Department of Human Services

Adopted Permanent Rules Relating to the Surveillance and Integrity Review Program

Rules as Adopted

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 investigating fraud, theft, or abuse by vendors or recipients of health services through the medical assistance, general assistance medical care, consolidated chemical dependency treatment, MinnesotaCare, catastrophic health expense protection programs, prepaid ~~medical assistance programs~~ health plans, 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 vendors and recipients of health services. Additionally, parts 9505.2160 to 9505.2245 establish standards applicable to the health service and financial records of vendors of health services through medical assistance, general assistance medical care, consolidated chemical dependency treatment, MinnesotaCare, 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, 152, 245, 245A, 252, 253, 254A, 254B, 256, 256B, 256D, 256E, and 609.

Subp. 2. **Applicability.** Parts 9505.2160 to 9505.2245 apply to local agencies, vendors participating in a program, and recipients of health services through a program. To the extent that provisions of a contract between the department and prepaid health plans have functionally equivalent requirements, the

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department shall exempt the prepaid health plans from the specific requirements of parts 9505.2160 to 9505.2245.

9505.2165 DEFINITIONS.

[For text of subpart 1, see M.R.]

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

A. in the case of a vendor, a pattern of practices that is 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 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) repeated submission of claims 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 9505.2180;

(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 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) 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; 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. The following practices are deemed to be abuse by a recipient:

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(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. 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 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 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 health services for self-inflicted injuries or trauma;~~

~~(14)~~ repeatedly obtaining emergency room health services for nonemergency care; or

~~(15)~~ (14) repeatedly using medical transportation to obtain health services from providers located outside the local trade area ~~for~~ when health services ~~that~~ appropriate to the recipient's physical or mental health needs can be ~~provided~~ obtained inside the local trade area. For purposes of this subitem, "local trade area" has the meaning given in part 9505.0175, subpart 22.

Subp. 2a. **Electronically stored data.** "Electronically stored data" means data stored in a typewriter, word processor, computer, existing or preexisting computer system or computer network, magnetic tape, or computer disk.

[For text of subp 3, see M.R.]

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. ~~any~~ making a false statement, false claim, or false representation ~~made~~ to a program where the person knows or should reasonably know the statement, claim, or representation is false; and

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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.

[For text of subp 5, see M.R.]

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

Subp. 6a. [See repealer.]

Subp. 6b. [See repealer.]

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

Subp. 6e. **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. 6f. **Pattern.** "Pattern" means an identifiable series

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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, 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, catastrophic health expense protection program, MinnesotaCare, consolidated chemical dependency program, prepaid ~~medical assistance programs~~ health plans, 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" has the meaning given in part 9505.0175, subpart 38, and also includes a personal care provider.

[For text of subp 10, see M.R.]

Subp. 10a. **Responsible party.** "Responsible party" has the meaning given in Minnesota Statutes, section 256B.0627, subdivision 1, paragraph (d).

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

A. in the case of a vendor, excluding or limiting the scope of the health services for which a vendor 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 health services from a designated primary care case manager or other designated health service providers. The restriction of a recipient must be indicated in an eligibility verification system. For purposes of restriction, designated health service providers do not include long-term care facilities.

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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.

[For text of subp 13, see M.R.]

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

[For text of subps 15 and 16, see M.R.]

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.

[For text of subp 17, see M.R.]

9505.2175 HEALTH SERVICE RECORDS.

Subpart 1. **Documentation requirement.** As a condition for payment by a program, a vendor 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 7. Program funds paid for a health service not documented in a recipient's health service record shall be recovered by the department.

Subp. 2. **Required standards for health service records.** A vendor 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;

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(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 vendor or supervisor as required under parts 9505.0170 to 9505.0475.

D. The record must state:

(1) the recipient's case history and health condition as determined by the vendor'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 vendor's order for service.

[For text of subps 3 and 4, see M.R.]

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

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B. except as provided in part 9505.2190, subpart 1, must contain a hard copy of the vendor'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.

[For text of subp 6, see M.R.]

Subp. 7. **Requirements for personal care provider service records.** A personal care provider record must meet the requirements of subparts 1 and 2 and must document:

A. the physician's initial order for personal care services, which shall be included within a reasonable time after the start of such services, and documentation that the physician's order has been reviewed by the physician at least once every 365 days;

B. the Department of Human Services care plan completed by the supervising registered nurse which details the nurse's instruction to the personal care assistant;

C. the department's notice of prior authorization which identifies the amount of personal care service and registered nurse supervision authorized for the recipient;

D. the department's notice of approval or denial of a relative hardship waiver request; ~~and~~

E. whether the recipient is in a shared care arrangement;

F. the following daily documentation requirements:

(1) in an individual care arrangement, the following documentation must be made by each personal care assistant of services provided to the recipient:

(a) the recipient's name;

(b) the name of the personal care assistant providing services;

(c) the day, month, and year the personal care services were provided;

(d) ~~the site where personal care services were provided;~~

~~(e)~~ the total number of hours spent providing personal care services to the recipient;

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~~(f)~~ (e) the time of arrival and the time of departure of the personal care assistant at the site where services were provided;

~~(g)~~ (f) the personal care services provided;

~~(h) the amount of time spent providing services in the recipient's residence;~~

~~(i) the amount of time spent providing services outside of the recipient's residence;~~

~~(j)~~ (g) notes by the personal care assistant regarding changes in the recipient's condition, documentation of calls to the supervising nurse, and other notes as required by the supervising nurse;

~~(k)~~ (h) the personal care assistant's signature; and

~~(l)~~ (i) the recipient's signature, stamp, or mark, or the responsible party's signature, if the recipient requires a responsible party; and

(2) in a shared care arrangement, the ~~following~~ ~~separate~~ documentation requirements in subitem (1) must be ~~made by each personal care assistant of services provided to~~ met separately for each recipient~~:~~;

~~(a) the recipient's name;~~

~~(b) the names of the other recipients sharing personal care services;~~

~~(c) the name of the personal care assistant providing services;~~

~~(d) the day, month, and year the personal care services were provided;~~

~~(e) the site where personal care services were provided;~~

~~(f) the total number of hours spent providing personal care services to each recipient;~~

~~(g) the time of arrival and the time of departure of the personal care assistant at the site where services were provided;~~

~~(h) the personal care services provided;~~

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~~(i) the amount of time spent in the provision of services at the shared care residence;~~

~~(j) the amount of time spent in the provision of services outside of the shared care residence;~~

~~(k) notes by the personal care assistant regarding changes in a recipient's condition, documentation of calls to the supervising nurse, and other notes as required by the supervising nurse;~~

~~(l) the personal care assistant's signature; and~~

~~(m) each recipient's signature, stamp, or mark, or the responsible party's signature if the recipient requires a responsible party;~~

~~F.~~ G. authorization by the recipient's responsible party, if any, for personal care services provided outside the recipient's residence;

~~G.~~ H. authorization by the responsible party, who is a parent of a minor recipient or a guardian of a recipient, which is approved and signed by the supervising nurse, to delegate to another adult the responsible party function for absences of at least 24 hours but not more than six days; and

~~H.~~ I. supervision by the supervising nurse, including the date ~~and time of day~~ of the provision of supervision of personal care services as specified in part 9505.0335, subpart 4.

9505.2180 FINANCIAL RECORDS.

Subpart 1. **Financial records required of vendors.** The financial records, including written and electronically stored data, of a vendor who receives payment for a recipient's services under a program must contain the material specified in items A to H:

A. payroll ledgers, canceled checks, bank deposit slips and any other accounting records prepared for the vendor;

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

health services;

C. evidence of the vendor'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. the vendor's appointment books for patient appointments and the schedules 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 vendor; and

H. employee records for those persons currently employed by the vendor or who have been employed by the vendor at any time within the previous five years which under Minnesota Statutes, chapter 13, would be considered public data for a public employee such as employee name, salary, qualifications, position description, job title, and dates of employment; in addition employee records shall include the current home address of the employee or the last known address of any former employee.

[For text of subp 2, see M.R.]

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 vendor 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 records related to services under a program. The medical assistance recipient's authorization of the release and review of health service 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 for medical assistance. This presumption

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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 records.** A vendor shall grant the department access during the vendor'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 vendor no less than 24 hours before obtaining access to a health service or financial record, unless the vendor waives notice.

9505.2190 RETENTION OF RECORDS.

Subpart 1. **Retention required; general.** A vendor shall retain all health service and financial records 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 vendor withdrawal or termination.** A vendor who withdraws or is terminated from a program must retain or make available to the department on demand the health service and financial records as required under subpart 1.

Subp. 3. **Record retention under change of ownership.** If the ownership of a long-term care facility or vendor 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 event of a contested case, the vendor 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 claim or payment is made under a program. Photocopying shall be done on the vendor's premises unless removal is specifically permitted by the vendor. If a vendor 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 vendor must furnish copies at the vendor'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 shall investigate vendors or recipients to monitor compliance with program requirements 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 any person, agency, organization, or other entity that is necessary to an investigation under subpart 1. 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. consultants under contract in part 9505.0185;

E. recipients and their responsible relatives;

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

G. professional associations of vendors 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 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, 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 vendor, the vendor's employees, and entities under contract with the vendor 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 its investigation under subparts 1 to 3, the department shall determine whether:

A. the vendor 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 actions.**

A. After completing the determination required under subpart 4, the department shall take one or more of the actions specified in subitems (1) to (6):

(1) close the investigation when no further action is warranted;

(2) impose administrative sanctions according to part 9505.2210;

(3) seek monetary recovery according to part 9505.2215;

(4) refer the investigation to the appropriate state regulatory agency;

(5) refer the investigation to the attorney general or, if appropriate, to a county attorney for possible civil or criminal legal action; or

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

B. After completing the determination required under subpart 4, the department may seek recovery of investigative costs from a vendor under Minnesota Statutes, section 256B.064, subdivision 1d.

9505.2205 COMMISSIONER TO DECIDE IMPOSITION OF SANCTION.

The commissioner shall decide what sanction shall be imposed against a vendor or recipient under part 9505.2210. The commissioner 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 vendor or recipient to comply with program rules;

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 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 vendor 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 to C are administrative sanctions that the commissioner may impose for the conduct specified in subpart 1.

A. For any vendor, the actions are:

(1) referral to the appropriate peer review mechanism or licensing board;

(2) suspending or terminating the vendor's participation;

(3) suspending or terminating the participation of any person or corporation with whom the vendor has any ownership or control interest;

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

(5) requiring prior authorization of services; and

(6) restricting the vendor's participation in a program.

B. For a provider, the actions ~~also include~~ in item A, and in addition:

(1) requiring a provider agreement of limited duration;

(2) requiring a provider agreement which stipulates specific conditions of participation; and

(3) review of the provider's claims before payment.

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

(1) referral for appropriate health counseling to correct inappropriate or dangerous use of health 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 vendor 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 vendor 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 shall seek monetary recovery:

A. from a vendor, 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 vendor, 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.

[For text of subps 2 and 3, see M.R.]

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 vendor 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

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constitute a rebuttable presumption regarding the calculation of monetary recovery. If the presumption is not rebutted by the vendor in the appeal process, the department shall use the extrapolation as the monetary recovery figure specified in subpart 3.

[For text of subps 2 and 3, see M.R.]

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

The commissioner shall suspend a vendor who has been convicted of a crime related to Medicare or medical assistance as provided in 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 vendor or recipient of a monetary recovery or administrative sanction that is to be imposed by the department. For vendors, the notice shall be sent by certified mail. For recipients, the notice shall be sent by first class mail. The department shall place an affidavit of the first class mailing in the recipient's file as an indication of the date of mailing and the address.

A. In all cases, the notice shall state:

(1) the factual basis for the department's determination according to part 9505.2200, subpart 4;

(2) the actions the department plans to take;

(3) the dollar amount of the monetary recovery, if any;

(4) how the dollar amount was computed;

(5) the right to dispute the department's determinations and to provide evidence; and

(6) the right to appeal the department's proposed action under part 9505.2245.

B. In cases of vendor suspension or termination under part 9505.2235, in addition to the requirements of item A, the

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notice shall state:

(1) the length of the suspension or termination;

(2) the effect of the suspension or termination;

(3) the earliest date on which the department shall consider a request for reinstatement;

(4) the requirements and procedures for reinstatement; and

(5) the vendor's right to submit documents and written argument against the suspension for review by the commissioner before the effective date of suspension or termination.

The submission of documents and written argument for review by the commissioner under subitem (5) does not stay the deadline for filing a formal appeal under part 9505.2245.

Subp. 2. **Effective date of recovery or sanction.** For vendors, 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.

[For text of subp 3, see M.R.]

9505.2235 SUSPENSION OR TERMINATION OF VENDOR PARTICIPATION.

Subpart 1. **Effect of suspension or termination.** 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 suspension or termination from participation. No 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.** A vendor who is under suspension or terminated from participation is eligible to apply for reinstatement as a provider or vendor 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 participation requirements of part 9505.0195 and Code of Federal Regulations, title 42, section 1002.215.

Subp. 3. **Prohibited submission of vendor's claims.** A provider 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 provider 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 provider if the commissioner determines that the provider knew or had reason to know of the suspension or termination.

9505.2236 RESTRICTION OF PROVIDER OR VENDOR PARTICIPATION.

Subpart 1. **Effect of restriction on a provider or vendor.** The provider agreement of a vendor who is restricted from participation shall be amended by the restriction specified in the notice of action to the vendor provided under part

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9505.2230. A vendor 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 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 vendor, either directly or indirectly, for restricted services or charges specified in the notice of action.

Subp. 2. **Reinstatement of restricted provider or vendor.** A vendor who is restricted from participation is eligible to apply for reinstatement as an unrestricted provider or vendor at the end of the period of restriction. The department shall review a vendor's application to determine whether the vendor is qualified to participate without restrictions as specified by the participation requirements of part 9505.0195 and Code of Federal Regulations, title 42, section 1002.215.

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

9505.2240 NOTICE TO THIRD PARTIES ABOUT DEPARTMENT ACTIONS FOLLOWING INVESTIGATION.

Subpart 1. **Notice about vendors.** After the department has taken an action against a vendor as specified in part 9505.2210, subpart 2, item A or B, and the right to appeal has been

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exhausted or the time to appeal has expired, the department shall issue the notices required in items A to C.

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 (2), (3), or (5), by publishing the notice in a general circulation newspaper in the geographic area of Minnesota generally served by the vendor in the majority of its health services to Minnesota program recipients. The notice shall include the vendor's name and service type, the action taken by the department, and the effective date or dates of the action.

C. If the vendor requests reinstatement and the department approves the request for reinstatement, the department shall give written notice to the vendor and those notified in items A and B about the action taken under part 9505.2210, subpart 2, item A, subitem (2), (3), or (5), and the reinstatement.

[For text of subp 2, see M.R.]

9505.2245 APPEAL OF DEPARTMENT ACTION.

Subpart 1. **Vendor's right to appeal.** A vendor may appeal the department's proposed actions under parts 9505.2210, 9505.2215, and 9505.2220, under the provisions of Minnesota Statutes, sections 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 vendor believes is correct;

(3) the authority in the statute or rule upon which the vendor 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.

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

C. Before the appeal hearing, the commissioner may suspend or reduce payment to the provider, except a nursing facility or convalescent care facility, if the commissioner determines that action is necessary to protect the public welfare and the interests of the medical assistance program.

[For text of subp 2, see M.R.]

REPEALER. Minnesota Rules, part 9505.2165, subparts 6a and 6b, are repealed.

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