Department of Human Services

Adopted Permanent Rules Relating to Surveillance and Utilization Review of Medical Assistance Services

Rules as Adopted

SURVEILLANCE AND UTILIZATION REVIEW OF MEDICAL ASSISTANCE SERVICES

9505.0180 SURVEILLANCE AND UTILIZATION CONTROL PROGRAM.

Subpart 1. [See repealer.]

Subp. 2. **Duty to implement.** The department shall carry out a program of a surveillance and utilization review under parts ~~9505.1750 to 9505.2150~~ 9505.2160 to 9505.2245 and Code of Federal Regulations, title 42, part 455, and a program of utilization control under Code of Federal Regulations, title 42, part 456. These programs together constitute the surveillance and utilization control program.

Subp. 3. **Surveillance and utilization review.** The surveillance and utilization review program must have a post payment review process to ensure compliance with the medical assistance program and to monitor both the use of health services by recipients and the delivery of health services by providers. The process must comply with parts ~~9505.1750 to 9505.2150~~ 9505.2160 to 9505.2245.

Subp. 4. **Utilization control.** The department shall administer and monitor a program of utilization control to review the need for, and the quality and timeliness of, health services provided in a hospital, long-term care facility, or institution for the treatment of mental diseases. A facility certified for participation in the medical assistance program must comply with the requirements of Code of Federal Regulations, title 42, part 456 for utilization control.

9505.2160 SCOPE AND APPLICABILITY.

Subpart 1. **Scope.** Parts 9505.2160 to 9505.2245 govern procedures to be used by the department in identifying and

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investigating fraud, theft, or abuse by providers or recipients of health services through the medical assistance, general assistance medical care, consolidated chemical dependency treatment, children's health plan, catastrophic health expense protection programs, home and community-based services under a waiver from the Health Care Financing Administration of the United States Department of Health and Human Services, or any other health service program administered by the department, and for the imposition of sanctions against providers and recipients of health services. Additionally, parts 9505.2160 to 9505.2245 establish standards applicable to the health service and financial records of providers of health services through medical assistance, general assistance medical care, consolidated chemical dependency treatment, children's health plan, or catastrophic health expense protection programs.

Parts 9505.2160 to 9505.2245 must be read in conjunction with titles XVIII and XIX of the Social Security Act; Code of Federal Regulations, title 42; Minnesota Statutes, chapters 62E, 145, 245, 245A, 252, 253, 254A, 254B, 256, 256B, 256D, 256E, and 609~~;-parts-9500.1070;-9505.0010-to-9505.0491;-9505.0500-to-9505.0540;-9505.1000-to-9505.1040;-9505.1100-to-9505.1380;-9505.2390-to-9505.2500;-9505.3010-to-9505.3230;-9505.5000-to-9505.5105;-9530.6800-to-9530.7030;-and-other-rules-of-the-department-establishing-health-service-standards-for-a-program~~.

Subp. 2. **Applicability.** Parts 9505.2160 to 9505.2245 apply to local agencies, providers participating in a program, and recipients of health services through a program.

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 provider, a pattern of practices that ~~are~~ is inconsistent with sound fiscal, business, or health service practices, and that result in unnecessary costs to the

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programs, or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health service. ~~Abuse by a provider is characterized by, but not limited to~~ The following practices are deemed to be abuse by a provider:

(1) submitting repeated claims from which required information is missing or incorrect;

(2) submitting repeated claims using procedure codes which overstate the level or amount of health service provided;

(3) submitting repeated claims for health services which are not reimbursable under the programs;

(4) submitting repeated duplicate claims for the same health service provided to the same recipient;

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

(6) ~~submitting claims for health services which exceed those requested or agreed to by the recipient or the recipient's responsible relative or guardian or the standard required by federal or state law or rule for a program~~ repeated submission of claims for 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) repeatedly failing to disclose or make available to the department the recipient's health service records or the provider's financial records as required by part 9505.2180;

(10) failing to properly report duplicate payments from third party payers for covered 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 repeated submission of false information for the purpose of obtaining prior authorization, inpatient hospital admission certification under parts 9505.0500 to 9505.0540, or a second surgical opinion as required under part 9505.5035;

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

(15) ~~continuing to engage in a practice that is abusive of a program after receiving the department's written warning that the conduct must cease;~~

~~(16)~~ 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 provider has received reimbursement from or should have billed to the program;

~~(17)~~ (16) payment by a provider of program funds to a vendor whom the provider knew or had reason to know was suspended or terminated from program participation;

~~(18)~~ (17) repeatedly billing a program for services after entering into an agreement with a third party payer to accept an amount in full satisfaction of the payer's liability; or

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. ~~Abuse by a recipient is characterized by, but not limited to, the presence of one of the following conditions~~ 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

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that are not medically necessary and that are paid for through a program;

(2) obtaining duplicate services for the same health condition from a multiple number of providers. Duplicate service does 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 plan 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 ~~in any manner~~ 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 provider;

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

(11) ~~otherwise~~ obtaining health service by false pretenses.

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

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Subp. 4. **Fraud.** "Fraud" means medical assistance fraud as defined in Minnesota Statutes, section 609.466.

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 written or diagrammed documentation of the nature, extent, and evidence of the medical necessity of a health service provided to a recipient by a provider and billed to a program.

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

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

Subp. 7. **Primary care case manager.** "Primary care case manager" means a provider designated by the department who is a physician or a group of physicians, who is employed by or under contract with the Department of Human Services, and who is responsible for the direct care of a recipient, and for coordinating and controlling access to or initiating or supervising other health care services needed by the recipient.

Subp. 8. **Program.** "Program" means the Minnesota medical assistance program, the general assistance medical care program, catastrophic health expense protection program, children's health plan, consolidated chemical dependency program, home and community-based services under a waiver from the Health Care Financing Administration of the United States Department of Health and Human Services, or any other health service program administered by the department.

Subp. 9. **Provider.** "Provider" ~~means a vendor of health services as defined~~ has the meaning given in part 9505.0175, subpart 38.

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

Subp. 11. **Restriction.** "Restriction" means:

A. in the case of a provider, excluding or limiting

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the scope of the health services for which a provider may receive a payment through a program for a reasonable time; or

B. in the case of a recipient, limiting the recipient's participation in a program for a period of 24 months, to only health services which have been prior authorized, or to health services from a designated primary care case manager or other designated health service providers. The restriction of a recipient must be indicated on the recipient's medical identification card or other form of program identification, under part 9505.0145, subpart 4. For purposes of restriction, designated health service providers do not include ~~skilled-or-intermediate-care-nursing-services~~ long-term care facilities.

Subp. 12. **Suspending participation or suspension.** "Suspending participation" or "suspension" means making a provider ineligible for reimbursement by a program 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.** "Terminating participation" means making a provider ineligible for reimbursement by a program.

Subp. 15. **Theft.** "Theft" means the act defined in Minnesota Statutes, section 609.52, subdivision 2, clause (3)(c).

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

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

~~9505.2170-BULLETINS,-MANUALS,-AND-FORMS-RELATED-TO-PROGRAM.~~

~~Subpart-1.--Department-issuance.--The-department-may-issue bulletins,-manuals,-and-forms-prescribed-by-the-commissioner~~

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~~that-are-consistent-with-parts-9505.2160-to-9505.2245-and-are needed-to-assist-providers,-local-agencies,-and-recipients-in complying-with-parts-9505.2160-to-9505.2245-and-other-rules-of the-programs.~~

~~Subp.-2.--**Provider-compliance.**--A-provider-shall-comply with-the-requirements-of-procedures-and-forms-prescribed-by-the commissioner-under-subdivision-1.~~

9505.2175 HEALTH SERVICE RECORDS.

Subpart 1. **Documentation requirement.** As a condition for payment by a program, a provider must document each occurrence of a health service provided to a recipient. The health service must be documented in the recipient's health service record as specified in subpart 2 and, when applicable, subparts 3 to 6. Program funds paid for a health service not documented in a recipient's health service record shall be recovered.

Subp. 2. **Required standards for health service records.** A provider must keep a health service record as specified in items A to I.

A. The record must be legible at a minimum to the individual providing care.

B. The recipient's name must be on each page of the recipient's record.

C. Each entry in the health service record must contain:

(1) the date on which the entry is made;

(2) the date or dates on which the health service is provided;

(3) the length of time spent with the recipient if the amount paid for the service depends on time spent;

(4) the signature and title of the person from whom the recipient received the service; and

(5) when applicable, the countersignature of the provider or the supervisor as required under parts 9505.0170 to 9505.0475.

D. The record must state:

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(1) the recipient's case history and health condition as determined by the provider's examination or assessment;

(2) the results of all diagnostic tests and examinations; and

(3) the diagnosis resulting from the examination.

E. The record must show the quantity, dosage, and name of prescribed drugs ordered for or administered to the recipient.

F. The record must contain reports of consultations that are ordered for the recipient.

G. The record must contain the recipient's plan of care, individual treatment plan, or individual program plan. For purposes of this item, "plan of care" has the meaning given in part 9505.0175, subpart 35; "individual treatment plan" has the meaning given in part 9505.0477, subpart 14; and "individual program plan" has the meaning given in part 9535.0100, subpart 15.

H. The record must report the recipient's progress or response to treatment, and changes in the treatment or diagnosis.

I. The record of a laboratory or X-ray service must document the provider's order for service.

Subp. 3. **Requirements for pharmacy service records.** A pharmacy service record must comply with the requirements of subparts 1 and 2 and Minnesota Rules, part 6800.3110, relating to pharmacy licensing and operations, and Minnesota Rules, part 6800.3950, relating to electronic data processing of pharmacy records. However, the pharmacy service record must be a hard copy made at the time of the request for service and must be kept for five years as required under part 9505.2190, subpart 1.

Subp. 4. **Requirements for medical transportation service records.** A medical transportation record must meet the requirements of subparts 1 and 2 and must document:

A. the origin, destination, and distance traveled in providing the service to the recipient;

B. the type of transportation; and

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C. if applicable, a physician's certification for nonemergency, ancillary, or special transportation services as defined in part 9505.0315, subpart 1, items A and F.

Subp. 5. **Requirements for medical supplies and equipment records.** A medical supplies and equipment record must meet the requirements of subparts 1 and 2 and:

A. must document that the medical supply or equipment meets the criteria in parts 9505.0210 and 9505.0310; and

B. except as provided in part 9505.2190, subpart 1, must contain a hard copy of the provider's order or prescription for the medical supply or equipment and the name and amount of the medical supply or equipment provided for the recipient.

Subp. 6. **Requirements for rehabilitative and therapeutic services.** Rehabilitative and therapeutic service records must meet the requirements of subparts 1 and 2 and must meet the criteria in part 9505.0412.

9505.2180 FINANCIAL RECORDS.

Subpart 1. **Financial records required of providers.** The financial records of a provider who receives payment for a recipient's services under a program must contain the material specified in items A to H:

A. ~~accounting records, such as~~ payroll ledgers, canceled checks, ~~and~~ bank deposit slips and any other accounting records prepared for the provider;

B. contracts for services or supplies that relate to the provider's costs and billings to a program for the recipient's health services;

C. evidence of the provider's charges to recipients and to persons who are not recipients, consistent with the requirements of Minnesota Statutes, chapter 13;

D. evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to third party payers or programs;

E. ~~patient~~ the provider's appointment books for patient appointments and ~~supervision~~ the provider's schedules

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for patient supervision, if applicable;

F. billing transmittal forms;

G. records showing all persons, corporations, partnerships, and entities with an ownership or control interest in the provider as defined in Code of Federal Regulations, title 42, section 455.101; and

H. employee records for those persons currently employed by the provider or who have been employed by the provider at any time within the previous five years which under the Minnesota Government Data Practices Act would be considered public data for a public employee such as employee name, salary, qualifications, position description, job title, and dates of employment; and in addition employee records shall include the current home address of the employee or the last known address of any former employee.

Subp. 2. **Additional financial records required for long-term care facilities.** A long-term care facility must maintain:

A. the records required under subpart 1;

B. purchase invoices; and

C. records of the deposits and expenditure of funds in the recipients' resident fund accounts as required under part 9505.0425.

9505.2185 ACCESS TO RECORDS.

Subpart 1. **Recipient's consent to access.** A recipient of medical assistance is deemed to have authorized in writing a provider or others to release to the department for examination according to Minnesota Statutes, section 256B.27, subdivision 4, upon the department's request, the medical assistance recipient's health service ~~and financial~~ records related to services under a program. The medical assistance recipient's authorization of the release and review of health service ~~and financial~~ records for services provided while the person is a medical assistance recipient shall be presumed competent if given in conjunction with the person's application

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for ~~a program~~ medical assistance. This presumption shall exist regardless of whether the application was signed by the person or the person's guardian or authorized representative as defined in part 9505.0015, subpart 8.

Subp. 2. **Department access to provider records.** A provider shall grant the department access during the provider's regular business hours to examine health service and financial records related to a health service billed to a program. Access to a recipient's health service record shall be for the purposes in part 9505.2200, subpart 1. The department shall notify the provider no less than 24 hours before obtaining access to a health service or financial record, unless the provider waives notice.

9505.2190 RETENTION OF RECORDS.

Subpart 1. **Retention required; general.** A provider shall retain a health service and financial record related to a health service for which payment under a program was received or billed for at least five years after the initial date of billing. Microfilm records satisfy the record keeping requirements of this subpart and part 9505.2175, subpart 3, in the fourth and fifth years after the date of billing.

Subp. 2. **Record retention after provider withdrawal or termination.** A provider who withdraws or is terminated from a program must retain or make available to the department on demand the health service and financial records required under subpart 1.

Subp. 3. **Record retention under change of ownership.** If the ownership of a long-term care facility or provider service changes, the transferor, unless otherwise provided by law or written agreement with the transferee, is responsible for maintaining, preserving, and making available to the department on demand the health service and financial records related to services generated before the date of the transfer as required under subpart 1 and part 9505.2185, subpart 2.

Subp. 4. **Record retention in contested cases.** In the

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event of a contested case, the provider must retain health service and financial records as required by subpart 1 or for the duration of the contested case proceedings, whichever period is longer.

9505.2195 COPYING RECORDS.

The department, at its own expense, may photocopy or otherwise duplicate any health service or financial record related to a health service for which a provider makes a claim or receives payment under a program. Photocopying shall be done on the provider's premises unless removal is specifically permitted by the provider. If a provider fails to allow the department to use the department's equipment to photocopy or duplicate any health service or financial record on the premises, the provider must furnish copies at the provider's expense within two weeks of a request for copies by the department.

9505.2200 IDENTIFICATION AND INVESTIGATION OF SUSPECTED FRAUD AND ABUSE.

Subpart 1. **Department investigation.** The department ~~may~~ shall investigate providers or recipients to monitor compliance with program requirements ~~or to identify~~ for the purposes of identifying fraud, theft, or abuse in the administration of the programs.

Subp. 2. **Contacts to obtain information.** The department may contact ~~persons, agencies, organizations, and others~~ any person, agency, organization, or other entity that ~~may be~~ is necessary to an investigation under subpart 1. ~~Examples~~ Among those who may be contacted are:

A. government agencies;

B. third party payers, including Medicare;

C. professional review organizations as defined in Minnesota Statutes, section 145.61, subdivision 5, or their representatives;

D. a professional services advisory committee established under part 9505.0185 or its representative;

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E. recipients and their responsible relatives;

F. providers and persons employed by or under contract to providers;

G. professional associations of providers and their peers;

H. recipients and recipient advocacy organizations; and

I. members of the public.

Subp. 3. **Activities included in department's investigation.** The department's ~~investigation may include, but is not limited to, the activities specified in items A to G~~ authority to investigate extends to the examination of any person, document, or thing which is likely to lead to information relevant to the expenditure of funds, provision of services, or purchase of items identified in part 9505.2160, subpart 1, provided that the information sought is not privileged against such an investigation by operation of any state or federal law. Among the activities which the department's investigation may include are as follows:

A. examination of health service and financial records;

B. examination of equipment, materials, prescribed drugs, or other items used in or for a recipient's health service under a program;

C. examination of prescriptions for recipients;

D. interviews of contacts specified in subpart 2;

E. verification of the professional credentials of a provider, the provider's employees, and entities under contract with the provider to provide health services or maintain health service and financial records related to a program;

F. consultation with the department's peer review mechanisms; and

G. determination of whether a health service provided to a recipient meets the criteria of parts 9505.0210 and 9505.0215.

Subp. 4. **Determination of investigation.** After completing

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its investigation under subparts 1 to 3, the department shall determine whether:

A. the provider or the recipient is in compliance with the requirements of a program;

B. insufficient evidence exists that fraud, theft, or abuse has occurred; or

C. the evidence of fraud, theft, or abuse supports administrative, civil, or criminal action.

Subp. 5. **Postinvestigation action.** After completing the determination required under subpart 4, the department shall take one or more of the actions specified in items A to F:

A. close the investigation when no further action is warranted;

B. impose administrative sanctions according to part 9505.2210;

C. seek monetary recovery according to part 9505.2215;

D. refer the investigation to the appropriate state regulatory agency;

E. refer the investigation to the attorney general or, if appropriate, to a county attorney for possible ~~administrative,~~ civil~~,~~ or criminal legal action; or

F. issue a warning that states the practices are potentially in violation of program laws or regulations.

9505.2205 COMMISSIONER TO DECIDE IMPOSITION OF SANCTION.

The commissioner shall decide what sanction shall be imposed against a provider or recipient under part 9505.2210. The commissioner ~~may~~ shall consider the recipient's personal preferences in the designation of a primary care case manager. In addition, the commissioner shall consider the following factors in determining the sanctions to be imposed:

A. nature and extent of fraud, theft, or abuse;

B. history of fraud, theft, or abuse;

C. willingness of provider or recipient to ~~obey~~ comply with program rules;

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D. actions taken or recommended by other state regulatory agencies; and

E. in the case of a recipient, the local trade area and access to medically necessary services in the designation of a primary care case manager or other restrictions.

9505.2210 IMPOSITION OF ADMINISTRATIVE SANCTIONS.

Subpart 1. **Authority to impose administrative sanction.** The commissioner ~~may~~ shall impose administrative sanctions or issue a warning letter if the department's investigation under part 9505.2200 determines the presence of fraud, theft, or abuse in connection with a program or if the provider or recipient refuses to grant the department access to records as required under part 9505.2185.

Subp. 2. **Nature of administrative sanction.** The actions specified in items A and B are administrative sanctions that the commissioner may impose for the conduct specified in subpart 1.

A. For a provider, the actions are:

(1) referral to the appropriate peer review mechanism;

(2) transfer to a provider agreement of limited duration;

(3) transfer to a provider agreement which stipulates specific conditions of participation;

(4) suspending or terminating the provider's participation;

(5) requiring attendance at provider education sessions provided by the department;

(6) requiring prior authorization of the provider's services;

(7) review of the provider's claims before payment; and

(8) restricting the provider's participation in a program.

B. For a recipient, except as provided in subpart 3, the actions are:

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(1) referral for appropriate health counseling to correct inappropriate or dangerous use of health care services;

(2) restriction of the recipient; and

(3) referral to the appropriate adult or child protection agency.

Subp. 3. **Emergency health services excepted from restrictions.** Emergency health services provided to a restricted recipient by a provider shall be eligible for payment by a program if the service provided is otherwise eligible for payment by a program. The department may require the provider to provide documentation of the emergency circumstance with the emergency service payment claim.

9505.2215 MONETARY RECOVERY.

Subpart 1. **Authority to seek monetary recovery.** The commissioner ~~may~~ shall seek monetary recovery:

A. from a provider, if payment for a recipient's health service under a program was the result of fraud, theft, or abuse, or error on the part of the provider, department, or local agency; or

B. from a recipient, if payment for a health service provided under a program was the result of fraud, theft, or abuse, or error on the part of the recipient absent a showing that recovery would, in that particular case, be unreasonable or unfair.

Subp. 2. **Methods of monetary recovery.** The commissioner shall recover money described in subpart 1 by the following means:

A. permitting voluntary repayment of money, either in lump sum payment or installment payments;

B. using any legal collection process;

C. deducting or withholding from program payments money described in subpart 1; and

D. withholding payments to a provider under Code of Federal Regulations, title 42, section ~~7.21;-or~~

~~E.---requesting-Medicare-to-withhold-payments-pending~~

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~~recovery of money described in subpart 1~~ 447.31.

Subp. 3. **Interest charges on monetary recovery.** If the department permits the use of installment payments to repay money described in subpart 1, the department may assess interest on the funds to be received at the rate established by the Department of Revenue under Minnesota Statutes, section 270.75. Interest may accrue from the effective date of recovery, as specified in part 9505.2230, subpart 2.

9505.2220 USE OF RANDOM SAMPLE EXTRAPOLATION IN MONETARY RECOVERY.

Subpart 1. **Authorization.** For the purpose of part 9505.2215, the commissioner shall be authorized to calculate the amount of monetary recovery from a provider of money erroneously paid based upon extrapolation from systematic random samples of claims submitted by the provider and paid by the program or programs. The department's random sample extrapolation shall constitute a rebuttable presumption regarding the calculation of monetary recovery. If the presumption is not rebutted by the provider in the appeal process, the department shall use the extropolation as the monetary recovery figure specified in subpart 3.

Subp. 2. **Decision to use samples.** The department shall decide whether sampling and extrapolation are to be used in calculating a monetary recovery according to the following criteria:

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.

Subp. 3. **Sampling method.** The department shall use the methods in items A to D in calculating the amount of monetary recovery by random sample extrapolation.

A. Samples of a given size shall be selected in such a way that every sample of that size shall be equally likely to be selected.

B. Samples shall only be selected from claims for

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health services provided within the interval that coincides with the interval during which money allegedly was erroneously provided and for which recovery will be made.

C. The sampling method, including sample size, sample selections, and extrapolation from the results of the sample, shall be according to statistical procedures published in the following text: W. Cochran, Sampling Techniques, John Wiley and Sons, New York 3rd Ed. (1977). Sampling Techniques is incorporated by reference and is available through the Minitex interlibrary loan system.

D. The sample size will be sufficiently large so that the estimate of the amount which would be recovered by a full audit will be within five percent of that amount with 95 percent confidence. ~~The department will recover the amount which would be recovered by a full audit, less the five percent factor lower end point of a (two sided) 95 percent confidence interval for that amount~~ A two-sided 95 percent confidence interval for that amount will be computed. The department's calculated monetary recovery is the lower end of that confidence interval.

9505.2225 SUSPENSION OF PROVIDER CONVICTED OF CRIME RELATED TO MEDICARE OR MEDICAL ASSISTANCE.

The commissioner shall suspend a provider who has been convicted of a crime related to Medicare or medical assistance as provided in ~~part 9505.0475. The provider shall be notified as specified in part 9505.0475, subpart 5, and shall have the right to appeal as specified in part 9505.0475, subpart 6~~ Minnesota Statutes, sections 256B.064 and 256D.03, subdivision 7, clause (b). The procedures in part 9505.0475 shall be followed in the suspension process.

9505.2230 NOTICE OF AGENCY ACTION.

Subpart 1. **Required written notice.** The department shall give notice in writing to a provider or recipient of a monetary recovery or administrative sanction that is to be imposed by the department. The notice shall be sent by first class mail. The department shall place an affidavit of the mailing in the

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provider's or recipient's file as an indication of the date of mailing and the address. The notice shall state:

A. the factual basis for the department's determination according to part 9505.2200, subpart 4;

B. the actions the department plans to take;

C. the dollar amount of the monetary recovery, if any;

D. how the dollar amount was computed;

E. the right to dispute the department's determinations and to provide evidence; and

F. the right to appeal the department's proposed action under part 9505.2245.

Subp. 2. **Effective date of recovery or sanction.** For providers, the effective date of the proposed monetary recovery or sanction shall be the first day after the last day for requesting an appeal as provided in part 9505.2245, subpart 1, item B. For recipients, the effective date of the proposed action shall be 30 days after the recipient's receipt of the notice required under subpart 1. If an appeal is made under part 9505.2245, the proposed action shall be delayed pending the final outcome of the appeal, except as provided by part 9505.2231. Implementation of a proposed action following the resolution of an appeal may be postponed if in the opinion of the commissioner the delay of action is necessary to protect the health or safety of the recipient or recipients.

Subp. 3. **Effect of department's administrative determination.** Unless a timely and proper appeal made under part 9505.2245 is received by the department, the administrative determination of the department shall be considered final and binding.

9505.2231 SUSPENSION OR WITHHOLDING OF PAYMENTS TO PROVIDERS BEFORE APPEAL.

Subpart 1. **Grounds for suspension or withholding.** The commissioner is authorized to suspend ~~a provider from program participation~~ or withhold payments to a provider before an

appeal provided in part 9505.2245, if:

A. there is substantial likelihood that the department will prevail in an action under parts 9505.2160 to 9505.2245;

B. there is a substantial likelihood that the provider's practice, which is the basis for the department's determination made under part 9505.2200, subpart 4, will continue in the future;

C. there is reasonable cause to doubt the provider's financial ability to repay the amount determined to be due; or

D. suspending participation or withholding payment is necessary to comply with Minnesota Statutes, section 256B.064, subdivision 2.

Subp. 2. **Exception to prehearing suspension or withholding.** The commissioner shall not order a prehearing suspension or withholding of payments to a nursing home or ~~board and care home~~ convalescent care facility.

Subp. 3. **Federal share.** When an overpayment has been made by the department, the commissioner is authorized to recover from a provider the federal share when it is due to the federal government under federal law and regulations.

9505.2235 SUSPENSION OR TERMINATION OF PROVIDER PARTICIPATION.

Subpart 1. **Effect of suspension or termination as provider.** The provider agreement of a vendor who is under suspension or terminated from participation shall be void from the date of the suspension or termination. A suspension or termination from medical assistance does not mean suspension or termination from another program unless the suspension or termination is extended to that program. The vendor who is under suspension or terminated from participation shall not submit a claim for payment under a program, either through a claim as an individual or through a claim submitted by a clinic, group, corporation, or professional association except in the case of claims for payment for health services provided before the vendor's suspension or termination from participation. No

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payments shall be made to a vendor, either directly or indirectly, for services provided under a program from which the vendor had been suspended or terminated.

Subp. 2. **Reinstatement of vendor as provider.** A vendor who is under suspension or terminated from participation is eligible to apply for reinstatement as a provider at the end of the period of suspension or when the basis for termination no longer exists. The department shall review a vendor's application to determine whether the vendor is qualified to participate as specified by the provider participation requirements of part 9505.0195 and Code of Federal Regulations, title 42, sections 1002.230 to 1002.234.

Subp. 3. **Prohibited submission of vendor's claims.** A clinic, group, corporation, or other professional association shall not submit a claim for a health service under a program provided by a vendor who is under suspension or terminated from participation unless the health service was provided before the vendor's suspension or termination. If a clinic, group, corporation, or other professional association receives payment under a program for a health service provided by a vendor after the vendor's suspension or termination from participation, the department shall recover the amount of the payment and may impose administrative sanctions against the clinic, group, corporation, or other professional association if the commissioner determines that the provider knew or had reason to know of the suspension or termination.

9505.2236 RESTRICTION OF PROVIDER PARTICIPATION.

Subpart 1. **Effect of restriction on a provider.** The provider agreement of a provider who is restricted from participation shall be amended by the restriction specified in the notice of action to the vendor provided under part 9505.2230. The provider who is restricted from participation shall not submit a claim for payment under a program for services or charges specified in the notice of action, either through a claim as an individual or through a claim submitted by

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a clinic, group, corporation, or professional association, except in the case of claims for payment for health services otherwise eligible for payment and provided before the restriction. No payments shall be made to a provider, either directly or indirectly, for restricted services or charges specified in the notice of action.

Subp. 2. **Reinstatement of restricted provider.** A provider who is restricted from participation is eligible to apply for reinstatement as an unrestricted provider at the end of the period of restriction. The department shall review a provider's application to determine whether the provider is qualified to participate without restrictions as specified by the provider participation requirements of part 9505.0195 and Code of Federal Regulations, title 42, sections 1002.230 to 1002.234.

Subp. 3. **Prohibited submission of restricted provider's claims.** A clinic, group, corporation, or other professional association shall not submit a claim for a health service furnished under a program by a provider who is restricted from furnishing the health service or submitting a charge or claim, unless the health service was provided before the provider's restriction. If a clinic, group, corporation, or other professional association receives payment for a health service furnished under a program by a provider restricted from participation, the department shall recover the amount of the payment and may impose administrative sanctions against the clinic, group, corporation, or other professional association if the commissioner determines that the clinic, group, corporation, or other professional association knew or had reason to know of the restriction.

9505.2240 NOTICE TO THIRD PARTIES ABOUT DEPARTMENT ACTIONS FOLLOWING INVESTIGATION.

Subpart 1. **Notice about providers.** After the department has taken an action against a provider as specified in part 9505.2210, subpart 2, item A, and the right to appeal has been exhausted or the time to appeal has expired, the department

shall issue the notices required in items A and B.

A. The department 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 appeal.

B. The department shall notify the general public about action taken under part 9505.2210, subpart 2, item A, subitem (4) or (8), by publishing the notice in a general circulation newspaper in the ~~provider's local trade area~~ geographic area of Minnesota generally served by the provider in the majority of its health services to Minnesota program recipients. The notice shall include the provider's name and service type, the action taken by the department, and the effective date or dates of the action.

Subp. 2. **Information and notice about recipients.** After the department has taken an action against a recipient as specified in part 9505.2210, subpart 2, item B, subitem (2), and the recipient's right to appeal has been exhausted or the time to appeal has expired, the department must notify the recipient's primary care case manager and other health care providers about the restriction imposed on the recipient and the circumstances leading to the restriction. Notice shall include the recipient's name and program, the nature of the restriction imposed on the recipient, a list of providers to whom the recipient is restricted, and the beginning and ending dates of the restriction.

9505.2245 APPEAL OF DEPARTMENT ACTION.

Subpart 1. **Provider's right to appeal.** A provider may appeal the department's proposed actions under ~~part~~ parts 9505.2210, 9505.2215, and 9505.2220, under the provisions of Minnesota Statutes, section 14.57 to 14.62.

A. The appeal request shall specify:

(1) each disputed item, the reason for the dispute, and estimate of the dollar amount involved for each disputed item;

(2) the computation that the provider believes is correct;

(3) the authority in the statute or rule upon which the provider relies for each disputed item; and

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal~~;-and~~

~~(5)-other-information-required-by-the commissioner~~.

B. An appeal shall be considered timely if written notice of appeal is received by the commissioner as provided by statute.

Subp. 2. **Recipient's right to appeal.** A recipient may appeal any sanction proposed by the department under Minnesota Statutes, section 256.045, and part 9505.0130.

REPEALER. Minnesota Rules, parts 9505.0180, subpart 1; 9505.1750; 9505.1760; 9505.1770; 9505.1780; 9505.1790; 9505.1800; 9505.1810; 9505.1820; 9505.1830; 9505.1840; 9505.1850; 9505.1860; 9505.1870; 9505.1880; 9505.1890; 9505.1900; 9505.1910; 9505.1920; 9505.1930; 9505.1940; 9505.1950; 9505.1960; 9505.1970; 9505.1980; 9505.1990; 9505.2000; 9505.2010; 9505.2020; 9505.2030; 9505.2040; 9595.2050; 9505.2060; 9505.2070; 9505.2080; 9505.2090; 9505.2100; 9505.2110; 9505.2120; 9505.2130; 9505.2140; and 9505.2150; are repealed on the effective date of these rules.

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