**Department of Human Services**

**Adopted Permanent Rules Relating to Surveillance and Integrity Review**

## 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, abuse, or error by vendors or recipients of health services through a program as defined in part 9505.2165, subpart 8, that is 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 a program.

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, 256L, and 609.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(21) billing for services that were ~~not provided in compliance with regulatory agency requirements or that were~~ outside of the scope of the vendor's license, or in the case of a vendor that is not required to hold a license, billing by a vendor for

services that the vendor is not authorized to provide under applicable regulatory agency requirements; or

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

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

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

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

[For text of subitems (3) to (12), see M.R.]

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

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

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

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

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

(2) obtaining emergency room services for nonemergency care;

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

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

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

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

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

[For text of item A, see M.R.]

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

[For text of item C, see M.R.]

[For text of subps 4a and 5, see M.R.]

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

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

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

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

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

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

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

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

[For text of subps 9 and 10, see M.R.]

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

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

A. requiring the recipient for a period of 24 or 36 months of eligibility to obtain health services from~~:~~

~~(1)~~ a designated primary care provider, hospital, pharmacy, or other designated health service provider located in the recipient's local trade area; ~~and~~ or

~~(2) an agency licensed by the Minnesota Department of Health according to Minnesota Statutes, chapter 144A, as a class A home care agency or a designated Medicare-certified home health agency; or~~

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

Subp. 11. [See repealer.]

[For text of subps 12 to 14, see M.R.]

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

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

Subp. 16a. **Vendor.** "Vendor" has the meaning given to "vendor of medical care" in Minnesota Statutes, section 256B.02, subdivision 7. The term "vendor" includes a

provider and also a personal care assistant. A vendor is subject to criminal background checks according to Minnesota Statutes, section 245C.03.

[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 9. 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.

[For text of items A to F, see M.R.]

G. The record must contain the recipient's plan of care, individual service plan as required by Minnesota Statutes, section 256B.092, or individual treatment plan. For purposes of this item, "plan of care" has the meaning given in part 9505.0175, subpart 35; and "individual treatment plan" has the meaning given in part 9505.0323, subpart 1.

[For text of items H and I, see M.R.]

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

Subp. 4. **Medical transportation service records.** A medical transportation record must meet the requirements of subparts 1 and 2 and be signed by the driver and contain the following statement: "I certify and swear that I have accurately reported in this mileage log the miles I actually drove and the dates and times I actually drove them. I understand that misreporting the miles driven and hours worked is fraud for which I could face criminal prosecution or civil proceedings." Each transportation record for each trip must document:

A. the description and address of both the origin and destination, and the mileage for the most direct route from the origin to the destination;

B. the type of transportation provided;

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;

D. the name of the driver and license number of the vehicle used to transport the recipient;

E. whether the recipient is ambulatory or nonambulatory;

F. the time of the pick up and the time of the drop off with a.m. and p.m. designations;

G. the number of ~~recipients~~ occupants in the vehicle; and

H. the name of the extra attendant when an extra attendant is used to provide special transportation services.

Subp. 5. **Durable medical equipment records.** A durable medical equipment record must meet the requirements of subparts 1 and 2 and must document:

A. the type of equipment, including the brand and model names, the model number, and serial number, if available;

B. whether the equipment is being rented or purchased by the recipient;

C. when equipment is sold to a recipient, whether the equipment is under warranty and the length of the warranty;

D. repairs made by the current durable medical equipment provider to the equipment;

E. a shipping invoice or a shipping invoice with a delivery service ~~tracking log~~ manifest showing the date of delivery that proves that the medical equipment was delivered to the recipient; and

F. a physician's order or licensed practitioner's order for the equipment that specifies the type of equipment and the expected length of time the equipment will be needed by the recipient.

Subp. 5a. **Medical supply record.** A medical supply record must meet the requirements of subparts 1 and 2 and must document:

A. a physician's order or licensed practitioner's order for the supplies that indicates the type of supply needed, the expected length of time the supplies will be needed, and the quantity needed;

B. the type and brand name of the supplies delivered to the recipient;

C. the quantity of each supply delivered to the recipient; and

D. a shipping invoice or a shipping invoice with a delivery service tracking log showing the date of delivery that proves the medical supply was delivered to the recipient.

Subp. 6. **Rehabilitative and therapeutic services records.** Rehabilitative and therapeutic service records must meet the requirements of subparts 1 and 2 ~~and~~, must meet the criteria in part 9505.0412, and must document:

A. objective and measurable goals that relate to the recipient's functioning;

B. the need for the level of service;

C. the reason the skills of a professional physical therapist or occupational therapist are needed; and

D. a ~~physician's~~ licensed practitioner's order for the rehabilitative and therapeutic services.

Subp. 7. **Personal care provider service records.** Health care service records maintained by a personal care provider, consumer-directed home care provider, ~~telehomecare provider,~~ or fiscal agent must meet the requirements of subparts 1 and 2 and must document:

A. a physician's initial order for personal care services in the form required by the commissioner, which shall be included prior to, or within 30 days 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 care plan completed by the supervising qualified professional which details the qualified professional's instruction to the personal care assistant;

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

D. whether the recipient is in a shared care arrangement, and if so, the record must also meet the documentation requirements of Minnesota Statutes, section 256B.0655, subdivision 5, paragraph (g);

E. whether the recipient is using the flexible services use option authorized by Minnesota Statutes, section 256B.0655, subdivision 6;

F. whether the recipient is using a fiscal agent and if so, the name of the agent;

G. whether the recipient is using a consumer-directed service delivery alternative;

H. for all care arrangements, the following documentation must be made for each day that care is provided by each personal care assistant who provides care to the recipient:

(1) the recipient's name;

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

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

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

(5) the time of arrival at the site where personal care services were provided and the time of departure from the site where services were provided, including a.m. and p.m. designations;

(6) the personal care services provided;

(7) notes by the personal care assistant regarding changes in the recipient's condition, documentation of calls to the supervising qualified professional, and other notes as required by the supervising qualified professional;

(8) the personal care assistant's signature on the time sheets which record the hours worked by the personal care assistant, and must contain the following statement: "I certify and swear that I have accurately reported on this time sheet the hours I actually worked, the services I provided, and the dates and times worked. I understand that misreporting my hours is fraud for which I could face criminal prosecution and civil proceedings"; and

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

I. in a shared care arrangement, the following additional requirements apply:

(1) each personal care assistant must satisfy the daily documentation requirements in item H and the documentation requirements of Minnesota Statutes, section 256B.0655, subdivision 5, paragraph (g), for each recipient;

(2) the qualified professional must document supervision of shared care services including:

(a) ongoing monitoring and evaluation of the effectiveness and appropriateness of shared care;

(b) the date, time of day, and number of hours spent supervising the provision of shared services;

(c) whether the supervision was face-to-face or another method of supervision;

(d) changes in the recipient's condition;

(e) scheduling issues; and

(f) recommendations;

(3) the qualified professional must document consent by the recipient or the recipient's responsible party, if any, for shared care; and

(4) the qualified professional must document revocation by the recipient or the recipient's responsible party, if any, of the shared care option;

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

K. 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

L. supervision by the supervising qualified professional, including the date of the provision of supervision of personal care services as specified in part 9505.0335, subpart 4.

Subp. 8. **School-based service records.** A health service record for a child with an individualized education plan who receives covered school-based services, special

transportation, or assistive technology devices must meet the requirements of subparts 1 and 2 and must include the following information:

A. the medical diagnosis or condition that indicates the need for an individual education program (IEP);

B. a current, complete copy of the recipient's IEP, individualized family service plan, or individual interagency intervention plan that documents the type, frequency, duration, and scope of the covered IEP services to be provided and measurable outcomes;

C. a copy of the recipient's release of information to bill a Minnesota health care program for IEP services signed by the recipient's parent or legal representative, or a copy of the notice provided by the district to the parent or legal representative under Minnesota Statutes, section 125A.21, subdivision 2, paragraph (b);

D. the name of the school district that provided the service and the recipient's date of birth;

E. for IEP assistive technology devices, a description of the device, including type of device, manufacturer, model, and quantity of devices, and a copy of the invoice or rental agreement; and

F. for IEP special transportation services:

(1) mileage for the most direct route from the place where the recipient is picked up and transported to the school setting where IEP covered services are provided to the recipient;

(2) type of service provided and service code;

(3) name, title, and signature of a person who can verify that the recipient received IEP special transportation on the dates specified; and

(4) documentation that the recipient received another MHCP-covered IEP service on the date for which the special transportation is billed.

Subp. 9. **Language interpreter services.** A language interpreter service record must meet the requirements of subparts 1 and 2 and must document:

A. the name of the interpreter;

B. the name of the company that employed the interpreter;

C. the relationship of the interpreter to the recipient;

D. the languages spoken by the recipient and a statement that the recipient has limited English language proficiency;

E. a statement that the billed interpreter services were provided directly to the recipient while the recipient received a medically necessary covered health service; and

F. the length of time in hours and minutes that the language interpreter spent with the recipient during the direct person-to-person covered health service.

**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 I:

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

[For text of items B to F, see M.R.]

G. records showing all persons, corporations, partnerships, and entities with an ownership or control interest in the vendor;

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 employee's time sheets, current home address of the employee or the last known address of any former employee, and criminal background checks, when required; and

I. delivery tracking information, where applicable, such as the provider's shipping invoice, delivery manifest, or the delivery service's tracking slip.

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

**9505.2185 ACCESS TO RECORDS.**

Subpart 1. **Recipient's consent to access.** A recipient 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 recipient's health service records related to services under a program. The recipient's authorization of the release and review of health service records for services provided while the person is a recipient shall be presumed competent if given in conjunction with the person's application for a program. 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 records.** A vendor shall grant the department access during the department's normal business hours to examine health service and financial records related to a health service billed to a program. A vendor shall make its records available at the vendor's place of business on the day for which access was requested, unless the vendor and the department both agree that the records will be viewed at another location. Access to a recipient's health service record or vendor's records 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. The department's normal business hours are 8:00 a.m. to 5:00

p.m. Monday through Friday, excluding state holidays as defined in Minnesota Statutes, section 645.44, subdivision 5.

**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 or electronically stored 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. Vendors must maintain and store records in a manner that will allow for review by the department within the times set forth in part 9505.2185, subpart 2.

[For text of subps 2 to 4, see M.R.]

**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 on the day of the audit unless removal is specifically permitted by the vendor. If requested, a vendor must help the department duplicate any health service record or financial record, including hard copy or electronically stored data on the day of the audit.

**9505.2197 VENDOR'S RESPONSIBILITY FOR ELECTRONIC RECORDS.**

A vendor's use of electronic record keeping or electronic signatures shall meet the following requirements:

A. use of electronic record keeping or electronic signatures does not alter the vendor's obligations under state or federal law, regulation, or rule;

B. the vendor is responsible for all claims submitted by the vendor or the vendor's designee to the department regardless of the format in which the health service or financial record is maintained;

C. the vendor must ensure that the use of electronic record keeping does not limit the commissioner's access to records;

D. upon request, the vendor shall help department staff to access and copy all records, including encrypted records and electronic signatures; and

E. the vendor must establish a mechanism or procedure to ensure that:

(1) the act of creating the electronic record or signature is attributable to the vendor, according to Minnesota Statutes, section 325L.09;

(2) the electronic records and signatures are maintained in a form capable of being retained and accurately reproduced;

(3) the department has access to information that establishes the date and time that data and signatures were entered into the electronic record; and

(4) the vendor's use of electronic record keeping or electronic signatures does not compromise the security of the records.

**9505.2200 IDENTIFYING FRAUD, THEFT, ABUSE, OR ERROR.**

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

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

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 and program payments were properly made;

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

C. the evidence of fraud, theft, abuse, or error 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 (8):

(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, peer review mechanism, or licensing board;

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

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

(7) refer the investigation to the appropriate child or adult protection agency; or

(8) place the recipient in the ~~designated provider~~ restricted recipient program.

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 IMPOSITION OF VENDOR SANCTIONS.**

The commissioner shall decide what sanction shall be imposed against a vendor under part 9505.2210. The commissioner shall consider the following factors in determining the sanctions to be imposed on a vendor:

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

B. history of fraud, theft, abuse, or error; and

C. actions taken or recommended by other state regulatory agencies.

**9505.2207 PLACEMENT OF RECIPIENT IN RESTRICTED RECIPIENT PROGRAM.**

The commissioner shall decide based upon information gathered under part 9505.2200 whether to place a recipient in the restricted recipient program. The commissioner shall consider the recipient's access to the local trade area, access to medically necessary services, and personal preference in the choice of providers.

**9505.2210 ADMINISTRATIVE SANCTIONS FOR VENDORS.**

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, abuse, or error in connection with a program or if the vendor 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) suspending or terminating the vendor's participation;

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

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

(4) requiring prior authorization of services; and

(5) lockout of the vendor's participation in a program.

B. For a provider, the actions 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.

Subp. 3. [See repealer.]

**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, 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, 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 program payments; and

D. withholding payments to a provider under Code of Federal Regulations, title 42, section 447.31.

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

**9505.2220 MONETARY RECOVERY; RANDOM SAMPLE EXTRAPOLATION.**

Subpart 1. **Authorization.** For the purpose of part 9505.2215, the commissioner is authorized to calculate the amount of monetary recovery from a vendor based upon extrapolation from a systematic random sample of claims submitted by the vendor 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 vendor in the appeal process, the department shall use the extrapolation as the monetary recovery figure specified in subpart 3.

Subp. 2. **Decision to use samples.** The department may use sampling and extrapolation to calculate a monetary recovery if:

A. the claims to be reviewed represent services to 50 or more recipients; or

B. there are more than 1,000 claims to be reviewed~~; or~~.

~~C. complete reajudication would be excessively costly or impractical. This test is met if the cost of conducting a review of 100 percent of the individual claims will result in a cost that is disproportionate to the amount that can probably be recovered, or if a review is otherwise impractical.~~

Subp. 3. **Statistical method.** The department shall use the methods in items A to ~~E~~ D in calculating the amount of monetary recovery by random sample extrapolation. The federal share of overpayment determined by the federal government under a federal random sample extrapolation method shall be recovered by the department from a medical

assistance vendor according to Minnesota Statutes, section 256B.0641, subdivision 1, clause (1).

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, these samples are called simple random samples. The department may choose to employ other sampling designs, such as the stratified random sampling, if it determines that those designs are more likely to lead to greater precision, or a closer approximation to the population mean. The department shall tell the provider the sampling method the department is using prior to drawing the sample.

B. Samples shall only be selected from claims for health services provided within the interval of time that coincides with the interval during which money allegedly was overpaid and for which recovery will be made.

C. The sampling method, including drawing the sample, calculating values, and extrapolating from the results of the sample, shall be performed 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. Samples must consist of at least 50 claims. Each stratum in a stratified sample must contain at least 30 claims or, if a population stratum contains less than 30 claims, all of the claims in that population stratum.

D. ~~Samples must consist of at least 50 claims. Each stratum in a stratified sample must contain at least 30 claims or, if a population stratum contains less than 30 claims, all of the claims in that population stratum.~~ The vendor shall be required to pay the department the estimated overpayment only if the null hypothesis that the mean overpayment is less than or equal to zero can be rejected with probability less than 0.05. The amount owed to the department shall be the mean overpayment multiplied by the number of claims in the population. With simple random samples, the mean overpayment is the sum of all differences between correct and actual charges in the sample, divided

by the number of claims in the sample. With stratified samples, the mean overpayment is the sum of the products of the mean differences within strata and the proportion of all claims in the population that are in the strata.

~~E. Standard techniques for extrapolating from a sample to the population shall be used to determine the amount owed to the department. With simple random samples, the amount owed to the department shall be the mean overpayment, multiplied by the number of claims in the population. The mean overpayment is the total overpayment estimated from the sample divided by the number of claims in the sample.~~

**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, placement in the restricted recipient program, 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.

[For text of items A and B, see M.R.]

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

**9505.2238 PLACEMENT IN RESTRICTED RECIPIENT PROGRAM.**

Subpart 1. **Effect of placement.** A recipient who has been placed in the restricted recipient program is eligible to receive health care services only from the designated providers. A recipient is placed in the restricted recipient program for a period of 24 months of eligibility. The period of 24 months of eligibility begins at the time of placement in the restricted recipient program. A recipient will be given 30 days to designate specific providers. At the end of the 30 days, the department shall designate specific providers for a recipient who has failed to designate specific providers. A recipient who has been

prohibited from using the personal care assistant choice or consumer-directed services option shall be prohibited from using that option for a period of 24 months of eligibility.

Subp. 2. **Change in selected providers.** A recipient may change designated providers under the following circumstances:

A. ~~if the recipient moves outside of the designated provider's local trade area~~ a recipient may change designated providers for any stated reason after the initial three months of restriction, provided the changes do not occur more than twice in one year; and

B. ~~the~~ a recipient ~~is discharged by the designated provider; or~~ may change designated providers as often as needed under the circumstances in subitems (1) to (3):

(1) if the recipient moves outside of the designated provider's local trade area;

(2) if the recipient is discharged by the designated provider; or

(3) other circumstances that require the recipient to change designated providers.

~~C. other circumstances require the recipient to change designated providers.~~

~~A recipient who seeks to change designated providers under this subpart must wait three months after the initial selection of a provider, and may change designated providers no more than twice in one year.~~ The department shall grant the recipient's request to change designated providers under this subpart if the change is consistent with protecting the integrity of the restricted recipient program.

Subp. 3. **Placement renewal.** After a recipient has completed an initial 24-month period of eligibility in the restricted recipient program, the department may renew the recipient's placement in the restricted recipient program under part ~~9509.2165~~ 9505.2165, subpart 2, item C, by sending written notice to the recipient. The recipient will remain placed in the restricted recipient program pending the resolution of an appeal of the

placement renewal. If the recipient's placement is not renewed, the recipient shall be notified by the department that the recipient's participation in the restricted recipient program is over. Renewal of the recipient's placement in the restricted recipient program shall be for an additional period of 36 months of eligibility.

Subp. 4. **Emergency health services.** Emergency health services provided to a recipient in the restricted recipient program by a vendor shall be eligible for payment if the service provided meets the definition of an emergency in part 9505.0175, subpart 11. The vendor must provide documentation of the emergency circumstances with the emergency service payment claim.

**9505.2240 NOTICE TO THIRD PARTIES.**

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 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 (1), (2), (4), 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 (1), (2), (4), or (5), and the reinstatement.

Subp. 2. **Information and notice about recipients.** After the department has placed the recipient in the restricted recipient program as specified in parts 9505.2207 and 9505.2238 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 provider and other health care providers that the recipient has been placed in the restricted recipient program and the circumstances leading to the placement. Notice shall include the recipient's name, program, the nature of the placement of the recipient in the restricted recipient program, a list of providers from whom the recipient may receive medical services, and the beginning and ending dates of the placement period. The recipient's placement in the restricted recipient program must be indicated in an eligibility verification system.

**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.

[For text of items A and B, see M.R.]

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 program.

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

**REPEALER.** Minnesota Rules, parts 9505.2165, subpart 11; and 9505.2210, subpart 3, are repealed.