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STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO MINNESOTA RULES, PARTS 9505.0500 TO 9505.0540, GOVERNING INPATIENT HOSPITAL ADMISSION CERTIFICATION IN THE MEDICAL ASSISTANCE AND GENERAL ASSISTANCE MEDICAL CARE PROGRAMS.

STATEMENT OF NEED AND REASONABLENESS

Minnesota Rules, parts 9505.0500 to 9505.0540 establish a system for reviewing the utilization of inpatient hospital care services under the Medical Assistance (MA) and General Assistance Medical Care (GAMC) Programs. These rules are designed to guard against excess payments and to reduce expenditures which result from inappropriate hospitalization of MA and GAMC recipients.

Minnesota Statutes, Section 256B.04 subdivision 15, requires the department to establish a program to safeguard against the unnecessary or inappropriate use of medical assistance services, against unnecessary or inappropriate hospital admissions or lengths of stay, and against underutilization of services in any health care delivery system subject to fixed rate reimbursement. The department is directed, under Minnesota Statutes, section 256D.03, subdivision 7(b) to establish standards for utilization review in the GAMC program that conform to the procedures established for the Medical Assistance program.

The temporary rules were adopted on May 10, 1984, and the permanent rule on March 26, 1985. The rule was also amended on March 24, 1987.

Since adopting these rules and the amendments to them, the department has identified several additional areas of the rules that need to be amended. The need for these amendments arises from inconsistency with related rules, the need for incorporating a second surgical opinion process, and confusion over criteria for a readmission considered as a second admission or a readmission considered as continuous with the first admission.

The department solicited the opinion of an advisory committee before and during the preparation of the proposed amendments to the rule. The committee was composed of representatives from the Minnesota Medical Association, Minnesota Hospital Association, Council of Hospital Corporations, and individual hospitals. The committee also included the medical review agent and utilization review specialists. (See appendix A for committee membership.) The committee met on December 2, 1987, February 4, 1988, and March 4 1988, to review the amendments proposed by the department. Members of the committee supported the department's desire to address these concerns.

In addition the department established a task force of utilization review specialists to assist in the development of processes and criteria. (See appendix B for membership of the task force). The task force included members of the advisory committee who maintained a link between task force recommendations and the advisory committee's opinion.

The proposed amended rules, designated as Minnesota Rules, Parts 9505.0500 to 9505.0540 are hereby affirmatively presented by the Department as required by Minnesota Statutes,Section 256B.04, subdivisions 2 and 15, Section 256B.503, Section 256D.03 subdivision 7(b) and in accordance with the provisions of the Minnesota Administrative Procedures Act, Minnesota Statutes chapter 14, and the rules of the Office of Administrative Hearings.

Part 9505.0500 DEFINITIONS.

The proposed amendments to the definitions are necessary to clarify the meaning of terms which may be subject to multiple interpretations, and to be consistent with medical usage, statutes and other related rules.

Subp. 3. Admission certification. This amendment is necessary because it clarifies that the determination that it is medically necessary to admit a recipient as an inpatient to a hospital includes the determination that all or part of the inpatient services provided to the recipient are medically necessary. The amendment is reasonable because it covers the kind of cases where admission may be medically necessary but continued inpatient hospital services may not be medically necessary. The department should not be expected to pay for services that were not medically necessary, but at the same time providers (hospitals, admitting physicians and vendors of services) should be eligible for payment of services that were medically necessary.

The amendment deleting Minnesota Rules, Parts 9500.0750 to 9500.1080, and adding Minnesota Rules, Parts 9505.1070, subparts 1, 4, 6, 12 to 15, and 23; 9500.1090 to 9500.1155; 9505.0170 to 9505.0475 is necessary and reasonable because they bring the citations up to date with existing rules.

Subp. 3a. Admitting diagnosis. The amendment describes the initial diagnosis that is the basis for examination and treatment given by the admitting physician. It is necessary to define "admitting diagnosis" because the term can be subject to different interpretations unless it is clearly defined. It is also necessary to define this term to distinguish it from "principal diagnosis" which is the diagnosis determined by reviewing the recipient's medical record after discharge from hospital. The definition of admitting diagnosis is reasonable because it is universally accepted according to the American Medical Record Association (AMRA). The AMRA is an association of medical record professionals which has been in existence since 1939. The association organizes health care data and specifies universal definitions of medical terms to facilitate collection of uniform and comparable health information from all hospitals.

Subp. 4 (A). Authorization number. This definition is necessary to clarify a term used in this rule and in the associated second surgical opinion rule (Rule 68). It is also necessary to distinguish the term

authorization number from the term certification number. The authorization number is the number issued by the medical review agent that establishes that the recipient needs a surgical procedure requiring a second surgical opinion, i.e., that the surgical procedure is medically appropriate. The certification number is the number issued by the medical review agent that establishes that the recipient needs the inpatient hospital services, i.e., that inpatient hospital services are medically necessary.

The authorization number will be required for any surgical procedure requiring a second surgical opinion, regardless of whether the surgical service is to be provided on an inpatient or an outpatient basis. However, if the physician offering to provide the surgical service recommends that the surgical service should be provided on an inpatient basis, then the provider is required to obtain a certification number in addition to the authorization number, to establish the need of inpatient hospital services.

It is reasonable to ask providers to obtain an authorization number because the issuance of the authorization number reassures the department that the surgical procedure is medically appropriate and it assures providers that they will be paid for the surgical procedure performed by them.

Subp. 5. Certification number. This amendment is necessary and reasonable because it clarifies that the certification number is the number issued by the medical review agent to indicate that an admission is medically necessary. It is also necessary to amend the definition to distinguish it from the authorization number issued by the medical review agent, which establishes that the surgical procedure requiring a second surgical opinion is medically appropriate [refer to SNR for subpart 4(A)].

Subp. 9. Continued stay review. The amendment is necessary and reasonable to clarify that the review determines that all or part of the services provided in the hospital after a recipient's admission are medically necessary.

Subp. 10a Diagnostic category. The term "diagnostic category" is defined with reference to applicable rules promulgated by the commissioner. The diagnostic category may be modified with 30 days notice, and published in the State Register as permitted under Minnesota Statutes, section 256.969, subdivision 2. The definition is reasonable and necessary to distinguish and group the different types of inpatient hospital services that are clinically coherent and uniform with respect to cost.

Subp. 10b. Diagnostic category validation or validate the diagnostic category. This definition is necessary to inform providers of the process of comparing the medical record to the information submitted on the inpatient hospital billing form required by the Department. The diagnostic category determines reimbursement, and the department assigns the diagnostic category based on information given by the provider. The definition is reasonable because it allows a determination of the accuracy of the information upon which the diagnostic category was assigned.

Subp. 14. Inpatient hospital services. The amendment is necessary and reasonable to clarify that the inpatient hospital services are services that are provided after the recipient is admitted to the care of the

hospital, and hospital services are made available to the recipient on a continuous 24 hour-a-day basis. The amendment is necessary because it distinguishes inpatient services from outpatient services for which no admission certification is required. The amendment is reasonable because it is consistent with common medical usage and with the definition in parts 9500.1090 to 9500.1155 (Rule 54).

Subp. 16. Medical Assistance or MA. The amendment is necessary because it identifies the funding programs that come under the purview of this rule and clarifies that GAMC is one of the funding sources and is included in all references to MA throughout this rule. Minnesota Statutes, section 256D.03,subd.7(b) requires the department to establish standards for utilization review in the GAMC program that conform to procedures established for the Medical Assistance program. It is reasonable to use one term in order to delete unnecessary words in a reference frequently repeated in the rule.

Subp.18. Medical review agent. The amendment is necessary to clarify that the medical review agent's authority includes giving second surgical opinions whenever that is a term of the contract with the department. The amendment is reasonable because it is consistent with the authority given to the medical review agent in parts 9505.5000 to 9505.5105, a related medical assistance rule.

Subp.19a. Medically appropriate or medical appropriateness. The terms medically appropriate or medical appropriateness refer to the determination by the department, or by it's authorized representative, the medical review agent, that the recipient needs the surgical procedure. The determination is made by seeing if the recipient's needs meet the criteria in part 9505.0540 or if a third surgical opinion has determined the need of the surgical procedure.

This amendment is necessary because the term medical appropriateness can be subject to different interpretations if it is not clearly defined. It is also necessary to distinguish the term "medically appropriate" from the term "medically necessary" which means that the recipient's diagnosis and condition requires inpatient hospital services, and, under the criteria in part 9505.0540 cannot be provided on an outpatient basis. The determination of medical appropriateness is made independently of the determination of medical necessity. If the surgical procedure requiring a second surgical opinion is determined to be medically appropriate, and if the admitting physician recommends that the surgery be provided on an inpatient hospital basis, then a determination of medical necessity is required.

The term "medically appropriate" is also the term used in a related medical assistance rule, parts 9505.5000 to 9505.5105, and it is necessary to use the same term in these rule parts to ensure consistency between the rules. The amendment is reasonable because the department should be able to determine the appropriateness of the surgical procedure requiring a second surgical opinion before it pays out of MA and GAMC funds.

Subp.22. Physician adviser. The amendment is necessary to clarify the area of expertise required from the physician advisor. It is both reasonable and necessary to delete the word "primary diagnosis" because

there is no universally accepted definition of that term. In contrast, both the terms "admitting diagnosis" and "principal diagnosis" are consistent with the definitions used by the AMRA.

Subp.23a. Principal diagnosis. Principal diagnosis describes the condition that was the foremost basis for causing the admission of the recipient to the hospital. This diagnosis is determined after study of the medical records and upon discharge of the recipient from the hospital. The principal diagnosis provides information for use in the diagnostic category validation process. The amendment is necessary because it informs providers of the diagnosis that is used in the diagnostic category validation process, and on which their payment is based. It is also necessary because it eliminates any confusion between the principal diagnosis and the admitting diagnosis, which is the diagnosis determined before the patient is admitted to hospital. It is reasonable because this definition is universally accepted according to the AMRA.

Subp.23b. Principal procedure. Principal procedure refers to the procedure that is performed as a specific treatment of a recipient's principal diagnosis. The procedure also provides information to allow a determination of the medical necessity of inpatient hospital care and for use in the diagnostic category validation process.

The definition is necessary because it informs providers of the procedure that the department or medical review agent will consider in the diagnostic category validation process. It is reasonable because this definition is universally accepted according to the AMRA.

Subp.23c. Provider. "Provider" is a term used to refer to a person or institution who is eligible for medical assistance payment for providing covered services to a recipient. The definition is necessary to clarify it's meaning. It is also necessary to clarify that hospitals, admitting physicians and vendors of other services are included in the definition because those are terms used throughout the rule for persons who are eligible for payment. This definition is reasonable because it is consistent with Minnesota Rule parts 9505.0010 to 9505.0150, which rule governs eligibility for medical assistance.

Subp.24. Readmission. It is necessary to inform providers and recipients of the extended time frame for readmissions. The complexity of medical care and the potential for fragmented care make it reasonable to extend the time frame of review of readmissions from 7 to 15 days. The per admission prospective payment system causes an incentive to discharge and readmit recipients. The extended time frame serves as a safeguard against unnecessary, inappropriate or underutilization of services because it allows for more thorough detection of such occurences. The amendment is also reasonable because it is consistent with the Medicare prospective payment system which expanded the review of readmissions from 7 to 15 days.

Subp.27. Retrospective review. The amendment is necessary to indicate that other functions of the retrospective review process will be to gather the information necessary to validate the diagnostic category, and to determine the medical appropriateness of a surgical procedure requiring a second surgical opinion.

The diagnostic category can be validated only retrospectively, because it is determined after the department receives the billing form from the hospital. It is also reasonable to add this function to the retrospective review process because the information necessary to validate the diagnostic category is contained in the medical record which is also the document used for reviewing medical necessity.

It is reasonable to allow a retrospective review of the medical appropriateness of a surgical procedure requiring a second surgical opinion because the department has a responsibility to determine the need for the surgical procedure if the provider is eligible for reimbursement from MA funds. In most cases medical appropriateness will be determined before the surgical procedure. However, if there is an emergency or incidental surgery, or if the surgical procedure is performed before the recipient applies for MA or GAMC and the recipient is later determined to be eligible retroactively, then the provider has the option to perform the surgical procedure and obtain the determination of medical appropriateness through a retrospective review. This process ensures that the surgical procedure was necessary, but at the same time it ensures that urgent medical care is not delayed while the provider obtains the determination.

Subp.28. Second surgical opinion. Second surgical opinion refers to the confirmation or denial of the medical appropriateness of a proposed surgery by the medical review agent or, if there is no medical review agent, by the second physician. This definition is necessary to eliminate any confusion between the second surgical opinion, and the opinion of the admitting physician and the third surgical opinion.

Minnesota Rules, Parts 9505.5000 to 9505.5105 establish a system for requiring a second opinion for certain surgical procedures. The same rule parts also establish the procedures to be followed by hospitals while providing inpatient hospital services. However this procedure proved to be cumbersome, and it confused hospitals to have different procedures for a few elective surgeries. Therefore the department believes it is necessary and reasonable to incorporate the procedures for inpatient hospital admission for surgical procedures requiring a second surgical opinion into parts 9505.0500 to 9505.0540. These parts now describe admission certification procedures for inpatient hospital services including procedures for elective surgeries. It is thus reasonable to define second surgical opinion because the rule parts that follow deal with the term frequently.

Subp.29. Transfer. This definition is necessary to clarify that a transfer is a situation in which a recipient is transported directly from one hospital to another with no change in the level of care provided. The word "directly" has the meaning given to it in the American Heritage Dictionary (The American Heritage Dictionary, Second College Edition,1985), i.e. without intervening persons, conditions, or agencies ; immediate. A direct transfer occurs when the hospital codes the recipient's disposition status as "discharged to another hospital". This is reasonable because not all recipients treated for inpatient hospital services receive the entire treatment for an episode in one hospital or one service within a hospital.

Although direct transfers are technically readmissions, it is necessary to differentiate them from readmission situations in which there has been a change in the level of care between discharge and readmission. This is important for coding claims and retaining consistent data, and for record keeping within the hospital. This definition is also reasonable because it is consistent with the definition of "transfer" in part 9500.1100, subpart 50.

9505.0510 SCOPE

It is necessary and reasonable to emphasize that this rule must be read in conjunction with the Department's rules pertaining to inpatient hospital reimbursement and second surgical opinions. In addition, it is necessary to inform affected parties that this rule will apply to hospitals outside the state. This part is necessary in order to clarify that all out of state hospitals who have not received prior authorization for providing inpatient hospital services (as required under Minnesota Rules, parts 9505.0170 to 9505.0475) are required to follow the same admission certification procedures as Minnesota hospitals.

It is reasonable that out of state hospitals be subject to the same process as Minnesota hospitals because they receive funds from the same MA or GAMC programs as Minnesota hospitals. It is also reasonable to regulate admission certification procedures for out of state hospitals serving Minnesota recipients because Minnesota Statutes, section 256B.04, subdivision 15 directs the commissioner to safeguard against unnecessary or inappropriate use of medical assistance services, against excess payments, against unnecessary or inappropriate hospital admissions or lengths of stay, and against underutilization of services in <u>any</u> health care delivery system subject to fixed rate reimbursement.

It is necessary and reasonable to inform providers that admission certification must be obtained each time a recipient is admitted to a different hospital or unit with a different provider number because the information removes confusion about a procedure required to obtain payment. It is also necessary and reasonable to amend the rule by defining the term "provider number" to clarify its meaning and inform affected persons.

9505.0520 INPATIENT ADMISSION CERTIFICATION

Subp.2. Exclusions from admission certification or prior admission certification. The amendment is necessary and reasonable because it identifies situations that are not subject to admission certification prior to admission. Certain medical conditions either do not allow for the delay inherent in the pre-admission determination of medical necessity, or the medical necessity of the condition is beyond dispute. Therefore it is necessary and reasonable to exempt those conditions from the prior admission certification requirement.

Subp.2, item A. It is necessary to clarify that admission certification is not required before an emergency admission. Due to the nature of an emergency, it would be unreasonable to require certification prior to admission. However, it is reasonable to require certification within a given period of time retrospectively (subpart 4, item B), so that

the department can determine whether the admission was medically necessary. The new language, particularly the inclusion of the word "before," clarifies that admission certification is necessary, but not before the admission occurs which is usually the case.

Subp.2, item B. The amendment is necessary to identify situations that are not subject to the admission certification process prior to admission. Admission certification is not required for the delivery of a newborn or a stillbirth. If the admission of a woman does not result in a delivery within twenty four hours, the admission will be reviewed by the medical review agent to determine the medical necessity of the services provided. The hospital shall not be denied admission certification for medically necessary services. Admission certification will be denied only if the medical review agent determines that the admission was not medically necessary.

This provision is reasonable because the medical necessity of the hospitalization of a woman for the delivery of a child is beyond dispute. The average time between the onset of contractions and the birth of a child is approximately fourteen hours. The twenty four hour time frame is reasonable because it reflects the nature of the admission. Some admissions may result in a delivery, and no admission certification will be required. However, there may be other admissions relating to pregnancy or ante partum which do not result in a delivery, and which involve a determination of whether the inpatient hospital services were medically necessary. Those admissions may, for example, have been more appropriate for outpatient treatment. It is reasonable that such admissions should be subject to retroactive admission certification.

Subp.2, item C. It is necessary to inform providers that treatment for chemical dependency is no longer subject to the admission certification process of parts 9505.0500 to 9505.0540. This amendment is reasonable because of the implementation of Minnesota Statutes,section 254A.03 which creates an alcohol and other drug abuse section in the department of human services and directs the Commissioner to establish by rule, the criteria for chemical use assessment and for determining the appropriate level of chemical dependency care for each recipient. (See Minnesota Rules, parts 9530.6600 to 9530.6655 (Rule 25).

It is also necessary and reasonable to require that all MA and GAMC chemical dependency treatment be paid through the Consolidated Chemical Dependency Treatment Fund (CCDTF). Minnesota Statutes, section 254B.03 subdivision 5 gives the Commissioner authority to promulgate rules to operate the Chemical Dependency fund and Minnesota Rules, parts 9530.7000 to 9530.7030 (Rule 24) govern payments for chemical dependency treatment. Part

Subp.3. Admitting physician responsibilities. It is necessary and reasonable to delete this reference due to the implementation of the Consolidated Chemical Dependency Treatment Fund (refer to SNR part 9505.0520, subpart 2, item C).

Subp.3, item B, subitem 6. It is necessary to amend this subitem to clarify and emphasize that a readmission includes the situation in which a recipient is transferred directly to a different hospital (Refer to SNR for part 9505.0500, subpart 29).

It is reasonable that the admitting physician provide this information to the medical review agent upon request for admission certification as it is important for the medical review agent and the Department to collect data to identify patterns of readmission which may signal inappropriate care.

Subp.3, item B, subitem 8. The Medical Review Agent is authorized by the department to determine the medical appropriateness of a surgical procedure requiring a second surgical opinion. This amendment is necessary because it clarifies that the admitting physician also has to provide information regarding the appropriateness of a surgical procedure if the information provided in subitems 1 to 7 is insufficient for the medical review agent to determine whether the surgical procedure is medically appropriate or not. It is reasonable because the medical review agent should have the authority to request more information in order to make a fully informed decision about the medical appropriateness of a surgical procedure. Adoption of this amendment will require the deletion of the phrase "a second surgical opinion and" from item C, subitem (3).

Subp.3, item B, subitem 9. There are certain situations outlined in the associated medical assistance rule, part 9505.5040, when surgical procedures are exempt from the requirement of a second opinion. This provision is necessary to inform admitting physicians that if they claim exemption from the second surgical opinion, then they will have to provide the medical review agent with the information necessary to prove that the surgical procedure meets the criteria for exemption. This provision is reasonable because the medical review agent should be provided with the information necessary to make the determination of whether the surgical procedure is in fact exempt from a second opinion, and thus avoid unnecessary payments.

Subp.3, item C, subitems 4 and 5. Subpart 1 of the proposed amendment of part 9505.5090 provides that if the medical review agent denies a surgical procedure requiring a second surgical opinion but a third physician agrees with the admitting physician that such procedure is medically appropriate, then the medical review agent will issue an authorization number. It is necessary and reasonable that the admitting physician should be responsible for informing the medical review agent that the procedure has been approved by a third physician because the admitting physician or the physician who offers to provide the surgical procedure is responsible under part 9505.5055 to obtain the opinion of the third physician and will be reimbursed for the surgery if the medical review agent issues a certification number.

Subp.3, item E. This provision refers to the verification provided by the admitting physician to the hospital that the surgical procedure requiring a second surgical opinion has been approved by a third physician. The approval of a third physician is obtained on a form required by the department. It is necessary and reasonable that the

admitting physician should provide information to the hospital because under subpart 4 item D, the hospital is responsible for submitting the documentation to the medical review agent.

Subp.3, item F. It is necessary to amend this item to make the billing procedures for second surgical opinion consistent with those for inpatient hospital services. The amendment is reasonable because it is less cumbersome to enter authorization numbers on invoices rather than to attach separate authorization forms as is done at present.

Subp.4, item A. It is necessary and reasonable to delete this language due to the implementation of Consolidated Chemical Dependency Treatment Fund (refer to SNR part 9505.0520, subpart 2, item C).

It is also necessary to inform providers that in the case of a surgical procedure requiring a second surgical opinion, the hospital shall obtain an authorization number. This is reasonable because the issuance of the authorization number reassures the department that the surgical procedure is medically appropriate and it assures providers that they will be paid for the surgical procedure performed by them. It is also reasonable because the hospital is required to obtain an authorization number in order to be reimbursed for surgical services provided under rule parts 9505.5000 to 9505.5105 (Rule 68).

Subp.4, item B, subitems 1, 2 and 3. It is necessary and reasonable to delete "In an emergency admission" and replace it with "event" due to the inclusion of second surgical opinion and certain pregnancy situations as subitems which refer to situations other than emergencies. It is necessary to inform the provider of time restrictions for contacting the medical review agent to obtain a retroactive certification or authorization number for an emergency admission, surgical procedure which requires a second surgical opinion, and obstetric (relating to pregnancy and ante partum) admissions without delivery.

Forty-eight hours from the time of admission is a reasonable amount of time in which to require the provider to contact the medical review agent to obtain a certification number for an emergency admission, or an authorization number for a procedure requiring a second surgical opinion. This is the time frame in force at present and it has proved to be workable. Seventy-two hours from the time of admission is a reasonable amount of time to require the provider to contact the medical review agent and obtain a certification number for an obstetrics (relating to pregnancy and ante partum) admission that does not result in a delivery within 24 hours of admission. The 72 hours begins at the time of the recipient's admission, therefore, the provider has 48 hours to contact the medical review agent after the first 24 hours of the admission have elapsed without delivery.

Subp.4, item C. It is necessary to amend this provision to inform the hospital that it has to enter the prior authorization number and the second surgical opinion authorization number on all invoices to be eligible for payment of MA and GAMC funds. The amendment is reasonable because it makes the admission certification process easier and less cumbersome.

Subp.4, item D. This provision informs the hospital of the time frame within which it must submit a verification of approval of the surgical procedure by a third physician. It is necessary and reasonable because the medical review agent must be sure that approval has been obtained before issuing a certification number. The time frame is reasonable because twenty days is sufficient time for the hospital to contact the admitting physician and obtain the verification.

Subp.6, item B. Medical review agent responsibilities This amendment is necessary because it clarifies that the medical review agent's authority extends to the determination of medical appropriateness of a surgical procedure requiring a second surgical opinion. It is reasonable because the commissioner has been directed to establish methods and standards for determining inappropriate utilization of MA and GAMC services by Minnesota Statutes, section 256B.04,subdivisions 2 and 15 and section 256D.03 subdivision 7(b). The commissioner is also authorized by Health Care Financing Administration to contract out its authority to make the determination. (See section 1902(d) Social Security Act (42 U S C ); 42 C F R 433.15; and 42 CFR 456.1 to 456.145).

The medical review agent ensures that the care that recipients receive is medically necessary, appropriate, and of a quality that meets professionally recognized standards of care.

Subp.6, item D. It is necessary and reasonable to send a notice by certified letter because the date of receipt of notice is required to set the time frame in which the admitting physician, hospital or recipient must ask for reconsideration or appeal. The medical review agent should inform the recipient of the determination because the recipient is the affected party and has a right to appeal the decision.

Subp.6, item E. It is necessary to inform providers and recipients that, in the case of surgical procedures requiring a second surgical opinion, the medical review agent will also determine whether the surgical procedure was medically appropriate. This is reasonable because it is consistent with the responsibilities of the department and the medical review agent under parts 9505.5000 to 9505.5105, which govern second surgical opinions. Since the medical review agent already has the responsibility to determine the medical necessity of the admission of retroactively eligible recipients, this amendment will ensure that procedures for admission certification and second surgical opinion cases are similar, and will reduce costs and minimize confusion.

Subp.6, item F. It is necessary to clarify all duties and responsibilities of the medical review agent in the admission certification process. This item specifies that the medical review agent may use several methods of medical record reviews depending on the circumstances of the case and the point at which it is reviewed. It is reasonable that the review process be performed by the medical review agent as a logical extension of the certification process. Concurrent and continued stay reviews ensure continued medical necessity of a hospitalization. Retrospective reviews verify medical appropriateness of surgical procedures, and medical necessity of admissions and of services provided.

Subp.6, item G. This amendment informs providers, recipients, and the medical review agent that the medical review agent has the responsibility to provide for a reconsideration of the determination that surgical procedures for which a provider requested exemption under part 9505.5040, items B, C, or F (emergencies, incidental surgeries, or surgeries provided before the recipient applied for MA/GAMC benefits), were not entitled to an exemption or were not medically appropriate. It is necessary and reasonable to provide for a reconsideration in such situations because the determination is often a medical decision and should be evaluated by independant physician advisers before the provider is denied reimbursement. This amendment is also reasonable because the provider has already performed the surgical procedure and should be allowed another opportunity to explain the case before reimbursement is denied.

Subp.6, item J. It is necessary and reasonable to provide that the medical review agent shall mail a certified letter because a certified letter sets the time frame within which the provider must request reconsideration or file an appeal.

Subp.6, item K. It is necessary and reasonable to delete this language and responsibility due to the implementation of Consolidated Chemical Dependency Treatment Fund (refer to SNR part 9505.0520, subpart 2, item C).

Subp.6, item L. It is necessary and reasonable to add the diagnostic category validation process to the duties and responsibilities of the medical review agent, because that is one of the functions performed by the medical review agent. It is necessary for the Department to take actions to ensure that payment is made for the correct diagnostic categories. It is reasonable for the medical review agent to compare the hospital medical record with the inpatient hospital billing form to ensure accuracy in billing.

Subp.6, item M. This provision is necessary and reasonable because it clarifies that the responsibilities and duties of the medical review agent are not necessarily limited to those listed in subpart 6. The contract between the Department and the medical review agent may include other responsibilities and duties mutually agreed upon by the parties. This provision is consistent with section 1902(d) of the Social Security Act; 42 C.F.R.433.15; and 42 C.F.R 456.1 to 456.145 which give the department the authority to contract out its responsibilities to the medical review agent. It is also more efficient and cost effective for the department to delegate the medical review functions rather than to develop the necessary expertise and technology required for an effective review.

Subp.8, items A and B. Procedure for admission certification or authorization of surgical procedure requiring a second surgical opinion. This subpart describes the procedure to be followed by the medical review agent for issuing a certification or an authorization number. It is necessary to inform providers, recipients and the medical review agent of the relevant procedures, and to specify the differences and similarities between the procedures for obtaining the certification number and those for obtaining the authorization number in order to inform affected parties and avoid confusion.

It is necessary and reasonable that as far as practical, the procedures for issuing a certification and an authorization number should be combined, so that a provider calling to obtain a certification number can, simultaneously, obtain an authorization number. This makes the system more efficient and cost effective, and eliminates much of the confusion which results from having separate procedures.

The amendment clarifies that the clinical evaluator shall determine whether the surgical procedure is medically appropriate or meets the criteria for exemption from the second surgical opinion. If one of the two conditions exists, the medical review agent shall issue the authorization number. This provision is necessary and reasonable because if the surgical procedure falls within the list of elective surgeries published under Minnesota Statutes, section 256B.02 subdivision 8, then it requires a second surgical opinion prior to reimbursement. Part 9505.5040 (promulgated under authority from Minnesota Statutes, section 256B.o4 subdivisions 2 and 15) enumerates a list of circumstances in which the surgical procedure can get an exemption from the second surgical opinion requirement. The medical review agent has the authority and the necessary expertise to make the determination of medical appropriateness and exemptions.

Subp.8, item C. Item C specifies the procedure to be followed by the medical review agent if the clinical evaluator determines that a procedure does not meet the criteria for exemption under part 9505.5040. If the clinical evaluator determines that the surgical procedure has not been approved for reimbursement by Medicare, or that obtaining a second opinion does not require travel outside the local trade area, or that the recipient does not have good cause for not obtaining the second opinion, then the medical review agent shall notify the physician by phone, and also notify the admitting physician and the recipient by mail within twenty days of the determination.

It is necessary and reasonable to inform the admitting physician by phone and by mail, because if the exemption is denied, there will be no reimbursement for services provided. Timely notification will ensure that the admitting physician does not incur financial responsibility. Twenty days gives the medical review agent sufficient time to study the medical record without producing undue delay for the recipient. This is the time frame being used at present and it has proved to be workable.

If the provider requests exemption on the grounds of emergency or incidental surgery, then the provider is required to submit all relevant information (specified in subpart 3) to the medical review agent within forty eight hours of the incident. This provision is necessary and reasonable for the reasons explained in subpart 4 item B. If the provider requests exemption on the ground that the recipient had not applied for MA or GAMC when the surgical procedure was performed, then the provider may be required to submit the medical record of the recipient to the medical review agent within thirty days of the request.

This provision is reasonable because if the recipient is retroactively eligible for MA then the provider will be eligible for reimbursement. But the medical review agent still has a duty to ensure that the recipient was eligible for MA/GAMC at the time of surgery and that the surgical procedure was medically appropriate, before the department reimburses the provider. This determination can be made only if the medical record is provided to the medical review agent within a reasonable time. This requirement is consistent with the requirement for admission certification, provided in subpart 5.

If the medical review agent determines that the surgical procedure is not entitled to an exemption on any of the grounds mentioned above, or that the surgical procedure is not medically appropriate, the medical review agent shall deny the authorization number and notify by certified mail, within twenty days, the admitting physician and hospital of the denial and of their right to request reconsideration or to appeal.

This provision is necessary and reasonable because these exemptions are obtained after the surgery has been performed, and providers have to be notified that they will not be reimbursed for services delivered. It is reasonable to give providers an opportunity to prove their case in a reconsideration and to inform them of their right to appeal, because they have already incurred an expense for which they seek reimbursement. It is also reasonable that the notice be by certified mail because the date of receipt of notice is required to set the time frame within which the provider must ask for reconsideration or appeal. For reasons stated above, twenty days is a reasonable amount of time for the medical review agent to make the determination and send the notice.

Subp.8, items D and E. If the clinical evaluator is unable to determine that the surgical procedure is medically appropriate, the evaluator shall contact a physician adviser. This is both necessary and reasonable, because the clinical evaluator can be a registered nurse or a licensed physician who may not be a specialist in the area of diagnosis of the patient.

A determination that a surgical procedure is medically appropriate should be made only by a person who has expertise in the area of the recipient's diagnosis, or a related area. Therefore if the clinical evaluator is unable to make the determination, the request should be referred to a physician adviser, who by definition has the expertise necessary to make a determination regarding medical appropriateness. If the physician adviser believes that the surgical procedure is medically appropriate, it is necessary and reasonable for the medical review agent to issue an authorization number. This procedure is consistent with the procedure for obtaining an admission certification.

Subp.8, item F. This amendment informs recipients, providers, and the medical review agent of the procedure to be followed if the physician adviser is unable to determine that the surgical procedure is medically appropriate. This amendment is necessary because the process for obtaining an authorization number after the medical review agent's denial is different from the process used for the certification number.

If the physician adviser is unable to determine that the surgical procedure is medically appropriate, the medical review agent shall inform the admitting physician that the recipient may obtain the opinion of a third physician, as provided under the second surgical opinion rule (Rule 68). The third opinion in the case of surgical procedures is more comprehensive than the admission certification procedure. Under the admission certification process the second physician adviser reviews the same documentation provided by the admitting physician. Under the authorization process the recipient can have a face to face third opinion by a physician of the recipient's choice. This is reasonable because under the certification process the recipient is not denied the medical service - only the inpatient hospital environment. In the authorization process, the recipient is denied the surgical service. Therefore the recipient should have a more comprehensive review even at the third opinion stage.

Subp.8, item G. It is necessary to clarify that it is the admitting physician's responsibility to request admission certification, and this includes the responsibility to request a second physician adviser's opinion if the first physician adviser is unable to determine that the admission is medically necessary. If the admitting physician does not request a second physician adviser's opinion, the medical review agent shall deny the admission certification.

This is reasonable because the admitting physician is expected to know the procedures established by the department and to request a second physician adviser's opinion if it is needed. This is also reasonable because it is the admitting physician who will be reimbursed for services provided, and therefore, should be held responsible for following the procedures required for reimbursement. It is reasonable for the medical review agent to notify the recipient of the denial because the recipient will be denied inpatient hospital services because of this decision. It is also reasonable to notify the admitting physician and the hospital of the denial, because they will be denied admission certification if they do not take any further steps.

It is necessary and reasonable to clarify that the request for a second physician adviser's opinion pertains to a determination of medical necessity and whether an admission certification number should be issued, and not to the medical appropriateness of a surgical procedure.

Subp.8, item I. The amendment provides for a written notification of the denial to the admitting physician, the hospital and the recipient. It is necesssary that all affected parties be informed of the procedures to be followed and their recourse against the decision. It is reasonable to provide appeal for the recipient because Minnesota Statutes, section 256.045 requires it. It is reasonable that the notice to the admitting physician and the hospital inform them of their right to request reconsideration because they are directly affected by the denial of inpatient certification and should know that they have an opportunity to prove their case to the department.

Subp.9. Reconsideration. This amendment is necessary and reasonable as it clarifies that the medical review agent will also provide for a reconsideration of denial of an authorization number under some

circumstances (Refer to SNR of Subp.8, item C). It also clarifies the process and time frame of requesting a reconsideration. It is reasonable that the request for reconsideration should include the medical record and that the provider should have the option to submit additional information because that record and documentation will be the basis of the reconsideration decision by the medical review agent.

It is intended that the medical review agent will begin the reconsideration process upon receipt of the request and medical record. No further information will be accepted after that time except at the request of the medical review agent. In addition, it is reasonable and necessary that the reconsideration process be completed within 45 days of the receipt of the request and medical record with the final determination made by the majority of physicians involved in the reconsideration.

The change in time frame was selected in conjunction with the suggestions of the advisory committee, appointed for development of this rule. The change in days is to accommodate rescheduling due to medical emergencies and a review of the written determination by each physician involved in the reconsideration before the Medical Review agent notifies the provider. It is necessary to clarify that the reconsideration process will include three physician advisors. It is reasonable that a majority consensus will determine the outcome because it is possible to have different views on the same medical record.

It is necessary to inform affected parties and is reasonable that providers take advantage of established appeal processes when there is a denial of medical necessity. It is necessary to clarify providers' options to have a case reassessed if the certification number has been denied or withdrawn. The provider has the option of a medical review provided by the reconsideration process, or a contested case hearing provided by Minnesota Statutes, chapter 14. The provider is required to request a reconsideration or a chapter 14 contested case hearing within 30 days of written notification. If the provider allows the time to lapse without requesting a reconsideration or an appeal of denial or withdrawal of certification, the provider has relinquished those options.

It is reasonable that the two processes be available within an established time frame in order to ensure timely and meaningful review. If a provider requests a reconsideration within the required time and disagrees with the outcome, that provider may appeal through a chapter 14 contested case hearing if requested within 30 days of reconsideration notification. However, if the provider allows the 30 days to elapse without request, the provider has relinquished the option to appeal. The time limit is reasonable because it is consistent with Minnesota Statutes, section 256.045 sub 7 (1987).

Subp.9a. Retention or withdrawal of certification number. This section sets forth the situations that are subject to a retention or withdrawal of a certification number and the appeal process that is available. It is necessary and reasonable to inform affected parties of the process pertaining to readmissions or transfers and to allow a reconsideration or appeal in case of disagreement.

Subp.10, items A to E. Medical record review and determination. It is necessary and reasonable to clarify the role of the medical review agent under contract with the Department. These items specify that the review agent will validate the diagnostic category as part of the medical record review and will supply the Department with the necessary information to adjust the reimbursement as applicable (refer to SNR part 9505.0520, subpart 6, item L).

In addition, it is necessary and reasonable to inform the providers of a denial determination and of their right to appeal (refer to SNR part 9505.0520, subpart 9). Extension of the notice mailing time from 24 hours to five working days was accepted by the advisory committee and by the medical review agent as reasonable because it balances allowing sufficient time to complete a required procedure and the need of the hospital and admitting physician to receive a confirmation of the verbal determination as soon as possible in order to prevent a possible misunderstanding of the decision. The change in time frame is necessary to give extra working days to this procedure in order to accomodate a review of the written determination by the physician who made any of the decisions in subpart D.

Subp.10, item F. The medical review agent has the responsibility, under subpart 6, items B and F, to conduct a retrospective review to determine the medical appropriateness of a surgical procedure and to determine if the surgical procedure is exempt from the second surgical opinion requirement.

It is necessary for an effective retrospective review that the medical review agent should have access to all documentation supporting the opinion of the third physician that the surgical procedure was medically appropriate or that the surgical procedure was exempt from the second surgical opinion requirement. It is reasonable to give the medical review agent the authority to ask the hospital for additional documentation if the medical review agent finds that the medical record is inadequate to justify the opinion of the third or the admitting physician.

It is also necessary and reasonable that the documentation be submitted at the expense of the hospital, because the hospital is responsible for submitting all relevant information to the medical review agent and the hospital will be reimbursed for the surgical procedure if the medical review agent finds that it was medically appropriate, or that the surgical procedure was exempt from a second surgical opinion. Twenty working days is sufficient time for the hospital to comply with the request of the medical review agent. This provision is also reasonable because it is consistent with the provision for retrospective review of admission certification.

Subp.10, item G. This amendment is necessary in order to define and clarify the procedure for medical record review and determination in readmission situations. In order to be eligible for a second admission payment in a readmission situation, the provider must meet the medical necessity criteria for admission of a recipient, and the additional criteria outlined in part 9505.0540 subpart 3.

The payment for readmissions could be affected by the medical review agent's determination of the nature of discharge and readmission according to the criteria in part 9505.0540 subparts 3 to 5.

If the clinical evaluator cannot determine the reasons for a recipient's discharge and readmission according to the criteria in part 9505.0540 subparts 3 to 5, it is necessary to permit another source of determination. It is reasonable that the readmission situation be referred to a physician adviser who has the necessary level of expertise to make the determination. This procedure is reasonable because it is currently being utilized for determination of medical necessity and is being expanded to include readmission situations.

It is necessary to notify the provider of the determination when there is a discrepency between the provider's determination and that of the medical review agent. It is reasonable that the medical review agent notify the provider of the determination by certified mail, in order to catalog the date on which the provider received the letter and to ensure that the provider received the notification letter. It is reasonable that the provider be notified of the right to have the medical review agent's determination reconsidered or appealed.

Subp.11. Consequences of withdrawal of admission certification or authorization number ; general. It is necessary to amend this subpart to inform providers that the department shall withdraw the certification or the authorization number under certain circumstances, and to make the language consistent with parts 9500.1090 to 9500.1155, which is the reimbursement rule (Rule 54). This amendment also clarifies the medical review agent's role as the Department's authorized representative.

Medical necessity and medical appropriateness are the criteria for use of MA or GAMC funds to pay for inpatient hospital services Therefore it is reasonable not to use MA or GAMC funds for inpatient hospital admissions or services that are neither medically necessary nor medically appropriate. For the same reason, it is also reasonable to withdraw admission certification if the hospital does not submit information necessary to prove that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, that some or all of the inpatient hospital services provided were medically necessary, or that the surgical procedure was medically appropriate.

The medical review agent is responsible for reviewing excess use or inappropriate use of MA services, and if the hospital fails to provide the relevant information, the medical review agent will conclude that the services were not provided in a proper manner. The following provisions specify the consequences of withdrawl of admission certification for a hospital, admitting physician, and other vendors that are involved in providing inpatient services.

Subp.11, item A. This amendment refers to the consequences of withdrawal of admission certification and denial or recovery of payment from hospitals if the admission was not medically necessary or was not documented as medically necessary.

It is necessary to delete language pertaining to the previous payment methodology and reasonable to clarify that the consequences of withdrawal of an admission certification pertains to the current payment system reflected in the hospital reimbursement rule. It is necessary and reasonable to delete the word debited, as a specific subpart has been established for methods of recovery of payment in part 9505.0520, subpart 15. It is reasonable to delete and move specific language as it pertains to the conditions outlined in items B and D.

Subp.11, item B. (Existing Rule) It is necessary to delete language pertaining to a previous payment methodology that reimbursed hospitals on a per diem basis. This amendment is reasonable because it is consistent with the new payment methodology provided in parts 9500.1090 to 9500.1155.

Subp.11, item B (Proposed Amended Rule). It is necessary to amend the rule in order to clarify the consequences for hospitals if additional inpatient hospital services are determined not medically necessary or are not documented to be medically necessary. The medical review agent makes the determination either in a continued stay review, a concurrent stay review, or a retrospective review. If the medical review agent determines that services were or will not be medically necessary, then the department can deny or recover payment under part 9505.0520 subpart 15. If all necessary services were not provided, then the department shall refer the matter to the Surveillance and Utilization Review Section.

It is reasonable for the department to take action and not reimburse a hospital for a portion of an inpatient stay that was not medically necessary. This provision is consistent with Minnesota Statutes, section 256B.04 subd.15 which requires the Commissioner to safeguard against unnecessary or inappropriate use of MA services and against excess payments.

It is necessary and reasonable to refer the matter to the Department's Surveillance and Utilization Review Section to determine whether payment previously made should be recovered in part or in whole, or whether other actions should be taken. Such actions are authorized by Minnesota Statutes, section 256B.064 (1982) and Minnesota Rules, parts 9505.1705 to 9505.2150 (1983). It is also reasonable and necessary for the matter to be referred to the Surveillance and Utilization Review Section (SURS) of the Department if the hospital failed to provide all medically necessary services prior to discharging the recipient, because SURS has responsibility to investigate the circumstances of why a provider failed to provide services for which payment was made.

Subp.11, item C (Proposed Amended Rule). It is necessary to amend the rule in order to clarify that when an admission was not medically necessary, the determination will result in withdrawal of all MA or GAMC funds including payment to admitting physicians and other vendors of inpatient hospital services.

This amendment is reasonable because the admission should never have taken place, and services performed after the admission, by the admitting physician and other vendors, were not medically necessary either. It is reasonable and necessary for the matter to be referred to the Surveillance

and Utilization Review Section of the Department, (SURS) if the admitting physician and other vendors failed to provide all medically necessary services prior to discharging the recipient, because SURS has responsibility to investigate the circumstances of why a provider failed to provide services for which payment was made. This amendment is consistent with the purpose of Minnesota Statutes, section 256B.04 subd.15 which requires the Commissioner to safeguard against unnecessary or inappropriate use of MA services.

Subp.11, item D (Proposed Amended Rules). The amendment is necessary to clarify the consequences to admitting physicians and other vendors of services, for additional inpatient hospital services that are found not medically necessary. It is reasonable that payment be denied or recovered from a physician and other vendors for these additional services.

It is necessary and reasonable to refer the matter to the Department's Surveillance and Utilization Review Section (SURS) to determine whether payment previously made should be recovered in part or in whole, whether other actions should be taken. Such actions are authorized by Minnesota Statutes, section 256B.064 (1982) and Minnesota Rules, parts 9505.1750 to 9505.2150 (1983). It is also reasonable and necessary for the matter to be referred to SURS if the admitting physician and other vendors failed to provide all medically necessary services prior to discharging the recipient, because SURS has responsibility to investigate the circumstances of why a provider failed to provide services for which payment was made.

Subp.11, item E. It is necessary to delete the existing rule because that provision has been moved to item D of this subpart.

The medical review agent can ask the hospital to submit the recipient's medical record or any other information which will enable the medical review agent to make an effective determination of the medical necessity of the services provided. If the hospital fails to comply with the medical review agent's request to submit documentation, or if the information submitted by the hospital was insufficient to prove the medical necessity of the services provided, the medical review agent will deny all or part of the payment.

It is reasonable that the department or the medical review agent have the authority to request copies of the medical record and other information to substantiate the medical necessity of an MA or GAMC admission, because these records and information provide evidence of the facts. In some cases rule procedures require review of medical records and other information by personnel other than the clinical evaluator (See 9505.0520, subp.10, Medical record review). In these circumstances it is necessary to request that a copy of the medical record be mailed or taken out of the hospital because it is not geographically or financially feasible for the department personnel, medical review agent, or physicians to review them at the hospital.

It is necessary for the department, the medical review agent, and the physician to have complete information regarding a case in order to make an informed decision. It is reasonable that, if adequate information is not

submitted and an informed decision cannot be made, the department will conclude that there has been inappropriate utilization of services and shall deny all or part of the payment.

It is necessary and reasonable to request that the records be sent within twenty working days, because timeliness in making the decisions of medical necessity and utilization is important to both the department and the provider. Twenty days is sufficient time for the hospital to copy and mail the requested information, and is consistent with the time provided to hospitals for providing medical records in other similar situations.

Subp.11, item F. The amendment refers to situations when the medical review agent reviews all the relevant documents and determines that the surgical procedure was not medically appropriate or that the surgical opinion was not entitled to an exemption from a second surgical opinion. The amendment also covers situations where the hospital affirms that a third physician has approved the medical appropriateness of the surgical procedure or has approved the exemption, but fails to submit documentation to substantiate the opinion of the third physician. In all such circumstances, payment for the surgical procedure shall be denied or recovered from the hospital, admitting physician or the vendor.

This amendment is necessary because it informs providers of the circumstances in which they can be denied payment for performing surgical procedures. It is reasonable because it is consistent with the purpose of Minnesota Statutes, section 256B.04 subd.15, which directs the commissioner to safeguard against excess payments and against overutilization of MA services. The method of recovery is also reasonable because it is consistent with recovery in other cases of medical necessity provided in items A to D, and is more cost effective.

Subp.12. Reconsideration of denial or withdrawal of admission certification. It is necessary and reasonable to provide an alternative to the Chapter 14 contested case hearing conducted by an administrative law judge. The Department has developed the reconsideration process set forth in 9505.0520, subpart 9 for reviewing denials and withdrawals of certification because it is a more efficient and timely process for the provider and the Department.

Subp.15. Recovery of payment after withdrawal of admission certification or denial of authorization of second surgical procedure opinion. This amendment is necessary and reasonable in order to clarify the Department's policy for recovery and adjustments to overpayments to providers. The amendment is reasonable because a notice that certification is withdrawn or that a surgical procedure authorization is denied is sufficient indication that, if a reconsideration or chapter 14 appeal is not requested within the time limits, the department shall recover payment. It is administratively burdensome for the Department to send another notice restating that it will recover payment when a reconsideration or an appeal is not requested. Similarly, the letter notifying the provider that the reconsideration or appeal has upheld the withdrawal or denial is sufficient notice that payment will be adjusted.

It is necessary to inform the providers of the methods that the Department will use for recovery and adjustment. The methods that may be used to adjust overpayments are : direct adjustments to incorrect invoices, adjustments to other invoices, or by request for corrected invoices. These methods are reasonable because they are normal business operating procedures. The amendment states that the Department is not limited to these methods, but may take any other remedy in accordance with state and federal rules if circumstances require.

Part 9505.0521. PROHIBITION OF RECOVERY FROM RECIPIENT.

It is necessary to inform providers that they cannot seek part or full payment from the recipient if the reimbursement has been denied by the department. This is reasonable because it is consistent with the code of federal regulations (42 C.F.R. 447.15) which says that providers must accept State payment as payment in full. This provision is also reasonable because providers are expected to provide only medically necessary services, and to follow the procedures established by the department. To allow recovery in situations where the services were not medically necessary or medically appropriate, would result in undue burden on the recipient.

Part 9505.0522. RECIPIENT'S RIGHT TO APPEAL.

It is necessary to inform the recipient that he or she has the right to appeal the decision of the medical review agent to deny him or her treatment in an inpatient hospital setting because it was not deemed medically necessary, or medically appropriate. It is reasonable to allow the recipient to appeal because the denial of inpatient hospital services directly affects the recipient. This amendment is consistent with Minnesota Statutes section 256.045.

Part 9505.0530. INCORPORATION BY REFERENCE OF CRITERIA TO DETERMINE MEDICAL NECESSITY.

It is necessary and reasonable to inform affected parties of the change in address for the request of the most recent copy of the Appropriateness of Evaluation Protocol criteria.

Part 9505.0540. CRITERIA TO DETERMINE MEDICAL NECESSITY OR APPROPRIATENESS.

Subp.1. Determination for admission for purpose other than chemical dependency treatment. This amendment is necessary because it informs affected parties of the criteria which the medical review agent will follow in determining the medical appropriateness of a surgical procedure. It is reasonable because Minnesota Statutes section 256B.02 subd.8 paragraphs (a),(d) and (y) direct the Commissioner to publish the criteria used for determining medical appropriateness in the State Register.

Subp.2. Determination for admission for chemical dependency treatment. It is necessary and reasonable to delete this language due to the implementation of Consolidated Chemical Dependency Treatment Fund (refer to SNR part 9505.0520, subpart 2, item C).

Subp.3 to 6. Readmissions. The readmissions criteria were developed by a special task force composed of hospital utilization review professionals, the medical review agent and the Department. Under the present payment system the provider is reimbursed through a predetermined rate for each admission. This per admission prospective payment system creates the incentive for hospitals to discharge and readmit patients, thereby collecting additional payments. However, hospitals should be financially indifferent to discharging and readmitting recipients because these are medical decisions.

The readmission criteria differentiate between readmissions which will be considered as second admissions and for which the provider will be paid separately, readmissions which will be considered as continuous with the first admission and for which the provider will be eligible only for one DRG payment, and readmissions which will be considered as transfers and for which the provider will be eligible for a transfer payment. The readmission criteria will function as safeguards against unnecessary or inappropriate use of medical assistance services, excess payments and underutilization such as fragmented care and premature discharge as required by Minnesota Statutes, section 256B.04, subdivision 15.

The readmissions criteria do not determine medical necessity, instead they apply after medical necessity has been established and a recipient is found to have been readmitted within 15 days of discharge from a prior hospitalization. The readmission criteria are also necessary to clarify and provide notice to hospitals and physicians of the Department's procedures for handling readmission situations.

All readmission situations will be determined by the hospital, and be retrospectively reviewed by the medical review agent through procedures set forth in part 9525.0520, subpart 10. The readmission criteria are designed to encompass all circumstances that may arise in readmission situations and to serve as a screen to eliminate as many cases as possible from physician review which is costly and time consuming.

If the clinical evaluator who initially reviews the medical records cannot make a determination, a physician adviser will be consulted. The medical review agent will apply the readmissions criteria set forth in part 9505.0540 subparts 3 to 6, to information contained in the medical records for both admissions to make the determination. It is reasonable to use the medical records of the admissions because they are legal documents which record all information pertinent to a hospitalization. It is imperative, and clearly stated in the amendment, that the medical records state why a recipient was discharged from the hospital, why that recipient was readmitted, and what the recipient's medical status was at these times. Information not contained in the medical record may be used at the discretion of the Department.

Subp.3. Readmission considered as a second admission. This subpart is necessary and reasonable in order to establish criteria for readmissions that will be counted as two separate admissions, will retain both certification numbers and will be eligible for two DRG payments. It addresses readmissions to the same and different hospitals. This section explains that the medical records for the admission and readmission, as

determined by the hospital, will be retrospectively reviewed by the medical review agent to establish, according to Items A to D, that the admission and readmission are indeed two separate admissions.

This provision is necessary and reasonable because the medical review agent should have the authority to determine that the department is billed correctly and that hospitals have provided proper care to recipients. This section explains that the retrospective review procedure outlined in part 9505.0520, subpart 10 will be utilized. Hospitals will retain certification numbers for readmissions, as determined by these items, as long as they comply with the requirements in parts 9505.0520 to 9505.0540 (Rule 48).

Subp.3, item A. It is necessary and reasonable that the admission and readmission be considered as two separate admissions when the reason for the readmission resulted from actions taken by the recipient to leave the hospital against the medical advice (AMA) of the physician at the previous admission. When the physician advises the recipient that continued treatment is medically necessary, and the recipient refuses to adhere to that advice and chooses to leave the hospital, it is beyond the hospital's control to provide any further services to that recipient. The discharge status of the recipient must be clearly documented in the medical record of the first admission.

Subp.3, item B. It is necessary and reasonable that the admission and readmission be considered as two separate admissions in the event that the recipient is noncompliant with medical advice and the readmission occurs from the noncompliant actions of the recipient. When the recipient refuses to adhere to medical advice regarding care, treatment or follow-up discharge planning, the treatment of the recipient is outside the hospital's control. Examples of noncompliant behavior include: refusal to take medication, refusal to attend clinic appointments, refusal to return for scheduled treatment without notification, or refusal to schedule needed treatment. All medical advice given to the recipient, and any evidence that the recipient was noncompliant must be documented in the medical records.

Subp.3, item C. It is necessary and reasonable that the admission and readmission be considered as two separate admissions when the recipient is suffering from a separate episode of an illness or from a condition that is episodic. An episodic illness, such as asthma, is expected to reoccur but, because of its unpredictable nature, it is difficult to determine when it will reoccur. It is reasonable for a readmission to be considered as a separate admission for another episode of an illness that clearly could not be prevented or treated at the first admission. The medical records must clearly document that the episode was arrested, that the recipient was stable at the time of discharge, that proper education was provided to the recipient (and/or the recipient's family), and that treatment was aggressive and well coordinated.

Subp.3, item D. It is necessary and reasonable that the admission and readmission be considered as two separate admissions when it is appropriate according to prevailing medical standards, practice, and usage to discharge and readmit. Examples include situations when the reason for discharge and

readmission is medical and it is the accepted standard of medical practice to allow a certain period of time between procedures, or when a recipient must be stabilized to recover from a fever or infection before indicated treatment can be provided.

Subp.4. Readmission considered as continuous with admission. This subpart is necessary and reasonable in order to establish criteria for readmissions which occur within 15 days that will be considered as continuous with the first admission and therefore have the certification number for the second admission withdrawn and be eligible for payment of one DRG only. This section refers to readmissions to the same or different hospitals.

It is expected that in the circumstances outlined in items A to C, the hospital will combine both admissions and submit one payment claim to the Department. The admission and readmission will be considered as one admission for the determination of outlier status. It is conceivable that the principal diagnosis for the combined admission will be different than that for the first admission. The medical review agent will review the medical records retrospectively to determine whether the admission and readmission should be combined, and to verify that the hospital submitted only one payment claim.

This section refers to part 9505.0520, subpart 10, as the procedure utilized for retrospective reviews. The admission and readmission will be combined under one certification number, as determined in Items A to C, as long as requirements of parts 9505.0520 to 9505.0540 (Rule 48) are met.

Subp.4, item A. It is necessary and reasonable to combine both admissions in the event that the readmission resulted from the inability of the hospital or physician to provide medically necessary treatment because of hospital or physician preference or scheduling conflict. The care provided during the readmission is care that should or could have been provided during the first admission. Therefore, the readmission is to be considered as a continuation of the first admission. Scheduling is an internal hospital management issue and it is the responsibility of the hospital and physician to schedule tests and subsequent surgery in a manner that is appropriate. The Department is indifferent to scheduling conflicts as long as the admission and readmission are managed in such a way that prevailing medical standards practice and usage are followed.

Subp.4, item B. It is necessary and reasonable to combine an admission and readmission to the same hospital, or withdraw the certification for the first admission, when readmission to a different hospital occurs because the discharge and readmission resulted from inappropriate medical standards, practice and usage. A readmission to the same hospital should be combined with the first admission allowing the hospital to provide all medically necessary services. The certification number given to the first hospital when a readmission to a different hospital occurs will be withdrawn because the first hospital did not provide appropriate care. The potential compromise in the quality of care provided to the recipient in these situations is not condoned, and will be referred to the proper authority.

Subp.4, item C. It is necessary and reasonable to combine an admission and readmission to the same hospital when the recipient exercises the option to delay inpatient hospital services and this choice is compatible with prevailing medical standards, practice, and usage. Examples of recipient preference include choosing to delay treatment in order to make arrangements for work or child care, or choosing to delay treatment until a preferred physician is available. In situations of recipient preference, the recipient is planning to return for treatment in a reasonable amount of time as determined by the recipient and physician. Therefore it is reasonable that the hospital continues treatment that could have been provided during the first admission and duplicative diagnostic measures and treatment are not necessary.

Subp.5. Readmission eligible for transfer payment. This subpart is necessary and reasonable in order to establish criteria for admissions and readmissions that will be considered eligible for a transfer payment. The transfer payment is defined in part 9500.1130, subpart 7, item A, and basically states that a hospital will be reimbursed on a per diem basis instead of a per admission basis if the recipient is moved directly to another hospital after admission to one hospital. Both hospitals will retain their certification numbers.

It is reasonable that when there is an admission and readmission to different hospitals under the circumstances described in Items A to C, both hospitals should be reimbursed in this manner because they have, essentially, apportioned the treatment of the recipient. Because not all medically necessary treatment was provided during the first admission the first hospital should not receive a full per admission payment. However, because the first hospital, in good faith, provided some medically necessary treatment it should be reimbursed for services rendered. Hospitals will retain certification numbers for admissions and readmissions, as determined in Items A to C, as long as they comply with the requirements stipulated in parts 9505.0520 to 9505.0540 (Rule 48).

Subp.5, item A. This item states that if the recipient exercises the option to delay or change location of inpatient hospital services and this choice is compatible with prevailing medical standards, practice, and usage, then the admission and subsequent readmission to a different hospital will be reimbursed with a transfer payment.

This is reasonable and necessary because if the recipient voluntarily chooses to be admitted to a new hospital then the decision is out of the admitting hospital's control, and it should be paid for medically necessary services that it provided. At the same time the readmitting hospital provides the remaining medically necessary services and so payment should be apportioned between the two hospitals. Examples of recipient preference include the recipient choosing to have a procedure or surgery at a hospital that specializes in that procedure or surgery, or choosing to move to hospital that is closer to the recipient's home or family. In situations of recipient preference, the recipient is planning to undergo the necessary treatment in a reasonable amount of time as agreed upon by the recipient and physician.

Subp.5, item B. It is necessary and reasonable to reimburse an admission and readmission to a different hospital with a transfer payment when the recipient is referred to a different hospital because the recipient's medically necessary treatment is outside the scope of the first hospital's available services. When a hospital admits a recipient and subsequently discovers that medically necessary treatment is out of the scope of its services, the hospital should refer the recipient to another hospital. The result will be that the second hospital will provide a portion of the necessary service. However, because the hospital has provided some but not all of the medically necessary care, it is reasonable to reimburse that hospital on a per diem basis (transfer payment). Because some of the medically necessary services were provided by the first hospital, the hospital of the readmission will also be reimbursed on a per diem basis (transfer payment).

The amendment stipulates, however, that if a hospital admits a recipient knowing that all of the medically necessary services cannot be provided the certification number for that admission will be withdrawn, except in emergency situations. This is reasonable because in emergencies it is more important to admit recipients and provide immediate care even though the hospital is aware that all medically necessary services are not available. However if there is no emergency and the hospital knows it cannot provide all medically necessary services, then it has a duty to refer the recipient to another hospital and it should not be paid for wrongful admissions.

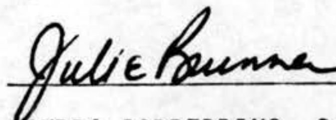
Subp.5, item C. It is necessary and reasonable to reimburse both an admission and readmission of the same recipient to different hospitals with a transfer payment when the readmission resulted because of a delay in medically necessary treatment due to a hospital or physician scheduling conflict or preference occurring during the first admission. The first hospital will receive a prorated payment because not all medically necessary treatment was provided for the recipient during that admission. When, in good faith, the first hospital reschedules treatment which falls within the parameters of prevailing medical standards and practice, but the recipient chooses to have treatment at another hospital, both hospitals will receive a transfer payment. It is reasonable for the second hospital to receive a transfer payment because it is continuing the care provided during the first hospital stay.

Subp.6. Physician adviser's review of readmission. This subpart is necessary because it addresses readmission situations that require the additional expertise of a physician adviser. It is reasonable that a physician adviser review admission situations because the physician has the knowledge necessary to review the situation and furthermore, physician review is an activity currently employed by the medical review agent and the Department when situations of medical necessity, underutilization, and overutilization cannot be determined by the clinical evaluator. It is reasonable that a physician adviser also review readmission situations when the clinical evaluator cannot make a determination, because the physician adviser has the additional expertise to do so.

SRF/DM

The Department will not present expert witnesses to testify concerning the provisions of these proposed rules on behalf of the department.

September 7 , 1988



SANDRA GARDEBRING, Commissioner
Department of Human Services

SRF/DM