical record review and determination in readmission situations. In order to be eligible for a second admission payment in a readmission situation, the provider must meet the medical necessity criteria for admission of a recipient, and the additional criteria outlined in part 9505.0540 subpart 3.

The payment for readmissions could be affected by the medical review agent's determination of the nature of discharge and readmission according to the criteria in part 9505.0540 subparts 3 to 5.

If the clinical evaluator cannot determine the reasons for a recipient's discharge and readmission according to the criteria in part 9505.0540 subparts 3 to 5, it is necessary to permit another source of determination. It is reasonable that the readmission situation be referred to a physician adviser who has the necessary level of expertise to make the determination. This procedure is reasonable because it is currently being utilized for determination of medical necessity and is being expanded to include readmission situations.

It is necessary to notify the provider of the determination when there is a discrepency between the provider's determination and that of the medical review agent. It is reasonable that the medical review agent notify the provider of the determination by certified mail, in order to catalog the date on which the provider received the letter and to ensure that the provider received the notification letter. It is reasonable that the provider be notified of the right to have the medical review agent's determination reconsidered or appealed.

Subp.11. Consequences of withdrawal of admission certification or authorization number ; general. It is necessary to amend this subpart to inform providers that the department shall withdraw the certification or the authorization number under certain circumstances, and to make the language consistent with parts 9500.1090 to 9500.1155, which is the reimbursement rule (Rule 54). This amendment also clarifies the medical review agent's role as the Department's authorized representative.

Medical necessity and medical appropriateness are the criteria for use of MA or GAMC funds to pay for inpatient hospital services Therefore it is reasonable not to use MA or GAMC funds for inpatient hospital admissions or services that are neither medically necessary nor medically appropriate. For the same reason, it is also reasonable to withdraw admission certification if the hospital does not submit information necessary to prove that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, that some or all of the inpatient hospital services provided were medically necessary, or that the surgical procedure was medically appropriate.

The medical review agent is responsible for reviewing excess use or inappropriate use of MA services, and if the hospital fails to provide the relevant information, the medical review agent will conclude that the services were not provided in a proper manner. The following provisions specify the consequences of withdrawl of admission certification for a hospital, admitting physician, and other vendors that are involved in providing inpatient services.

Subp.11, item A. This amendment refers to the consequences of withdrawal of admission certification and denial or recovery of payment from hospitals if the admission was not medically necessary or was not documented as medically necessary.

It is necessary to delete language pertaining to the previous payment methodology and reasonable to clarify that the consequences of withdrawal of an admission certification pertains to the current payment system reflected in the hospital reimbursement rule. It is necessary and reasonable to delete the word debited, as a specific subpart has been established for methods of recovery of payment in part 9505.0520, subpart 15. It is reasonable to delete and move specific language as it pertains to the conditions outlined in items B and D.

Subp.11, item B. (Existing Rule) It is necessary to delete language pertaining to a previous payment methodology that reimbursed hospitals on a per diem basis. This amendment is reasonable because it is consistent with the new payment methodology provided in parts 9500.1090 to 9500.1155.

Subp.11, item B (Proposed Amended Rule). It is necessary to amend the rule in order to clarify the consequences for hospitals if additional inpatient hospital services are determined not medically necessary or are not documented to be medically necessary. The medical review agent makes the determination either in a continued stay review, a concurrent stay review, or a retrospective review. If the medical review agent determines that services were or will not be medically necessary, then the department can deny or recover payment under part 9505.0520 subpart 15. If all necessary services were not provided, then the department shall refer the matter to the Surveillance and Utilization Review Section.

It is reasonable for the department to take action and not reimburse a hospital for a portion of an inpatient stay that was not medically necessary. This provision is consistent with Minnesota Statutes, section 256B.04 subd.15 which requires the Commissioner to safeguard against unnecessary or inappropriate use of MA services and against excess payments.

It is necessary and reasonable to refer the matter to the Department's Surveillance and Utilization Review Section to determine whether payment previously made should be recovered in part or in whole, or whether other actions should be taken. Such actions are authorized by Minnesota Statutes, section 256B.064 (1982) and Minnesota Rules, parts 9505.1705 to 9505.2150 (1983). It is also reasonable and necessary for the matter to be referred to the Surveillance and Utilization Review Section (SURS) of the Department if the hospital failed to provide all medically necessary services prior to discharging the recipient, because SURS has responsibility to investigate the circumstances of why a provider failed to provide services for which payment was made.

Subp.11, item C (Proposed Amended Rule). It is necessary to amend the rule in order to clarify that when an admission was not medically necessary, the determination will result in withdrawal of all MA or GAMC funds including payment to admitting physicians and other vendors of inpatient hospital services.

This amendment is reasonable because the admission should never have taken place, and services performed after the admission, by the admitting physician and other vendors, were not medically necessary either. It is reasonable and necessary for the matter to be referred to the Surveillance

and Utilization Review Section of the Department, (SURS) if the admitting physician and other vendors failed to provide all medically necessary services prior to discharging the recipient, because SURS has responsibility to investigate the circumstances of why a provider failed to provide services for which payment was made. This amendment is consistent with the purpose of Minnesota Statutes, section 256B.04 subd.15 which requires the Commissioner to safeguard against unnecessary or inappropriate use of MA services.

Subp.11, item D (Proposed Amended Rules). The amendment is necessary to clarify the consequences to admitting physicians and other vendors of services, for additional inpatient hospital services that are found not medically necessary. It is reasonable that payment be denied or recovered from a physician and other vendors for these additional services.

It is necessary and reasonable to refer the matter to the Department's Surveillance and Utilization Review Section (SURS) to determine whether payment previously made should be recovered in part or in whole, whether other actions should be taken. Such actions are authorized by Minnesota Statutes, section 256B.064 (1982) and Minnesota Rules, parts 9505.1750 to 9505.2150 (1983). It is also reasonable and necessary for the matter to be referred to SURS if the admitting physician and other vendors failed to provide all medically necessary services prior to discharging the recipient, because SURS has responsibility to investigate the circumstances of why a provider failed to provide services for which payment was made.

Subp.11, item E. It is necessary to delete the existing rule because that provision has been moved to item D of this subpart.

The medical review agent can ask the hospital to submit the recipient's medical record or any other information which will enable the medical review agent to make an effective determination of the medical necessity of the services provided. If the hospital fails to comply with the medical review agent's request to submit documentation, or if the information submitted by the hospital was insufficient to prove the medical necessity of the services provided, the medical review agent will deny all or part of the payment.

It is reasonable that the department or the medical review agent have the authority to request copies of the medical record and other information to substantiate the medical necessity of an MA or GAMC admission, because these records and information provide evidence of the facts. In some cases rule procedures require review of medical records and other information by personnel other than the clinical evaluator (See 9505.0520, subp.10, Medical record review). In these circumstances it is necessary to request that a copy of the medical record be mailed or taken out of the hospital because it is not geographically or financially feasible for the department personnel, medical review agent, or physicians to review them at the hospital.

It is necessary for the department, the medical review agent, and the physician to have complete information regarding a case in order to make an informed decision. It is reasonable that, if adequate information is not

submitted and an informed decision cannot be made, the department will conclude that there has been inappropriate utilization of services and shall deny all or part of the payment.

It is necessary and reasonable to request that the records be sent within twenty working days, because timeliness in making the decisions of medical necessity and utilization is important to both the department and the provider. Twenty days is sufficient time for the hospital to copy and mail the requested information, and is consistent with the time provided to hospitals for providing medical records in other similar situations.

Subp.11, item F. The amendment refers to situations when the medical review agent reviews all the relevant documents and determines that the surgical procedure was not medically appropriate or that the surgical opinion was not entitled to an exemption from a second surgical opinion. The amendment also covers situations where the hospital affirms that a third physician has approved the medical appropriateness of the surgical procedure or has approved the exemption, but fails to submit documentation to substantiate the opinion of the third physician. In all such circumstances, payment for the surgical procedure shall be denied or recovered from the hospital, admitting physician or the vendor.

This amendment is necessary because it informs providers of the circumstances in which they can be denied payment for performing surgical procedures. It is reasonable because it is consistent with the purpose of Minnesota Statutes, section 256B.04 subd.15, which directs the commissioner to safeguard against excess payments and against overutilization of MA services. The method of recovery is also reasonable because it is consistent with recovery in other cases of medical necessity provided in items A to D, and is more cost effective.

Subp.12. Reconsideration of denial or withdrawal of admission certification. It is necessary and reasonable to provide an alternative to the Chapter 14 contested case hearing conducted by an administrative law judge. The Department has developed the reconsideration process set forth in 9505.0520, subpart 9 for reviewing denials and withdrawals of certification because it is a more efficient and timely process for the provider and the Department.

Subp.15. Recovery of payment after withdrawal of admission certification or denial of authorization of second surgical procedure opinion. This amendment is necessary and reasonable in order to clarify the Department's policy for recovery and adjustments to overpayments to providers. The amendment is reasonable because a notice that certification is withdrawn or that a surgical procedure authorization is denied is sufficient indication that, if a reconsideration or chapter 14 appeal is not requested within the time limits, the department shall recover payment. It is administratively burdensome for the Department to send another notice restating that it will recover payment when a reconsideration or an appeal is not requested. Similarly, the letter notifying the provider that the reconsideration or appeal has upheld the withdrawal or denial is sufficient notice that payment will be adjusted.

It is necessary to inform the providers of the methods that the Department will use for recovery and adjustment. The methods that may be used to adjust overpayments are : direct adjustments to incorrect invoices, adjustments to other invoices, or by request for corrected invoices. These methods are reasonable because they are normal business operating procedures. The amendment states that the Department is not limited to these methods, but may take any other remedy in accordance with state and federal rules if circumstances require.

Part 9505.0521. PROHIBITION OF RECOVERY FROM RECIPIENT.

It is necessary to inform providers that they cannot seek part or full payment from the recipient if the reimbursement has been denied by the department. This is reasonable because it is consistent with the code of federal regulations (42 C.F.R. 447.15) which says that providers must accept State payment as payment in full. This provision is also reasonable because providers are expected to provide only medically necessary services, and to follow the procedures established by the department. To allow recovery in situations where the services were not medically necessary or medically appropriate, would result in undue burden on the recipient.

Part 9505.0522. RECIPIENT'S RIGHT TO APPEAL.

It is necessary to inform the recipient that he or she has the right to appeal the decision of the medical review agent to deny him or her treatment in an inpatient hospital setting because it was not deemed medically necessary, or medically appropriate. It is reasonable to allow the recipient to appeal because the denial of inpatient hospital services directly affects the recipient. This amendment is consistent with Minnesota Statutes section 256.045.

Part 9505.0530. INCORPORATION BY REFERENCE OF CRITERIA TO DETERMINE MEDICAL NECESSITY.

It is necessary and reasonable to inform affected parties of the change in address for the request of the most recent copy of the Appropriateness of Evaluation Protocol criteria.

Part 9505.0540. CRITERIA TO DETERMINE MEDICAL NECESSITY OR APPROPRIATENESS.

Subp.1. Determination for admission for purpose other than chemical dependency treatment. This amendment is necessary because it informs affected parties of the criteria which the medical review agent will follow in determining the medical appropriateness of a surgical procedure. It is reasonable because Minnesota Statutes section 256B.02 subd.8 paragraphs (a),(d) and (y) direct the Commissioner to publish the criteria used for determining medical appropriateness in the State Register.

Subp.2. Determination for admission for chemical dependency treatment. It is necessary and reasonable to delete this language due to the implementation of Consolidated Chemical Dependency Treatment Fund (refer to SNR part 9505.0520, subpart 2, item C).

Subp.3 to 6. Readmissions. The readmissions criteria were developed by a special task force composed of hospital utilization review professionals, the medical review agent and the Department. Under the present payment system the provider is reimbursed through a predetermined rate for each admission. This per admission prospective payment system creates the incentive for hospitals to discharge and readmit patients, thereby collecting additional payments. However, hospitals should be financially indifferent to discharging and readmitting recipients because these are medical decisions.

The readmission criteria differentiate between readmissions which will be considered as second admissions and for which the provider will be paid separately, readmissions which will be considered as continuous with the first admission and for which the provider will be eligible only for one DRG payment, and readmissions which will be considered as transfers and for which the provider will be eligible for a transfer payment. The readmission criteria will function as safeguards against unnecessary or inappropriate use of medical assistance services, excess payments and underutilization such as fragmented care and premature discharge as required by Minnesota Statutes, section 256B.04, subdivision 15.

The readmissions criteria do not determine medical necessity, instead they apply after medical necessity has been established and a recipient is found to have been readmitted within 15 days of discharge from a prior hospitalization. The readmission criteria are also necessary to clarify and provide notice to hospitals and physicians of the Department's procedures for handling readmission situations.

All readmission situations will be determined by the hospital, and be retrospectively reviewed by the medical review agent through procedures set forth in part 9525.0520, subpart 10. The readmission criteria are designed to encompass all circumstances that may arise in readmission situations and to serve as a screen to eliminate as many cases as possible from physician review which is costly and time consuming.

If the clinical evaluator who initially reviews the medical records cannot make a determination, a physician adviser will be consulted. The medical review agent will apply the readmissions criteria set forth in part 9505.0540 subparts 3 to 6, to information contained in the medical records for both admissions to make the determination. It is reasonable to use the medical records of the admissions because they are legal documents which record all information pertinent to a hospitalization. It is imperative, and clearly stated in the amendment, that the medical records state why a recipient was discharged from the hospital, why that recipient was readmitted, and what the recipient's medical status was at these times. Information not contained in the medical record may be used at the discretion of the Department.

Subp.3. Readmission considered as a second admission. This subpart is necessary and reasonable in order to establish criteria for readmissions that will be counted as two separate admissions, will retain both certification numbers and will be eligible for two DRG payments. It addresses readmissions to the same and different hospitals. This section explains that the medical records for the admission and readmission, as

determined by the hospital, will be retrospectively reviewed by the medical review agent to establish, according to Items A to D, that the admission and readmission are indeed two separate admissions.

This provision is necessary and reasonable because the medical review agent should have the authority to determine that the department is billed correctly and that hospitals have provided proper care to recipients. This section explains that the retrospective review procedure outlined in part 9505.0520, subpart 10 will be utilized. Hospitals will retain certification numbers for readmissions, as determined by these items, as long as they comply with the requirements in parts 9505.0520 to 9505.0540 (Rule 48).

Subp.3, item A. It is necessary and reasonable that the admission and readmission be considered as two separate admissions when the reason for the readmission resulted from actions taken by the recipient to leave the hospital against the medical advice (AMA) of the physician at the previous admission. When the physician advises the recipient that continued treatment is medically necessary, and the recipient refuses to adhere to that advice and chooses to leave the hospital, it is beyond the hospital's control to provide any further services to that recipient. The discharge status of the recipient must be clearly documented in the medical record of the first admission.

Subp.3, item B. It is necessary and reasonable that the admission and readmission be considered as two separate admissions in the event that the recipient is noncompliant with medical advice and the readmission occurs from the noncompliant actions of the recipient. When the recipient refuses to adhere to medical advice regarding care, treatment or follow-up discharge planning, the treatment of the recipient is outside the hospital's control. Examples of noncompliant behavior include: refusal to take medication, refusal to attend clinic appointments, refusal to return for scheduled treatment without notification, or refusal to schedule needed treatment. All medical advice given to the recipient, and any evidence that the recipient was noncompliant must be documented in the medical records.

Subp.3, item C. It is necessary and reasonable that the admission and readmission be considered as two separate admissions when the recipient is suffering from a separate episode of an illness or from a condition that is episodic. An episodic illness, such as asthma, is expected to reoccur but, because of its unpredictable nature, it is difficult to determine when it will reoccur. It is reasonable for a readmission to be considered as a separate admission for another episode of an illness that clearly could not be prevented or treated at the first admission. The medical records must clearly document that the episode was arrested, that the recipient was stable at the time of discharge, that proper education was provided to the recipient (and/or the recipient's family), and that treatment was aggressive and well coordinated.

Subp.3, item D. It is necessary and reasonable that the admission and readmission be considered as two separate admissions when it is appropriate according to prevailing medical standards, practice, and usage to discharge and readmit. Examples include situations when the reason for discharge and

readmission is medical and it is the accepted standard of medical practice to allow a certain period of time between procedures, or when a recipient must be stabilized to recover from a fever or infection before indicated treatment can be provided.

Subp.4. Readmission considered as continuous with admission. This subpart is necessary and reasonable in order to establish criteria for readmissions which occur within 15 days that will be considered as continuous with the first admission and therefore have the certification number for the second admission withdrawn and be eligible for payment of one DRG only. This section refers to readmissions to the same or different hospitals.

It is expected that in the circumstances outlined in items A to C, the hospital will combine both admissions and submit one payment claim to the Department. The admission and readmission will be considered as one admission for the determination of outlier status. It is conceivable that the principal diagnosis for the combined admission will be different than that for the first admission. The medical review agent will review the medical records retrospectively to determine whether the admission and readmission should be combined, and to verify that the hospital submitted only one payment claim.

This section refers to part 9505.0520, subpart 10, as the procedure utilized for retrospective reviews. The admission and readmission will be combined under one certification number, as determined in Items A to C, as long as requirements of parts 9505.0520 to 9505.0540 (Rule 48) are met.

Subp.4, item A. It is necessary and reasonable to combine both admissions in the event that the readmission resulted from the inability of the hospital or physician to provide medically necessary treatment because of hospital or physician preference or scheduling conflict. The care provided during the readmission is care that should or could have been provided during the first admission. Therefore, the readmission is to be considered as a continuation of the first admission. Scheduling is an internal hospital management issue and it is the responsibility of the hospital and physician to schedule tests and subsequent surgery in a manner that is appropriate. The Department is indifferent to scheduling conflicts as long as the admission and readmission are managed in such a way that prevailing medical standards practice and usage are followed.

Subp.4, item B. It is necessary and reasonable to combine an admission and readmission to the same hospital, or withdraw the certification for the first admission, when readmission to a different hospital occurs because the discharge and readmission resulted from inappropriate medical standards, practice and usage. A readmission to the same hospital should be combined with the first admission allowing the hospital to provide all medically necessary services. The certification number given to the first hospital when a readmission to a different hospital occurs will be withdrawn because the first hospital did not provide appropriate care. The potential compromise in the quality of care provided to the recipient in these situations is not condoned, and will be referred to the proper authority.

Subp.4, item C. It is necessary and reasonable to combine an admission and readmission to the same hospital when the recipient exercises the option to delay inpatient hospital services and this choice is compatible with prevailing medical standards, practice, and usage. Examples of recipient preference include choosing to delay treatment in order to make arrangements for work or child care, or choosing to delay treatment until a preferred physician is available. In situations of recipient preference, the recipient is planning to return for treatment in a reasonable amount of time as determined by the recipient and physician. Therefore it is reasonable that the hospital continues treatment that could have been provided during the first admission and duplicative diagnostic measures and treatment are not necessary.

Subp.5. Readmission eligible for transfer payment. This subpart is necessary and reasonable in order to establish criteria for admissions and readmissions that will be considered eligible for a transfer payment. The transfer payment is defined in part 9500.1130, subpart 7, item A, and basically states that a hospital will be reimbursed on a per diem basis instead of a per admission basis if the recipient is moved directly to another hospital after admission to one hospital. Both hospitals will retain their certification numbers.

It is reasonable that when there is an admission and readmission to different hospitals under the circumstances described in Items A to C, both hospitals should be reimbursed in this manner because they have, essentially, apportioned the treatment of the recipient. Because not all medically necessary treatment was provided during the first admission the first hospital should not receive a full per admission payment. However, because the first hospital, in good faith, provided some medically necessary treatment it should be reimbursed for services rendered. Hospitals will retain certification numbers for admissions and readmissions, as determined in Items A to C, as long as they comply with the requirements stipulated in parts 9505.0520 to 9505.0540 (Rule 48).

Subp.5, item A. This item states that if the recipient exercises the option to delay or change location of inpatient hospital services and this choice is compatible with prevailing medical standards, practice, and usage, then the admission and subsequent readmission to a different hospital will be reimbursed with a transfer payment.

This is reasonable and necessary because if the recipient voluntarily chooses to be admitted to a new hospital then the decision is out of the admitting hospital's control, and it should be paid for medically necessary services that it provided. At the same time the readmitting hospital provides the remaining medically necessary services and so payment should be apportioned between the two hospitals. Examples of recipient preference include the recipient choosing to have a procedure or surgery at a hospital that specializes in that procedure or surgery, or choosing to move to hospital that is closer to the recipient's home or family. In situations of recipient preference, the recipient is planning to undergo the necessary treatment in a reasonable amount of time as agreed upon by the recipient and physician.

Subp.5, item B. It is necessary and reasonable to reimburse an admission and readmission to a different hospital with a transfer payment when the recipient is referred to a different hospital because the recipient's medically necessary treatment is outside the scope of the first hospital's available services. When a hospital admits a recipient and subsequently discovers that medically necessary treatment is out of the scope of its services, the hospital should refer the recipient to another hospital. The result will be that the second hospital will provide a portion of the necessary service. However, because the hospital has provided some but not all of the medically necessary care, it is reasonable to reimburse that hospital on a per diem basis (transfer payment). Because some of the medically necessary services were provided by the first hospital, the hospital of the readmission will also be reimbursed on a per diem basis (transfer payment).

The amendment stipulates, however, that if a hospital admits a recipient knowing that all of the medically necessary services cannot be provided the certification number for that admission will be withdrawn, except in emergency situations. This is reasonable because in emergencies it is more important to admit recipients and provide immediate care even though the hospital is aware that all medically necessary services are not available. However if there is no emergency and the hospital knows it cannot provide all medically necessary services, then it has a duty to refer the recipient to another hospital and it should not be paid for wrongful admissions.

Subp.5, item C. It is necessary and reasonable to reimburse both an admission and readmission of the same recipient to different hospitals with a transfer payment when the readmission resulted because of a delay in medically necessary treatment due to a hospital or physician scheduling conflict or preference occurring during the first admission. The first hospital will receive a prorated payment because not all medically necessary treatment was provided for the recipient during that admission. When, in good faith, the first hospital reschedules treatment which falls within the parameters of prevailing medical standards and practice, but the recipient chooses to have treatment at another hospital, both hospitals will receive a transfer payment. It is reasonable for the second hospital to receive a transfer payment because it is continuing the care provided during the first hospital stay.

Subp.6. Physician adviser's review of readmission. This subpart is necessary because it addresses readmission situations that require the additional expertise of a physician adviser. It is reasonable that a physician adviser review admission situations because the physician has the knowledge necessary to review the situation and furthermore, physician review is an activity currently employed by the medical review agent and the Department when situations of medical necessity, underutilization, and overutilization cannot be determined by the clinical evaluator. It is reasonable that a physician adviser also review readmission situations when the clinical evaluator cannot make a determination, because the physician adviser has the additional expertise to do so.

SRF/DM

The Department will not present expert witnesses to testify concerning the provisions of these proposed rules on behalf of the department.

September 7 , 1988

Julie Brunner

SANDRA GARDEBRING, Commissioner
Department of Human Services

SRF/DM

Appendix A

MEMBERS OF RULE 48 AMENDMENTS ADVISORY COMMITTEE

Bob Elkema
Minnesota Medical Association
Suite 400
2221 University Ave. SE
Minneapolis, MN 55414
#378-1875

Sue Grimmius
Medical Records/Utilization Review
Hennepin County Medical Center
701 Park Ave.
Minneapolis, MN 55415
#347-2647

James Koppel
Vice President, Operations and Policy
Council of Hospital Corporations
2550 University Ave. West
St. Paul, MN 55114
#641-1121

Maxine McNamara
Chairperson
Twin City Utilization Review Coordinators
Quality Assurance/Medical Records
Mount Sinai Hospital
2215 Park Ave.
Minneapolis, MN 55404
#871-3700, beeper 164

Linda Roe
Manager, Patient Care Coordination Dept.
Blue Cross/Blue Shield of MN
P.O. Box 64560
St. Paul, MN 55164
#456-8437

Vern Silvernale
Vice President, Health Care Finance
Minnesota Hospital Association
2221 University Ave. SE
Minneapolis, MN 55414
#331-5571

Sue Wedman
North Memorial Hospital
3300 Oakdale North
Robbinsdale, MN 55422
#520-5048

Appendix B.

MEMBERS OF READMISSION TASK FORCE

Vicki Anderson
UR Coordinator
St. Paul Ramsey Medical Center
640 Jackson St.
St. Paul, MN 55101
#221-5670

Becky Enos
Vice President
St. Paul Ramsey Medical Center
640 Jackson St.
St. Paul, MN 55101
#221-2188

Therese Froehle
Director of Customer Services
St. Joseph's Medical Center
523 North Third Street
Brainerd, MN 56401
#(218) 829-2861 ext.1150

Sue Grimmius
Medical Records/Utilization Review
Hennepin County Medical Center
701 Park Ave.
Minneapolis, MN 55415
#347-2647

Joe Heidkamp
St. Paul Ramsey Medical Center
640 Jackson St.
St. Paul, MN 55101
#221-2083

Susan Klein
Director of Quality Management
Mercy Medical Center
4050 Coon Rapids Boulevard
Coon Rapids, MN 55433-2586
#422-4548

Jim Koppel
Vice President, Operations and Policy
Council of Hospital Corporations
2550 University Ave. West
St. Paul, MN 55114
#641-1121

Peggy McLay
Supervisor of Utilization Review
Rochester Methodist Hospital
201 W. Center Street
Rochester, MN 55902
#(507) 236-7376

Maxine McNamara
Chairperson
Twin City Utilization Review Coordinators
Quality Assurance/Medical Records
Mount Sinai Hospital
2215 Park Ave.
Minneapolis, MN 55404
#871-3700, beeper 164

Mickey Reichenbach
Patient Care Coordination Dept.
Blue Cross/Blue Shield of MN
P.O. Box 64560
St. Paul, MN 55164
#456-8503

Linda Roe
Manager, Patient Care Coordination Dept.
Blue Cross/Blue Shield of MN
P.O. Box 64560
St. Paul, MN 55164
#456-8537

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO DEPARTMENT OF HUMAN SERVICES RULES GOVERNING INPATIENT HOSPITAL ADMISSION CERTIFICATION IN THE MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PROGRAMS

AFFIDAVIT OF MAILING

Nancy Storelee, being first duly sworn, deposes and says:

That on the 28th day of September, 1988, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notices by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid, to all persons and associations who have requested that their names be placed on file with the Department of Human Services for the purpose of receiving notice of hearing by this Department.

Nancy Storelee

Subscribed and sworn to before me

this 28 day of Sept., 1988

Louise J. Breidel

LOUISE J. BREIDEL
NOTARY PUBLIC—MINNESOTA
DAKOTA COUNTY
MY COMM. EXP. SEPT. 22, 1990

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Amendments to Department of Human Services Rules Governing Inpatient Hospital Admission Certification in the Medical Assistance and General Assistance Medical Care Programs, Parts, 9505.0500 to 9505.0540

NOTICE OF HEARING AND NOTICE OF INTENT TO CANCEL HEARING IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO NOTICE OF INTENT TO ADOPT RULES WITHOUT A PUBLIC HEARING

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in Rooms 2A and 2B, Human Services Building, 444 Lafayette Road, St.Paul, Minnesota, 55155, on November 14, 1988 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

PLEASE NOTE, HOWEVER, THAT THE HEARING WILL BE CANCELLED IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO THE NOTICE OF INTENT TO ADOPT THESE SAME RULES WITHOUT A PUBLIC HEARING PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between November 3, 1988 and November 13, 1988 at (612) 297-4997.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Howard Kaibel, Administrative Law Judge, Office of Administrative Hearings, 500 Flour Exchange Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341-7608, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge may at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the

agency is willing t lopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Law Judge will write a report as provided for in Minnesota Statutes, sections 14.15 and 14.50. The rule hearing is governed by Minnesota Statutes, sections 14.14 to 14.20 and by Minnesota Rules, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

Minnesota Rules, Parts 9505.0500 to 9505.0540, establish a system for reviewing the utilization of inpatient hospital services under the Medical Assistance and General Assistance Medical Care programs. These rules are designed to guard against excess payments and to reduce expenditures which result from inappropriate hospitalization of MA and GAMC recipients.

Besides persons receiving MA and GAMC services, this rule affects providers of MA/GAMC services who are responsible for following the procedures specified in the rule, and the medical review agent who is responsible for reviewing the necessity of admissions and the appropriateness of the surgical services provided.

The proposed amendments to these rules remove inconsistencies between this rule and Minnesota Rules, parts 9500.1090 to 9500.1155, which is a related medical assistance and general assistance medical care rule. Parts 9500.1090 to 9500.1155 govern the reimbursement for inpatient hospital services to be provided to Medical Assistance and General Assistance Medical Care recipients, and have to be read in conjunction with the present rule.

The amendments expand the time frame for readmissions and clarify the criteria for a readmission considered as a second admission, a readmission considered as continuous with the first admission, and a readmission considered as a transfer. The amendments also specify procedures to be followed by providers of Medical Assistance and General Assistance Medical Care to be eligible for reimbursement, and incorporate the second surgical opinion process into the admission certification process.

The amended rule contains definitions of terms used in the rule and amends existing definitions. It amends the scope of the rule, exclusions from admission certification requirements, and the time requirements for excluding obstetrical services from admission certification requirements. The rule expands the responsibilities of the admitting physician, the medical review agent and the Department. It specifies the procedures to be followed by providers to obtain the authorization number or certification number. It contains changes to reconsideration procedures, procedures for retention or withdrawal of certification number, and medical record review and determination by the medical review agent.

The amended e contains additional consequ s of withdrawal of admission certification or authorization number, and provides for recovery of payment after withdrawal of admission certification or authorization number. It prohibits recovery from the recipient, provides the recipient with right to appeal if the recipient is denied inpatient hospital services, and provides for physician adviser's review of readmissions.

The agency's authority to adopt the proposed rules is contained in Minnesota Statutes, section 256B.04, subdivisions 2 and 15, section 256B.503, and section 256D.03 subdivision 7(b). Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854. This rule is also available for viewing at each of the county welfare or human service agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule contact Anu Seam, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 297-4997.

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

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

Minnesota Statu , chapter 10A. requires each l ist to register with the State Ethi Practices Board within five da after he or she commences lobbying. A lobbyist is defined in Minnesota Statutes, section 10A.01, subdivision 11, as any individual:

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

(b) who spends more than $250, not including 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, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

for Julie Brunner

SANDRA S. GARDEBRING
Commissioner

Dated: 9/6/88

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Amendments to Rules of the Department of Human Services Governing Inpatient Hospital Admission Certification in the Medical Assistance and General Assistance Medical Care Programs Parts, 9505.0500 to 9505.0540

NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING AND NOTICE OF INTENT TO ADOPT A RULE WITH A PUBLIC HEARING IF TWENTY-FIVE OR MORE PERSONS REQUEST A HEARING

Notice is hereby given that the State Department of Human Services proposes to adopt the above-entitled rule without a public hearing following the procedures set forth in Minnesota Statutes, section 14.22 to 14.28. The specific statutory authority to adopt the rule is Minnesota Statutes, section 256B.04, subdivisions 2 and 15, section 256B.503, and section 256D.03 subdivision 7(b).

Persons interested in this rule shall have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule and comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, section 14.131 to 14.20. PLEASE NOTE THAT IF TWENTY-FIVE OR MORE PERSONS SUBMIT WRITTEN REQUESTS FOR A PUBLIC HEARING WITHIN THE 30-DAY COMMENT PERIOD, A HEARING WILL BE HELD ON MONDAY, NOVEMBER 14, 1988, UNLESS A SUFFICIENT NUMBER WITHDRAW THEIR REQUEST, IN ACCORDANCE WITH THE NOTICE OF PUBLIC HEARING ON THESE SAME RULES PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between November 3, 1988 and November 13, 1988, at (612) 297-4997.

Persons who wish to submit comments or a written request for a public hearing must submit such comments or requests to: Anu Seam, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 297-4997.

Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on November 2, 1988.

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

A free copy of this rule is available upon request for your review from: Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854. A copy of the proposed amended rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

Minnesota Rules, parts 9505.0500 to 9505.0540, establish a system for reviewing the utilization of inpatient hospital services under the Medical Assistance and General Assistance Medical Care programs. These rules are designed to guard against excess payments and to reduce expenditures which result from unnecessary hospitalization of MA and GAMC recipients.

Besides persons receiving Medical Assistance and General Assistance Medical Care services, this rule affects providers of Medical Assistance and General Assistance Medical Care services who are responsible for following the procedures specified in the rule, and the medical review agent who is responsible for reviewing the necessity of admissions and the appropriateness of the surgical services provided.

The proposed amendments to these rules remove inconsistencies between this rule and Minnesota Rules, parts 9500.1090 to 9500.1155, which is a related medical assistance and general assistance medical care rule. Parts 9500.1090 to 9500.1155 govern the reimbursement for inpatient hospital services to be provided to Medical Assistance and General Assistance Medical Care recipients, and have to be read in conjunction with the present rule.

The amendments expand the time frame for readmissions and clarify the criteria for a readmission considered as a second admission, a readmission considered as continuous with the first admission, and a readmission considered as a transfer. The amendments also specify procedures to be followed by providers of Medical Assistance and General Assistance Medical Care to be eligible for reimbursement, and incorporate the second surgical opinion process into the admission certification process.

The amended rule contains definitions of terms used in the rule and amends existing definitions. It amends the scope of the rule, exclusions from admission certification requirements, and the time requirements for excluding obstetrical services from admission certification requirements.

The rule expands the responsibilities of the admitting physician, the medical review agent and the Department. It specifies the procedures to be followed by providers to obtain the authorization number or certification number. It contains changes to reconsideration procedures, procedures for retention or withdrawal of certification number, and medical record review and determination by the medical review agent.

The amended rule contains additional consequences of withdrawal of admission certification or authorization number, and provides for recovery of payment after withdrawal of admission certification or authorization number. It prohibits recovery from the recipient, provides the recipient with right to appeal if the recipient is denied inpatient hospital services, and provides for physician adviser's review of readmissions.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854, upon request.

Adoption of these rules will not result in additional spending by local public bodies in the excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854.

If no hearing is required upon adoption of the rule, the rule and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Anu Seam, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816.

State of Minnesota

by Julie Brunner
SANDRA S. GARDEBRING
Commissioner

Dated: 5/6/88

STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO DEPARTMENT OF HUMAN SERVICES RULES GOVERNING INPATIENT HOSPITAL CERTIFICATION IN THE MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PROGRAMS

AFFIDAVIT OF ADDITIONAL MAILING

Nancy Storelee, being first duly sworn, deposes and says:

That on the 28th day of September, 1988, at the City of St. Paul, County of Ramsey, State of Minnesota, I mailed the attached Notices by depositing in the State of Minnesota Central Mail System for first class mailing, a copy thereof, properly enveloped, with postage prepaid to the following parties:

-The 87 Minnesota County Human Services Agencies
-Rule 48 Advisory Committee
-Individual Hospitals
-Border Medical Association
-Border Hospital Association

Nancy Storelee

Subscribed and sworn to before me

this 28 day of Sept., 1988

Louise J. Breidel

LOUISE J. BREIDEL
NOTARY PUBLIC—MINNESOTA
DAKOTA COUNTY
MY COMM. EXP. SEPT. 22, 1990

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Amendments to Department of Human Services Rules Governing Inpatient Hospital Admission Certification in the Medical Assistance and General Assistance Medical Care Programs, Parts, 9505.0500 to 9505.0540

NOTICE OF HEARING AND NOTICE OF INTENT TO CANCEL HEARING IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO NOTICE OF INTENT TO ADOPT RULES WITHOUT A PUBLIC HEARING

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in Rooms 2A and 2B, Human Services Building, 444 Lafayette Road, St.Paul, Minnesota, 55155, on November 14, 1988 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

PLEASE NOTE, HOWEVER, THAT THE HEARING WILL BE CANCELLED IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO THE NOTICE OF INTENT TO ADOPT THESE SAME RULES WITHOUT A PUBLIC HEARING PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between November 3, 1988 and November 13, 1988 at (612) 297-4997.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Howard Kaibel, Administrative Law Judge, Office of Administrative Hearings, 500 Flour Exchange Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341-7608, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge may at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the

agency is willing to ɔt. No additional evidence ma_ e submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Law Judge will write a report as provided for in Minnesota Statutes, sections 14.15 and 14.50. The rule hearing is governed by Minnesota Statutes, sections 14.14 to 14.20 and by Minnesota Rules, parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

Minnesota Rules, Parts 9505.0500 to 9505.0540, establish a system for reviewing the utilization of inpatient hospital services under the Medical Assistance and General Assistance Medical Care programs. These rules are designed to guard against excess payments and to reduce expenditures which result from inappropriate hospitalization of MA and GAMC recipients.

Besides persons receiving MA and GAMC services, this rule affects providers of MA/GAMC services who are responsible for following the procedures specified in the rule, and the medical review agent who is responsible for reviewing the necessity of admissions and the appropriateness of the surgical services provided.

The proposed amendments to these rules remove inconsistencies between this rule and Minnesota Rules, parts 9500.1090 to 9500.1155, which is a related medical assistance and general assistance medical care rule. Parts 9500.1090 to 9500.1155 govern the reimbursement for inpatient hospital services to be provided to Medical Assistance and General Assistance Medical Care recipients, and have to be read in conjunction with the present rule.

The amendments expand the time frame for readmissions and clarify the criteria for a readmission considered as a second admission, a readmission considered as continuous with the first admission, and a readmission considered as a transfer. The amendments also specify procedures to be followed by providers of Medical Assistance and General Assistance Medical Care to be eligible for reimbursement, and incorporate the second surgical opinion process into the admission certification process.

The amended rule contains definitions of terms used in the rule and amends existing definitions. It amends the scope of the rule, exclusions from admission certification requirements, and the time requirements for excluding obstetrical services from admission certification requirements. The rule expands the responsibilities of the admitting physician, the medical review agent and the Department. It specifies the procedures to be followed by providers to obtain the authorization number or certification number. It contains changes to reconsideration procedures, procedures for retention or withdrawal of certification number, and medical record review and determination by the medical review agent.

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The agency's authority to adopt the proposed rules is contained in Minnesota Statutes, section 256B.04, subdivisions 2 and 15, section 256B.503, and section 256D.03 subdivision 7(b). Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854. This rule is also available for viewing at each of the county welfare or human service agencies in the State of Minnesota.

Additional copies will be available at the hearing. If you have any questions on the content of the rule contact Anu Seam, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 297-4997.

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

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

Minnesota Statut chapter 10A. requires each lo st to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minnesota Statutes, section 10A.01, subdivision 11, as any individual:

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

(b) who spends more than $250, not including 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, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

for Julie Brunner

SANDRA S. GARDEBRING
Commissioner

Dated: 9/6/88

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Amendments to Rules of the Department of Human Services Governing Inpatient Hospital Admission Certification in the Medical Assistance and General Assistance Medical Care Programs Parts, 9505.0500 to 9505.0540

NOTICE OF INTENT TO ADOPT A RULE WITHOUT A PUBLIC HEARING AND NOTICE OF INTENT TO ADOPT A RULE WITH A PUBLIC HEARING IF TWENTY-FIVE OR MORE PERSONS REQUEST A HEARING

Notice is hereby given that the State Department of Human Services proposes to adopt the above-entitled rule without a public hearing following the procedures set forth in Minnesota Statutes, section 14.22 to 14.28. The specific statutory authority to adopt the rule is Minnesota Statutes, section 256B.04, subdivisions 2 and 15, section 256B.503, and section 256D.03 subdivision 7(b).

Persons interested in this rule shall have 30 days in which to submit comment in support of or in opposition to the proposed rule or any part or subpart of the rule and comment is encouraged. Each comment should identify the portion of the proposed rule addressed, the reason for the comment, and any change proposed.

Any person may make a written request for a public hearing on the rule within the 30-day comment period. If 25 or more persons submit a written request for a public hearing within the 30-day comment period, a public hearing will be held unless a sufficient number withdraw their request in writing. Any person requesting a public hearing should state his or her name and address, and is encouraged to identify the portion of the proposed rule addressed, the reason for the request, and any change proposed. If a public hearing is required, the agency will proceed pursuant to Minnesota Statutes, section 14.131 to 14.20. PLEASE NOTE THAT IF TWENTY-FIVE OR MORE PERSONS SUBMIT WRITTEN REQUESTS FOR A PUBLIC HEARING WITHIN THE 30-DAY COMMENT PERIOD, A HEARING WILL BE HELD ON MONDAY, NOVEMBER 14, 1988, UNLESS A SUFFICIENT NUMBER WITHDRAW THEIR REQUEST, IN ACCORDANCE WITH THE NOTICE OF PUBLIC HEARING ON THESE SAME RULES PUBLISHED IN THIS STATE REGISTER AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between November 3, 1988 and November 13, 1988, at (612) 297-4997.

Persons who wish to submit comments or a written request for a public hearing must submit such comments or requests to: Anu Seam, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 297-4997.

Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on November 2, 1988.

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

A free copy of this rule is available upon request for your review from: Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854. A copy of the proposed amended rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

Minnesota Rules, parts 9505.0500 to 9505.0540, establish a system for reviewing the utilization of inpatient hospital services under the Medical Assistance and General Assistance Medical Care programs. These rules are designed to guard against excess payments and to reduce expenditures which result from unnecessary hospitalization of MA and GAMC recipients.

Besides persons receiving Medical Assistance and General Assistance Medical Care services, this rule affects providers of Medical Assistance and General Assistance Medical Care services who are responsible for following the procedures specified in the rule, and the medical review agent who is responsible for reviewing the necessity of admissions and the appropriateness of the surgical services provided.

The proposed amendments to these rules remove inconsistencies between this rule and Minnesota Rules, parts 9500.1090 to 9500.1155, which is a related medical assistance and general assistance medical care rule. Parts 9500.1090 to 9500.1155 govern the reimbursement for inpatient hospital services to be provided to Medical Assistance and General Assistance Medical Care recipients, and have to be read in conjunction with the present rule.

The amendments expand the time frame for readmissions and clarify the criteria for a readmission considered as a second admission, a readmission considered as continuous with the first admission, and a readmission considered as a transfer. The amendments also specify procedures to be followed by providers of Medical Assistance and General Assistance Medical Care to be eligible for reimbursement, and incorporate the second surgical opinion process into the admission certification process.

The amended rule contains definitions of terms used in the rule and amends existing definitions. It amends the scope of the rule, exclusions from admission certification requirements, and the time requirements for excluding obstetrical services from admission certification requirements.

The rule expands the responsibilities of the admitting physician, the medical review agent and the Department. It specifies the procedures to be followed by providers to obtain the authorization number or certification number. It contains changes to reconsideration procedures, procedures for retention or withdrawal of certification number, and medical record review and determination by the medical review agent.

The amended rule contains additional consequences of withdrawal of admission certification or authorization number, and provides for recovery of payment after withdrawal of admission certification or authorization number. It prohibits recovery from the recipient, provides the recipient with right to appeal if the recipient is denied inpatient hospital services, and provides for physician adviser's review of readmissions.

A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854, upon request.

Adoption of these rules will not result in additional spending by local public bodies in the excess of $100,000 per year for the first two years following adoption under the requirements of Minnesota Statutes, section 14.11. A fiscal note prepared according to the requirements of Minnesota Statutes, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816, telephone (612) 296-2854.

If no hearing is required upon adoption of the rule, the rule and the required supporting documents will be delivered to the Attorney General for review as to legality and form to the extent the form relates to legality. Any person may request notification of the date of submission to the Attorney General. Persons who wish to be advised of the submission of this material to the Attorney General, or who wish to receive a copy of the adopted rule, must submit the written request to Anu Seam, Department of Human Services, Rules Division, 444 Lafayette Road, St.Paul, MN 55155-3816.

State of Minnesota

for Julie Brunner
SANDRA S. GARDEBRING
Commissioner

Dated: 5/6/85

~~rate per admission; out-of-area hospital categorical rate per admission; categorical rate per admission for MSA and non-MSA hospitals statewide that do not have admissions in the base year; transfer reimbursement; or rate per admission~~ shall be eligible for reimbursement according to the criteria in parts 9505.0500 to 9505.0540.

Subp. 9. to 12. [Unchanged.]

REPEALER. *Minnesota Rules,* part 9500.1100, subpart 21a is repealed.

Department of Human Services

Proposed Permanent Rules Relating to Physician and Hospital Certification for Payment of Medical Assistance and General Assistance Medical Care for Inpatient Hospital Services

Notice of Hearing and Notice of Intent to Cancel Hearing If Fewer Than Twenty-five Persons Request a Hearing in Response to Notice of Intent to Adopt Rules Without a Public Hearing

NOTICE IS HEREBY GIVEN that a public hearing on the above-entitled matter will be held in Rooms 2A and 2B, Human Services Building, 444 Lafayette Road, St. Paul, Minnesota 55155, on November 14, 1988 commencing at 9:00 a.m. and continuing until all interested or affected persons have an opportunity to participate. The proposed rules may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rules, you are urged to participate in the rule hearing process.

PLEASE NOTE, HOWEVER, THAT THE HEARING WILL BE CANCELLED IF FEWER THAN TWENTY-FIVE PERSONS REQUEST A HEARING IN RESPONSE TO THE NOTICE OF INTENT TO ADOPT THESE SAME RULES WITHOUT A PUBLIC HEARING PUBLISHED IN THIS *STATE REGISTER* AND MAILED TO PERSONS REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES. To verify whether a hearing will be held, please call the Department of Human Services between November 3, 1988 and November 13, 1988 at (612) 297-4997.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the hearing record. All evidence presented should be pertinent to the matter at hand. Written material not submitted at the time of the hearing which is to be included in the hearing record may be mailed to Howard Kaibel, Administrative Law Judge, Office of Administrative Hearings, 500 Flour Exchange Building, 310 Fourth Avenue South, Minneapolis, Minnesota 55415; telephone (612) 341-7608, either before the hearing or within five working days after the public hearing ends. The Administrative Law Judge may at the hearing, order the record be kept open for a longer period not to exceed 20 calendar days. The comments received during the comment period shall be available for review at the Office of Administrative Hearings. Following the close of the comment period the agency and all interested persons have three business days to respond in writing to any new information submitted during the comment period. During the three-day period, the agency may indicate in writing whether there are amendments suggested by other persons which the agency is willing to adopt. No additional evidence may be submitted during the three-day period. The written responses shall be added to the rulemaking record. Upon the close of the record the Administrative Law Judge will write a report as provided for in *Minnesota Statutes,* sections 14.15 and 14.50. The rule hearing is governed by *Minnesota Statutes,* sections 14.14 to 14.20 and by *Minnesota Rules,* parts 1400.0200 to 1400.1200. Questions about procedure may be directed to the Administrative Law Judge.

Minnesota Rules, Parts 9505.0500 to 9505.0540, establish a system for reviewing the utilization of inpatient hospital services under the Medical Assistance and General Medical Care programs. These rules are designed to guard against excess payments and to reduce expenditures which result from inappropriate hospitalization of MA and GAMC recipients.

Besides persons receiving MA and GAMC services, this rule affects providers of MA/GAMC services who are responsible for following the procedures specified in the rule, and the medical review agent who is responsible for reviewing the necessity of admissions and the appropriateness of the surgical services provided.

The proposed amendments to these rules remove inconsistencies between this rule and *Minnesota Rules,* parts 9500.1090 to 9500.1155, which is a related medical assistance and general assistance medical care rule. Parts 9500.1090 to 9500.1155 govern the reimbursement for inpatient hospital services to be provided to Medical Assistance and General Assistance Medical Care recipients, and have to be read in conjunction with the present rule.

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The amended rule contains definitions of terms used in the rule and amends existing definitions. It amends the scope of the rule, exclusions from admission certification requirements, and the time requirements for excluding obstetrical services from admission certification requirements. The rule expands the responsibilities of the admitting physician, the medical review agent and the Department. It specifies the procedures to be followed by providers to obtain the authorization number or certification number. It contains changes to reconsideration procedures, procedures for retention or withdrawal of certification number, and medical record review and determination by the medical review agent.

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The agency's authority to adopt the proposed rules is contained in *Minnesota Statutes,* section 256B.04, subdivisions 2 and 15, section 256B.503, and section 256D.03 subdivision 7(b). Adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption under the requirements of *Minnesota Statutes,* section 14.11. A fiscal note prepared according to the requirements of *Minnesota Statutes,* section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St. Paul, MN 55155-3816, telephone (612) 296-2854.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St. Paul, MN 55155-3816, telephone (612) 296-2854. This rule is also available for viewing at each of the county welfare or human service agencies in the State of Minnesota.

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(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 travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communication or urging others to communicate with public officials; or

(b) who spends more than $250, not including 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, 625 North Robert Street, St. Paul, Minnesota 55101, telephone (612) 296-5148.

Sandra S. Gardebring
Commissioner

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

Notice of Intent to Adopt a Rule Without a Public Hearing and Notice of Intent to Adopt a Rule With a Public Hearing If Twenty-five or More Persons Request a Hearing

NOTICE IS HEREBY GIVEN that the State Department of Human Services proposes to adopt the above-entitled rule without a public hearing following the procedures set forth in *Minnesota Statutes*, section 14.22 to 14.28. The specific statutory authority to adopt the rule is *Minnesota Statutes*, section 256B.04 subdivisions 2 and 15, section 256B.503, and 256D.03, subdivision 7(b).

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Comments or requests for a public hearing must be received by the Department by 4:30 p.m. on November 2, 1988.

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

A free copy of this rule is available upon request for your review from: Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St. Paul, MN 55155-3816, telephone (612) 296-2854. A copy of the proposed amended rule may be viewed at any of the county welfare or human service agencies in the State of Minnesota.

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A Statement of Need and Reasonableness that describes the need for and reasonableness of each provision of the proposed rule and identifies the data and information relied upon to support the proposed rule has been prepared and is available from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St. Paul, MN 55155-3816, telephone (612) 296-2854, upon request.

Adoption of these rules will not result in additional spending by local public bodies in the excess of $100,000 per year for the first two years following adoption under the requirements of *Minnesota Statutes*, section 14.11. A fiscal note prepared according to the requirements of *Minnesota Statutes*, section 3.98, subdivision 2, estimating the fiscal impact of the rule is available upon request from Nancy Storelee, Department of Human Services, Rules Division, 444 Lafayette Road, St. Paul, MN 55155-3816, telephone (612) 296-2854.

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Sandra S. Gardebring
Commissioner

Rules as Proposed

9505.0500 DEFINITIONS.

Subpart 1. and 2. [Unchanged.]

Subp. 3. **Admission certification.** "Admission certification" means the determination of the medical review agent that all or part of a recipient's inpatient ~~hospitalization is~~ hospital services are medically necessary and that medical assistance or general assistance medical care funds may be used to pay the admitting physician, hospital, and other vendors of inpatient hospital services for providing medically necessary services, subject to parts ~~9500.0750 to 9500.1080,~~ 9500.1070, subparts 1, 4, 6, 12 to 15, and 23; 9500.1090 to 9500.1155; 9505.0170 to 9505.0475; 9505.1000 to 9505.1040~~.~~; and 9505.5000 to 9505.5105.

Subp. 3a. **Admitting diagnosis.** "Admitting diagnosis" means the physician's tentative or provisional diagnosis of the recipient's condition as a basis for examination and treatment when the physician requests admission certification.

Subp. 4. [Unchanged.]

Subp. 4a. **Authorization number.** "Authorization number" means the number issued by the medical review agent that establishes that the surgical procedure requiring a second surgical opinion is medically appropriate.

Subp. 5. **Certification number.** "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 6. to 8. [Unchanged.]

Subp. 9. **Continued stay review.** "Continued stay review" means a review and determination, after the admission certification and during a patient's hospitalization, of the medical necessity of continuing inpatient hospital services to the ~~recipient's stay at a hospital level of care~~ recipient.

Subp. 10. [Unchanged.]

Subp. 10a. **Diagnostic category.** "Diagnostic category" means the list of diagnosis-related groups in the diagnostic classification system established under *Minnesota Statutes*, section 256.969, subdivision 2, and defined in part 9500.1100, subpart 20.

Subp. 10b. **Diagnostic category validation or validate the diagnostic category.** "Diagnostic category validation" or "validate the diagnostic category" refers to the process of comparing the medical record to the information submitted on the inpatient hospital billing form required by the department to ascertain the accuracy of the information upon which the diagnostic category was assigned.

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seeks medical assistance or general assistance medical care ~~program~~ payment for inpatient hospital services provided to ~~recipients who are Minnesota residents. Instate admitting physicians who admit a Minnesota resident who is a recipient to an out-of-state hospital must comply with parts 9505.0500 to 9505.0540. Out-of-state admitting physicians who admit a Minnesota resident who is a recipient to an in-state hospital must comply with parts 9505.0500 to 9505.0540~~ a Minnesota recipient must comply with the requirements of parts 9505.0500 to 9505.0540 unless the hospital or admitting physician has received prior authorization for inpatient hospital services under parts 9505.0170 to 9505.0475. Admission certification must be obtained when a recipient moves from one hospital with a provider number to another hospital with a different provider number or from one unit within a hospital to another unit with a different provider number in the same hospital. For purposes of this part, "provider number" means a number issued by the department to a provider who has signed a provider agreement under part 9505.0195.

9505.0520 INPATIENT ADMISSION CERTIFICATION.

Subpart 1. [Unchanged.]

Subp. 2. **Exclusions from admission certification or prior admission certification.** Admission for inpatient hospital services under items A ~~and B~~ to C shall be excluded from the requirement in subpart 1.

A. Admission certification is not required before an emergency admission ~~may occur without prior admission certification~~ and shall be subject to subpart 4, item B.

B. Admission certification is not required for delivery of a newborn or a stillbirth, inpatient dental procedures, or inpatient hospital services for which a recipient has been approved under Medicare. However, denial of an inpatient hospital service under Medicare ~~because the service is not medically necessary~~ shall also constitute sufficient grounds for denying ~~payment~~ admission certification for the service under medical assistance. The admission of a pregnant woman that does not result in the delivery of a newborn or a stillbirth within 24 hours of her admission shall be subject to retroactive admission certification.

C. Admission of a recipient who has been approved by the county for inpatient hospital services for chemical dependency as specified in parts 9530.6600 to 9530.6655 may occur without admission certification, provided that the inpatient hospital chemical dependency services to the recipient during the recipient's stay in the hospital are not to be billed to medical assistance under parts 9500.1090 to 9500.1155.

Subp. 3. **Admitting physician responsibilities.** The admitting physician who seeks medical assistance or general assistance medical care program payment for an inpatient hospital service to be provided to a recipient ~~for a purpose other than chemical dependency treatment~~ shall:

A. [Unchanged.]

B. Request admission certification by contacting the medical review agent either by phone or in writing and providing the information in subitems (1) to ~~(8)~~ (9):

(1) to (5) [Unchanged.]

(6) whether the admission is a readmission or a transfer;

(7) [Unchanged.]

(8) information from the plan of care and the reason for admission as necessary for the medical review agent to determine if admission is medically necessary or the procedure requiring a second surgical opinion is medically appropriate; or

(9) when applicable, information needed to prove that a procedure requiring a second surgical opinion meets the criteria for exemption from the requirement.

C. Provide the following information when applicable:

(1) surgeon's name and medical assistance provider number;

(2) expected date of surgery; ~~and~~

(3) affirmation that ~~a second surgical opinion and~~ prior authorization ~~have~~ has been received;

(4) affirmation that a procedure requiring a second surgical opinion that was denied by the medical review agent has been approved by a third physician; and

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Subp. 11. to 13. [Unchanged.]

Subp. 14. **Inpatient hospital service.** "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in ~~a~~ the hospital for the care and treatment of ~~a~~ the recipient. The inpatient hospital service may be furnished by a hospital, physician, or a vendor of an ancillary service which is prescribed by a physician ~~that may be paid~~ and which is eligible for ~~under~~ medical assistance or general assistance medical care reimbursement.

Subp. 15. [Unchanged.]

Subp. 16. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under title XIX of the Social Security Act and *Minnesota Statutes*, chapter 256B. For purposes of parts 9505.0500 to 9505.0540, "medical assistance" includes general assistance medical care unless otherwise specified.

Subp. 17. [Unchanged.]

Subp. 18. **Medical review agent.** "Medical review agent" means the representative of the commissioner who is authorized by the commissioner to make decisions about admission certifications, concurrent reviews, continued stay reviews, ~~and~~ retrospective reviews, and second surgical opinions if such opinions are a term of the agent's contract with the department.

Subp. 19. [Unchanged.]

Subp. 19a. **Medically appropriate or medical appropriateness.** "Medically appropriate" or "medical appropriateness" refers to a determination, by a medical review agent or the department, that the recipient's need for a surgical procedure requiring a second surgical opinion meets the criteria in part 9505.0540 or that a third surgical opinion has substantiated the need for the procedure.

Subp. 20. and 21. [Unchanged.]

Subp. 22. **Physician adviser.** "Physician adviser" means a physician who practices in the specialty area of the recipient's ~~primary~~ admitting or principal diagnosis or a specialty area related to the ~~primary~~ admitting or principal diagnosis.

Subp. 23. [Unchanged.]

Subp. 23a. **Principal diagnosis.** "Principal diagnosis" means the condition established, after study, to be chiefly responsible for causing the admission of the recipient to the hospital for inpatient hospital services.

Subp. 23b. **Principal procedure.** "Principal procedure" means a procedure performed for definitive treatment of the recipient's principal diagnosis rather than one performed for diagnostic or exploratory purposes or a procedure necessary to take care of a complication. When multiple procedures are performed for definitive treatment, the principal procedure is the procedure most closely related to the principal diagnosis.

Subp. 23c. **Provider.** "Provider" means an individual or organization under an agreement with the department to furnish health services to persons eligible for the medical assistance or general assistance medical care programs. Providers include hospitals, admitting physicians, and vendors of other services.

Subp. 24. **Readmission.** "Readmission" means an admission that occurs within ~~seven~~ 15 days of a discharge of the same recipient. The 15-day period does not include the day of discharge or the day of readmission.

Subp. 25. and 26. [Unchanged.]

Subp. 27. **Retrospective review.** "Retrospective review" means a review conducted after inpatient hospital services are provided to a recipient. The review is focused on validating the diagnostic category and determining the medical necessity of the admission, the medical necessity of any inpatient hospital services provided, the medical appropriateness of a surgical procedure requiring a second opinion, and whether all medically necessary inpatient hospital services were provided.

Subp. 28. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the medical appropriateness of a proposed surgery as specified in parts 9505.5000 to 9505.5105.

Subp. 29. **Transfer.** "Transfer" means the movement of a recipient after admission from one hospital directly to another.

9505.0510 ~~APPLICABILITY~~ SCOPE.

Parts 9505.0500 to 9505.0540 establish the standards and procedures for admission certification to be followed by admitting physicians and hospitals seeking medical assistance or general assistance medical care payment under parts 9500.1090 to 9500.1155 for inpatient hospital services provided to medical assistance or general assistance medical care recipients under *Minnesota Statutes*, chapters 256B and 256D. Parts 9505.0500 to 9505.0540 are to be read in conjunction with Code of Federal Regulations, title 42, and titles XVIII and XIX of the Social Security Act. The department retains the authority to approve prior authorizations established under parts 9505.5000 to ~~9505.5105~~ 9505.5030 and second surgical opinions established under parts 9505.5035 to 9505.5105. ~~Parts 9505.0500 to 9505.0540 do not apply to out-of-state hospitals and~~ A hospital or admitting ~~physicians~~ physician who ~~seek~~

(5) when requested by the medical review agent, documentation that the procedure requiring a second surgical opinion meets the criteria for exemption from the requirement.

D. Inform the hospital of the certification number.

E. Provide the hospital documentation necessary for the verification required in subpart 4, item D.

F. For purposes of billing, enter the certification number ~~on, and attach a copy of a necessary,~~ any required prior authorization ~~form~~ number, and ~~a~~ second ~~or third~~ surgical opinion ~~to all~~ authorization number on invoices submitted to the department for payment.

Subp. 4. **Hospital responsibilities.** A hospital that seeks medical assistance or general assistance medical care ~~program~~ payment for inpatient hospital services provided to a recipient shall:

A. Obtain the certification number and the authorization number, if required under parts 9505.5000 to 9505.5105, from the admitting physician ~~or, for an admission for chemical dependency treatment, from the person who conducted the assessment of the recipient for chemical dependency treatment as specified in parts 9530.6600 to 9530.6655~~.

B. ~~In an emergency admission~~ Within 48 hours after the occurrence of an event described in subitem (1) or (2), and within 72 hours of the event described in subitem (3), excluding weekends and holidays, inform, by phone, the medical review agent of the ~~emergency admission~~ event and provide the information required in subpart 3, items B and C, if applicable~~, within 48 hours of the emergency admission exclusive of weekends and holidays~~.

(1) An admission that is an emergency admission as specified in subpart 2.

(2) A surgical procedure requiring a second surgical opinion that meets the requirements of part 9505.5040, item B or C, for exemption from the second opinion.

(3) The admission of a pregnant woman that does not result in the delivery of a newborn or a stillbirth within 24 hours of her admission, as specified in subpart 2, item B.

For purposes of this subitem, the time limit for notifying the medical review agent is calculated beginning with the time of the admission of the pregnant woman.

If the hospital fails to notify the medical review agent within ~~48 hours excluding weekends and holidays~~ the required time limit, the hospital shall submit, at its own expense, a copy of the complete medical record to the medical review agent within 30 days after the recipient's discharge. Failure to submit the record within the 30 days shall result in denial of the certification number.

C. For billing purposes, enter the certification number and any required prior authorization number and second surgical opinion authorization number on all invoices submitted to the department for payment.

D. Within 20 days, exclusive of weekends and holidays, of the date of a written request by the medical review agent, obtain and submit to the medical review agent an admitting physician's verification that a procedure requiring a second surgical opinion has been approved by a third physician. The verification must include at least the signed form required by the department to approve a procedure requiring a second surgical opinion.

Subp. 5. [Unchanged.]

Subp. 6. **Medical review agent responsibilities.** The medical review agent shall:

A. [Unchanged.]

B. determine within 24 hours of receipt of the information, exclusive of weekends and holidays, whether admission is medically necessary, whether a surgical procedure requires a second surgical opinion or is exempt from the requirement, and whether a procedure requiring a second surgical opinion meets the criteria of appropriateness established in part 9505.0540 or requires the approval of a third physician;

C. [Unchanged.]

D. mail a written notice by certified letter of the admission certification determination to the admitting physician and the hospital, and a written notice to the recipient within five days of the determination, exclusive of weekends and holidays;

E. determine if admission of a retroactively eligible recipient was medically necessary and if the surgical procedure requiring a second opinion was medically appropriate;

F. conduct a concurrent, continued stay, or retrospective review of a recipient's medical record as specified in subpart 10;

G. provide for a reconsideration of a denial or withdrawal of admission certification, and of an authorization number denied or withdrawn under subpart 8, item C;

~~G.~~ H. recruit and coordinate the work of the physician advisers;

~~H.~~ I. notify the admitting physician and the person responsible for the hospital's utilization review, by phone, of a reconsideration decision within 24 hours of the decision, exclusive of weekends and holidays;

~~I.~~ J. mail a written notice by certified letter of the reconsideration decision to the admitting physician, the person responsible for the hospital's utilization review, and the department within ten days of the determination, exclusive of weekends and holidays;

~~J.~~ K. provide for consideration of a request for retroactive admission certification; ~~and~~

~~K. issue a certification number for a recipient whose condition requires chemical dependency treatment in a hospital as indicated in an assessment made according to parts 9530.6600 to 9530.6655~~

L. validate the diagnostic category; and

M. perform other duties as specified in the contract between the medical review agent and the department.

Subp. 7. [Unchanged.]

Subp. 8. **Procedure for admission certification or authorization of surgical procedure requiring a second surgical opinion.** The procedure for admission certification or authorization of a surgical procedure requiring a second surgical opinion shall be as in items A to H.

A. Upon receipt of the information requested in subpart 3, items B and C, if applicable, the clinical evaluator shall review the information and determine whether the admission is medically necessary or whether a procedure requiring a second surgical opinion is appropriate or meets the criteria for exemption from the requirement.

B. If the clinical evaluator determines ~~the admission is medically necessary~~ that one of the conditions in item A exists, the medical review agent shall issue a certification or authorization number.

C. If the clinical evaluator determines that a procedure requiring a second surgical opinion does not meet the criteria for exemption under part 9505.5040, except items B, C, and F, the medical review agent shall notify the admitting physician by phone and mail the admitting physician and the recipient a written notice within 20 days of the determination. If the exemption is denied, the recipient who wants the surgery may obtain a second or third surgical opinion. Exemptions from the second surgical opinion under part 9505.5040, items B and C, shall be subject to subpart 4, item B. Exemptions from the second surgical opinion under part 9505.5040, item F, shall be subject to part 9505.5096, subpart 4. If the medical review agent determines that the procedure requiring a second surgical opinion was not entitled to an exemption or that the surgical procedure was not medically appropriate under part 9505.5040, items B, C, and F, the medical review agent shall not issue or shall withdraw the authorization number and notify the admitting physician and the hospital of denial of the authorization number. The notice shall be in writing, mailed by certified letter within 20 days of the determination, and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under *Minnesota Statutes*, chapter 14.

D. If the clinical evaluator is unable to determine that the admission is medically necessary~~,~~ or that a procedure requiring a second surgical opinion is appropriate, the evaluator shall contact a physician adviser.

~~D.~~ E. If the physician adviser determines that the admission is medically necessary~~,~~ or that a procedure requiring a second surgical opinion is appropriate, the medical review agent shall issue a certification or authorization number.

~~E.~~ F. If the physician adviser is unable to determine that the admission is medically necessary~~,~~ or that a procedure requiring a second surgical opinion is appropriate, the physician adviser shall notify the clinical evaluator by phone, the clinical evaluator shall notify the admitting physician by phone, and the admitting physician may request a second physician adviser's opinion, except in the case of a procedure requiring a second surgical opinion. In this case, the medical review agent shall notify the admitting physician that the recipient may obtain the opinion of a third physician as provided in parts 9505.5050 to 9505.5105.

~~F.~~ G. If the admitting physician does not request a second physician adviser's opinion, the medical review agent shall deny the admission certification, shall not issue a certification number, and shall notify the admitting physician, the hospital, and the recipient of the denial. The notice to the recipient shall be in writing and shall state the reasons for the denial and the recipient's right to appeal under *Minnesota Statutes*, section 256.045, and part 9505.0522. The notices to the admitting physician and the hospital shall be in writing, shall state the reasons for the denial, and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under *Minnesota Statutes*, chapter 14.

If the admitting physician requests a second physician adviser's opinion about an admission, the clinical evaluator shall contact a second physician adviser.

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~~G.~~ H. If the second physician adviser determines that the admission is medically necessary, the medical review agent shall issue a certification number.

~~H.~~ I. If the second physician adviser is unable to determine that the admission is medically necessary, the medical review agent shall deny the admission certification ~~and~~, shall not issue a certification number, and shall notify the admitting physician, the hospital, and the recipient of the denial. The notice to the recipient shall be in writing and shall state the reasons for the denial and the recipient's right to appeal under *Minnesota* Statutes, section 256.045, and part 9505.0522. The notices to the admitting physician and the hospital shall be in writing and shall state the reasons for the denial and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under *Minnesota Statutes*, chapter 14.

Subp. 9. **Reconsideration.** The admitting physician or the hospital may request reconsideration of a decision to deny or withdraw an admission certification or an authorization number under subpart 8, item C. The admitting physician or the hospital shall submit the request in writing to the medical review agent together with the recipient's medical record and any additional information within 30 days of the date of receipt of the certified letter denying or withdrawing admission certification or the authorization number. Upon receipt of the request, the medical record, and any additional information, the medical review agent shall appoint at least three physician advisers, none of whom shall have been involved previously in the procedure for the recipient's admission certification or authorization number, to hear the reconsideration. The reconsideration may be conducted by means of a telephone conference call. ~~The admitting physician or the hospital may submit additional facts at their own expense to support the request for admission certification.~~ The physician advisers may seek additional facts and medical advice as necessary to decide whether the admission is medically necessary or whether the surgical procedure requiring a second surgical opinion meets the criteria of exemption or is medically appropriate under part 9505.5040, items B, C, and F. The reconsideration shall be completed within ~~30~~ 45 days of the receipt of the ~~request~~ information necessary to complete the reconsideration. The outcome of the reconsideration shall be the one chosen by the majority of the physician advisers appointed to consider the request. The admitting physician or the hospital may appeal the determination of the physician advisers according to the contested case provisions of *Minnesota Statutes*, chapter 14, by filing a written notice of appeal with the commissioner within ~~20~~ 30 days of the date of receipt of the ~~notice of the determination~~ certified letter upholding the denial or withdrawal of admission certification or authorization number. However, an admitting physician or hospital that does not request reconsideration or appeal under the contested case procedures of *Minnesota Statutes*, chapter 14, within 30 days after the denial or withdrawal of admission certification or authorization number is not entitled to an appeal under *Minnesota Statutes*, chapter 14.

Subp. 9a. **Retention or withdrawal of certification number.** When a hospital discharges a recipient who is subsequently readmitted to the same or a different hospital or transfers a recipient to another hospital, the readmission or transfer is subject to the procedures in part 9505.0540, subparts 3 to 6. The hospital or admitting physician who disagrees with the medical review agent's determination under this subpart may request reconsideration as specified in subpart 9.

Subp. 10. **Medical record review and determination.** As specified in the contract between the department and the medical review agent, upon the request of the department, or upon the initiative of the medical review agent, the medical review agent shall ~~be authorized to~~ conduct a concurrent, continued stay, or retrospective review of a recipient's medical record to validate the diagnostic category and to determine whether the admission was medically necessary, whether the inpatient hospital services were medically necessary, whether a continued stay will be medically necessary, ~~or~~ whether all medically necessary services were provided, or whether a surgical procedure requiring a second opinion was medically appropriate. The procedure for concurrent, continued stay, and retrospective reviews shall be as in items A to ~~D~~ G.

A. to C. [Unchanged.]

D. If a physician adviser determines that the recipient's admission was not medically necessary, that the recipient's continued stay will not be medically necessary, or that all medically necessary services were not provided, the medical review agent shall withdraw the previously issued certification number and shall notify the admitting physician and hospital by telephone within 24 hours of the determination and ~~by written notice~~ by certified letter mailed within ~~24 hours~~ five days, exclusive of weekends and holidays, of the determination. The notice shall state the right of the admitting physician and hospital to request a reconsideration or appeal under subpart 9.

E. If the diagnostic category validation shows that the diagnostic category was inaccurately assigned, the department shall adjust the reimbursement as applicable to the diagnostic category that is accurate for the recipient's condition.

F. If the medical review agent conducting a retrospective review finds the recipient's medical record is inadequate to justify that a surgical procedure requiring a second opinion is medically appropriate, or that an exemption under part 9505.5040 was appropriate, the medical review agent may request a hospital to submit, at the hospital's expense, documentation substantiating the opinion of the third physician that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate. The hospital shall submit the documentation within 20 days, exclusive of weekends and holidays, of the date of the notice requesting the documentation.

G. If the clinical evaluator is unable to determine from the documentation in the recipient's medical records the reasons for the recipient's discharge and readmission, the clinical evaluator shall submit the medical records of the recipient's discharge and readmission to a physician adviser. The physician adviser shall review the records and determine the nature of the discharge and readmission according to the criteria in part 9505.0540, subparts 3 to 5, and if the determination of the medical review agent is different from that of the admitting physician or hospital, then the medical review agent shall notify the admitting physician or hospital by certified letter mailed within five days, exclusive of weekends and holidays, of the determination. The notice shall state the right of the admitting physician and hospital to request a reconsideration under subpart 9.

Subp. 11. **Consequences of withdrawal of admission certification or authorization number; general.** The department or the medical review agent shall withdraw the certification number or authorization number and may take action as specified in items A to F if the medical review agent determines any of the following: (1) that the admission was not medically necessary ~~or~~; (2) that all medically necessary inpatient hospital services were not provided ~~or~~; (3) that some or all of the inpatient hospital services were not medically necessary~~, the department shall withdraw the certification number and may take action as specified in items A to E~~; (4) that within 20 days, exclusive of weekends and holidays, the hospital has failed to comply with the department's or the medical review agent's request to submit the medical record or other required information to support that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, or that some or all of the inpatient hospital services provided were medically necessary; or, that the information submitted by the hospital was inadequate to support that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, or that some or all of the inpatient hospital services provided were medically necessary; (5) that documentation submitted by the hospital at the request of the department or the medical review agent does not support that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate; or (6) that within 20 days, exclusive of weekends and holidays, the hospital has failed to comply with the medical review agent's request to submit documentation to substantiate the opinion of a third physician that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate.

A. For hospitals receiving payments ~~on a per admission basis~~ under parts 9500.1090 to 9500.1155, if the admission was not medically necessary or the medical record does not adequately document that the admission was medically necessary, the entire payment shall be ~~debited for an admission that was not medically necessary. If the admission was medically necessary but some or all of the inpatient hospital services were not medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150~~ denied or recovered as provided in subpart 15. If the hospital failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

B. ~~For hospitals receiving per diem payment, no payment shall be made if the admission was not medically necessary. If the stay or a portion of the stay was not medically necessary, no payment shall be made for the portion of the stay that was not medically necessary.~~ For hospitals receiving payments under parts 9500.1090 to 9500.1155, if the admission was medically necessary but some or all of the additional inpatient hospital services were not or will not be medically necessary, or the medical record does not adequately document that the additional inpatient hospital services were necessary, payment for the additional services shall be denied or recovered as provided in subpart 15. If the hospital failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

C. ~~If the medical review agent determines that additional inpatient hospital services will not be medically necessary, the medical review agent shall notify the hospital, admitting physician, and the recipient or the person designated by the recipient in the hospital record that no payment will be made for additional hospital services.~~

~~D.~~ If the admission was not medically necessary or the medical record does not adequately document that the admission was medically necessary, ~~the department may seek to recover payments made to physicians~~ payment shall be denied or recovered from the admitting physician and other vendors of inpatient hospital services as provided in subpart 15. If the admitting physician and other vendors failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

D. If additional inpatient hospital services were not or will not be medically necessary, or the medical record did not adequately document that the additional inpatient hospital services were medically necessary, payment for the additional services shall be denied or recovered from the admitting physician and other vendors of inpatient hospital services as provided in subpart 15. If the admission was medically necessary but some or all of the inpatient hospital services were not medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150. If the admitting physician

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and vendors failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

E. ~~If an inpatient hospital service is not medically necessary, payment for a service not medically necessary shall be denied to the vendor of the service except as provided in items A and B.~~ If within 20 days, exclusive of weekends and holidays, the hospital failed to comply with the department's or the medical review agent's request to submit the medical record or other required information to support (1) that the admission was medically necessary; (2) that all medically necessary inpatient hospital services were provided; or (3) that some or all of the inpatient hospital services provided were medically necessary; or, if the information submitted by the hospital was inadequate to support clauses (1) to (3) of this item, all or part of the payment shall be denied or recovered as provided in items A to D.

F. If the documentation does not support that the surgical procedure was medically appropriate or that the exemption under part 9505.5040 was appropriate, or if the hospital failed to comply with the medical review agent's request to submit documentation to substantiate the opinion of the third physician that the surgical procedure was medically appropriate or that the exemption under part 9505.5040 was appropriate, payment for the surgical procedure shall be denied or recovered from the hospital, admitting physician, or other vendors as provided in subpart 15.

Subp. 12. ~~Appeal~~ **Reconsideration of denial or withdrawal of admission certification or authorization number.** The denial or withdrawal of admission certification or authorization number may be ~~appealed to the medical review agent through the reconsideration process in~~ reconsidered under subpart 9.

Subp. 13. and 14. [Unchanged.]

Subp. 15. **Recovery of payment after withdrawal of admission certification or denial of authorization of second surgical procedure.** An admitting physician or hospital that receives a notice of withdrawal of a certification number or authorization number and that does not request reconsideration under subpart 9 or appeal under *Minnesota Statutes*, chapter 14, shall be subject to recovery of payment without further notice or right to appeal. If a reconsideration results in the denial or withdrawal of a certification number or authorization number, and the admitting physician or hospital does not appeal within the time permitted pursuant to other remedies, the department shall recover payment without further notice to the admitting physician and hospital. If an appeal results in the denial or withdrawal of a certification number or authorization number, the department shall recover the payment without further notice to the admitting physician and the hospital.

Recovery of overpayments may be made by:

A. adjusting the provider's invoice to the difference between the billed amount and the correct amount;

B. canceling the incorrect invoice and directing the provider to submit a correct invoice;

C. withholding or offsetting the payment due the provider for other medical assistance or general assistance medical care services; or

D. using any other remedy available under state or federal law or rules.

9505.0521 PROHIBITION OF RECOVERY FROM RECIPIENT.

The provider may not seek payment from the recipient for inpatient hospital services provided under parts 9505.0500 to 9505.0540 if the certification or authorization number is not issued or is withdrawn.

9505.0522 RECIPIENT'S RIGHT TO APPEAL.

A recipient who is denied inpatient hospital services because of the medical review agent's determination that the services are not medically necessary or who is denied a surgical procedure requiring a second surgical opinion because of the medical review agent's determination that the surgical procedure is not appropriate, may appeal the medical review agent's determination under *Minnesota Statutes*, section 256.045.

9505.0530 INCORPORATION BY REFERENCE OF CRITERIA TO DETERMINE MEDICAL NECESSITY.

The most recent edition of the Appropriateness Evaluation Protocol of the National Institutes of Health is incorporated by reference. The book is available at the Health Data Institute, ~~7 Wells Avenue, Newton~~ 20 Maguire Road, Lexington, Massachusetts, ~~02159~~ 02173, and it is also available through the Minitex interlibrary loan system. The book is subject to change.

The Criteria for Inpatient Psychiatric Treatment, 1981 edition, published by Blue Cross and Blue Shield of Minnesota are incorporated by reference. The criteria are available at Blue Cross and Blue Shield of Minnesota, P.O. Box 64560, Saint Paul, Minnesota 55164, and at the state law library, Ford Building, Saint Paul, Minnesota 55155. The criteria are not subject to frequent change.

9505.0540 CRITERIA TO DETERMINE MEDICAL NECESSITY OR APPROPRIATENESS.

Subpart 1. **Determination for admission for purpose other than chemical dependency treatment.** The medical review agent

shall follow the Appropriateness Evaluation Protocol and Criteria for Inpatient Psychiatric Treatment of Blue Cross and Blue Shield of Minnesota in determining whether a recipient's admission is medically necessary, whether the inpatient hospital services provided to the recipient were medically necessary, whether the recipient's continued stay will be medically necessary, and whether all medically necessary inpatient hospital services were provided to the recipient.

In determining whether a surgical procedure requiring a second surgical opinion is medically appropriate, the medical review agent shall follow the criteria published in the State Register pursuant to *Minnesota Statutes*, section 256B.02, subdivision 8, paragraph 21.

Subp. 2. **Determination for admission for chemical dependency treatment.** The assessment of a recipient's need for chemical dependency treatment in a hospital shall be made according to parts 9530.6600 to 9530.6655. ~~The person who conducted the assessment shall contact the medical review agent and request a certification number. If the person who conducted the assessment reports that the recipient meets the criteria for chemical dependency treatment in a hospital, the medical review agent shall issue a certification number.~~

Subp. 3. **Readmission considered as a second admission.** The medical review agent shall issue a certification number for a readmission that meets the criteria for medical necessity specified in subpart 1 whether the admitting and readmitting hospitals are the same or different. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. Both the admission and the readmission shall be subject to a retrospective review as provided in part 9505.0520, subpart 10. If the reason for the discharge and the reason for the readmission meet one set of circumstances specified in items A to D, the medical review agent shall determine that both the admission and the readmission shall retain the certification number subject to the hospitals' and admitting physicians' compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The readmission results from the recipient leaving the hospital against medical advice.

B. The readmission results from the recipient being noncompliant with medical advice that is recorded on the recipient's medical record as being given to the recipient at the admitting hospital. For purposes of this part, "recipient being noncompliant with medical advice" means that the recipient, fully informed of his or her medical condition, and fully understanding the need for the treatment and the follow-up discharge instructions, if any, refuses to adhere to the treatment or to follow the discharge instructions.

C. The readmission results from a new episode of the same diagnosis of an episodic illness or condition.

D. The readmission results from the fact that the recipient's discharge from the admitting hospital and readmission are medically necessary according to prevailing medical standards, practice, and usage.

Subp. 4. **Readmission considered as continuous with admission.** The medical review agent shall determine that a readmission of a recipient is continuous with the recipient's admission whether the admitting and readmitting hospitals are the same or different if the circumstances requiring the recipient's readmission meet one set of the circumstances specified in items A to C. The medical review agent shall issue a certification number if the readmission meets the criteria for medical necessity specified in subpart 1. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. Both the admission and the readmission shall be subject to a retrospective review as provided in part 9505.0520, subpart 10. Upon completing the retrospective review and determining whether the readmission and admission are consistent with item A, B, or C, the medical review agent shall take the action specified in the item that applies. Medical assistance payment for the inpatient hospital services retaining the certification number after the determination resulting from the retrospective review shall be paid according to parts 9500.1090 to 9500.1155 for the diagnostic category assigned to the recipient's principal diagnosis of the admission and readmission. In each circumstance, retention of the certification number shall be subject to the hospital's and admitting physician's compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The recipient was discharged from the admitting hospital without receiving the procedure or treatment of the condition diagnosed during the admission because of the hospital's or physician's preference or because of a scheduling conflict. If the admitting and readmitting hospitals are the same, the medical review agent shall withdraw the certification number of the readmission and determine the admission eligible to retain the certification number. If the admitting and readmitting hospitals are not the same, the medical review agent shall apply the requirements under subpart 5, item C, regarding readmission eligible for a transfer payment.

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B. The recipient's discharge was not appropriate according to prevailing medical standards, practice, and usage. If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admission eligible to retain the certification number and withdraw the certification number of the readmission. If the admitting and readmitting hospitals are different, the medical review agent shall withdraw the certification number of the admission and shall determine the readmission eligible to retain a certification number.

C. The recipient's discharge and readmission to the same hospital results from the preference of the recipient or the recipient's family that the recipient's treatment be delayed, that the recipient be discharged without receiving the necessary procedure or treatment, and that the recipient be readmitted for the necessary procedure or treatment. If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admission eligible to retain the certification number and withdraw the certification number of the readmission. If the admitting and readmitting hospitals are not the same, the medical review agent shall apply the requirements under subpart 5, item A, regarding readmission eligible for a transfer payment. For purposes of this part, "preference of the recipient or the recipient's family" means that the recipient or the recipient's family makes a choice to delay or change the location of inpatient hospital services, and the choice is compatible with prevailing medical standards, practices, and usage.

Subp. 5. **Readmission eligible for transfer payment.** The medical review agent shall issue a certification number for a readmission that is eligible for a transfer payment if the readmission meets the criteria for medical necessity specified in subpart 1 and a set of circumstances in item A, B, or C. The medical record of the admission must state why the recipient was discharged from the hospital and what the recipient's medical status was upon discharge, and the medical record of the readmission must state why the recipient is being readmitted and what the recipient's medical status is at readmission. The medical review agent shall conduct a retrospective review of the medical records, determine whether the readmission is consistent with the circumstances in item A, B, or C, and take the action specified in the item. Retention of the certification number by the hospital shall also be subject to the admitting physician's and hospital's compliance with all requirements of parts 9505.0500 to 9505.0540.

A. The readmission results from the preference of the recipient or the recipient's family that the recipient be discharged from the admitting hospital without receiving the necessary procedure or treatment and that the recipient be readmitted to a different hospital to obtain the necessary procedure or treatment. In this case, both hospitals shall retain their certification numbers subject to the hospitals' and admitting physicians' compliance with all requirements of parts 9505.0500 to 9505.0540, and medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1130, subpart 7, item A, for the inpatient hospital services necessary for the recipient's diagnosis and treatment.

B. The readmission results from a referral from one hospital to a different hospital because the recipient's medically necessary treatment was outside the scope of the first hospital's available services. In this case, both hospitals shall retain their certification numbers, and medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1130, subpart 7, item A, for the inpatient hospital services necessary for the recipient's diagnosis and treatment. If, however, the admission to the first hospital is not due to an emergency and the first hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for the recipient's treatment were outside the scope of the hospital's available services and the readmission to another hospital resulted because of the recipient's need for those services, the first hospital's certification number will be withdrawn.

C. The readmission results from a physician's or hospital's scheduling conflict at the admitting hospital. The medical review agent shall determine both hospitals eligible to retain their certification numbers. In this case, medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1130, subpart 7, item A, for the inpatient hospital services necessary for the recipient's diagnosis and treatment.

Subp. 6. **Physician adviser's review of readmission.** If the clinical evaluator is unable to determine from the documentation in the recipient's medical records the reasons for the recipient's discharge and readmission, the records shall be reviewed by the physician adviser, according to the procedure in part 9505.0520, subpart 10, item G.

Board of Psychology

Proposed Permanent Rules Relating to Licensing and Fees

Notice of Hearing

NOTICE IS HEREBY GIVEN that the Minnesota Board of Psychology (hereinafter "Board") will hold a public hearing in the above-captioned matter, pursuant to *Minnesota Statutes* §§ 14.131 to 14.20 (1986), in the upper level banquet room of the Fred Babcock VFW Post #5555, 710 Lakeshore Drive, Richfield, Minnesota 55423, on November 4, 1988, commencing at 9:00 a.m.

All interested or affected persons, including representatives of associations or other interested groups, will have an opportunity to participate. Such persons may present their views either orally at the hearing or in writing at any time prior to the close of the

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Amendments of Rules of the State Department of Human Services Governing Inpatient Hospital Admission Certification in the Medical Assistance and General Assistance Medical Care Programs, Minnesota Rules, Parts 9505.0500 to 9505.0540

FINDINGS OF FACT, CONCLUSIONS, AND ORDER ADOPTING RULE WITHOUT PUBLIC HEARING

Notice of the Commissioner's intent to adopt the above-entitled rule was published in the State Register on October 3, 1988, and was sent by United States mail to all persons on the list maintained by the agency pursuant to Minnesota Statutes, sections 14.14, subdivision 1a and 14.22, on September 28, 1988. The statement of need and reasonableness was prepared before the notice of intent to adopt a rule without a public hearing was mailed to all persons on the rulemaking mailing list and published in the State Register and was available to the public.

All persons were given the opportunity to submit comment on the rule for 30 days after notice of proposed rulemaking. No requests for a public hearing on the rule were received within the time period stated in the notice published in the State Register. Therefore, the agency did not receive requests for a public hearing from 25 or more persons which were not withdrawn. No requests for notice of submission to the attorney general were received by the agency. Written comments were received by the agency from Mr. Vern Silvernale, Vice President, Health Care Finance, Minnesota Hospital Association, within the time period stated.

Based on the comments and evidence in the record before the agency, I find the following:

1. 9505.0520, subpart 2, item B.

Mr. Vern Silvernale of Minnesota Hospital Association recommended a change in a related rule. The Department accepts his suggestion to modify part 9505.1130, subpart 5, item B and to clarify what claims will be denied by the Department.

Mr. Vern Silvernale also commented that the language of this section is inconsistent with the language in the related second surgical opinion rule (Part 9505.5015, subpart 4). He suggested that the Department amend this provision "to conform with existing Department policy" regarding third party liability.

The Department accepts this suggestion and amends the above provision as follows :

However, if an inpatient hospital service is also covered under Medicare, then denial of ~~an inpatient hospital~~ the service under Medicare ~~because the service is not medically necessary~~ on grounds other than medical necessity shall also constitute sufficient grounds for denying ~~payment~~ admission certification for the service under medical assistance.

This amendment is necessary because it ensures consistency between this rule and the reimbursement rule (part 9505.1130 subpart 5, item B) and the second surgical opinion rule (Part 9505.5000 to 9505.5105). The Department will determine "medical necessity" even if Medicare has denied services on the ground that they were not medically necessary. This is reasonable because the criteria for determining medical necessity are different for Medicare and for Medical Assistance. A determination that services were not medically necessary under Medicare does not therefore mean that services are not medically necessary under Medical Assistance.

If however services are denied under Medicare for other reasons, for example, delay in filing claims, procedural errors, etc., then Medical Assistance will deny admission certification. This is reasonable because Medical Assistance should not be required to pay for services which would have been paid under Medicare if the provider had been diligent.

The Department finds that this modification is not substantial but only clarifies the rule.

2. 9505.0520, subpart 4, item B, subitem 3.

Mr. Vern Silvernale suggested that the provision requiring retroactive certification for a pregnant woman whose admission does not result in the delivery of a newborn or a stillbirth within 24 hours of admission, be eliminated. He said that "the retroactive admission certification for most deliveries or a stillbirth within 24 hours would add to unnecessary paperwork for no useful purpose".

The Department declines to make the suggested change because the rule does not require retroactive admission certification for deliveries or a stillbirth within 24 hours. There will be no unnecessary paperwork because all that this provision requires is that if the admission of a pregnant woman does not result in a delivery or a stillbirth, retroactive certification is required.

3. 9505.0520, subpart 10, item F

Mr. Vern Silvernale recommends that the Department delete the provision that requires the hospital to submit, at the hospital's expense, documentation required by the medical review agent. He states that this provision "assumes total responsibility for record maintenance and accuracy to the hospitals".

The Department declines to make the suggested change because it is the hospital's responsibility to submit all relevant information to the medical review agent. It is also in the hospital's interest to do so because the hospital will be reimbursed for the surgical procedure if the medical review agent finds that it was medically appropriate, or that the surgical procedure was exempt from a second surgical opinion.

The Department also declines to make the change because the present rule already requires the hospital to submit, at its own expense, any information required by the medical review agent to conduct a retrospective review (See subpart 4, item B, and subpart 5). It would be inconsistent to change the financial requirement for second surgical opinion cases.

4. Part 9505.0540, subpart 4, item C

Part 9505.0540, subpart 4, item C deals with a situation where readmission will be considered as continuous with admission. Mr. Vern Silvernale commented that "by determining that the same hospital receives only one payment in a readmission you are inappropriately penalizing these hospitals". He suggested that the Department consider the readmission as a new admission.

The Department declines to accept this suggestion. This readmission criterion does not penalize a hospital because if the recipient had not chosen to delay treatment, and all necessary services were provided during the first admission, the hospital would receive payment for one admission only. In item C, the recipient returns for treatment only because all necessary services were not provided during the first admission, and the hospital continues treatment that it had begun earlier. Therefore it is reasonable to pay the hospital for one admission only.

5. 9505.0540, subpart 5, item B

Vern Silvernale of Minnesota Hospital Association suggested a modification in this provision. He said that the Department should add language to ensure that there is no confusion on what diagnosis would be considered within the capabilities of the hospital.

The Department accepts his suggestion. The above provision has been proposed by the Department as an amendment to parts 9505.0500 to 9505.0540. This provision is further modified to read as under :

If, however, the admission to the first hospital is not due to an emergency and the first hospital knew or had reason to know at the time of admission that inpatient hospital services that were medically necessary for the recipient's treatment or condition were outside the scope of the hospital's available services and the readmission to another hospital resulted because of the recipient's need for those services, the first hospital's certification number will be withdrawn.

The Department finds that the modification is not substantial and is only for the purpose of clarifying the rule.

The above-captioned rule is needed and reasonable.

NOW, THEREFORE, IT IS ORDERED that the rule identified as Inpatient Hospital Admission Certification in the Medical Assistance and General Assistance Medical Care Programs, Minnesota Rules, Parts 9505.0500 to 9505.0540, (as modified) is adopted this 1st day of December, 1988, pursuant to authority vested in me by Minnesota Statutes, section 256B.503, section 256B.04, subdivisions 2 and 15, and section 256D.03, subdivision 7(b). .

for Julie Brunner
SANDRA S. GARDEBRING
Commissioner

minnesota hospital association

REPRESENTING NONPROFIT HOSPITALS

October 25, 1988

Anu Seam
Department of Human Services
Rule Division
444 Lafayette Road
St. Paul, MN 55155-3816

Dear Ms. Seam:

I have enclosed the changes that the Minnesota Hospital Association would like considered for the following Rules:

- Inpatient Hospital Admission Certifications, Parts 9505.0500 to 9505.0540
- Prior Authorization of Health Services and the requirements of a second surgical opinion, Parts 9505.5000 to 9505.5105
- Inpatient Hospital Reimbursement, Parts 9500.1090 to 9500.1155

Please call if you have any questions.

Sincerely,

Vern Silvernale

Vern F. Silvernale, Vice President
Health Care Finance

FS/cj

Encl.

2221 UNIVERSITY AVENUE SE. SUITE 425 • MINNEAPOLIS, MINNESOTA 55414-3085 • PHONE (612) 331-5571

9505.0520 Inpatient Admissions Certifications

Page 8, lines 3 - 8

Subp. 4.B (3) The admission of a pregnant woman that does not result in the delivery of a newborn or a stillbirth within 24 hours of her admission, as specified in subpart 2, item B.

For purposes of this sub-item the time limit for notifying the medical review agent is calculated beginning with the time of the admission of the pregnant woman.

Issue: There continues to be a question over the necessity of this part of the rule. A retroactive admission certification for most deliveries or a stillbirth within 24 hours would add unnecessary paper work for no useful purpose.

Recommendation: Eliminate subpart.

9505.0520 Inpatient Admissions Certifications

Page 14, lines 29 - 36, Page 15, lines 1 - 4

Subp. 10 F. If the medical review agent conducting a retrospective review finds the recipient's medical record is inadequate to justify that a surgical procedure requiring a second opinion is medically appropriate, or that an exemption under part 9505.5040 was appropriate, the medical review agent may request a hospital to submit, at the hospital's expense, documentation substantiating the opinion of the third physician that the surgical procedure was medically appropriate, or that the exemption under part 9505.5040 was appropriate. The hospital shall submit the documentation within 20 days, exclusive of weekends and holidays, of the date of the notice requesting the documentation.

Issue: The hospital's financial responsibility for submitting documentation substantiating the opinion of the third physician. This assumes total responsibility for record maintenance and accuracy to the hospitals.

Recommendation: Delete the financial requirement from the hospital.

Page 14, line 34 may request a hospital to submit, ~~at the hospital's expense,~~

9505.0540 Criteria to determine medical necessity or appropriateness

Page 23, lines 18 - 27

Subp. 4. C. The recipients' discharge and readmission to the same hospital results from the preference of the recipient or the recipients's family that the recipient's treatment be delayed, that the recipient be discharged without receiving the necessary procedure or treatment, and that the recipient be readmitted for the necessary procedure or treatment. If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admission eligible to retain the certification number and withdraw the certification number of the readmission.

Issue: Application of the readmission policy for readmission to the same hospital or a different hospital. By determining that the same hospital receives only one payment in a readmission you are inappropriately penalizing these hospitals.

Recommendation: Eliminate the mandate to withdraw the certification number for readmission to the same hospital.

~~If the admitting and readmitting hospitals are the same, the medical review agent shall determine the admissions eligible to retain the certification number and withdraw the certification number of the readmission.~~

9505.0540 Criteria to Determine Medical Necessity or Appropriateness

Pages 24 & 25 Lines 30 - 36 and 1 - 10

Subp. 5.B. The readmission results from a referral from one hospital to a different hospital because the recipients's medically necessary treatment was outside the scope of the first hospital's available services. In this case, both hospitals shall retain their certification numbers, and medical assistance payment to each hospital shall be made according to the transfer payment established under part 9500.1130, subpart 7, item A, for the inpatient hospital services necessary for the recipient's diagnosis and treatment. If, however, the admission to the first hospital is not due to an emergency and the first hospital knew or had reason to know at the time of admission that the inpatient hospital services that were medically necessary for the recipient's treatment were outside the scope of the hospital's available services and the readmission to another hospital resulted because of the recipients's need for those services, the first hospital's certification number will be withdrawn.

Issue: The assumption is that all hospitals will be able to immediately determine if a patient is within the capabilities their services. The admitting diagnosis is also a criteria that needs to be identified, not only the condition.

Recommendation: Add language to insure that there is no confusion on what diagnosis would be considered within the capabilities of the hospital.

the recipient's treatment or condition were outside the scope of the hospital's available services and the readmission to another hospital resulted because of the recipient's need for those services, the first hospital's certification number will be withdrawn.

9505.5010 Prior Authorization

Page 3 & 4, lines 35 & 36 and 1-12

Subp. 4. Third party liability. A provider of a health service originally billed to Medicare or a third party payer as defined in part 9505.0015, subpart 46, for which Medicare or the third party payer denied payment or made a partial payment may retroactively submit a request for authorization if the provider wants to receive payment of the difference between the medical assistance or general assistance medical care payment rate for the service and the payment by the third party payer. The service is eligible for medical assistance or general assistance medical care reimbursement if it meets the criteria in part 9505.5030 and if the authorization request is submitted to the department along with a copy of the notice explaining the denial or partial payment within 20 working days of the date of the notice.

Issue: The language of this part is in conflict with 9500.1130. subp.5.B and 9505.0520 subp. 3.B which precludes payment for denied Medicare claims. 2

Recommendation: Retain this language and amend 9505.0520 and 9500.1130 to conform with existing Department policy.

9505.5075 Physician Responsibility

Page 7, line 13 - 17

The completed form must be returned to the physician offering to provide the surgical service and must be made available by the physician to the Department as provided in part 9505.5080, or, on request, to a medical review agent under contract to the department.

Issue: The requirement to maintain these records assumes a set period of time. That length of time should be identified.

Recommendation: The Department establishes a policy to identify, in rule, how long this record should be maintained.

9500.1130 Reimbursement Procedures

Page 3, lines 18 & 19

Subp. 5.B. Claims will not be reimbursed if inpatient hospital services have already been denied under Medicare.

Issue: The language of this subpart would limit the Department to the same services that are provided by Medicare. Because the Medicaid program covers services not covered under Medicaid, I would recommend changing the language to allow for a clearer understanding of services being denied.

Recommended Change:

Subp. 5.B. Claims will not be reimbursed for <u>covered Medicare</u> inpatient hospital services that have already been denied under Medicare.

In the Matter of the Adoption
of Amendments to the Rule of the State
Department of Human Services Relating to
Inpatient Hospital Admission Certification
in the Medical Assistance and General
Assistance Medical Care Programs,
Minnesota Rules, Parts 9505.0500 to 9505.0540

DECLARATION OF
COUNSEL

I, Neil Scott, Special Assistant Attorney General, do hereby declare that I have examined the above captioned rule, and the supporting rulemaking record, and that, based on my examination, the Administrative Procedure Act and Minnesota Rules, chapter 2010 have been followed. Any exceptions are listed below. For Attorney General billing purposes, the four-digit docket client code is 0866.

Special Assistant
Attorney General

Dated: 11/30/88

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-38___

Rush

TO: Rita Desmond
515 Transportation Building
St. Paul, MN 55155

FROM: Anu Seam
Rules Unit
444 Lafayette Road
St. Paul, MN 55155

SUBJECT: Review of Rules Adopted Without a Public Hearing; Minnesota Department of Human Services rules governing Inpatient Hospital Admission Certification (Parts 9505.0500 to 9505.0540), Inpatient Hospital Reimbursement (Parts 9500.1090 to 9500.1155), and Procedures for Prior Authorization and Second Surgical Opinion (Parts 9505.5000 to 9505.5105) for Medical Assistance and General Assistance Medical Care Programs.

Enclosed are the documents required to be submitted under Minnesota Rules, part 2010.0300 for your review of a rule adopted without a public hearing for the above entitled matter.

Official documents in this submitted material include:

1. A photocopy of the notices of solicitation of outside information or opinions as published in the State Register.

2. A copy of the proposed rules with a certificate of approval as to form by the revisor of statutes attached.

3. The notices of hearing and intent to cancel hearing if fewer than twenty-five persons request a hearing in response to notice of intent to adopt rules without a public hearing as mailed.

4. The notices of intent to adopt a rule without a public hearing and notice of intent to adopt a rule with a public hearing if twenty five or more persons request a public hearing as mailed.

5. The statements of need and reasonableness in support of the proposed rules complying with part 2010.0700.

6. The affidavits of mailing the notices of intent to adopt a rule without a public hearing. The affidavits state that the mailing list maintained by the agency pursuant to Minnesota Statutes, sections 14.22 and 14.14, subdivision 1a is accurate, complete, and current and that the notice of intent to adopt the rule without a public hearing was mailed to all persons and groups whose names appear on the list.

7. The affidavits of additional mailing.

8. A photocopy of :

A. The notices of hearing and intent to cancel hearing if fewer than twenty-five persons request a hearing in response to notice of intent to adopt rules without a public hearing as published in the State Register, and,

B. The notices of intent to adopt the rule without a public hearing and notice of intent to adopt a rule with a public hearing if twenty five or more persons request a hearing as published in the State Register.

9. Four copies of the rules as adopted. Any modification made to the proposed rule is reflected on the rule as adopted and is approved as to form by the revisor of statutes.

10. The findings of fact, conclusions, and order adopting the rules.

11. All written requests, submissions, or comments on the rules received by the agency except requests solely for copies of the rule or of the statement of need and reasonableness.

12. The declaration of the attorney in the attorney general's office who represents the agency.

13. No requests to be notified of submittal of the rule to the Attorney General.

If you have any questions on this submitted material, please call me at (612) 297-4997