STATE OF MINNESOTA

DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED
ADOPTION OF AMENDMENTS TO
MINNESOTA RULES, PARTS 9505.5000 TO
9505.5105, ESTABLISHING THE PROCEDURES
FOR PRIOR AUTHORIZATION OF HEALTH
SERVICES AND THE REQUIREMENTS OF A
SECOND SURGICAL OPINION AS CONDITIONS
OF REIMBURSEMENT TO PROVIDERS OF HEALTH
SERVICES FOR RECIPIENTS OF MEDICAL
ASSISTANCE AND GENERAL ASSISTANCE MEDICAL
CARE

STATEMENT OF NEED
AND REASONABLENESS

INTRODUCTION AND BACKGROUND

Minnesota Rules, parts 9505.5000 to 9505.5105 govern the operation of the Prior Authorization (PA) and Second Surgical Opinion (SSO) Programs. This rule was originally promulgated in October 1985 in response to a legislative mandate for the Medical Assistance (MA) and General Assistance Medical Care (GAMC) Programs to operate a Second Surgical Opinion Program. Prior to that time, the Department had an emergency rule that was effective in December 1984.

This rule (Rule 68) defines the process and requirements that are applicable to the Second Surgical Opinion and Prior Authorization Programs. The process and requirements set forth in this rule have worked well and have served to meet the needs of Department of Human Services (DHS) recipients and providers. However, as the program has evolved, it has become evident that there are more efficient and cost effective ways in which the Second Surgical Opinion Program could be operated. Hence, the Department of Human Services (the department) is proposing amendments to this rule that will have the following beneficial impact.

First, the Second Surgical Opinion authorization process will be combined with the certification for admission process. (See Minnesota Rules, parts 9505.0500 through 9505.0540.) This will mean that a provider calling to obtain a certification number will simultaneously, in the majority of cases, be able to obtain an authorization number authorizing the procedure requiring a second surgical opinion. Likewise, a substantially similar process will apply for surgical procedures requiring a Second Surgical Opinion that are to be performed on an outpatient basis.

The Medical Review Agent will utilize criteria developed by the department or the medical review agent to screen requests for authorization numbers for procedures requiring a Second Surgical Opinion. If a procedure meets the

criteria it will be authorized; if it does not, the existing process of obtaining a "hands-on" third opinion will be required if the recipient wishes to have the surgery.

The result of these amendments should be greater convenience and a less time consuming process for both the recipient and provider. In addition, the strain on existing resources in DHS should be somewhat alleviated by the implementation of these amendments.

The proposed amendments to Minnesota Rules, parts 9505.5000 to 9505.5105 are hereby affirmatively presented by the Department as required by Minnesota Statutes, section 256.991 and 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.

9505.5000 APPLICABILITY.

This amendment is necessary because some provisions in parts 9500.0750 to 9500.1100 have been repealed. The remaining provisions which apply to Rule 68 are : 9500.1070, subparts 1, 4, 6, 12 to 15, and 23. The new rule parts which govern MA and GAMC services are parts 9505.0170 to 9505.0475. The amendment is reasonable because part 9500.1070 refers to services covered under the MA Program. Minnesota Rules, parts 9505.5000 to 9505.5105 govern the policy and procedures to be followed for obtaining a second surgical opinion for certain MA and GAMC services. These rule parts should therefore be read in conjunction with the description of MA services provided in part 9505.1070 subparts 1, 4, 6, 12 to 15, and 23 and with parts 9505.0170 to 9505.0475.

It is also necessary and reasonable that this rule be read in conjunction with parts 9505.0500 through 9505.0540 (Rule 48), the admission certification rule. One of the benefits of amending the present rule is that there will be one common process for obtaining the inpatient admission certification number and the authorization number for a procedure requiring a second surgical opinion. The process is set out in detail in the admission certification rule, parts 9505.0500 to 9505.0540 (Rule 48), and the present rule contains references to Rule 48. It is therefore reasonable to read this rule in conjunction with Rule 48.

9505.5005 DEFINITIONS.

Subp.1a. Authorization number. This definition is necessary to clarify a term used in this rule and in the associated admission certification rule (Rule 48). It is reasonable to have such a number so that providers and the Department can identify which surgical procedures have been determined to be medically appropriate, and to eliminate any confusion at the time of reimbursement for surgical procedures requiring a second surgical opinion.

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.

Subp.1b. Certification number. This definition is used only to describe and identify the number issued by the Medical Review Agent to indicate that the admission is medically necessary, i.e. that the recipient needs inpatient hospital services. It is necessary to define this term to distinguish it from the authorization number which is the number issued by the medical review agent to establish that the surgical procedure is medically appropriate. It is reasonable and necessary to have such a number so that providers and the Department can identify which cases have been approved when submitting claims and processing them for reimbursement.

Subp.12a. Medical appropriateness or medically appropriate. The term medical appropriateness or medically appropriate is defined to indicate the standard that providers must meet in order to be reimbursed for a procedure requiring a Second Surgical Opinion. The definition is reasonable because the standard is defined with reference to the criteria developed to screen for the necessity of such surgical procedures, or the opinion of a second or third physician who is an expert on the subject and has reviewed the recipient's case.

Subp.12b. Medical Review Agent. The term "medical review agent" is defined to clarify that the commissioner may delegate the responsibility for making admission determinations, conducting concurrent reviews, continued stay reviews, retrospective reviews, and for determining the appropriateness of procedures requiring a Second Surgical Opinion as specified in the contract between the Department and the medical review agent.

This definition is reasonable because the commissioner is authorized by the Health Care Financing Administration to contract out the utilization review and medical review functions (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). In the absence of the medical review agent, the Department would have to employ physicians and equipment and develop the expertise to be able to perform an effective review. It is therefore more cost effective for the Department to delegate the utilization review function to a medical review agent.

Subp.18a. Second opinion or second surgical opinion. It is necessary to clarify that the second opinion is the opinion of the medical review agent on the medical appropriateness of the surgical procedure requiring a second surgical opinion. In case there is no contract between the Department and the medical review agent, then the second opinion is the opinion of the second physician.

This definition is reasonable because it is possible to have different opinions on whether certain surgical procedures are necessary or whether less invasive procedures should be tried first. A second surgical opinion is therefore required for certain elective surgeries where disagreement is possible.

Subp.18b. Third opinion or third surgical opinion. This definition is necessary because it clarifies that the third opinion is the opinion by a third physician after the medical review agent or the second physician have made their determination. It is also necessary to define this term to eliminate any confusion between the second opinion and the third opinion. The definition is reasonable, because if the medical review agent or the second physician does not agree with the physician offering to provide the surgical service, then there should be a third expert opinion on the medical appropriateness of the surgical procedure. In case of a split decision, the majority opinion will determine the medical appropriateness of the surgical procedure.

9505.5010 PRIOR AUTHORIZATION REQUIREMENTS

This amendment is necessary because it informs providers of the services for which they must obtain prior authorization. It is reasonable because it is consistent with the purpose of Minnesota Statutes, section 256.02 subd.8(y).

9505.5015 AFTER THE FACT AUTHORIZATION

Subp.1. Exceptions. It is necessary to specify that a health service for which reimbursement is sought after the delivery of the service, must still meet the standard of medical necessity and appropriateness set forth in parts 9505.5030.

All MA and GAMC services that require prior authorization are subject to the requirements of part 9505.5030. It is reasonable to require that authorization being requested after the delivery of service should meet the same criteria. This ensures consistency in the evaluation of all prior and later authorization requests for the same services. It also promotes the integrity of the prior authorization procedure and requires uniformity of treatment and review of both types of requests.

Subp. 2 Emergencies. This amendment is necessary because it clarifies that the process of requiring authorization before reimbursement will be the same even though the authorization is received retroactively. The procedure for submitting requests for authorization is specified in subpart 1.

The amendment is reasonable because a recipient should not have to wait for prior authorization before he receives health services in an emergency situation. At the same time the Department needs a mechanism to confirm that there was an emergency and that the treatment accorded to the recipient was medically appropriate. The retroactive prior authorization process meets both needs.

Subp. 3. Retroactive eligibility. This amendment is necessary and reasonable because the procedure for submitting requests for retroactive "prior authorization" is specified in subp. 1.

Subp. 4. Third party liability. This provision covers situations when a provider has insurance coverage or when health services are eligible for payment under Medicare.

It is necessary to inform providers that they are exempt from obtaining prior authorization before provision of service in some circumstances. This is reasonable because Minnesota Rules, particularly part 9505.0070 and federal regulations (42 C.F.R.433.135 to 433.148), require the provider to bill all available third-party payors and to obtain either payment or a denial of payment before billing the MA Program. These provisions also provide that MA payment can only be made up to the applicable MA/GAMC rate.

It is thus necessary and reasonable to provide for a mechanism by which providers can obtain MA/GAMC reimbursement if the third party either denies payment or pays less than what MA would pay. In such cases, the provider may retroactively submit a request for authorization of the health services provided, if the services are eligible for reimbursement according to part 9505.5030 and if the authorization request is made according to procedures specified for all other retroactive authorization requests. This mechanism prevents the possibility of nonpayment for appropriate services.

9505.5035 SURGICAL PROCEDURES REQUIRING SECOND OPINION

This amendment is necessary to clarify that the second surgical opinion is required for both inpatient and outpatient surgical procedures. The amendment is reasonable because Minnesota Statutes, section 256B.02, subd. 8(a) and (d) require a second surgical opinion prior to reimbursement for inpatient and outpatient elective surgeries.

It is necessary to inform providers that the Department will publish the list of elective surgeries requiring a second surgical opinion if the list has been revised since the last publication.

This provision is reasonable because providers should be aware of any change to the list of surgical procedures requiring a second opinion. However, there is no need to republish the same list each year unless it is revised, because providers are kept informed of current procedures through manuals and updates issued by the Department, and new providers are always notified and sent a list of the procedures by the Department after they are enrolled in the MA program.

9505.5040 EXEMPTIONS TO SECOND SURGICAL OPINION REQUIREMENTS

It is necessary to amend this provision to clarify that a surgical procedure must be medically appropriate, and, in addition, must meet the documentation requirements of part 9505.5096 before it is exempt from a second surgical opinion. This provision is reasonable because any surgical procedure requiring a second surgical opinion must also be determined to be necessary for the recipient according to the criteria developed by the Department. The provider is exempt from obtaining a second surgical opinion before providing the surgery. The medical review agent shall verify, by retrospective review, whether the surgical procedure was medically appropriate and whether the exemption was appropriate. This is reasonable because the department has been directed by the Legislature (Minnesota Statutes, section 256B.04 subd.15), to

establish a program to safeguard against the unnecessary use of medical assistance services. Therefore, it is the department's responsibility to determine if surgical procedures paid for by MA or GAMC funds are medically appropriate.

9505.5050 SECOND AND THIRD SURGICAL OPINIONS

Subpart 1. The Code of Federal Regulations, (42 C.F.R. 433.15) gives the commissioner the authority to contract out the utilization review function to a medical review agent. This subpart specifies that if the Department contracts with the medical review agent, and requires the medical review agent to determine the medical appropriateness of a surgical procedure requiring a second surgical opinion, then the recipient must obtain a second surgical opinion from the medical review agent. This provision is reasonable because the commissioner is authorized to delegate this review function to the medical review agent. It is also more efficient and cost effective for the Department because the medical review agent has the knowledge and the expertise to review the medical appropriateness of the surgical procedure.

Subp. 2. It is necessary to inform providers and recipients that if the review of the medical appropriateness of a surgical procedure requiring a second opinion is not part of the contract between the medical review agent and the Department, then the recipient must obtain the second surgical opinion from a second physician.

This provision is reasonable because physician providers have the necessary medical expertise and knowledge of the criteria for determining the medical appropriateness of the surgical procedure requiring a second surgical opinion.

Subp. 3. This amendment clarifies that the third surgical opinion is the opinion obtained after the medical review agent or the second physician have failed to substantiate the initial opinion. It is necessary and reasonable because in case of a split decision, there should be another opinion so that the determination of medical appropriateness is made according to the majority opinion.

9505.5055 SECOND OR THIRD OPINION BY A PHYSICIAN

Subp.1. This amendment is necessary to clarify the referral responsibilities of the physician who offers to provide the surgery. Part 9505.5050, subparts 2 and 3 specify the circumstances under which a second or third opinion is required. This provision specifies that if the recipient requires a second or third surgical opinion, the physician offering to provide the surgical service shall provide the recipient with names of appropriate physicians and with information regarding the consequences of not obtaining the required second or third surgical opinion.

The amendment is reasonable because physician providers are knowledgeable about which surgical procedures require a second or third opinion and who is qualified to render that opinion. Also, since the physician providing the surgical service will seek reimbursement for performing the surgery, it is reasonable to assign the responsibility of meeting the conditions of reimbursement to the same physician.

Subp. 2. It is necessary and reasonable to clarify that the physician who provides the second or third surgical procedure must be an expert in the condition that requires the surgical opinion. The criteria developed by the department relate to the experience of the physician in diagnosing and treating the condition which requires a second or third surgical opinion. This ensures that the opinion is provided by a physician with expert knowledge. It is also reasonable that such criteria are published in the State Register pursuant to the authority given to the Department in Minnesota Statutes, section 256B.02, subd.8. The State Register is the official public notification document for the state and has wide circulation.

9505.5060 PENALTIES

It is necessary and reasonable to amend this provision because parts 9500.0960 and 9500.1080 have been repealed, and the provisions regarding penalties for providers in case of noncompliance with the rules have been moved to parts 9505.0145, 9505.0465, and 9505.0475.

9505.5065 REIMBURSEMENT OF COST OF SECOND AND THIRD SURGICAL OPINIONS

The amendment is necessary and reasonable to clarify that this provision refers to two different reimbursements: (1) The cost of the second surgical opinion; and (2) The cost of the third surgical opinion.

Reimbursement for physician services in providing the second or third surgical opinion is covered under Minnesota Statutes, sections 256B.02, subdivision 8 and 256D.03, subdivision 4.

9505.5070 TIME LIMITS; SECOND AND THIRD OPINIONS; SURGERY

The amendments to this part clarify that the second surgical opinion is the opinion of the medical review agent required under part 9505.5050, subpart 1 or of the second physician required under part 9505.5050, subpart 2. This opinion must be obtained within 90 days of the initial opinion. If the second surgical opinion fails to substantiate the initial surgical opinion, and the recipient still wants the surgery, then the third surgical opinion must be obtained from a third physician under part 9505.5050, subpart 3. This opinion must be obtained within 45 days of the second opinion.

The amendments are reasonable because they allow recipients sufficient time to obtain required opinions and still ensure that the second opinions, third opinion, and the surgery are based, as much as possible, on the condition of the recipient at the time the surgery was first recommended.

9505.5075 PHYSICIAN RESPONSIBILITY

It is necessary to inform physicians providing the second or third surgical opinion that the completed form on which they have indicated their opinion must be submitted to the physician offering to provide the surgery and must be made available to the Department or the medical review agent on request. This requirement is reasonable because it permits the Department or the medical review agent to verify that a second or third surgical opinion was in

fact obtained, and that the provisions of the rule have been complied with. The Department needs this information to provide a meaningful review of utilization of medical services as it is required to do by Minnesota Statutes, section 256B.04 subd.15, and by federal regulations at 42 C.F.R. 456.1 to 456.145.

9505.5080. FAILURE TO OBTAIN REQUIRED OPINIONS

These amendments clarify what opinions the physician offering to provide the surgical service must obtain and what procedural requirements must be met before the Department reimburses costs associated with the surgery.

Subpart 1. The amendments to this subpart clarify that if the physician offering to provide the surgical procedure fails to obtain the second surgical opinion from the medical review agent (as required under part 9505.5050, subpart 1), then the Department will deny reimbursement for all costs associated with the surgery. This provision is necessary to comply with the the requirements of Minnesota Statutes, section 256B.04, subdivision 2 that MA/GAMC programs should be administered in an economical and efficient manner, and of section 256B.04, subdivision 15 that procedures should be medically appropriate.

Subp. 2. This subpart refers to situations when the physician offering to provide the surgical service fails to obtain the opinion of a second physician (as required under part 9505.5050, subpart 2) or of the third physician (required under part 9505.5050, subpart 3). The amendments clarify that in such situations the Department will deny all costs associated with the surgery, including costs incurred by other providers and hospitals.

This provision is necessary to comply with the statutory requirements that MA/GAMC programs should be administered in an economical and efficient manner, and that procedures should be medically appropriate. It is reasonable because all providers of services relating to the surgery are both in a position to and under an obligation to ascertain compliance with the requirements of these rules. Costs attributable to providers other than the physician performing the surgery, such as the hospital and anesthesiologist, are substantial. It is reasonable that those providers, who stand to benefit substantially, should be held responsible for verifying compliance before providing the services.

Subp. 3. This subpart also covers situations where a recipient requires a second surgical opinion under part 9505.5050, subpart 2, or a third surgical opinion under part 9505.5050, subpart 3.

If the second or third surgical opinion does not substantiate the need for a surgical procedure, then the physician offering to provide the surgical procedure shall submit the form completed by the second or third physician to the Department within 135 days of the initial opinion.

These amendments are reasonable because they are consistent with other parts of the rule which require the physician offering the surgical procedure to obtain the second and third opinions and to submit the requisite forms to the Department. It is also reasonable to require that second or third opinion

forms be submitted to the Department even if the surgery is not approved, because it enables the Department to compile statistics as to the effectiveness and cost benefits of the second surgical opinion requirement.

9505.5090 MEDICAL REVIEW AGENT AND DEPARTMENT RESPONSIBILITY

Subpart 1. Medical review agent responsibility. It is necessary to describe the obligations of the medical review agent in case of a contract between the Department and the medical review agent which requires the medical review agent to determine the medical appropriateness of surgical procedures requiring a second surgical opinion.

The medical review agent must issue an authorization number within one working day of the receipt of necessary information if the medical review agent determines that the recommended surgical procedure meets the criteria of medical appropriateness or if a third physician determines that the surgical procedure is medically appropriate. The medical review agent must also issue a certification number if the surgical procedure requires an inpatient hospitalization. This provision is reasonable because MA/GAMC payment can be made only if a procedure meets the criteria for medical appropriateness. The issuance of an authorization number is the mechanism used by the Department to ensure that the surgical procedure is medically appropriate and can be reimbursed. The medical review agent can review the information and make the determination within one working day. This is the time frame being used at present and it is also consistent with the time given to the medical review agent to make a determination of admission certification for inpatient hospital services under parts 9505.0500 to 9505.0540.

If the medical review agent determines that the surgical procedure is not medically appropriate, but the third physician determines that the procedure is medically appropriate, then the medical review agent shall assign an authorization number within one working day of receipt of information. This is consistent with the time given to the medical review agent to assign an authorization number in subpart 1. If the third physician agrees with the medical review agent that the surgical procedure is not medically appropriate, then the medical review agent must deny the authorization number and inform the recipient of his or her right to appeal.

This provision is necessary and reasonable because if there is a difference of opinion regarding whether the surgical procedure is medically appropriate or not, then the third surgical opinion should be the determining factor. If, however, two out of three physicians determine that the surgical procedure does not meet the criteria of medical appropriateness, then the procedure is not necessary, based on the information provided. The medical review agent and the opinion of the third physician are relevant indicators of the medical appropriateness of the requested surgical service.

Subp. 2. If no medical review agent. It is necessary to describe the responsibility of the Department and the procedures that the Department shall follow if there is no contract between the Department and the medical review agent. Minnesota Statutes, section 256.991 requires the Department to establish the methods and standards for determining inappropriate utilization of MA services requiring second surgical opinions.

It is reasonable that in the absence of a medical review agent, the Department will determine the medical appropriateness of the surgical procedure and assign or deny the authorization number. The procedure to be followed by the Department is consistent with the procedure that the medical review agent is required to follow.

9505.5096 REQUEST FOR EXEMPTION FROM SECOND SURGICAL OPINION

Subpart 1. Request for exemption; general. It is necessary to inform providers that if they believe that a surgical procedure is exempt from the second or third opinion requirement, they must obtain approval of that exemption from the medical review agent or the Department. This is reasonable because the Department has established criteria according to which certain elective surgeries require a second opinion before providers are reimbursed for services from MA funds. The exemptions are meant to cover circumstances when the requirement of a second medical opinion would endanger the health of a recipient, fail to be cost effective for the Department, or present an unreasonable burden for providers or recipients. The Department must have the authority to verify that the surgical procedure is exempt from the second surgical opinion to be able to ensure proper utilization of MA services. It is necessary to distinguish between circumstances when the exemption must be obtained before carrying out the surgical procedure, and circumstances when it may not be possible for the provider to obtain exemption before the surgery. It is reasonable that in the latter case, providers should have the option to obtain exemption after the surgery.

Subp. 2. Request for exemption before carrying out surgical procedure. In the case of an emergency, a surgery which is incidental to a major surgery or a surgery performed before the date of the recipient's application for MA/GAMC benefits, the provider can choose between the alternatives of providing the service first and attaching documentation of exemption to the prior authorization form later, or seeking approval of the exemption through the prior authorization form before providing service. In all other cases the provider must obtain an exemption either from the Department or from the medical review agent before providing the service.

It is necessary and reasonable to describe the process that a provider must follow to obtain an exemption before carrying out the surgical procedure. It is also necessary to specify how the process differs depending on whether or not the Department contracts with the medical review agent to review the medical appropriateness of a surgical procedure.

If the Department has a contract with the medical review agent, then the provider must call the medical review agent and provide all information necessary for the medical review agent to verify the facts and make a determination of the request for exemption. This is reasonable because if a contract does exist, then the medical review agent has the authority to review the medical appropriateness of surgical procedures. It is efficient and more convenient to give the medical review agent additional authority to review exemptions as well. This mechanism has been used for the last three years and has served the needs of the provider and the Department.

If the Department does not have a contract with the medical review agent, then the provider must use the prior authorization process detailed in part 9505.5010. This is reasonable because prior authorization is a condition of reimbursement for health services covered by the MA and GAMC Programs. It is more efficient and cost effective for the provider to follow the same procedure to be reimbursed for providing a surgical procedure that is exempt from the second surgical opinion requirement.

Subp. 3. Request for exemption after performing the surgical procedure. If a provider performs the surgical procedure and then requests an exemption, the medical review agent or the Department shall follow the same procedures as detailed in subpart 2.

This exemption applies only for surgical procedures provided during emergency, surgical procedures which are incidental to another major surgery, or surgical procedures performed before the date of the recipient's application for MA/GAMC benefits, which application is approved retroactively. It is necessary and reasonable to provide for exemptions after the surgical procedure so that emergency and incidental services are not delayed while the recipient awaits an authorization number. It is also reasonable that the Department or medical review agent should verify the need for the exemption later and use procedures consistent with procedures used in approving exemptions before performing the surgical procedure in order to apply the same standards and criteria of medical appropriateness which are used for reviewing surgical procedures that are not exempt.

Subp.4. Retroactive eligibility. Medical assistance may be granted retroactively for up to three months prior to the month of application (42 C.F.R. 435.914). Therefore, there may be instances in which a person is admitted, treated and discharged from hospital before the time that application for MA or GAMC benefits is made and eligibility granted. This provision is necessary to establish a process for providers to obtain payment for medically appropriate services provided to a person who had not made the application for MA and GAMC benefits and was not eligible at the time the surgery was performed, but who subsequently became retroactively eligible for the period of the surgery. It is reasonable to require the hospital to submit a copy of the medical record to the medical review agent in order for the medical review agent to make a determination of whether the surgical procedure was medically appropriate.

Subp. 5. Documentation required. It is necessary to inform providers of the documentation required to substantiate an exemption and of the Department's authority to withhold approval of the exemption until the documentation is submitted.

This provision is reasonable because it gives providers a financial incentive to comply with the documentation requirements. If the provider fails to comply, MA payment will be denied. It is also reasonable to require documentation from providers so that the Department or the medical review agent can determine the medical appropriateness of the surgical procedure and the need for an exemption. The reviewing authority should have all the information necessary in order to use the same standards and criteria of medical appropriateness which are used for reviewing surgical procedures without a request for exemption.

9505.5100 INDEPENDENT PHYSICIAN EVALUATION

It is necessary and reasonable to use the word "medically appropriate" instead of the word "necessary" so that there is no confusion between the terms medically appropriate used with reference to the second surgical opinion, and the term medically necessary used with reference to inpatient hospital certification.

9505.5105 FAIR HEARING AND APPEALS

Subp.1. It is necessary and reasonable to amend the sentence structure to clarify what actions of the Department the recipient can appeal from. There is no change in the substance of this provision.

Subp.5. It is necessary and reasonable to clarify that the commissioner shall make a ruling to uphold, reverse or modify the action of the medical review agent if the Department has delegated its review functions to the medical review agent and if the recipient requests a hearing from the decision of the medical review agent.

REPEALER

Part 9505.5095 deals with two mechanisms for request of exemptions from the second surgical opinion. In the present rules there is no difference between the different circumstances in which exemptions can be granted. The provider has a choice to either (1) request exemption after the surgery and at the time of submitting the claim for payment, or (2) request exemption before the surgery through the prior authorization process.

The amendments to parts 9505.5000 to 9505.5105 provide that except in the case of emergencies, incidental surgeries or retroactive eligibility, all exemptions should be obtained before providing the surgical procedure. The procedures to be followed by the provider have been detailed in part 9505.5096. It is therefore necessary to repeal this provision.

This provision is reasonable because since there is only one process to follow, it minimizes provider confusion on procedures. It also minimizes the possibility of providers not getting reimbursed for surgical services provided by them. This amendment takes into account surgical procedures which should not be delayed because of prior authorization and at the same time streamlines the entire system to make it move faster. The amendment has the support of the advisory committee.

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

September 7, 1988

Julie Brunner

for SANDRA GARDEBRING, Commissioner
Department of Human Services

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