9505.2165 DEFINITIONS.

Subpart 1. **Scope.** The terms in parts 9505.2160 to 9505.2245 shall have the meanings given them in this part and in part 9505.0175, the medical assistance definitions.

Subp. 2. **Abuse.** "Abuse" means:

A. in the case of a vendor, a pattern of practices that are inconsistent with sound fiscal, business, or health service practices, and that result in unnecessary costs to the programs or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health service. The following practices are deemed to be abuse by a vendor:

(1) submitting repeated claims, or causing claims to be submitted, from which required information is missing or incorrect;

(2) submitting repeated claims, or causing claims to be submitted, using procedure codes that overstate the level or amount of health service provided;

(3) submitting repeated claims, or causing claims to be submitted, for health services which are not reimbursable under the programs;

(4) submitting repeated duplicate claims, or causing claims to be submitted, for the same health service provided to the same recipient;

(5) submitting repeated claims, or causing claims to be submitted, for health services that do not comply with part 9505.0210 and, if applicable, part 9505.0215;

(6) submitting repeated claims, or causing claims to be submitted, for health services that are not medically necessary;

(7) failing to develop and maintain health service records as required under part 9505.2175;

(8) failing to use generally accepted accounting principles or other accounting methods which relate entries on the recipient's health service record to corresponding entries on the billing invoice, unless another accounting method or principle is required by federal or state law or rule;

(9) failing to disclose or make available to the department the recipient's health service records or the vendor's financial records as required by part 9505.2185;

(10) repeatedly failing to properly report duplicate payments from third party payers for covered health services provided to a recipient under a program and billed to the department;

(11) failing to obtain information and assignment of benefits as specified in part 9505.0070, subpart 3, or to bill Medicare as required by part 9505.0440;

(12) failing to keep financial records as required under part 9505.2180;

(13) repeatedly submitting or causing false information to be submitted for the purpose of obtaining a service agreement, prior authorization, inpatient hospital admission certification under parts 9505.0501 to 9505.0540, or a second surgical opinion as required under part 9505.5035;

(14) submitting a false or fraudulent application for provider status;

(15) soliciting, charging, or receiving payments from recipients or nonmedical assistance sources, in violation of Code of Federal Regulations, title 42, section 447.15, or part 9505.0225, for services for which the vendor has received reimbursement from or should have billed to the program;

(16) payment by a vendor of program funds to another vendor whom the vendor knew or had reason to know was suspended or terminated from program participation;

(17) repeatedly billing a program for health services after entering into an agreement with a third-party payer to accept an amount in full satisfaction of the payer's liability;

(18) repeatedly failing to comply with the requirements of the provider agreement that relate to the programs covered by parts 9505.2160 to 9505.2245;

(19) failing to comply with the ownership and control information disclosure requirements of Code of Federal Regulations, title 42, part 455;

(20) billing for services that were provided to a recipient without the request or consent of the recipient, the recipient's guardian, or the recipient's responsible party;

(21) billing for services that were outside of the scope of the vendor's license, or in the case of a vendor that is not required to hold a license, billing by a vendor for services that the vendor is not authorized to provide under applicable regulatory agency requirements; or

(22) billing for services in a manner that circumvents the program's spenddown requirement;

B. in the case of a recipient, the use of health services that results in unnecessary costs to the programs, or in reimbursements for services that are not medically necessary. The following practices are deemed to be abuse by a recipient:

(1) obtaining equipment, supplies, drugs, or health services that are in excess of program limitations or that are not medically necessary and that are paid for through a program;

(2) obtaining duplicate or comparable services for the same health condition from a multiple number of vendors, such as going to multiple pharmacies or physicians. Duplicate or comparable services do not include an additional opinion that is medically necessary for the diagnosis, evaluation, or assessment of the recipient's condition or required under program rules, or a service provided by a school district as specified in the recipient's individualized education program under Minnesota Statutes, section 256B.0625, subdivision 26;

(3) continuing to engage in practices that are abusive of the program after receiving the department's written warning that the conduct must cease;

(4) altering or duplicating the medical identification card for the purpose of obtaining additional health services billed to the program or aiding another person to obtain such services;

(5) using a medical identification card that belongs to another person;

(6) using the medical identification card to assist an unauthorized individual in obtaining a health service for which a program is billed;

(7) duplicating or altering prescriptions;

(8) misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services, or drugs;

(9) furnishing incorrect eligibility status or information to a vendor;

(10) furnishing false information to a vendor in connection with health services previously rendered to the recipient which were billed to a program;

(11) obtaining health services by false pretenses;

(12) repeatedly obtaining health services that are potentially harmful to the recipient;

(13) repeatedly obtaining emergency room health services for nonemergency care;

(14) repeatedly using medical transportation to obtain health services from providers located outside the local trade area when health services appropriate to the recipient's physical or mental health needs can be obtained inside the local trade area. For purposes of this subitem, "local trade area" has the meaning given in part 9505.0175, subpart 22; or

(15) repeatedly arranging for services and then canceling services in order to circumvent the spenddown requirement; and

C. in addition to the criteria in item B, the following practices are deemed to be abuse by a recipient enrolled in the restricted recipient program:

(1) obtaining medical services from a physician without a referral from the recipient's designated primary care provider;

(2) obtaining emergency room services for nonemergency care;

(3) obtaining prescriptions from a pharmacy other than the designated pharmacy; or

(4) obtaining health services from a nondesignated provider when the recipient has been required to designate a provider.

Subp. 2a. **Electronically stored data.** "Electronically stored data" means data stored by any electronic means, including, but not limited to, data stored in an existing or preexisting computer system or computer network, magnetic tape, or computer disk.

Subp. 3. **Federal share.** "Federal share" means the percent of federal financial participation in the cost of the state's medical assistance program.

Subp. 4. **Fraud.** "Fraud" means:

A. acts which constitute a crime against any program, or attempts or conspiracies to commit those crimes, including the following:

(1) theft in violation of Minnesota Statutes, section 609.52;

(2) perjury in violation of Minnesota Statutes, section 609.48;

(3) aggravated forgery and forgery in violation of Minnesota Statutes, sections 609.625 and 609.63;

(4) medical assistance fraud in violation of Minnesota Statutes, section 609.466; and

(5) financial transaction card fraud in violation of Minnesota Statutes, section 609.821;

B. making a false statement, false claim, or false representation to a program where the person knows or should reasonably know the statement, claim, or representation is false, including knowingly and willfully submitting a false or fraudulent application for provider status; and

C. a felony listed in United States Code, title 42, section 1320a-7b(b)(3)(D), subject to any safe harbors established in Code of Federal Regulations, title 42, part 1001, section 952.

Subp. 4a. **Health plan.** "Health plan" means a health maintenance organization or other organization that contracts with the department to provide health services to recipients under a prepaid contract.

Subp. 5. **Health services.** "Health services" has the meaning given in part 9505.0175, subpart 14.

Subp. 6. **Health service record.** "Health service record" means documentation of the health service that is electronically stored, written, or diagrammed that indicates the nature, extent, and evidence of the medical necessity of a health service provided by a vendor and billed to a program.

Subp. 6a. [Repealed, 19 SR 1898]

Subp. 6b. [Repealed, 19 SR 1898]

Subp. 6c. **Investigative costs.** "Investigative costs" are subject to the provisions of Minnesota Statutes, section 256B.064, subdivision 1d, and means the sum of the following expenses incurred by the department's investigator on a particular case:

A. hourly wage multiplied by the number of hours spent on the case;

B. employee benefits;

C. travel;

D. lodging;

E. meals; and

F. photocopying costs, paper, computer data storage or diskettes, and computer records and printouts.

Subp. 6d. **Lockout.** "Lockout" means excluding or limiting up to 24 months the scope of health services for which a vendor may receive payment through a program.

Subp. 6e. **Medically necessary or medical necessity.** "Medically necessary" or "medical necessity" has the meaning given in part 9505.0175, subpart 25.

Subp. 6f. **Ownership or control interest.** "Ownership or control interest" has the meaning given in Code of Federal Regulations, title 42, part 455, sections 101 and 102.

Subp. 6g. **Pattern.** "Pattern" means an identifiable series of more than one event or activity.

Subp. 7. **Primary care provider.** "Primary care provider" means a provider designated by the department who is a physician or a group of physicians, nurse practitioner, or physician assistant practicing within the scope of the provider's practice, who is responsible for the direct care of a recipient, and for coordinating and controlling access to or initiating or supervising other health services needed by the recipient.

Subp. 8. **Program.** "Program" means the Minnesota medical assistance program, the general assistance medical care program, MinnesotaCare, consolidated chemical dependency program, prepaid health plans, home and community-based services under a waiver from the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, or any other health service program administered by the department.

Subp. 9. **Provider.** "Provider" has the meaning given in part 9505.0175, subpart 38, and also includes a personal care provider.

Subp. 10. **Recipient.** "Recipient" means an individual who has been determined eligible to receive health services under a program.

Subp. 10a. **Responsible party.** "Responsible party" has the meaning given in Minnesota Statutes, section 256B.0655, subdivision 1h.

Subp. 10b. **Restricted recipient program.** "Restricted recipient program" means a program for recipients who have failed to comply with the requirements of the program. Placement in the restricted recipient program does not include long-term care facilities. Placement in the restricted recipient program means:

A. requiring the recipient for a period of 24 or 36 months of eligibility to obtain health services from a designated primary care provider, hospital, pharmacy, or other designated health service provider located in the recipient's local trade area; or

B. prohibiting the recipient from using the personal care assistant choice or consumer-directed services for a period of 24 months of eligibility.

Subp. 11. [Repealed, 33 SR 127]

Subp. 12. **Suspending participation or suspension.** "Suspending participation" or "suspension" means making a vendor ineligible for reimbursement through program funds for a stated period of time.

Subp. 13. **Suspending payments.** "Suspending payments" means stopping any or all program payments for health services billed by a provider pending resolution of the matter in dispute between the provider and the department.

Subp. 14. **Terminating participation or termination.** "Terminating participation" or "termination" means making a vendor ineligible for reimbursement through program funds.

Subp. 15. **Theft.** "Theft" means the act defined in Minnesota Statutes, section 609.52, subdivision 2.

Subp. 16. **Third-party payer.** "Third-party payer" means the term defined in part 9505.0015, subpart 46, and the Medicare program.

Subp. 16a. **Vendor.** "Vendor" has the meaning given to "vendor of medical care" in Minnesota Statutes, section 256B.02, subdivision 7. The term "vendor" includes a provider and also a personal care assistant. A vendor is subject to criminal background checks according to Minnesota Statutes, section 245C.03.

Subp. 17. **Withholding payments.** "Withholding payments" means reducing or adjusting the amounts paid to a provider to offset overpayments previously made to the provider.

Statutory Authority: *MS s 256B.04; 256D.03*

History: *15 SR 2563; 16 SR 960; 19 SR 1898; L 2002 c 277 s 32; 33 SR 127; L 2011 1Sp11 art 3 s 12*

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