Rules as Proposed (all new material)

12 MCAR S 2.064 Surveillance and Utilization Review program.

A. Introduction.

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

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

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

~~necessary to assist others in the interpretation of this rule. Such publications do not have the force and effect of law, however, they do contain the state agency's interpretation of this rule~~ to assist others in complying with this rule.

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

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

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

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

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

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

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

e. Failure of a provider to use generally accepted accounting principles, or other accounting methods which relate

entries on the medical or health care record to corresponding entries on the billing invoice, unless otherwise indicated by federal or state law or rule.

f. The repeated submission of claims by a provider for health care ~~that is contrary to the generally accepted standards of practice of a provider's field of practice or specialty~~ which is not medically necessary, or which is of an unacceptable quality.

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

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

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

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

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

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

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

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

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

7. "Medically necessary." Health care ~~that is within the generally accepted standards of practice of a provider's field of practice or specialty and is~~ which is rendered pursuant to the provider's authority under state law and within the scope of his/her license, if any, and is:

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

~~b.~~ Provided in response to life threatening conditions, or

~~c.~~ b. Provided in response to pain, or

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

~~e. Provided as periodic examination and diagnosis, or~~

~~f. Provided as preventive health care.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Records.

1. Medical and health care records.

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

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

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

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

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

(3) ~~Initial and final~~ Diagnoses, assessments or evaluations.

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

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

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

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

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

(9) Copies of consultation reports relating to a

particular recipient.

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

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

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

(1) Pharmacies.

(a) Prescriptions or equivalent computer record.

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

(2) Laboratories.

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

(b) Documentation of test results.

(3) Ambulance service and medical transportation providers.

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

(b) Trip tickets.

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

(4) Suppliers of medical equipment and nondurable supplies.

(a) Prescriptions.

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

2. Financial records.

a. Financial records pertaining to the provider's costs (if the provider is reimbursed on a cost basis) and

charges for health care provided to program recipients shall be developed and maintained.

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

(1) Purchase invoices.

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

(3) All contracts for supplies and services which relate to the ~~providers~~ provider's costs and charges for health care billed to the programs.

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

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

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

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

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

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

has submitted a claim for reimbursement, a cost report or a rate application which may be false in whole or in part or whether or not the health care was medically necessary. The SUR section shall notify the provider at least 24 hours before gaining access to such records. Upon the request of the provider, the SUR section shall present a copy of the recipient's written authorization to examine personal medical records unless the provider already has received written authorization from the recipient. A provider's refusal to grant the state agency access to examine records when authorized shall be grounds for sanction. ~~Nothing in this section shall be construed as applying to the Utilization Control Unit of the SUR section of the state agency.~~

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

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

6. In the event of a change of ownership of a facility or practice ~~all records generated prior to the change shall be retained by the provider assuming responsibility for the health care of recipients. Nothing in this provision shall have the effect of making either party involved in a change of ownership liable for the actions of the other party~~ the seller, unless otherwise provided by law or by written agreement, shall be responsible for maintaining and preserving all records generated prior to the date of sale. Responsibility for making records available for inspection after the date of sale is on the seller and the seller must take reasonable steps by contract or otherwise to maintain a right of access to those records which is necessary to substantiate his billings, cost reports, or rate applications.

7. In the event a provider withdraws or is terminated from the programs, all records developed during participation in

the programs, and not subject to the provisions of item 6 of this section, shall be retained by the provider for a period of five (5) years and shall be available for review by the state agency. Providers must retain records for at least 5 years after the date of billing.

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

D. Provider Surveillance and Utilization Review.

1. Identification of suspected fraud and abuse.

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

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

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

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

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

(4) Professional standards review organizations.

(5) Citizens, including recipients.

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

c. In assessing questions of abuse or medical

necessity, SUR shall ~~utilize health care professionals either employed by or serving as consultants to the state agency~~ consult with a review organization as defined in Minn. Stat. S 145.61 or other provider advisory committees as appointed by the Commissioner.

2. Investigation of suspected fraud or abuse.

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

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

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

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

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

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

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

(3) Interviews of program recipients.

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

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

(6) Examination of prescriptions written for program recipients.

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

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

(1) Determine that no further action is warranted

and so notify the provider.

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

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

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

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

a. Grounds for monetary recovery and sanctions.

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

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

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

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

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

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

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

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

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

(3) The commissioner shall suspend or terminate any

provider who has been suspended or terminated from participation in the Medicare program because of fraud or abuse in connection with the Title XVIII of the Social Security Act.

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

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

(2) Withholding of payments.

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

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

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

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

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

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

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

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

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

chosen for the sample;

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

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

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

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

(a) the nature of claims to be sampled;

(b) the sample size;

(c) the sample selection method; and

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

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

(5) If the department does not accept the provider's

rebuttal, the provider may appeal under procedures cited at F. of this rule.

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

(1) Referral to the appropriate state regulatory agency.

(2) Referral to the appropriate peer review mechanism.

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

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

(5) Suspending or terminating participation.

e. Notice to providers.

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

(2) The notice shall state:

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

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

(c) How such dollar value was computed;

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

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

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

(3) The effective date of the proposed monetary recovery or sanction shall be at least 20 calendar days following receipt of certified mail notifying the provider of the proposed action. If the provider appeals pursuant to F. of this rule, the action shall not be implemented until the commissioner's order is issued following the hearing on appeal, provided that the suspending or withholding of payment shall be

effective on the date the notice is received, if in the commissioner's opinion such action is necessary to protect the public welfare and interests of the program. However, the commissioner shall not order a prehearing suspension or withholding of payments to a nursing home or board and care home. Implementation of a proposed action following the hearing on appeal may be postponed if in the opinion of the commissioner the delayed action is necessary to protect the welfare or interests of program recipients.

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

(1) Nature and extent of offenses or violations;

(2) History of prior violations;

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

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

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

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

i. When a provider has been sanctioned in accordance

with subsection D.3.c. of this rule, after all appeals have been exhausted or the time in which to file an appeal has elapsed, the state agency shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made, sanctions imposed, appeals made and the results of any subsequent appeal.

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

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

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

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

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

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

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

E. Recipient Surveillance and Utilization Review.

1. Identification of suspected fraud and abuse.

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

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

c. In assessing the question of medical necessity, SUR

shall ~~utilize health care professionals either employed by or serving as consultants to the state agency~~ consult with a review organization as defined in Minn. Stat. S 145.61 or other provider advisory committees as appointed by the Commissioner.

2. Investigation of suspected fraud and abuse.

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

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

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

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

3. Sanctions.

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

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

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

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

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

(5) Duplicating or altering prescriptions.

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

(7) Knowingly furnishing incorrect eligibility

status or information to a provider.

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

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

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

(11) Otherwise obtaining health care by false pretenses.

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

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

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

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

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

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

c. Notice to recipients.

(1) The state agency shall cause the recipients to

be notified in writing of any sanction it intends to impose.

(2) The notice shall state:

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

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

(c) How such dollar amount was computed;

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

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

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

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

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

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

F. Appeal.

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

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

3. Nothing in this rule shall prevent a provider or recipient, upon receipt of a notice of intended sanction, from meeting with the commissioner to informally discuss the matter

in dispute, so long as a ~~Chapter 15 contested case~~ an appeal has not been commenced.

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