CHAPTER 4651
DEPARTMENT OF HEALTH
HEALTH CARE PROVIDER REPORTING

4651.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of this chapter, the following terms have the meanings given them.

Subp. 2. **Bad debt.** "Bad debt" means the actual amounts of charges that were not collected from patients who were considered as patients with the ability to pay, when a collection attempt has been made.

Subp. 3. **Billing and collection costs.** "Billing and collection costs" means all costs incurred as a result of, or while performing, the various functions involved in the process of billing and collecting for patient care services including: preparation of billings, submission of claims, receipt of cash, posting of payment, and collection of past due accounts. Billing and collection costs includes costs of the personnel performing or supervising these functions, including salary and benefits; costs of occupancy expenses, including rent, depreciation, and utilities; and costs for space used for these functions. Billing and collection costs also includes costs for billing and collection systems, whether manual or computerized; electronic claims processing systems; payments to collection agencies; billing and collection forms and supplies; postage; payments to outside billing service bureaus; or any other costs related to the billing and collection function.

Subp. 4. **Charity care.** "Charity care" means the total amount of dollars written off for uninsured or underinsured individuals who cannot pay for total charges billed because of limited income or unusual circumstances.

Subp. 5. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Health or an authorized agent.

Subp. 6. **Discounts, disallowed charges, and contractual adjustments.** "Discounts," "disallowed charges," and "contractual adjustments" means the portion of the amount billed that the provider is not allowed to collect due to contractual arrangements with a health plan or insurer.

Subp. 7. **Donations, grants, and subsidies.** "Donations," "grants," and "subsidies" means revenues or receipts from an individual, group, foundation, government entity, or corporate donor with or without specific purpose which are not in connection with payment for patient care and not for the purpose of research or education.

Subp. 8. **Education revenue.** "Education revenue" means the revenue and receipts received or earned by the clinic or health care provider to provide training or education to students, health care professionals, or members of the community.

Subp. 9. **Education–degree program costs.** "Education–degree program costs" means all costs associated with formally organized or planned programs of study approved by the governing body of the health care provider which result in the conferring of a degree or specialty designation. These activities must be licensed if required by state law or, if licensing is not required, then the program must be approved by the recognized national professional organization for that particular activity. Education–degree program costs also includes costs of the personnel performing or supervising these functions, including salary and benefits; costs of occupancy expenses, including rent, depreciation, and utilities; costs for space used for these functions; and any other costs related to this function such as supplies and equipment.

Subp. 10. **Education–other costs.** "Education–other costs" means all costs incurred for educational programs, including continuing education programs, staff development seminars, and other training programs for health care professional staff and any other clinic

personnel. Education–other costs also includes costs of the personnel performing or supervising these functions, including salary and benefits; costs of occupancy expenses, including rent, depreciation, and utilities; costs for space used for these functions; and any other costs related to this function such as registration fees, travel expenses, lodging, and course materials.

Subp. 11. **Encounter.** "Encounter" means a contact between a patient and a health care provider during which a service is rendered. Encounter also means an instance of the professional component of laboratory and radiology services. Patients may have more than one encounter per day. An encounter does not include failed appointments, telephone contacts, or the technical component of radiology or laboratory services.

Subp. 12. **Financial, accounting, and reporting costs.** "Financial, accounting, and reporting costs" means the cost of the accumulation of financial accounting information and the preparation and filing of internal and external financial, statistical, or utilization reports required by management; federal, state, county, or local governmental agencies; or other nongovernmental entities. Financial, accounting, and reporting costs includes general accounting, financial reporting, budgeting, cost accounting, payroll, accounts payable, inventory accounting, fixed assets accounting, or tax and government reporting, and costs of the personnel performing or supervising these functions, including salary and benefits; costs of occupancy expenses, including rent, depreciation, and utilities; costs for space used for these functions; and any other costs related to this function such as supplies and equipment.

Subp. 13. [Repealed, 20 SR 2405]

Subp. 14. **Malpractice costs.** "Malpractice costs" means any costs related to malpractice or professional liability. Malpractice costs includes premiums paid for malpractice and professional liability insurance, malpractice claim reserves, actual claims paid, premiums for tail insurance coverage, and attorney fees to defend claims.

Subp. 15. **MinnesotaCare tax.** "MinnesotaCare tax" means the tax due to the MinnesotaCare program established under Minnesota Statutes, section 295.52.

Subp. 16. **Other patient care costs.** "Other patient care costs" means other costs necessary for direct patient care other than patient care personnel costs as defined in subpart 16a. Other patient care costs includes all expenses for professional services purchased from other providers; drugs and medications; transportation of health care staff; laboratory, radiology, physical therapy, or optical supplies; costs for movable or nonmovable medical equipment, including depreciation on owned equipment or rental fees on leased equipment; medical equipment maintenance; information and communication systems that directly support health care professionals, such as laboratory information systems and paging systems; medical waste disposal, uniforms, linen service, and allocated occupancy expenses, including rent, depreciation, and utilities; and costs for space used for direct patient care services such as exam rooms, nurses stations, and laboratories.

Subp. 16a. **Patient care personnel costs.** "Patient care personnel costs" means all compensation costs for personnel involved in providing health care services directly to patients, including the costs of patient care personnel who own the reporting entity, who are employees of the reporting entity, or who are independent contractors. Patient care personnel costs includes salaries, benefits, fees, commissions, production bonuses, profit sharing, and any other form of compensation provided to patient care personnel.

Subp. 17. [Repealed, 20 SR 2405]

Subp. 18. **Patient registration, scheduling, and admissions costs.** "Patient registration, scheduling, and admissions costs" means all costs related to the processing of information necessary to provide care to patients, including costs for scheduling patient visits within and outside the provider's clinic, registering patients, maintaining medical records for patient visits, admissions, precertification, and other related functions. Patient registration, scheduling, and admissions costs also includes receptionists, appointment schedulers, medical transcriptionists, and preadmission review personnel, and costs of the personnel performing or supervising these functions, including salary and benefits; costs of occupancy expenses, including rent, depreciation, and utilities; costs for space used for these functions; and any other related expenses such as supplies and equipment.

Subp. 19. **Patient and public health education costs.** "Patient and public health education costs" means the costs associated with health promotion, wellness education, and disease–specific patient information. Patient and public health education costs includes all costs associated with providing educational programs or materials intended for patients or the public at large, including patient education materials that are printed or on video, and seminars, workshops, or classes, that are used to educate or inform patients or the general public on enhancing or modifying health behavior and promoting healthier lifestyles. Patient and public health education costs also include the costs of the personnel performing or supervising these functions, including salary and benefits; costs of occupancy expenses, including rent, depreciation, and utilities; costs for space used for these functions; and any other costs related to this function such as training materials, supplies, and equipment.

Subp. 20. **Promotion and marketing costs.** "Promotion and marketing costs" means all costs related to performing or supervising marketing activities such as advertising, printing, marketing, representative wages and fringe benefits, commissions, broker fees, travel, occupancy, and other expenses allocated to the marketing activity. Promotion and marketing costs does not include costs associated with health promotion, wellness education, and patient education programs.

Subp. 20a. **Provider identifier.** "Provider identifier" means the provider's unique provider identification number or, if the provider does not have a unique provider identification number, the provider's Minnesota license number. If the provider does not have a Minnesota license, then provider identifier means the provider's license number from another jurisdiction. After the Centers for Medicare and Medicaid Services implements a national provider identifier, provider identifier will mean the national provider identifier issued by the Centers for Medicare and Medicaid Services.

Subp. 21. **Research costs.** "Research costs" means the direct and general program costs for activities which are part of a formal program of medical or scientific research approved by the governing body of the health care provider. Research costs includes clinical, general health services, outcomes, and basic science research, and may or may not involve patients. Research costs includes the cost of the personnel performing or supervising these functions, including salary and benefits; costs of occupancy expenses, including rent, depreciation, and utilities; costs for space used for these functions; and any other costs related to this function such as supplies and equipment.

Subp. 22. **Research revenue.** "Research revenue" means all revenue or receipts received or due for activities which are part of a formal program of medical or scientific research approved by the governing body of the health care provider. Research revenue includes clinical research and basic science research and may or may not involve patients.

Subp. 23. **Utilization review and quality assurance costs.** "Utilization review and quality assurance costs" means the costs of programs or activities specifically established or designated for the purpose of monitoring and measuring the use of health care resources and the quality of care provided to patients, including utilization review, quality assurance, quality improvement, and peer review. Utilization review and quality assurance costs includes the costs of individuals who dedicate their time or a portion of their time to perform or supervise these functions, including salary and benefits; costs of occupancy expenses including rent, depreciation, and utilities; costs for space used for these functions; and any other related expenses such as supplies and equipment.

Statutory Authority: *MS s 62J.321; 62J.35*

History: *19 SR 1581; 20 SR 2405; L 2002 c 277 s 32*

4651.0110 HEALTH CARE PROVIDER REPORTING.

Subpart 1. [Repealed, 20 SR 2405]

Subp. 2. **Medical doctor and doctor of osteopathy reporting; date for filing; reporting period.** This subpart applies to health care providers who are medical doctors licensed under Minnesota Statutes, section 147.02, or doctors of osteopathy licensed under Minnesota Statutes, section 147.031. These health care providers shall file with the commissioner a health care provider financial and statistical report on or before April 1 of each year. The re-

port must be on forms or computer formats issued or approved by the commissioner and must contain data from the preceding calendar year.

The commissioner shall use a statistically valid sample of these providers whose solo practice or clinic has total revenues of less than $1,000,000 instead of requiring all such providers to submit the report. For purposes of this subpart, total revenues are as specified in part 4651.0120, item K. Providers selected to be in the sample shall complete the report on or before April 1 of the year sampled. Providers not selected to be in the sample are not required to complete the report.

Subp. 2a. **Chiropractor and dentist reporting; date for filing; reporting period.** This subpart applies to health care providers who are chiropractors licensed under Minnesota Statutes, section 148.06, or dentists licensed under Minnesota Statutes, section 150A.06. If the commissioner determines that collecting data from these health care providers is important for monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota or for estimating total Minnesota health care expenditures and trends, then the commissioner shall use a statistically valid sample of such providers. Providers selected to be in the sample shall file with the commissioner a health care provider financial and statistical report on or before April 1 of the year sampled. The report must be on forms or computer formats issued or approved by the commissioner and must contain data from the preceding calendar year. Providers not selected to be in the sample are not required to complete the report.

Subp. 3. **Clinic or group reporting.** Health care providers organized as a clinic or group may jointly file one report that meets the requirements of part 4651.0120 for the clinic or group.

Subp. 4. **Aggregate reporting.** An organization operating more than one clinic may report to the commissioner for all clinics. An organization may submit the data in the report for each clinic or in the aggregate for all clinics. If the data is submitted in the aggregate for all clinics, then the organization must include the name, address, and number of encounters for each clinic covered by the report.

Subp. 5. **Small business providers.** This subpart applies to health care providers who are required to report pursuant to subpart 2 or 2a. A health care provider whose solo practice or clinic has total revenues of less than $1,000,000 may file a short report in lieu of filing a report that meets the requirements of part 4651.0120. For purposes of this subdivision, total revenues are as specified in part 4651.0120, item K. The short report must include information required by part 4651.0120, items A to K, O, and P. The short report must also include expenses in the categories specified in part 4651.0120, item N, subitems (1), (3), (8), (9), (13), and (15).

Statutory Authority: *MS s 62J.321; 62J.35*

History: *19 SR 1581; 20 SR 2405*

4651.0120 REPORTING REQUIREMENTS.

The report must include:

A. the following statistical and demographic data: the clinic, group, or organization name, system ownership if applicable, county, telephone number, and federal tax identification number or employee identification number, as appropriate, and whether participating or nonparticipating in the Medicare program;

B. the name of the health care providers furnishing services at the health care provider's location, including each provider's identifier;

C. the total number of full–time equivalent employees for the health care provider by type of employee, including medical doctors, doctors of osteopathy, chiropractors, dentists, physician assistants, advanced practice nurses, registered nurses, other patient care personnel, other personnel who do not provide patient care, and provider services under agreement;

D. the number of encounters for the health care provider, broken down by Minnesota or non–Minnesota residency status;

E. the number of encounters by clinic site;

F. the type of accounting method, including accrual, cash, or modified cash, used to describe financial data on the form;

G. the signature and telephone number of the person completing the report and certification that the contents of the report are true to the best of that person's knowledge and, if a person who is not an employee of the clinic is used to assist in the preparation of the report, the name, address, employer, and telephone number of the person;

H. a statement of net patient receipts for the health care provider itemized by type of payer. Net patient receipt allocations may be calculated by making estimates based upon existing information and historical experience. Any reasonable method of allocation is acceptable. Net patient receipts may be calculated on historical experience using percentages applied to total revenue amounts. The provider of the data does not need to go back through all individual patient records from the previous year to sort out the information requested. Net patient receipts must be reported in the following categories:

(1) Medicare;

(2) medical assistance, general assistance medical care, and MinnesotaCare;

(3) other public payers;

(4) commercial insurers, preferred provider organizations, and nonprofit health plan corporations;

(5) health maintenance organizations, CISNs, and ISNs;

(6) workers' compensation and automobile personal injury;

(7) patient pay, including deductibles, copayments, self-filed insurance, and services not covered by insurance; and

(8) revenues from contracts which cannot reasonably be allocated to the categories in subitems (1) to (7);

I. a statement of net patient receipts which are received on a contractual per-member per-month capitated basis, where the amount the provider is reimbursed is not directly related to the amount or coding of services provided. Net patient receipt allocations may be calculated by making estimates based on existing information and historical experience. Any reasonable method of allocation is acceptable. Net patient receipts may be calculated on historical experience using percentages applied to total revenue amounts. The provider of the data does not need to go back through all individual patient records from the previous year to sort out the information requested;

J. a statement of other operating revenue for the health care provider itemized as follows:

(1) research revenue;

(2) education revenue;

(3) donations, grants, and subsidies, which are not for research or education;

(4) other operating revenues not captured in the categories in subitems (1) to (3); and

(5) the subtotal of other revenues which are the sum of subitems (1) to (4);

K. total revenues, which are the sum of items H and J, subitem (5);

L. a statement of charity care and bad debt;

M. an optional statement total of discounts, disallowed charges, and contractual adjustments;

N. a statement of expenses for the health care provider. The expense allocations may be calculated by making estimates based upon existing information and historical experience. Any reasonable method of allocation is acceptable. Expenses may be allocated based on the number of full-time equivalent employees performing the specific categorical tasks, on a percentage basis, on a square footage basis when allocating costs for space, or on the basis of any other allocation. The provider of the data does not need to conduct time studies or keep detailed time records for the purpose of allocating costs. The expenses must be reported in the following categories:

(1) patient care personnel costs;

(2) other patient care costs;

(3) malpractice costs;

(4) billing and collection costs;

(5) patient registration, scheduling, and admissions costs;

(6) financial, accounting, and reporting costs;

(7) utilization review and quality assurance costs;

(8) research costs;

(9) education–degree program costs;

(10) patient and public health education costs;

(11) education–other costs;

(12) promotion and marketing costs;

(13) MinnesotaCare tax;

(14) other costs not captured in subitems (1) to (13); and

(15) total expenses, which are the sum of subitems (1) to (14);

O. the time spent to complete the report; and

P. a statement indicating whether or not the respondent received outside assistance to complete the report.

Statutory Authority: *MS s 62J.321; 62J.35*

History: *19 SR 1581; L 1995 c 234 art 8 s 56; 20 SR 2405*

4651.0130 FILING OF REPORTS; EXTENSIONS.

A health care provider that shows reasonable cause may obtain from the commissioner an extension to file the report. The health care provider must provide the commissioner with a written request for an extension to file, specifying the reason or reasons for the requested extension, and the proposed date for filing the report. "Reasonable cause" means that the health care provider can demonstrate that compliance with the reporting requirements imposes an unreasonable cost to the health care provider, clinic, or group, or that technical or unforeseen difficulties prevent compliance.

Statutory Authority: *MS s 62J.35*

History: *19 SR 1581*

4651.0140 REVIEW OF REPORTS.

Subpart 1. **Completeness.** The commissioner shall review each report required by part 4651.0120 to determine that the report is complete. If the report is found to be complete or if the commissioner has not notified the health care provider within 60 days of receiving the report that the report is incomplete, then the report is deemed to be filed as of the day it was received. "Complete" means that the report contains adequate data for the commissioner to begin the review and is in a form determined to be acceptable by the commissioner according to this chapter.

Subp. 2. **Incomplete report.** A report determined by the commissioner to be incomplete must be returned to the health care provider with a statement describing the report's deficiencies. The health care provider must resubmit an amended report to the commissioner. If the report is resubmitted within 30 days and is determined to be complete by the commissioner, then it shall be deemed to be filed as of the day it was first received by the commissioner.

Subp. 3. **Amending reports.** If a health care provider discovers a material error in its statements or calculations in any of its submitted reports determined by the commissioner to be complete, the health care provider shall immediately inform the commissioner of the error and, within a reasonable time, submit a written amendment to the report. Submission of an amendment under this subpart does not affect the date of filing.

Subp. 4. **Error in reports.** If the commissioner discovers a material error in the statements or calculations in a report, the commissioner shall require the health care provider to amend and resubmit the report within a reasonable time. In determining a reasonable time,

the commissioner shall consider factors relevant to the amount of time necessary to amend the report.

Statutory Authority: *MS s 62J.35*

History: *19 SR 1581*

4651.0150 VARIANCES.

Subpart 1. **Data from other sources.** On a request by a provider or on the commissioner's own initiative, the commissioner shall determine whether to use data from other sources instead of collecting data required by this chapter. To make this determination, the commissioner shall consider whether:

A. the data from other sources are duplicative of data required under this chapter;

B. the data from other sources are available at a reasonable cost;

C. the commissioner has the resources readily available to use the data from other sources; and

D. the commissioner will be able to use the data from other sources to meet all statutory data collection, analysis, and privacy requirements.

Subp. 2. **Aggregate reporting for systems.** An organization operating a clinic which is part of a system of clinics, hospitals, or group purchasers may request to report to the commissioner for all components of the system as an aggregate. If the commissioner determines that the commissioner will be able to use the data from the system as an aggregate to meet all statutory data collection, analysis, and privacy requirements, then the commissioner shall grant the request.

Statutory Authority: *MS s 62J.321*

History: *20 SR 2405*