STATE OF MINNESOTA
MINNESOTA DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF PROPOSED AMENDMENTS TO RULES OF THE MINNESOTA DEPARTMENT OF HUMAN SERVICES ESTABLISHING REQUIREMENTS OF A SECOND MEDICAL OPINION AS A CONDITION OF MEDICAL ASSISTANCE PAYMENT TO PROVIDERS OF HEALTH SERVICES TO MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND MINNESOTACARE RECIPIENTS, MINNESOTA RULES, PARTS 9505.5005 and 9505.5035 to 9505.5105

STATEMENT OF NEED AND REASONABLENESS

Minnesota Rules, Parts 9505.5000 to 9505.5105 clarify policy and procedures for prior authorization of health services and establish a system for requiring a second medical opinion for certain elective surgical procedures. Both prior authorization and a second medical opinion, when required by these rules, are conditions of obtaining Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare payment. The proposed rule amendments affect only parts 9505.5005 and 9505.5035 to 9505.5105, the rule parts with the definitions, policies, and procedures related to the requirements of a second medical opinion. The rule parts related to prior authorization (parts 9505.5010 to 9505.5030) remain unchanged.

The authority for parts 9505.5035 to 9505.5105 is set forth in Minnesota Statutes, sections 256.991, 256B.0625, subdivisions 1 and 4a and 256D.03, subdivision 7(b). The second medical opinion program established under these rules has been known as the second surgical opinion program. However, because the authorizing statutes use the term "second medical opinion", the Department is revising the title to the term used in the statutes.

Permanent rules were adopted in October 1985 and amended in 1989.

The system of a second medical opinion is designed to safeguard against unnecessary and inappropriate expenditure of MA or GAMC MinnesotaCare funds. It ensures that certain elective surgical procedures are not paid from MA, GAMC, or MinnesotaCare funds unless an independent opinion by a person qualified through professional training and experience confirms their medical appropriateness for the recipients of the procedures. The independent opinion, a determination of the medical appropriateness of the elective surgical procedure for the recipient, will be rendered by a medical review agent under contract to the Department. The determinations of the medical review agent must be made by persons who are registered nurses or

physicians. Thus the system is one of utilization review as required under Minnesota Statutes, section 256B.04, subdivision 15, paragraph (1), providing the Department an opportunity to safeguard against unnecessary use of health services and to determine whether the proposed surgical procedure conforms to commonly accepted standards of the surgical profession.

The system using a contract with a medical review agent has been in place since 1988. The Department has had no complaints about the system itself. However, annually, there have been between 10 to 20 appeals of denial of authorization of the elective surgical procedure. Almost without exception the denial of authorization stemmed from the failure of the admitting physician or surgeon to request a determination of medical appropriateness **before** performing the surgical procedure. Thus the authorization of payment was denied because of a timeliness factor required under the present rules even if the performed surgical procedure was medically appropriate for the recipient and consistent with commonly accepted standards of practice. The Department believes utilization review properly should focus on the medical appropriateness of the procedure for the recipient. The proposed amendments do not remove the requirement to obtain a determination of medical appropriateness but rather enable a provider to choose whether to request a determination of medical appropriateness **before or after** performing the surgical procedure for which a second opinion is required. They afford the provider flexibility about when to request the determination. The proposed amendments will assist many eligible persons more readily to obtain medically necessary and appropriate surgical procedures as the provision of such services will not depend on the provider's obtaining a determination of medical appropriateness before performing the surgery. Instead, the provision of the elective surgical procedure will depend on the provider's professional judgment that the person's surgical procedure meets the criteria set forth in part 9505.5046. A determination resulting in issuance of an authorization number still must be obtained prior to payment.

The present plan for the provision of health care services under MA, GAMC, and MinnesotaCare is to move from fee-for-service to managed care. Consistent with this plan, it is highly unlikely that the Department will again take on the responsibility of determining the medical appropriateness of surgical procedures that require second medical opinions. The Department notes that its plan also is considering the outsourcing of programs such as prior authorization, a program of review of health services to assure their eligibility for payment thought MA, GAMC, and MinnesotaCare.

The Department adopted similar amendments to the prior authorization program in June 1995. Therefore, if the proposed amendments are adopted, both programs will afford the provider

flexibility in the timing of the required request for approval for payment through MA, GAMC or Minnesota Care.

Additionally, the proposed amendments provide for second opinions from the medical review agent under contract to the department and for third opinions and reconsiderations by physician advisors who are agents of the medical review agent, establish a reconsideration process, delete the requirement to obtain a second medical opinion from a second physician and possibly a third medical opinion from a third physician. The proposed amendments apply the requirement of obtaining a second medical opinion to the same surgical procedures for recipients of MinnesotaCare.

Finally, the proposed amendments incorporate those provisions of the rule governing hospital admission certification, parts 9505.0500 to 9505.0540, which regulate the actions of the medical review agent in determining the medical appropriateness of surgical procedures. Parts 9505.0500 to 9505.0540 are being amended to repeal these provisions. Thus, parts 9505.5035 to 9505.5100 will be the single source for requirements about the second medical opinion system.

The Department notes that the procedures set forth in parts 9505.5035 to 9505.5100 only apply to the designated elective surgical procedures being provided to recipients on a fee-for-service basis. If these same elective procedures are provided to a person enrolled in a plan of managed health care, the cost of the surgical procedure itself is met through the set, all inclusive capitated rate paid to the plan for each enrolled recipient. The plan itself is responsible for quality assurance and review procedures related to medical appropriateness and medical necessity.

These proposed amendments are hereby affirmatively presented by the Department as required under the Administrative Procedure Act, Minnesota Statutes, Chapter 14.

Because the rule requirements are being simplified and are expected to reduce the burden placed on providers and recipients, the Department did not convene an advisory task force. However, in October 1995 the Department sent a copy of the draft of the proposed rule amendments to representatives of providers and recipients, requesting their review and comment. The Department has not received any comments in response to the October 1995 mailing.

A Notice of Solicitation of Outside Information or Opinions was published in the State Register on 5 June 1995; an amended Notice was published in the State Register on 17 July 1995. In response to these Notices, the Department received one request for copies of rule drafts but did not receive any comments about the

substance of the rule.

9505.5005 DEFINITIONS.

Subp. 12. Medical assistance or MA. The proposed amendment clarifies that the term medical assistance includes general assistance medical care and MinnesotaCare, unless otherwise specified. This usage is consistent with Minnesota Statutes, section 256D.03, subdivision 7, clause (b) in regard to the general assistance medical care program and with section 256.9353, subdivisions 1 and 3, in regard to MinnesotaCare. The amendment is reasonable because the use of one term to refer to three programs subject to the same requirements is an abbreviation that shortens the rule.

Subp. 12a. Medical appropriateness or medically appropriate. The proposed amendment is necessary to remove references to rule provisions that are being deleted or revised. The medical review agent under contract to the department will determine medical appropriateness. The criteria for the determination, previously found in part 9505.0540, subpart 1 are being moved to proposed part 9505.5046. Therefore, a reference to part 9505.5046 is reasonable as it accurately informs affected persons.

Subp. 12b. Medical review agent. A definition of medical review agent is necessary to clarify its meaning for the second medical opinion program. The definition in the present rule refers to

parts 9505.0500 to 9505.0540. The proposed revision of the definition deletes that reference and clarifies that the status and function of the medical review agent for purposes of the second medical opinion rule.

Subp. 14. Physician and Subp. 14a. Physician advisor. Item B of the present definition of "physician" has been separated into Subp. 14a, Physician advisor, the term used in the proposed amendments to refer to persons who advise the medical review agent when the agent is unable to determine medical appropriateness or when the provider requests an additional medical opinion following the medical review agent's denial of an authorization number. The amendment is for structural purposes only.

Subp. 17a. Recipient ID Number. This term is a term used in these rules. It refers to an 8-digit permanent number assigned to a person who applies for MA, GAMC, or MinnesotaCare benefits. If the person is determined eligible for the health care benefits, the person receives a card listing this number which the person furnishes to the health care service provider. The recipient ID number is information that the admitting physician must give to the medical review agent. See part 9505.5075, item A. The definition is necessary and reasonable because it informs affected persons.

Subp. 17b. Reconsideration. This term refers to a procedure applicable to requests for admission certification under revised part 9505.0520, subparts 9, 9a, 9b and 9c. The procedure is being proposed in the revision of the second medical opinion rule so that the two systems of utilization review are parallel and provide the same safeguards for providers and recipients. The definition is necessary to clarify the term's meaning. The definition is reasonable as it informs the reader where to find specific information.

Subp. 18a. Second opinion or second ~~surgical~~ medical opinion. The first proposed amendment more correctly cites to all the rule parts related to second medical opinions. The second proposed amendment deletes the reference to the determination by a second physician under part 9505.5050, subpart 2 as this subpart is being deleted from the rule.

Subp. 18b. Third opinion or third surgical opinion. The proposed rule amendments delete the requirement for a third opinion from the rule. Thus this definition is no longer necessary. See the SNR 9505.5090, subpart 1 for a discussion of the deletion.

9505.5035 SURGICAL PROCEDURES REQUIRING SECOND OPINION

Subpart 1. General requirements. The amendments to this subpart

are technical. They set out the statutory references to the second medical opinion program and extend the requirement to obtain a second medical opinion for certain elective surgical procedures to MinnesotaCare recipients (see Minnesota Statutes, section 256.9362, subdivision 1.)

9505.5040 EXEMPTIONS TO SECOND SURGICAL OPINION REQUIREMENTS

The proposed amendment deletes this entire part. Language about the effect of eligibility of a surgical procedure for Medicare payment has been placed in proposed part 9505.5041. Thus item A is not necessary. Item B is no longer necessary as under part 9505.5075, item H, the physician must give such information to the review agent when requesting an authorization number. See the SNR for part 9505.5075, item H. Because a provider no longer will have to obtain an authorization number before performing the surgical procedure requiring a second opinion the exemption for emergencies (item C) is not necessary as the provider will be able to perform the emergency procedure and then request issuance of an authorization number. Items D and E are not necessary as recipients will not have to obtain a second surgical opinion from a second physician. Finally item F is no longer necessary because, under the restructured system, the provider may request an authorization number after the surgery is performed upon learning that the individual has retroactive MA or GAMC coverage for the period in which the surgery was performed. This policy

conforms to present practices about retroactive eligibility for MA and GAMC coverage for surgical procedures which do not require a second medical opinion. See part 9505.0450, subpart 3.

9505.5041 SURGICAL PROCEDURE ELIGIBLE FOR MEDICARE PAYMENT

This proposed part expands and thereby clarifies the provision that is being deleted from present part 9505.5040, item A.

Certain recipients are eligible for services through both MA and Medicare. Because MA is the payer of last resort, Medicare must be billed before MA. (See part 9505.0070, subparts 4 and 5 and part 9505.0440.) However, Medicare may require the recipient to make a copayment or meet a deductible. If the recipient is on MA, MA will pay the copayment and the deductible. When Medicare has in effect approved such surgical services as evidenced by such a partial payment, it is reasonable, administratively efficient, and cost effective to accept Medicare action as an independent determination of medical appropriateness of the surgical procedure. Permitting the provider to request an authorization number, if Medicare has denied payment for the service, is reasonable because it affords the provider an additional opportunity to substantiate the appropriateness of the procedure and thereby protects the entitlement of the recipient to services covered according to standards of the medical assistance program. Parts 9505.0440 and 9505.0450, subpart 4,

item A apply to billings for MA services. These standards take into consideration the time delay in billing that results from first billing Medicare. Reference to them is reasonable because it informs affected persons of the standards for MA billings for services to persons eligible for MA and Medicare.

9505.5045 CRITERIA TO DETERMINE WHEN SECOND MEDICAL OPINION IS REQUIRED.

The proposed amendment deletes item E. Minnesota Statutes, section 256B.04 and 256D.03 require the MA/GAMC programs to be administered in an efficient and economical way. As one means of meeting the requirement for efficiency and economy when the second surgical opinion rule was proposed in 1985, the Department relied on cost savings reported in an exhaustive study of Massachusetts' Medicaid Surgical Opinion Program as detailed in "Medical Care", January 1983. The study demonstrated a cost savings would result for procedures having a 4 percent or greater rate of non-confirmation. The Department selected the 5 percent figure because historical data indicated it was statistically relevant and had a positive cost/benefit ratio. However, since the rules were adopted, the Department has not found it necessary to use this provision. Furthermore, because of changes in medical practice in the years since the rules' adoption, the Department does not anticipate using it in the future.

9505.5046 CRITERIA TO DETERMINE MEDICAL APPROPRIATENESS.

This proposed part incorporates the language related to criteria to determine medical appropriateness that is being deleted from the second paragraph of subdivision 1 of part 9505.0540. Additionally, it lists all statutes authorizing the second medical opinion program rather than only subdivision 24 of section 256B.0625. This part is necessary and reasonable as it informs affected persons.

9505.5050 SECOND AND THIRD SURGICAL OPINIONS.

Subpart 1. Second surgical opinion by medical review agent. As discussed in the introduction to the SNR, one of the purposes of these rule amendments is to incorporate into one set of rules all requirements for second surgical opinions. Therefore, second surgical opinion requirements are being deleted from parts 9505.0520, subparts 6 and 8 and 9505.0540. Subpart 1 of part 9505.5050 is being deleted as the references are inaccurate. See proposed amendments to part 9505.5075, physician responsibility, and part 9505.5076, medical review agent determination.

Subp. 2. Second surgical opinion by a second physician. This subpart is no longer necessary as the department's contract with the medical review agent for determinations of medical appropriateness replaces a second opinion from a second

physician. The purpose of a second medical opinion by a second physician was to afford both the provider and the recipient an opportunity to verify the first physician's opinion. It was in essence seen by the Department as helping to ensure recipients receive the medical treatment needed. The proposed amendments to these rules continue to afford both the provider and the recipient opportunities to substantiate the medical appropriateness of the surgical procedure.

See part 9505.5077, determination by physician advisor, which permits an admitting physician to request a second and a third medical opinion from a physician advisor and a second physician advisor respectively. See also part 9505.5078 which permits an admitting physician to request reconsideration by a panel of three physicians as a way to resolve conflicting opinions about the medical appropriateness of a surgical procedure. Moreover, the admitting physician may submit to the physician advisors or the panel additional information relevant to the surgical procedure. See part 9505.5082, subpart 2, item B. Deleting the requirement that a recipient obtain a second opinion from a second physician eliminates the recipient's burden to see another physician. This requirement has particularly hard for the rural Minnesota recipient who had to travel a long distance or in bad weather. It places the burden of substantiating the appropriateness on the admitting physician who is licensed to make decisions about medical services. Thus this part is deleted because it is no longer necessary or reasonable.

Subp. 3. Third surgical opinion. This subpart is being deleted as under the proposed review by a physician advisor and the reconsideration procedure have replaced the opinion from a third physician. See the discussion above in the SNR of subpart 2. Thus the proposed rule retains the opportunity for a further review of a denial. The proposed rule provides for review in an administratively efficient way and removes the recipient's burden of visiting another physician.

9505.5055 SECOND OR THIRD OPINION BY A PHYSICIAN.

This part is being deleted in its entirety. The amended rule places the responsibility for determining the medical appropriateness of a surgical procedure on the medical review agent and the physician advisors. The medical review agent and physician advisor make the determination based on the information provided by the treating (admitting) physician. A recipient does not have to obtain a second surgical opinion from a second or a third physician. See the SNR for part 9505.5050 above. Staff of the Appeals and Regulations Division report that under the present rule some recipients seek second and third opinion from physicians who appear to be more apt to agree that a surgical procedure is medically appropriate. Thus eliminating this possibility by placing the burden of demonstrating medical appropriateness on the admitting physician is reasonable because it deters "doctor shopping" and thereby supports the administration of the program in an efficient and economic manner

as required under Minnesota Statutes, section 256B.0625. Thus this part is no longer necessary or reasonable.

9505.5060 PENALTIES

Part 9505.5060 is being deleted and all of its provisions placed in part 9505.5091. See part 9505.5091. The proposed renumbering does not in any way affect the content but places the content near the end of the rule as a way to emphasize the flow of required procedures and deemphasize penalties.

9505.5065 REIMBURSEMENT OF COST OF SECOND AND THIRD SURGICAL OPINIONS.

The proposed amendment deletes this part which is no longer necessary because recipients will no longer have to obtain second and third opinions from physicians.

9505.5070 TIME LIMITS; SECOND AND THIRD OPINIONS; SURGERY.

The proposed amendment deletes this part. The amended rule does not impose any time limits for either obtaining the second opinion or performing the surgery if is determined medically appropriate. Also as discussed above, under part 9505.5065, recipients will no longer have to obtain second and third opinions from second and third physicians. Thus, the part is not necessary.

9505.5075 PHYSICIAN RESPONSIBILITY.

The proposed amendment to this part replaces all references to second and third opinions by a physician and removes all requirements for submitting a form containing information substantiating a second or third opinion by a physician. See the discussion above in the SNR for parts 9505.5050 and 9505.5055. Thus it is necessary and reasonable to delete all requirements for a procedure that is obsolete.

The proposed amendment sets out the information that must be provided to the medical review agent by the physician offering to provide the surgical service. The provision is reasonable as it is the burden of the physician who will perform the surgery to justify that the surgical procedure for which he or she will be paid from public funds meets the standard of medical appropriateness. It is reasonable to require the physician to request the determination of medical appropriateness before submitting a claim for payment as the requirement avoids submittal of claims that will be rejected if they have been denied, or submitted without, an authorization number. (See the definition of authorization number in part 9505.5005, subpart 1a, item B.) Thus, requiring the claim for payment to have an authorization number before it is submitted for payment is administratively efficient and cost effective. The information required in items A to I replaces information related to surgical procedures for which a second opinion is required that is being deleted from part 9505.0520, subpart 3, items B and C. Informational requirements that relate specifically to the

hospital admission certification program have not been placed in the proposed amendment, part 9505.5075 as they are irrelevant to the second opinion program. They include the date of hospital admission (item B (5)) and whether the admission is a readmission or a transfer (item B(6)). Other items have been omitted because the proposed amendments do not provide for second and third physician opinions or exemptions from the second medical opinion process. (Item C (4) and (5).) Item C (3), affirmation that prior authorization has been received is omitted as unnecessary because this information is irrelevant to the determination of the medical appropriateness of the surgical procedure. Items A to I identify the provider and the recipient, give information about why the surgical procedure is appropriate for the recipient. Requiring this information is reasonable because the provider is in the best position to have it and the medical review agent needs the information to make the determination about medical appropriateness. Items G and H are necessary and reasonable because they inform the medical review agent about circumstances surrounding the surgery that may affect the determination of medical appropriateness of the surgery.

9505.5076 MEDICAL REVIEW AGENT DETERMINATION

This proposed part, and proposed parts 9505.5077 and 9505.5078 replace material in present part 9505.5090. The purpose of this revision is to clarify the procedure and to facilitate its use by

providers and recipients. For the foreseeable future, it is the intent of the department to contract with a medical review agent to perform all activities necessary for the second medical opinion system. The department believes contracting for the program is administratively cost effective and efficient and also assures the determinations of medical appropriateness will be made by professionally qualified and experienced staff.

Subpart 1. Qualified staff. This subpart is necessary to set forth the qualifications of persons who will be used by the medical review agent to determine the medical appropriateness of surgical procedures requiring a second medical opinion. Registered nurses and licensed physicians are persons who have been found to meet the statutory requirements for licensure as health care providers. It is reasonable to require their expertise in conducting the second medical opinion program because it assures the determinations are being made by medical personnel licensed to make judgments about medical services.

Subp. 2. Medical review agent's determination upon receipt of required information. This subpart is necessary to set forth the responsibility of the medical review agent to obtain and review the information required to decide whether the surgical procedure is medically appropriate. Requiring the agent to issue notices within 24 hours of receipt of the information is consistent with the present requirement (part 9505.5090, subpart 1) that the medical review agent, if agreeing that a surgical procedure is appropriate, assign an authorization number within one working

day. Retaining the 24 hour requirement is reasonable because it assures the provider and recipient a timely decision. The department notes that part 9505.5082 addresses the requirements for all notices about authorization numbers, approvals and denials. See the SNR for proposed part 9505.5082.

Subp. 3. Medical review agent unable to determine medical appropriateness. In some circumstances such as those where a difference of opinion exists within the medical profession or where the information is incomplete, the medical review agent may be unable to determine whether a surgical procedure requiring a second opinion is medically appropriate. These medical circumstances may require the expertise and knowledge of a specialist. Thus, it is reasonable to require the medical review agent to consult a physician advisor who by licensure and specialty board certification has been found qualified to make judgments about the requested medical and surgical practice. The department notes that consultation with a physician advisor replaces the requirement in the present rules, part 9505.0520, subpart 3, item D, and 9505.5050, subpart 3 that a recipient obtain a third physician opinion. See the SNR for parts 9505.5050 and 9505.5055.

Subp. 4. Retrospective review of medical record. Initial determinations made by the medical review agent are based on information given by the physician over the telephone.

Typically, the medical review agent does not review the medical records about the recipient's surgical procedure. This approach is consistent with the present procedure requiring the physician to obtain an authorization number before performing the surgical procedure unless the procedure met one of the exceptions. The proposed amendments permit the physician to perform the surgical procedure requiring a second opinion and then request an authorization number. Authorizing the medical review agent to conduct on-site retrospective reviews of a recipient's medical records on a surgical procedure is reasonable as the medical record is expected to have the information needed to determine the medical appropriateness of the procedure. Additionally the authorization of on-site retrospective reviews is consistent with part 9505.2185, which requires the provider to grant the department access to examine a record of the recipient's health service billed to department health care program. Under the contract between the department and the medical review agent, the department has delegated to the agent the responsibility of retrospectively screening surgical procedures subject to the second surgical opinion requirement.

9505.5077 DETERMINATION BY PHYSICIAN ADVISOR.

In amending parts 9505.5035 to 9505.5100, the department is proposing to follow determination procedures similar to those set forth in parts 9505.0500 to 9505.0540, for medical review agent decision's about hospital admission certification. Thus both

sets of rules, which affect the same or similar services under MA, provide for opinions from physician advisors and second physician advisors and reconsideration (see part 9505.5078.) The department believes this approach is necessary and reasonable as it affords both the admitting physician and the recipient an efficient and cost effective review process by the physician's peers and avoids the delay to be expected in obtaining a decision through the more lengthy appeal process, set forth in part 9505.5100.

Subpart 1. Physician advisor opinion. As noted above for part 9505.5076, subpart 2, the medical review agent may consult a physician advisor about the medical appropriateness of a surgical procedure requiring a second opinion. Additionally, an admitting physician whose request for an authorization number for a surgical procedure has been denied may request the determination of a physician advisor about the medical appropriateness of the surgical procedure. This procedure replaces the present provision that permits a recipient to obtain a second surgical opinion from a second physician if the medical review agent has determined the surgical procedure is not medically appropriate. Permitting the admitting physician to make such a request affords the admitting physician and the recipient the opportunity for a decision made by a professional peer of the admitting physician and at the same time removes the recipient's burden under the present rule of visiting a second physician to obtain a second opinion. See the definition of physician advisor in part

9505.5005, subpart 14a. In response to requests, it is reasonable that the physician advisor, when he or she determines the surgical procedure is medically appropriate, directs the medical review agent's issuance of an authorization number because the physician advisor's licensure and certification are evidence of the advisor's qualifications to judge the appropriateness of surgical procedures. However, it is necessary to specify what happens if the physician advisor is unable to determine the medical appropriateness of the surgical procedure. Placing on the admitting physician the burden of requesting another opinion is reasonable as the admitting physician has first hand knowledge of the recipient's condition and thus is in a position to consider whether there are medically appropriate alternatives to the surgical procedure requested for the recipient. If the admitting physician does not request a second physician advisors opinion, denial of the authorization number is reasonable because it can be assumed the admitting physician agrees with the medical review agent's determination. Requesting a physician advisor's opinion after a denial of an authorization number also affords the admitting physician the opportunity to submit additional information. See part 9505.5082, subpart 2, item B which requires a notice of denial of authorization number to state that the admitting physician may submit additional information to document the medical appropriateness of the surgical procedure.

Subp. 2. Second physician advisor's opinion. See the discussion

above about this part and also subpart 1.

9505.5078 RECONSIDERATION

As discussed above in the first paragraph of the SNR for part 9505.5077, reconsideration is a step available now to an admitting physician in response to a denial or withdrawal of an authorization number. See part 9505.0520, subpart 9. Part 9505.5078 is proposed as part of the reorganization of the rules related to hospital admission certification (parts 9505.0500 to 9505.0545) and to second medical opinions (parts 9505.5035 to 9505.5100). It continues and clarifies the present procedure.

Subpart 1. Reconsideration requested by physician. Permitting the admitting physician to request reconsideration affords the admitting physician and the recipient another opportunity for a review and decision by professional peers of the admitting physician. Requiring that the request for reconsideration be made to the medical review agent, in writing, and within 30 days of receipt of the notice of the medical review agent's denial are the present requirements in part 9505.0520. Department and medical review agent experience is that these requirements have worked well for the recipient, the admitting physician, and the department. They meet the need of the admitting physician and recipient to obtain a timely decision and the need of the medical review agent to conclude the matter. The information the admitting physician must submit is that needed to identify the admitting physician and the patient (the recipient) and determine

medical appropriateness of the requested procedure. Including the phrase "any other relevant information" permits the admitting physician to include facts or evidence not previously given to the medical review agent or first or second physician advisors which the admitting physician believes supports the medical appropriateness of the surgical procedure. Allowing the admitting physician to supplement the record is reasonable as an added safeguard to assure an in-depth, thorough consideration of the request.

Subp. 2. Reconsideration; three physician advisors. This subpart specifies the procedure for reconsideration. The intent of reconsideration is to provide recipients with an independent evaluation of the requested surgical procedure. An odd number of panel members eliminates the likelihood of a tied decision. Three was chosen as the required number of panelists to facilitate the availability of physician to serve, especially in areas of surgical practice which require high specialization. It is, therefore, reasonable to specify that the three physician advisors appointed to conduct the reconsideration did not take part in previous determinations about the surgical procedure for which the admitting physician is requesting reconsideration. Setting a time limit of 60 days after receipt of the required information for the decision or reconsideration is reasonable as it balances the need for a timely decision and the work schedules of the physician advisors. See Minnesota Statutes, section 256.045, subdivision 7.

Subp. 3. Reconsideration; medical review agent. This subpart specifies who is responsible to notify the admitting physician about the outcome of the reconsideration. Requiring the medical review agent to take this action is reasonable because the medical review agent has the responsibility to make determinations of medical appropriateness on behalf of the Department. Requiring a notice by certified mail assures delivery of the notice according to the addresses given by the admitting physician. See subpart 1 for required information. See the SNR of part 9505.5082 about required contents of notices.

9505.5079 INELIGIBILITY TO SERVE AS PHYSICIAN ADVISOR.

The intent of the second medical opinion system is to review requested surgical procedures for which a second opinion is required to determine whether they are medically appropriate. The determination of the appropriateness of the surgical procedure is consistent with Minnesota Statutes, sections 256B.04, subdivision 15, utilization review which requires the commissioner to avoid the unnecessary and inappropriate use of medical assistance services. The credibility of the system requires that the reviewers conduct an arms-length review using current professional community standards and criteria of medical appropriateness. Thus this part is necessary to clearly set out when an individual will be disqualified as a physician advisor because of a potential conflict of interest. The provision clarifies the disqualification criteria and reduces the

likelihood of misunderstanding. The situations specified in items A to D are those in which a physician has either a financial interest in providing the recipient's care or personal contact with the recipient which may be viewed as creating a conflict of interest. Moreover, the financial interest of physicians or their past contact with the recipient is contrary to the "new look" approach required under the second opinion system.

9505.5080 FAILURE TO OBTAIN REQUIRED OPINION.

This part specifies the consequences for a physician who fails to obtain a required second medical opinion. The proposed amendment of this part deletes subpart 2 and 3. The revised second medical opinion substitutes the determination of the medical review agent and the physician advisors under contract to the medical review agent based on the information submitted by the physician offering to provide the surgical procedure for a second and third physician's opinion. Subparts 2 and 3 which relate to the opinions of a second and third physician, therefore, are not necessary.

Replacing the term "reimbursement" by "payment" is not a substantive change but reflects the current community standard and practice. Payment for surgical procedures is based on the providers' previously submitted usual and customary charges which may or may not reflect their actual costs. "Payment" is the term used by Medicare and by Minnesota in its State Medicaid Plan and

the Minnesota Health Care Programs Provider Manual. (This manual is the implementation guide for providers of health services paid through the medical assistance, general assistance medical care, and MinnesotaCare programs.) The amendment is necessary and reasonable to assure consistency with the current community standard.

9505.5082 NOTICE ABOUT DETERMINATION OF MEDICAL APPROPRIATENESS

This is a new part, proposed to bring together all notice requirements related to second medical opinions. Previously, these requirements were repeated in several different rule parts. It is reasonable to consolidate the notice requirements into one part as it assists the reader, avoids confusion, and shortens the rule. Requiring the medical review agent to inform affected parties and send notices about determinations is necessary to assure completion of the medical review agent's responsibility in a businesslike manner. The requirement of notice within 24 hours of the determination, exclusive of weekends and holidays, is the present requirement notification by phone by the medical review agent under part 9505.0520, subpart 6, item C.

Subpart 1. Notice approving authorization number. Requiring the medical review agent to notify, by phone, the physician of a determination that a surgical procedure is medically appropriate facilitates the prompt transmission of the determination to the physician and enables timely scheduling and performance of the

surgical procedure. Requiring a mailed notice is reasonable as such a notice is tangible evidence of the medical review agent's determination and, in the event of a denial, sets out the further reviews available to a recipient and an admitting physician.

Subp. 2. Notice denying authorization number. This subpart addresses the requirements for notice if the medical review agent determines the surgical procedure is not medically appropriate or the medical review agent is unable to reach a decision. Denial of an authorization number means that the surgical procedure requiring a second opinion will not be covered by medical assistance payment. Thus, the denial of the number has the effect of denying the surgical procedure to the medical assistance recipient for whom the service was requested. Minnesota Statutes, section 256.045 permits a recipient who is denied a service to appeal the denial. Item A is reasonable because it assures the notice to the recipient will have information about the recipient's ability to appeal the denial. Item B requires the notice to the physician to state the reason for the denial and to inform the physician of the opportunity for further review of the medical appropriateness of the surgical procedure. There are at least two possible reasons that further review may result in a determination the procedure is medically appropriate: incomplete information submitted by the physician requesting approval and a difference of opinion among the physician's peers. Item B therefore is reasonable as it enables

the requesting physician to decide what is in the recipient's best interests. Item C addresses the notice required following a reconsideration determination that the surgical procedure is not medically appropriate. See the definition of reconsideration in part 9505.5005, subpart 17a and the reconsideration procedure specified in part 9505.5078. The determination resulting from the reconsideration is the medical review agent's final determination. However, Minnesota Statutes, section 256B.04, subdivision 15, paragraph (3) permits a vendor to appeal a determination that services which have already been provided are not reasonable or necessary pursuant to the contested case procedures of Minnesota Statutes, chapter 14. Requiring the notice about the reconsideration determination to inform the physician of the appeal possibility is reasonable as it gives the physician information needed to make an informed choice. The Department notes that there is at least one other statute related to appeals of denials of a determination of medical necessity for inpatient hospital services. Thus, it is reasonable to add the phrase, "unless another procedure is required by statute" to assure compliance with statutes related to provider appeals. Item D specifies the notice required if the medical review agent withdraws an authorization number as a result of a retrospective review of the recipient's inpatient hospital record. See part 9505.5076, subpart 3. Withdrawing the authorization number means the surgical procedure is not eligible for medical assistance payment. Providing for physician advisor review of

the decision to withdraw the authorization number is reasonable as it assures the admitting physician will have an opportunity to submit additional facts to the physician advisor and obtain the expertise of a peer. See the definition of physician advisor in part 9505.5005, subpart 14a.

9505.5085 PROHIBITION OF PAYMENT REQUEST

This part of the present rule is being continued with only a minor amendment. A similar amendment is proposed in part 9505.5080. See the SNR for part 9505.5080 for a discussion.

9505.5090 MEDICAL REVIEW AGENT AND DEPARTMENT RESPONSIBILITY.

This part is being deleted in its entirety because it is no longer necessary. The medical review agent's responsibilities are specified in proposed part 9505.5076. See also the definition of medical review agent in part 9505.5005, subpart 12b. As stated in the definition, the medical review agent is the representative of the commissioner who is authorized by contract to make decisions about second medical opinions. Thus, the Department itself does not make determinations about the medical appropriateness of each surgical procedure that requires a second medical opinion.

9505.5096 REQUEST FOR EXEMPTION FROM SECOND SURGICAL OPINION.

The present rule requires physicians offering to provide a surgical service requiring a second medical opinion to obtain the second medical opinion before providing the service. Physicians, who fail to do so, generally do not receive medical assistance payment for the surgical procedure. However, the present rule in part 9505.5040 exempts certain services from the requirement under specific circumstances such as emergencies. Although the proposed amendments continue the requirement that the physician obtain the determination of medical appropriateness of surgical procedures as a condition of receiving medical assistance payment, the proposed amendments will allow the physician to request the determination either before or after performing the surgical procedure. Thus, part 9505.5040, related to circumstances justifying exemptions from obtaining the required second opinion before the surgical procedure is performed is being deleted and part 9505.5096, which specifies the procedure to obtain an exemption, is no longer necessary and is deleted.

9505.5100 INDEPENDENT PHYSICIAN EVALUATION

The introduction to this SNR discussed the procedural changes that the adoption of these rule amendments will bring about. These amendments provide for second opinions from the medical review agent under contract to the department and for third opinions and reconsiderations by physician advisors who are agents of the medical review agent. Additionally, proposed part 9505.5076, subpart 3 permits the medical review agent to conduct

an on-site retrospective review of a recipient's medical record on a surgical procedure to obtain information needed to verify medical appropriateness of the procedure. These new procedures place the responsibility for determining the medical appropriateness of a surgical procedure requiring a second opinion on the medical review agent. The medical review agent is obligated to conduct all reviews that are required under parts 9505.5035 to 9505.5105 by providing the professional and technical expertise of registered nurses and physicians. See part 9505.5076, subpart 1. Therefore, an independent evaluation by a physician selected by the recipient and approved by the commissioner will not be necessary as independent evaluations are available throughout the procedure conducted by the medical review agent. Therefore, because part 9505.5100 is no longer necessary for these purposes, it is being repealed.

9505.5105 FAIR HEARINGS AND APPEALS

Subpart 1. Appealable actions. The proposed amendment of Item A restructures the language to clarify that part 9505.5020, subpart 1 relates to the prior authorization program and parts 9505.5035 to 9505.5091 relates to the second medical opinion program. This amendment is technical and has no substantive effect. The phrase within the time limits is necessary and reasonable because it informs the reader of the criteria of promptness. The amendment of item C clarifies that the medical review agent issues denials

and that these denials may be appealed. The proposed amendment also clarifies that the internal review process specified in the rule, Reconsideration, must be completed before a recipient may appeal a denial. See the SNR for part 9505.5078, Reconsideration. The amendment is reasonable as it informs recipients and avoids confusion.

Subp. 2. No right to appeal. The technical amendment to this subpart deletes the reference to a repealed statute and clarifies the citation of Minnesota Statutes, section 256B.0625 by adding the specific subdivisions which relate to second medical opinion requirements. The amendment is necessary and reasonable to give affected persons correct information.

Expert Witnesses

In the event a public hearing is held pursuant to the request of 25 or more persons, the Department does not plan to present outside expert witnesses.

Date: 11/21/95

MARIA R. GOMEZ
Commissioner of Human Services