9-30-96 DRAFT

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED ADOPTION OF AMENDMENTS TO MINNESOTA RULES GOVERNING INPATIENT HOSPITAL ADMISSION CERTIFICATION IN THE MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND MINNESOTACARE PROGRAMS, PARTS 9505.0500 TO 9505.0545

STATEMENT OF NEED AND REASONABLENESS

Minnesota Rules, parts 9505.0500 to 9505.0545 establish a system for reviewing the utilization of inpatient hospital services under the Medical Assistance (MA), General Assistance Medical Care (GAMC) and MinnesotaCare Programs. These rules are designed to guard against excess payments and to reduce expenditures which result from inappropriate hospitalization of MA, GAMC, and MinnesotaCare recipients.

Minnesota Statutes, section 256B.04 subdivision 15, requires the Department to establish a program to safeguard against the unnecessary or inappropriate use of inpatient hospital 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 also 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. Additionally Minnesota Statutes, section 256.9353, subdivision 3, paragraph (c) requires admission for inpatient hospital services to MinnesotaCare clients to be certified as medically necessary except as specified in clauses (1) and (2) of paragraph (c).

Minnesota Rules, parts 9505.0500 to 9505.0540 were adopted on March 26, 1985 and amended on March 24, 1987 and January 10, 1989.

Since adopting these rules and their amendments, the Department has identified several additional areas of the rule that need to be amended. The need for the amendments arises from the following issues.

- The necessity for consistency with related rules, specifically Minnesota Rules, parts 9500.1090 to 9500.1140 which establish a prospective payment system for inpatient hospital services under MA and GAMC. Minnesota Statutes, section 256.9685 establishes the payment system for inpatient hospital services. This

section states that inpatient hospital services must meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b), to be eligible for payment. As stated above, these statutes require utilization provisions for inpatient hospital services paid under MA, GAMC, and MinnesotaCare and thus apply to inpatient hospital services. Therefore, consistency between the two rules is essential.

- Clarifying that the rule applies to inpatient hospital admissions under MinnesotaCare.

- Updating the rule to be consistent with changes in the Department's information and claims processing systems, such as the expansion of the Minnesota Medicaid Information System (MMIS).

- Assuring consistency between the rule and Department procedure such as the conversion to a pre-billing admission certification program and the clarification of review and appeal mechanisms and payment adjustments.

- Reorganizing the rule for clarification and simplification, and a format to better relate the procedural steps to each other.

- Making technical and grammatical changes to improve the rules' readability.

The Department notes that proposed amendments to rules Governing the Second Medical Opinion Program removed from parts 9505.0500 to 9505.0545 all provisions related to the second medical opinion program and placed these procedural requirements in a single set of rules, parts 9505.5035 to 9505.5105. See 20 S.R.1680, December 26, 1995.

Therefore, this Statement of Need and Reasonableness will discuss only the proposed amendments to the hospital admission certification program, parts 9505.0500 to 9505.0545 as published in the State Register.

An advisory committee assisted the Department in developing the proposed amendments to the rule. The committee was composed of representatives from the Minnesota Hospital and Health Care Partnership, The Minnesota Association, Council of Hospital Corporations, Minnesota Psychiatric Association, 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 May 8, 1991, June 5, 1991, July 17, 1991, August 21, 1991, October 2, 1991 and January 23, 1992 to review the amendments proposed by the Department.

Members of the committee supported the Department's desire to address these concerns. A technical subcommittee met to discuss issues concerning adopting medical necessity criteria for psychiatric admissions of children and adolescents. This subcommittee met on January 23, 1992. In August 1995, a draft of the proposed amendments was mailed to the committee members for their review and comment. The Department did not receive any responses.

The proposed amendments to Minnesota Rules, parts 9505.0500 to 9505.0545 are hereby affirmatively presented by the Department as required under the Minnesota Administrative Procedures Act, Minnesota Statutes, chapter 14, and the rules of the Office of Administrative Hearings.

Minnesota Statutes, section 14.131 specifies information that a Statement of Need and Reasonableness must include in addition to justification of the proposed rules.

(1) As noted above, the Department is proposing to amend an existing rule which affects hospitals, admitting physicians, and other health care providers of inpatient hospital services and the recipients of the inpatient hospital services. The costs of complying with the rule have been borne and will continue to be borne by health services providers. Insofar as the procedure for determining the medical necessity of an inpatient hospital admission identifies unnecessary admissions, recipients should benefit by avoiding the burden of unnecessary medical procedures.

(2) The Department believes the proposed rule amendments will neither increase nor decrease revenues or the expenditure of state and local funds.

(3) The proposed amendments will assure continued compliance with the requirements in Minnesota Statutes, sections 256.9353, subdivision 3, paragraph (c); 256B.04, subdivision 15; and 256D.03, subdivision 7(b). Although, as stated above, the amendments are not expected to affect revenues or the expenditure of state and local funds, the Department believes the amendment removing the time limit for requesting certification of an inpatient hospital admission will result in a less intrusive method of achieving the intent of the statutory requirement to safeguard against unnecessary or inappropriate use of inpatient hospital services and against unnecessary or inappropriate hospital admissions or lengths of stay. The review of the certification request will focus only on the medical necessity of the admission and the services provided during the admission.

(4) The Department has determined that there are no alternative methods for achieving the purpose of the proposed rule amendments.

(5) The probable costs of complying with the proposed rule amendments will remain the same as complying with the present rule.

(6) There are no differences between the proposed rule amendments and existing federal regulations.

PART 9505.0501 **SCOPE**

Proposed part 9505.0501 is former part 9505.0510 which is moved to the beginning of the rule to make such information available for the reader's use as early as possible. Such information assists the reader's understanding of the rule's contents. It is reasonable to reorganize the rule into a logical progression of information and procedures.

This part establishes the scope of the rule, states the federal and statutory authority for the rule, and references related rules. It is necessary to inform affected parties that these rules should be read in conjunction with the federal regulations and state statutes that govern its administration.

The scope is being revised to clarify that the requirement of admission certification applies to inpatient hospital services for MinnesotaCare recipients. This is necessary to comply with Minnesota Statutes, section 256.9353, subdivision 3, paragraph (c).

The phrase "in addition to admission certification" was added to the last statement in this part. It is necessary to clarify that an admission may require prior authorization or second medical opinion authorization in addition to admission certification and that the requirement for admission certification does not release the provider's obligation to obtain a required prior authorization or second medical opinion. The purpose of each program [prior authorization, admission certification, and second medical opinion] is to safeguard against unnecessary utilization of health care services. However, because the reasons for monitoring health care services under these programs may differ, it is reasonable to require providers to comply with all requirements. A health care service may require prior authorization because it is investigative, or newly developed or modified. Admission certification screens admissions for medical necessity at a hospital level of care. Therefore, if a particular inpatient hospital service is investigative and being provided on an inpatient basis, the provider must obtain both prior authorization and admission certification unless the service is exempt. Likewise, if a procedure requiring a second medical opinion, such as a hysterectomy, is being performed in a hospital at an inpatient level of care, both admission certification and second medical opinion authorization are

required. (Currently, a second medical opinion authorization can be obtained at the same time the admission is certified.) This amendment is necessary to inform the provider of all requirements that must be met in order to be eligible for payment.

Certain portions of present part 9505.0510 do not appear in proposed part 9505.0501 because they are no longer necessary and are being deleted.

It is reasonable and necessary to delete the sentence including the phrase "unless the hospital or admitting physician has received prior authorization" because, under certain circumstances, an admission may require both prior authorization and admission certification. The only circumstance in which prior authorization replaces admission certification is for planned admissions in hospitals that are not located in Minnesota or the local trade area. It is necessary to delete this phrase to eliminate the conflict between this rule and the rule governing prior authorization. It is reasonable to maintain consistency between rules affecting the same program services.

The language that requires admission certification to be obtained when a recipient is transferred has been moved to part 9505.0520, subpart 1, as an amendment. This is necessary and reasonable as amended subpart 1 will contain all the circumstances for which a physician must obtain admission certification. It is reasonable to combine portions of the rule with similar content.

Part 9505.0505 DEFINITIONS (formerly Part 9505.0500)

Except for subpart 24a, the definitions in this part have been in part 9505.0500. Because their need and reasonableness has been previously established, this SNR only will present the definitions for which the Department is proposing amendments.

Subpart 1. Scope. The amendment of this subpart is necessary to include the proposed rule, part 9505.0545, within the scope of the rules to which the definitions apply. The amendment is reasonable because it informs affected persons.

Subp. 2. Admission. This term describes the process by which a recipient becomes an inpatient at a hospital. It is necessary to amend it in order to be consistent with changes to parts 9500.1090 to 9500.1140, which governs hospital payment rates under medical assistance. Adding language that describes the time of birth as an admission is reasonable because there are separate claims for rate establishment and payment for the mother and baby. Before this amendment, one claim was submitted by the hospital for both mother and baby.

Subp. 3. Admission certification. Clarifying that admission certification applies to MinnesotaCare is necessary to assure consistency with Minnesota Statutes, section 256.9353, subdivision 3, paragraph (c). The clarification is reasonable as it informs interested persons. The other amendments to this subpart are necessary because they remove citations to repealed or obsolete rule parts. They are reasonable to accurately inform affected persons.

Subp. 3a. Admitting diagnosis. This term describes the diagnosis that is assigned to a patient's condition upon admission to a hospital. Deleting it is necessary and reasonable because it is self-explanatory and a commonly known and used term by the medical profession.

Subp. 4. Admitting physician. The amendment of this term deletes a phrase that is not necessary.

Subp. 6. Clinical evaluator. A definition of this term is no longer necessary as the proposed amendments remove the term from these rules. See part 9505.0520, subpart 8.

Subp. 9. Continued stay review. The amendments of this definition are necessary to clarify when a continued stay review may occur. This review may occur at any time after the recipient's inpatient hospital admission has been issued a certification number. Thus at the time of the review, the recipient may still be in the hospital or may have been discharged. The amendments are reasonable as they inform affected persons of the purpose of such a review, a determination of whether continued inpatient hospital services to the recipient are or were medically necessary.

Subp. 10a. Diagnostic categories. This term describes the different types of inpatient hospital services that are clinically coherent and homogeneous with respect to cost. The purpose of the amendment is to broaden the application of the categories to include characteristics that reflect the MA and GAMC population more accurately, such as neonate and children's diagnoses. The changes to the term are necessary to assure consistency with Minnesota Statutes, section 256.969, subdivision 2. It is reasonable to maintain consistency with statutes to avoid confusion.

Subpart 10b. Diagnostic category validation. This term refers to the process of validating diagnostic categories. The amendment to this term is necessary as these rules do not use the phrase "validate the diagnostic category". It is reasonable to delete words within a definition that are unnecessary thereby simplifying the rule. The revision does not change the meaning of the term.

Subp. 11. Emergency. The proposed amendment is necessary to assure consistency with the definition of the term in the rule, part 9505.0175, subpart 11, that applies to medical assistance services. Assuring consistency of rules affecting the same program is reasonable because it avoids confusion among affected persons.

Subp. 12. General assistance medical care or GAMC. Hospital admission certification requirements under these rules apply to the general assistance medical care program. Thus, the term is used in these rules. The proposed amendment is reasonable as the reference to the establishing statutes simplifies the rule and assures consistency.

Subp. 13. Hospital. This term defines a specific type of facility, a hospital. The amendment revises the definition to be the same as that in part 9500.1100, subpart 25 which applies to hospital payment rates under medical assistance. It is necessary and reasonable to be consistent with parts 9500.1090 to 9500.1140 which also apply to inpatient hospital services under MA, GAMC, and MinnesotaCare.

Subp. 14. Inpatient hospital service. This term specifies the services that are subject to these rules. The amendment is necessary for simplification and consistency with the requirements of Minnesota Statutes, section 256.969, subdivisions 2b and 2c and parts 9500.1090 to 9500.1140. The portion deleted did not further the understanding of the term; therefore, it is reasonable to delete it to simplify the rule. The phrase "including outpatient services provided by the same hospital that immediately precede the admission" was added to this definition to avoid the unbundling of services included in a patient's stay, by a provider and thereby gain additional payment. This amendment makes the definition the same as that in the rule setting hospital payment rates. See part 9500.1100, subpart 27. It is reasonable that to have consistent definitions in rules affecting the same programs to avoid confusion.

Subp. 15. Local agency. This term does not occur in this rule. Therefore, it is reasonable to delete it because it is not necessary.

Subp. 16. Medical assistance. This definition is being amended to include MinnesotaCare, one of the three Department health care programs subject to the admission certification program. Including MinnesotaCare within the definition is reasonable as a means to shorten the rule.

Subp. 17. Medical record. The amendment of this subpart is necessary and reasonable because it replaces the citation of a repealed rule part with its successor.

Subp. 18. Medical review agent. This term defines the entity authorized by the commissioner and under contract with Department to carry out certain responsibilities under these rules. The amendment is necessary to clarify the responsibilities of the agent for administering the admission certification program. The amended language is more representative of the medical review agent's responsibilities than the current definition which states that the medical review agent is authorized to "make decisions" concerning various components of the program. It is reasonable to clarify the responsibilities of the medical review agent to further the reader's understanding.

Subp. 19. Medically necessary. The amendment to this term is merely technical to correct the citation to the rule part establishing the criteria for medical necessity. A correct citation is necessary and reasonable to assist affected persons to comply with the rule.

Subp. 20a. MinnesotaCare. This subpart is necessary to clarify a term used in this rule. The definition is reasonable as relies on the meaning established by the legislature.

Subp. 23. Prior authorization. This term refers to the procedure used by the Department to authorize medical assistance payment for certain health services. It is necessary to amend the term to refer to the Minnesota Statutes authorizing the program as the statute that is the basis for the rules. It is necessary to delete the word "regulations" from the definition because it is a federal term and not appropriate in this context.

Subp. 23a. Principal diagnosis. This term defines the fundamental diagnosis attributed to a patient's condition. The revision is necessary to clarify this definition. The word being deleted, "chiefly", is redundant and unnecessary as the inherent meaning of the term "principal" is that only one condition is determined as responsible for a recipient's admission. The revision is reasonable because it simplifies the rule and furthers understanding. It does not change the intent or meaning of the term.

Subp. 23c. Provider. This term defines the entity that furnishes health services under the MA, GAMC, MinnesotaCare programs. The revision simplifies the definition as examples of provider types are not necessary. See part 9505.0175, subpart 38 which applies to all medical assistance services. The deletion does not change the substance of the definition.

Subp. 23d. Provider number. Provider number is a term used in these rules. A definition is necessary to clarify its meaning. Part 9505.0195 regulates provider participation in the medical assistance program. Upon approving a provider's participation, the Department issues the provider an unique identification

number that the provider places on health care program billings submitted to the Department for payment. The definition is reasonable because it informs affected persons.

Subp. 24a. Recertification. This term defines the process used for authorizing the continued hospitalization of a medical assistance recipient. It is necessary to add this definition to the rule because it is a new component of the medical record review process and is required under 42 CFR 456.60 (b) and (c), which states that a physician must recertify a patient's continued need for inpatient hospital services every 60 days from the date of admission. This provision only applies to medical assistance admissions as general assistance medical care and MinnesotaCare are state established and funded programs that are not subject to federal regulations. The definition is reasonable as it is consistent with the federal requirements necessary to obtain federal financial participation in accordance with Minnesota Statutes, section 256B.04, subdivision 4.

Subp. 25. Recipient. The phrase "has applied to the local agency and has been determined and" does not increase an understanding of the rule. It is therefore unnecessary and burdensome and its deletion simplifies the rule. Clarifying that the term also includes a person eligible for MinnesotaCare is necessary and reasonable as inpatient hospital services to MinnesotaCare recipients are subject to the admission certification program.

Subp. 25a. Recipient ID Number. This term is 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. The definition is necessary and reasonable because it informs affected persons.

Subp. 26. Reconsideration. The revision of this definition is necessary to cite the subparts related to reconsideration that are being added to the rule. The revision is reasonable as it informs affected persons.

Subp. 27 Retrospective review. This term relates to a review process that occurs after a patient's discharge. It is necessary to expand the definition to include the verification of recertification because this is a new component of the medical record review procedure. It is reasonable to include all components of the review for completeness and accuracy.

Subp. 29. Transfer. This term describes the situation in which the treatment of a patient takes place in two or more hospitals

without a break in inpatient care. The amendment is necessary because a transfer, either between hospitals or between certain specified units of a hospital, requires a certification number as a new admission under the provider codes of the new Minnesota Medicaid Information System (MMIS). An example of such a transfer is the movement of a patient from the hospital's medical unit to the hospital's rehabilitation unit. Therefore, it is necessary to inform the reader of what constitutes a transfer and is subject to these rules. It is reasonable to revise the rule to inform affected persons.

9505.0510 SCOPE

This part has been renumbered as part 9505.0501. See the SNR for part 9505.0501.

9505.0515 MEDICAL REVIEW AGENT'S QUALIFIED STAFF

This proposed part is necessary to specify the qualified staff that the medical review agent must provide to conduct the hospital admission certification program. 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 hospital admission certification because it assures the determinations of the medical necessity of the inpatient hospital admission are being made by medical personnel licensed to make judgments about medical services.

9505.0520 INPATIENT ADMISSION CERTIFICATION.

Subpart 1. Requirement for admission certification.

This subpart specifies when a provider must obtain admission certification. The major amendment to this subpart deletes the requirement to obtain an admission certification number prior to the recipient's admission.

The original rule required that admission certification be obtained before the admission of a recipient except in certain circumstances such as emergencies (see subpart 2). Amendments in 1987 added a provision that allowed admission certification to be obtained after admission but within 30 days of the date of discharge. See current rule part 9505.0520, subpart 14. According to the SNR for the 1987 amendments, this provision was determined necessary and reasonable because it facilitated obtaining any additional information that was required to make a determination of medical necessity. This provision had an impact on the behavior of providers which was not foreseen. Although its intent was to allow sufficient time to obtain needed information, as stated above, in practice, it changed the scope

of the certification program from a preadmission certification to a post-admission certification program.

As the post-admission certification program evolved, it became evident that the Department was required to enforce an administrative deadline that was essentially arbitrary in its length of time. As a result, the Department was focusing its efforts on administrative procedures rather than the medical necessity of the requested inpatient hospital services. In 1992, law was enacted allowing the commissioner to establish exemptions to specific requirements based on diagnosis, procedure, or service after publishing notice in the State Register and allowing a 30-day comment period. See Laws of Minnesota 1992, Chapter 512, Article 5, section 22 encoded at Minnesota Statutes, section 256.9685, subdivision 1. A State Register notice was published on July 6, 1992 eliminating the 48-hour and 72-hour post admission and 30-day post discharge deadlines for obtaining admission certification.

Currently, the majority of admissions are certified after discharge.

However, the rule continues to require the Department to focus on administrative deadlines rather than medical necessity issues. For example, admission certification must be denied when requested after the 30-day post discharge deadline without regard to whether the inpatient hospital services were medically necessary. See present subpart 14. This occurs whether or not the cause of the delay was under the provider's control. The rule also requires out-of-state hospitals to adhere to this deadline. This requirement is unrealistic considering the extremely low volume of Minnesota MA/GAMC, MinnesotaCare patients that are admitted to out-of-state hospitals on an emergency basis and the obvious unfamiliarity of these providers with Minnesota admission certification requirements.

Thus, the Department proposes to amend the rule by removing the 30-day post discharge deadline for a hospital's request for retroactive admission certification of special circumstances (subpart 4, item B and subpart 14) and requiring that admission certification be obtained before billing the Department for the inpatient hospital services provided. [The Department notes that the proposed rule amendments will delete all of subparts 4 and 14.] This is reasonable because it allows the Department to focus on the medical necessity of the recipient's inpatient hospital services instead of administrative issues. It is also reasonable because it is consistent with federal regulations and Minnesota Statutes that require the Department to safeguard against unnecessary and inappropriate use of medical assistance services, against excess payment, against unnecessary or inappropriate hospital admissions or lengths of stay. See Minnesota Statutes, section 256B.04, subdivision 15.

Deletion of the phrase "prior to the recipient's admission" is necessary to allow for the new requirement permitting providers to obtain admission certification before billing for inpatient hospital services.

Other Amendments to Subpart 1:

The reference to subpart 14 is being deleted because subpart 14 is being repealed. Subpart 14 refers to retroactive admission certification. (See SNR, subpart 14, current rule.)

The phrase "an admission providing" has been replaced with "a hospital or admitting physician furnishing" for clarification. This is necessary because "admitting physicians, hospitals and other providers" furnish inpatient hospital services, not "admissions." The word "receive" has been replaced by "obtain" for clarification. This distinction is necessary because it clarifies that it is the provider's responsibility to procure a certification number rather than have it given to them. Both of these amendments are technical changes that do not affect the substance of the rule but aid the reader's understanding.

Subpart 1, Item A

This proposed item further defines the circumstances in which a provider must obtain admission certification. It is necessary for clarification. Empirical evidence indicates some confusion on the part of providers as to the circumstances under which admission certification must be requested. The proposed language is similar to that in the current rule part 9505.0510, Scope, which is being amended as proposed part 9505.0501. This language more appropriately belongs in part 9505.0520 which sets out the admission certification process. However, the reference in part 9505.0510 to "provider number" has not been moved to this subpart. Because the term "provider number" applies to all MA, GAMC, and MinnesotaCare services, its definition is being placed in part 9505.0505 as proposed subpart 23d.

The basic component of the admission certification program is to require admission certification when a recipient is admitted to a hospital. To comply with federal regulations and Minnesota Statutes, it is necessary for the Department to safeguard against unnecessary or inappropriate admissions. The admission certification program screens admissions for medical necessity and level of care. It is reasonable to clarify that admission certification is required for all admissions to inpatient hospital treatment unless they are specifically excluded (see part 9505.0520, subpart 2) or being combined according to readmissions criteria (see part 9505.0540, subparts 3 to 5). This is not a change from the current rule.

It is necessary to state that a provider obtain admission

certification when a recipient is readmitted to a hospital. Historically, many providers have not requested admission certification for a readmission and have used the certification number issued for the initial admission on the readmission claim. It is necessary to clarify that admission certification must be requested for a readmission unless the readmission is being combined with the first admission due to circumstances outlined in part 9505.0540, subparts 1 to 3. It is reasonable to require that readmissions be screened for medical necessity because they are, essentially, admissions and subject to the same requirements. In practice, a readmission requires additional screening (using readmission criteria) because a recipient is being or has been admitted to an acute level of care so soon after being discharged. It is reasonable to clarify this requirement to enhance understanding of the rule and further compliance.

This amendment also states that admission certification is to be obtained when a recipient is transferred to a hospital. (See the definition of transfer in part 9505.0505, subpart 29.) It is necessary to screen transfers for medical necessity by requiring admission certification because they are hospital admissions but to a different hospital. (See the above discussion about readmissions.) It is reasonable to inform providers of this requirement to increase understanding and further compliance.

Subpart 1, Item B

This proposed item is necessary to explain that a certification number is only valid for the admission for which it was issued. Adding this statement to the rule is necessary because empirical evidence shows that some provider confusion exists about the use of certification numbers. The Department found that providers were reporting incorrect certification numbers and duplicating certification numbers on claims. This practice undermines the program's objective. Therefore, it is reasonable to clarify that a certification number is only valid for the admission for which it was issued (unless combining admissions according to part 9505.0540, subparts 1 to 3).

Subpart 1, Item C

This proposed item is necessary to advise an interested person that the provider must request admission certification for the recipient within 30 days of the date of admission or a statutorily allowed penalty will be imposed on the provider. It is reasonable to advise providers of a possible statutorily allowed penalty. Thirty days is a sufficient amount of time for the provider to request certification for admission of a recipient. Currently, most requests for certification of admission are made within 30 days. It is more efficient to have providers request certification numbers from the Department in a

timely manner.

Subp. 2 Exclusions from admission certification.

This subpart specifies the types of admissions that are exempt from admission certification.

The proposed modification of this subpart reflects the amendment in subpart 1, eliminating the requirement of obtaining admission certification before admission and permitting admission certification any time before billing.

A statement has been added about the applicability of other rule requirements to these admissions. It clarifies that the other requirements of the rule do apply to these admissions, such as medical record review, medical necessity, and reconsideration. This is necessary to comply with federal regulations and Minnesota Statutes requiring that the Department safeguard against unnecessary and inappropriate utilization of health care services. It is reasonable to require that an admission meet standards of medical necessity even though it is exempt from admission certification.

Subp. 2, Item A Current Rule

Item A of the current rule is being deleted. Because the amended rule allows admission certification to occur at any time before billing, exempting providers from having to obtain admission certification before an emergency admission is not necessary. Furthermore, the reference to subpart 4, item B, is being deleted as all of subpart 4 is being deleted.

Subpart 2, Proposed Item A (formerly item B)

This item states that the delivery of a newborn or stillborn is exempt from admission certification. This provision is in the current rule.

The proposed amendment clarifies that the admission of a newborn resulting from birth is exempt from admission certification. The amendment is necessary as the hospital payment rule (parts 9500.1090 to 9500.1140) as amended in 1993 requires providers to submit a separate claim for newborns. It is reasonable to exempt a newborn from admission certification because inpatient hospital services provided to a newborn at birth are medically necessary and it is the community standard of medical practice to furnish these inpatient hospital services.

A further amendment of this item (formerly item B) removes the requirement of retroactive admission certification in the case of the admission of a pregnant woman that does not result in delivery of a newborn or a stillborn within 24 hours of her

admission. The amendment is necessary and reasonable because any admission resulting in a delivery is medically necessary and should not be subject to an arbitrary time limit (24 hours) when the issue is the diagnosis and treatment required.

Subp. 2, Present Item B

The exemption of inpatient dental procedures from admission certification is in present item B. The proposed revision removes this exemption from the admission certification requirement and thus under the revised rule inpatient dental procedures will be subject to admission certification. This amendment is necessary to safeguard against the unnecessary or inappropriate use of MA services following the revision of Department policy which revised the prior authorization requirement for inpatient dental procedures. Until this revision, all dental procedures performed on an inpatient hospital basis had to be prior authorized but were exempt from admission certification procedures. However, dental procedures performed in an inpatient hospital will need prior authorization only if the procedure would otherwise require prior authorization on an outpatient basis. Therefore, it is reasonable to require admission certification of admissions to an inpatient hospital for dental procedures to assure that inpatient hospital services for these procedures are medically necessary. It also is reasonable that the admission certification requirements for procedures performed by dentists in an inpatient hospital setting be consistent with the requirements for procedures performed by physicians in an inpatient hospital because such consistency avoids misunderstanding and is administratively efficient.

Subp. 2. Proposed item B

Present item B excludes from admission certification inpatient hospital services for which a recipient is approved under Medicare. However, inpatient hospital services for which a recipient is approved under Medicare are no longer exempt from admission certification unless they are a Medicare crossover claim. (A Medicare crossover claim results from the admission of a recipient whose primary coverage is Medicare and secondary coverage is Medicaid [also known as "medical assistance" in Minnesota]. Thus, it is a billing for health care services to a person who is covered by Medicare Part A and who also is a medical assistance recipient. Medicare pays the major portion of the cost of the inpatient hospital services and the MA billing is for the deductible and copayment amounts according to part 9505.0440.) Admission certification of such inpatient hospital services is not necessary or reasonable as the Medicare payment is evidence the service meets the federal standards of medical necessity. Additionally, it is reasonable to exempt these admissions because the state's cost of certifying these admissions would exceed the sum of the cost reimbursed to the

state by the federal government and the savings achieved through denying admission certification.

The statement concerning "denial of the service under Medicare on grounds other than medical necessity" has been deleted because it is no longer relevant. The original intent of the provision was to prevent providers from billing the Department for admissions that were denied under Medicare when administrative procedures were not followed. It was not intended to refer to denials for reasons of exhausted benefits or no entitlement.

Subp. 2, Item C, present rule

The exclusion of chemical dependency treatment services approved by the county is deleted. These chemical dependency treatment services are paid for pursuant to parts 9530.6600 to 9530.6655 through the consolidated chemical dependency treatment fund. These chemical dependency treatment services are not eligible for payment under parts, 9500.1090 to 9500.1155, the inpatient hospital medical assistance reimbursement rule. Therefore, because chemical dependency treatment services do not fall within the scope of parts 9505.0500 to 9505.0540, it is reasonable to delete references to them.

Subp. 2, Proposed item C

The proposed amendment deletes the requirement to obtain admission certification for an admission of a recipient which was prior authorized to a hospital not located in Minnesota or the local trade area. It is reasonable to exempt the admission of a recipient who has prior authorization because it eliminates duplicative procedures and paperwork and reduces the cost of administration for the providers and the Department. Prior authorization and retrospective review provide sufficient protection against unwarranted medical expense and inappropriate hospitalization.

Subp. 3. Admitting physician and hospital responsibilities.

This subpart specifies the responsibilities of the admitting physician or hospital in obtaining admission certification.

This subpart has been modified to include hospital responsibilities as well as admitting physician responsibilities. This amendment is necessary and reasonable because empirical evidence shows that admitting physicians and hospitals have developed arrangements about which one will request admission certification, the admitting physician or the hospital. According to the medical review agent, these arrangements are convenient and expedient for the parties and do not affect the program's operation. Therefore, amending the rule to reflect a

pragmatic practice is reasonable since it allows the providers more flexibility in accomplishing the requirements of this rule.

The words "to be" have been deleted from the phrase "to be provided to a recipient" in the first statement in this subpart. This amendment is necessary as a result of the proposed amendment in subpart 1 which allows providers to obtain admission certification at any time before billing. Because the admitting physician or hospital may initiate the procedure in subpart 3 at any time before, during or after the admission has occurred, the inpatient hospital services may or may not have been provided. The deleted phrase referred only to inpatient hospital services "to be" provided and ignored inpatient hospital services that "have already been" provided to a recipient. Therefore, it is reasonable to omit a reference to a specific time.

Subp. 3, Item A, present rule

The proposed amendment deletes the sentence that MA and GAMC payment shall be denied when a required prior authorization is not obtained prior to admission. This is necessary and reasonable because it is inappropriate for this rule to address issues pertaining to prior authorization which is governed by another rule.

Subp. 3, Item B, renumbered as proposed item A

Subitem (2): The amendment adds the recipient's sex to the information required. This item has been routinely collected in the past. Its inclusion is reasonable because it aids in the accuracy of matching claims to certification files in the payment process.

Subitem (4): The amendment adds the phrase "or principal procedure, when applicable" to this subitem. There may be a difference between "primary procedure" and "principal procedure" for a patient admitted for inpatient hospital services. The primary procedure is the procedure identified at the patient's admission as the one that is needed. However, sometimes after admission the need for a different procedure is identified and is the actual procedure performed. This is the "principal procedure." Thus, the amendment is necessary to assure that the admission certification, and thereby the billing, is for the actual procedure performed. The amendment also is reasonable as it is consistent with the amendment in subpart 1 allowing for admission certification to occur any time before billing. The amendment about the publisher of the volume, International Classification of Diseases - Clinical Modification is necessary and reasonable because it updates the information and thereby gives interested persons accurate information.

Subitem (5): Because the amendment in subpart 1 allows providers

to obtain admission certification after admission and before billing, it is necessary and reasonable to require that the actual date of admission be provided. However, if the provider is requesting admission certification before admission, the expected date of admission should be provided as in the past.

Subitem (7): The phrase "or principal diagnosis, when applicable" has been added to this subitem. See the SNR of subitem 4. If the admission has occurred, it is preferable that the provider furnish the principal diagnosis because it is the diagnosis determined to be the cause of the recipient's condition. If the admission has not occurred, the admitting diagnosis is required.

Subitems (8): Revising this subitem to read "if admission is or was medically necessary" is necessary to be consistent with the rule amendments permitting the provider to obtain admission certification after the recipient's discharge and before billing the Department.

Subp. 3, Current item C, renumbered as proposed item B The revision of item C correlates with the change in the introductory statement to this subpart in which "hospital" is added to 'Admitting physician responsibilities'. It is necessary to change the statement "inform the hospital" to "inform all other providers involved in the admission" because the provider who obtained the certification may be either the admitting physician or the hospital. It is reasonable that the provider who obtains the certification number, furnish that number to all other providers involved in the admission for billing purposes.

Subp. 3. Current item D, renumbered as proposed item C The proposed amendment deletes the language related to the prior authorization number as the prior authorization program is governed by another rule, parts 9505.5000 to 9505.5030.

Subp. 4 (Current Rule) Hospital responsibilities.

This entire subpart is being deleted. Hospital responsibilities have been placed in subpart 3 with admitting physician responsibilities (see the SNR for subpart 3.) See the SNR of subpart 2 about the deletion of the exemption of emergency admissions and the revised exemption applicable to deliveries of newborns and stillbirths. See the SNR of subpart 1 about removal of the time limits on requesting admission certification. Item C is deleted as prior authorization requirements appropriately are in the rules specific to that program.

Subp. 5 (Current Rule) Retroactive Eligibility

This subpart describes the process for obtaining admission certification in the case of retroactive eligibility. It is

necessary to delete this subpart to be consistent with proposed amendments in subpart 1 which permit certification at any time before billing.

Subp. 6 (Current Rule) Medical review agent responsibilities.

It is necessary and reasonable to delete this subpart about medical review agent responsibilities because the medical review agent's responsibilities are being moved to other rule parts or have been identified as more appropriately the responsibility of an admitting physician or hospital.

Subp. 6, Item A (Current Rule): Subpart 3, item B lists this item as the responsibility of an admitting physician or hospital. Referring to it here is redundant and, therefore, not necessary.

Subp. 6, Item B (Current Rule): The requirement of this item referring to the medical review agent's responsibility to make an admission certification determination within 24 hours has been moved to subpart 8, proposed item H, one step in the admission certification procedure. It is reasonable to place the procedure and the timelines to be met by the medical review agent into the same subpart because it is administratively efficient and avoids confusion.

Subp. 6, Item C (Current Rule): This item referring to the medical review agent's responsibility to notify the provider of an admission certification determination by telephone within 24 hours is being moved to proposed subpart 8, item H. Therefore, it is necessary and reasonable to delete item C to avoid confusion.

Subp. 6, Item D (Current Rule): This item refers to the medical review agent's responsibility to mail a written notice of the admission certification determination to the provider within 5 days. This requirement is being moved to subpart 8, proposed item H concerning the procedure for admission certification. See the SNR for subpart 6, item B, above.

Subp. 6, Item E (Current Rule): Deletion of this item about retroactive eligibility is consistent with the deletion of current subpart 5.

Subp. 6, Item F (Current Rule): This item refers to the medical review agent's responsibility to conduct reviews of medical records. Its deletion is reasonable because revised subpart 10 specifies the requirements for these reviews.

Subp. 6, Item G (Current Rule): This item refers to the medical review agent's responsibility to have a reconsideration process. Its deletion is reasonable because the reconsideration process is specified in revised subparts 9 to 9c.

Subp. 6, Item H (Current Rule): This item refers to the medical review agent's responsibility to recruit and coordinate the work of the physician advisers. The material is no longer necessary as the relationship is set forth in subpart 9b.

Subp. 6, Item I (Current Rule): This item refers to the medical review agent's responsibility to notify the provider of the reconsideration decision. It is being deleted as its substance is now in revised subpart 9c.

Subp. 6, Item J (Current Rule): This item refers to the medical review agent's responsibility to provide written notice to the provider of the reconsideration decision. It is being deleted as its substance is in revised subpart 9c.

Subp. 6, Item K (Current Rule): This item is being deleted. Retroactive admission certification as referred to in this item is no longer necessary in the admission certification process because the deadline for obtaining a certification number has been removed (see 9505.0520, subpart 1 and its SNR).

Subp. 6, Item L (Current Rule): This item refers to the medical review agent's responsibility to validate the diagnostic category. It is being deleted as its substance is being placed in subpart 10, item A, as revised.

Subp. 6, Item M (Current Rule): This item is being deleted because it is not necessary. The medical review agent is an entity under contract to the Department to carry out the admission certification procedure. Thus the contract may specify other duties necessary to implement the requirements of these rules about the admission certification procedure.

Subpart 7 (Current Rule) Ineligibility to serve as physician adviser.

This subpart refers to the circumstances in which a physician is not eligible to serve as a physician adviser. The proposed amendment is necessary and reasonable because it clarifies that the ineligibility to serve as a physician or physician adviser applies throughout the admission certification procedure under these rules under the circumstances in items A to D. The circumstances specified in items A to D are those in the current rule.

Subpart 8 Procedure for admission certification.

This subpart specifies the procedure used for admission certification.

Throughout this subpart the amendment replaces the term "clinical evaluator" with the term "medical review agent." The

responsibility for reviewing information, determining medical necessity and consulting physicians belongs to the medical review agent, the entity under contract to the Department for these functions. The rule is not the appropriate place to specify who will actually do the functions. Therefore, it is necessary and reasonable to clearly identify the medical review agent as responsible for the procedure because it informs affected persons and avoids confusion.

Subp. 8, Item A: This subpart states what the medical review agent must do upon receiving a request for admission certification and the information necessary to make the determination. The reference to item C has been deleted because the proposed amendment to subpart 3 deletes item C.

Subp. 8, Item B: The amendment clarifies the nature of the medical review agent's determination, that is "the admission is medically necessary." The clarification is reasonable to avoid confusion and misunderstanding.

Subp. 8, Item C: The amendment of this item clarifies that the medical review agent is to contact a physician in the event the agent is unable to make a determination. This is reasonable as the term "physician adviser" applies to the persons conducting the reconsideration procedure under subparts 9 to 9c.

Subp. 8, Item D: The amendment of this item is necessary to clarify that it is a physician and not a physician adviser. The term "physician adviser" applies to persons conducting the reconsideration procedure under subparts 9 to 9c.

Subp. 8, Item E: This item relates to the process for a provider's requesting the opinion of a second physician. It is continued without substantive change. However, the term physician adviser is revised to physician to be consistent with actual practice. A physician adviser is the individual who conducts reconsideration. See subpart 9 to 9c.

"Admitting physician" has been replaced with "provider" to be consistent with proposed revisions to subpart 3 about admitting physician and hospital responsibilities. Revised subpart 3 permits either the admitting physician or the hospital to contact the medical review agent to request a certification number. "Provider" is a general term applied to entities that have an agreement with the Department to provide medical assistance services. See the definition in renumbered part 9505.0505, subpart 23c. Admitting physicians and hospitals are providers. Using the term "provider" is reasonable because it is an abbreviation which simplifies the rule.

A limit of twenty-four hours to request a second physician's opinion is reasonable as it facilitates timely completion of the

process.

Subp. 8, Item F: Item F combines the second paragraph of present item G and all of present item H. It is part of the rule's restructuring and continues, without substantive change, the process related to opinions of second physicians who review the medical necessity of an admission.

As discussed above, "admitting physician" has been replaced with "provider" and "clinical evaluator" with "medical review agent."

Subp. 8, item G: The provisions of this item which are being deleted are being moved to other rule items as part of the overall rule reorganization.
This item specifies the process when the first physician is unable to determine whether admission is medically necessary and the provider does not request the opinion of a second physician or a second physician is unable to determine whether an admission is medically necessary. As revised it combines the first paragraph of item G and item I of this subpart. Because the resulting situation is the same if the original physician or the second physician is unable to determine that the admission is medically necessary, it is reasonable to combine the two items into one.

Notification of the admitting physician, hospital and recipient has been moved to item H to simplify item G. The language about recipients' and providers' appeals is also placed in proposed item H, as notices must have this information.

Subp. 8, Item H: Proposed item H states that a determination of medical necessity shall be made within 24 hours of receipt of the requested information and that a written notice shall be mailed by certified letter to the hospital and admitting physician within 5 working days of the determination. These provisions of the current rule were moved to this item from subpart 6, items B, C and D of the current rule as it is reasonable to combine provisions of similar content into the same subpart.

The amendment changes one notice requirement; the medical review agent will only contact <u>by phone</u> the provider who originally requested the admission certification, not both the admitting physician and hospital. This is reasonable because empirical evidence indicates that, in many situations, the party not requesting admission certification is not aware of the process and is more confused than informed by the phone call. Thus confining the notice to the provider making the request avoids confusion and is administratively efficient.

The Department notes that amended subpart 3, item C, requires the party requesting the admission certification to furnish the certification number to all other providers affected by the

recipient's admission.

Proposed item H continues the present requirement that, in the case of a denial, the medical review agent contact both the admitting physician and hospital by certified letter. Continuation of requiring the denial notice to be sent by certified letter is reasonable as it provides evidence for tolling the request for a reconsideration of the denial under subpart 9. The proposed item does not continue the requirement to send notice of approval of the admission certification request by certified mail as the approval ends the admission certification process.

If a provider requests a review by a second physician, it is reasonable to allow a 24-hour period for making an admission certification determination after receipt of the request. The length of time, 24-hours, is the same as allowed in proposed item E.

The requirements for the content of the determination notices in the case of denials were moved to this item from subpart 8, items G and I of the current rule and is the current practice.

The proposed amendment sets forth an additional procedural step to be used by the admitting physician or the hospital before making an appeal of an admission certification denial under Minnesota Statutes, section 256.9685. See part 9505.0545 about provider appeals. The additional step permits an admitting physician or hospital to request reconsideration of the denial. See the definition of reconsideration in part 9505.0505, subpart 26. See subparts 9 to 9c about the reconsideration process. This amendment continues internal procedures designed to address provider disagreements. Such internal procedures are administratively efficient and cost effective as the provider does not incur the delay that may be associated with an appeal to the commissioner or the costs associated with an appeal to the courts.

Subp. 8, Item I: This proposed item states that the Department or the medical review agent may request a copy of the recipient's medical record to substantiate the medical necessity of an admission. In order to safeguard against unnecessary and inappropriate utilization of inpatient hospital services, it is reasonable that the Department and the medical review agent have as much information as necessary on which to base a determination of medical necessity. If a question exists about the medical necessity of an admission, the Department or the medical review agent may need a copy of the medical record to obtain additional information. The medical record is a comprehensive picture of the recipient's status at admission and of what occurred at admission and during the admission. It is more complete than information provided over the telephone. Therefore, it is

reasonable that this record be provided if requested for a determination. This proposed item also requires that the medical record be submitted within 30 days of the date of the Department's or medical review agent's request. This is reasonable because 30 days is sufficient time to locate, copy and mail the medical record. [This 30-day time requirement is in current rule subpart 9.] If the medical record is not submitted, the Department's or medical review agent's determination of medical necessity will be based only on the information received over the phone, which, in some cases, may be insufficient to resolve all questions related to the medical necessity of the admission.

Subpart 9 (Current Rule) Reconsideration requested.

This subpart sets forth the requirements to initiate the reconsideration process. The amendments specify when and how the provider may request reconsideration.

Items A to C describe the circumstances when a provider may request a reconsideration. The circumstance in item A is in the current rule. A reconsideration following a withdrawal of the admission certification number (item B), although not specifically stated in the current rule, has been available to providers because it is a denial of payment for inpatient hospital services rendered. It is necessary and reasonable, however, to include it in the rule for clarification and completeness. Item C refers to determinations by the medical review agent to deny or withdraw certification numbers as a result of applying the readmissions criteria in 9505.0540. Determinations of this nature are in subpart 9a of the current rule. Placing them in item C of subpart 9 is reasonable as a consolidation of provisions of similar content.

Reconsideration is an internal review process initiated by the provider when an admission certification number has been denied or withdrawn as a result of a determination that the admission is or was medically unnecessary. Its purpose is to afford the provider an opportunity to refute the certification denial or withdrawal determination of the medical review agent and provide evidence that the admission was medically necessary. The process includes a medical review by three physician advisers. See the definition of reconsideration in part 9505.0500, subpart 26. Requiring a written request is reasonable to provide evidence and create a record and thereby avoid confusion. The required contents of the request are necessary and reasonable to ascertain the recipient's health status by reviewing the recipient's medical record and the reason for the dispute and, thereby, enable the physician advisers to determine whether the admission is medically necessary.

Material in present subpart 9 about the appointment of physician advisers, and completion of the reconsideration is being placed in proposed subparts 9b and 9c as part of the rule restructuring.

Subpart 9a. Retention or withdrawal of certification number. This subpart is being deleted as part of the restructuring of the rule. The opportunity for the provider to request reconsideration is being placed in subpart 9. The material about medical record review and determination after admission is consolidated in subpart 10.

Subp. 9b. Reconsideration; physician advisers appointed. This subpart continues the present requirements of subpart 9 about the appointment of at least three physician advisers and the advisers' responsibility.

The language about conducting the reconsideration by a conference call is being deleted because conference calls are no longer part of the procedure. Materials related to the request for admission certification and, as appropriate, the recipient's medical records, are mailed to each of the three physician reviewers who will carry out the reconsideration. Each physician adviser independently reviews the information, makes a determination, and then returns her or his decision to the medical review agent.

The statement that physician advisers may seek additional facts and medical advice has been deleted as the provider is responsible for providing all necessary information when requesting reconsideration. See subpart 9. Permitting additional information after the reconsideration has begun would circumvent the provider's responsibility to furnish complete and meaningful information when requesting the reconsideration. It could also unduly prolong the process or make it difficult for the medical review agent to complete the process within the required time limit.

Proposed subpart 9b continues the requirement of present subpart 9 that the reconsideration decision shall be the majority opinion of the three physician advisers.

Identifying the criteria the physician advisers must use in the reconsideration is necessary to set a uniform standard. It is reasonable to use the criteria of medical necessity set forth in these rules because the criteria are readily available to the affected parties and have been adopted in compliance with the requirements of Minnesota Statutes, chapter 14.

Subp. 9c. Completion of the reconsideration. This proposed subpart specifies the time limit for completing the

reconsideration and the required notice to the provider who requested the reconsideration. The deadline for completing the reconsideration process has been changed from 45 days (see current subpart 9a) to 60 days. Because the reconsideration process will be conducted by mailing the information to and from physician advisers, it is reasonable that additional time be allowed for delays in this system.

The proposed amendment requires the medical review agent to notify the provider who requested consideration by telephone within 24 hours after the receipt of the physician advisers' determinations, exclusive of weekends and holidays. Notice by telephone within 24 hours of the decision is reasonable as it facilitates completing the process promptly and, if admission has been determined medically necessary, attending to the recipient's need for inpatient hospital services.

The proposed amendment requires the medical review agent to call only the provider who initially requested the reconsideration. This is reasonable because one contact should be sufficient for phone communication. It would be an undue burden for the medical review agent to contact both the hospital and admitting physician by phone, when, in some instances, one is not even aware that a reconsideration has been requested. Both the admitting physician and hospital will be notified in writing within 10 working days of the date of receiving the physician advisers' reconsideration decision. Follow-up of the telephone notice by a written notice is reasonable as the written notice documents the decision and avoids misunderstanding. Requiring the notice to state the right of the admitting physician and hospital to request an appeal is necessary and reasonable to assure the provider is informed of an opportunity for further review of an adverse determination. See Minnesota Statutes, section 256.9685, subdivisions 1b to 1d.

Subp. 10. Medical record review and determination after admission. This subpart addresses reviews and determinations of medical necessity of the admission after the recipient has been admitted to the hospital. The amendments are necessary to reflect actual practice, be consistent with other proposed rule amendments, and clarify the role of the physician to be consulted by the medical review agent.

The proposed amendment removes the reference to the contract between the Department and the medical review agent. The rule sets standards for the contract. Therefore, reference to the contract is not necessary when the rule itself authorizes a medical review agent to conduct concurrent, continued stay, and retrospective reviews.

The word "shall" was changed to "may." The Department and the medical review agent as the commissioner's agent have the authority to perform a medical record review for any MA, GAMC, or

MinnesotaCare admission. However, this amendment is necessary because medical record reviews and determination are conducted only on a certain percent of admissions. Therefore, not all admissions will have a medical record review. The revision is reasonable to clarify this.

The phrase "the inpatient hospital services" is being revised to "all the inpatient hospital services provided to the recipient" as a clarification. The clarification is reasonable because it informs the affected persons and avoids dispute and misunderstanding. The clarification is consistent with other rules of the Department about the review of medical records. See parts 9505.2175 and 9505.2185

Addition of the phrase "was medically necessary" is a clarification consistent with present practice of continued stay reviews which may be performed retrospectively. These are primarily outlier reviews; see proposed item E and its SNR.

Replacing the term "clinical evaluator" by "medical review agent" has been discussed in the SNR of part 9505.0505, subpart 6.

Item A. Establishing the diagnosis and procedure codes for diagnostic category validation is a necessary step in the medical record review as the diagnostic and procedure codes affect the diagnostic category assigned to a claim and thus the payment for it. Moving this requirement to item A from present item E is part of the reorganization of the rule. [See present item E, which is being repealed and the definition of diagnostic category validation in part 9505.0505, subpart 10b.] It is not a new requirement.

Item B. The components in this item have been restructured for clarity and readability. The word "shall" has been replaced with "may" when referring to the medical review agent's request for additional information. The intent is to permit the medical review agent to determine whether additional information is needed and thereby avoid burdening the provider with the cost of sending unnecessary records and information. This is reasonable because the person reviewing the medical record is competent to make that decision. When additional information is requested, it is reasonable to require the admitting physician or hospital to bear the expense as the provider has the information and is responsible to justify the recipient's need for the inpatient hospital services.

Item C. The amendments to this item are for purposes of clarification and grammatical simplification. Clarifying that the medical review agent consults a physician is consistent with this step of the actual procedure. Physician advisers are used for the reconsideration process. See subpart 9.

Item D. This item is being amended to make a clearer distinction between retrospective admission reviews and continued stay reviews. Requirements about continued stay reviews are being moved to a new item E. See the SNR of item E.

Deletion of the phrase "by telephone within 24 hours" is reasonable because there is no urgency necessitating 24 hour phone notification when a certification number for an admission is withdrawn retrospectively. Because the admitting physician and hospital have already provided the inpatient hospital services, they are unable to modify their liability. Thus timeliness of notice is a moot issue. The revised rule continues the present rule's option for the provider to request a reconsideration of the withdrawal of the certification. See subparts 9, 9b and 9c.

The phrase "or appeal" has been deleted from the final sentence of this item. The term "or appeal" refers to a chapter 14 contested case hearing under which an appeal is heard by a third party. This deletion reflects the proposed change in subpart 9 which requires a provider to use the medical review agent's internal review procedure of reconsideration before initiating an appeal under Minnesota Statutes, section 256.9685, subdivision 1b to 1d. The Department notes that the present rule allows a provider to request reconsideration. See subpart 9 and its SNR.

Item E. As noted above, the function of this proposed item is similar to item D but addresses continued stay reviews rather than retrospective reviews. Instead of withdrawing the certification number for the entire admission as in item D above, certification will be withdrawn only for the portion of the continued stay that is determined medically unnecessary. Continued stay reviews primarily examine hospital stays which are day outliers (see the definitions in part 9500.1100, subparts 18 and 36) and per diem admissions which are reimbursed incrementally. A continued stay review may be conducted while the recipient is still in the hospital or after the recipient's discharge to determine the medical necessity of all or part of the recipient's continued stay.

This item requires the medical review agent, if the recipient is still an inpatient, to notify the admitting physician and hospital by telephone within 24 hours and by certified letter within 5 working days of a determination that all or part of continued stay was not or will not be medically necessary. A notice within 24 hours is reasonable if the recipient is still in the hospital so the admitting physician and the hospital have full opportunity to determine what action is necessary before incurring costs which will not be met through medical assistance. If the patient has been discharged when the continued stay is performed, requiring only the notification letter, mailed within five working days, is reasonable as the admitting physician and

hospital have already provided the inpatient hospital services and they are unable to modify their liability. It is reasonable to require the notice to inform the hospital and admitting physician that they may request a reconsideration so that they have the opportunity to make an informed choice.

Present Item E. This item refers to diagnostic category validation. Although during the medical record review, the medical review agent establishes the diagnostic and procedure codes from the medical record, the actual validation process is more involved and is not a component of the medical record review. The diagnostic category validation adjustment process has been moved to item A of this subpart. Language about the payment adjustment that may be needed if the diagnostic category was inaccurately assigned is being placed in subpart 11, item C.

Item F. This item is being revised to refer to recertification which is the procedure documenting a recipient's continued need for inpatient hospital services. Although recertification is a new component of the medical record review process, it is not a new component of the admission certification program. The recertification process is a federal regulation set forth in 42 CFR 456.60 (b)(1) and (2). It requires a physician to recertify that a recipient requires inpatient hospital services at least every 60 days from the date of admission. Currently, admitting physicians complete a form stating that the recipient continues to need inpatient hospital services.

Under the proposed amendments, the medical review agent will review the medical record to ensure that it documents the recipient's continued need for inpatient hospital services. Currently, the provider must complete and send to the Department a recertification form. Thus the amendment removes this burden from the provider and relies on the recipient's medical record. The amendment is reasonable because the medical record is the appropriate source of information about the recipient's condition and need for inpatient hospital services and using it rather than an additional form reduces the burden on the provider. This provision also states that the medical review agent will deny that portion of a stay that has not been recertified. This is reasonable and necessary because Minnesota Statutes, section 256B.15 requires the Department to safeguard against paying for services, such as inpatient hospital services, that are not, or are no longer, medically necessary.

Item G. The changes to this item are technical only to clarify the rule and correct the citation of the rule part containing the criteria.

Subpart 11. (Proposed Rule) Payment adjustments. (current headnote, Consequences of withdrawal of admission certification

or authorization number; general)
This subpart is retitled to more accurately describe its contents. When admission certification is withdrawn in a retrospective review, payment adjustments may be necessary.

Replacing the introductory paragraph by citing the items specifying the actions appropriate to the circumstance is reasonable because it removes repetitive language and thereby shortens the rule. See items A to E. The deletion does not change the intent or meaning of the present subpart.

Federal regulations and state statutes require the use of both prepayment and postpayment review to safeguard against excess payments and to determine if service utilization is reasonable and necessary. (See Minnesota Statutes, section 256B.04, subd. 15.) State statutes permit the Department to adjust payments based on the findings of audits of patient records. (See Minnesota Statutes, section 256.969, subdivision 5a.) Therefore, it is reasonable and necessary for the Department to recover payments for admissions that have been retrospectively determined medically unnecessary.

Item A. The revision adds the phrase "admitting physicians and other providers of inpatient hospital services receiving payment through medical assistance". The phrase has been in current rule item C, which is being deleted. Restructuring the rule by placing this language in item A is reasonable as the same circumstance, withdrawal of certification, may affect not only hospitals but also other providers of services while the recipient is in the hospital and the restructuring shortens the rule.

The reference to subpart 15 has been deleted because subpart 15 is being deleted. (See the SNR of subpart 15.)

Revising the cited rule parts to 9505.2160 to 9505.2245 is necessary and reasonable because these rule parts are the successor to parts 9505.1750 to 9505.2150 which were repealed.

Item B. The revision adds the phrase "admitting physicians and other providers of inpatient hospital services receiving payment through medical assistance". The phrase has been in current rule item D, which is being deleted. Restructuring the rule by placing this language in item B is reasonable as the same circumstance, withdrawal of certification, may affect not only hospitals but also other providers of services while the recipient is in the hospital and the restructuring shortens the rule.

The reference to subpart 15 has been deleted because subpart 15 has been deleted. (See the SNR of subpart 15.)

Item C. (Current rule) This current item is being deleted. See the SNR of item A above.

Item D. (Current rule) This current item is being deleted. See the SNR of item B above.

Item C. (Proposed rule) The substantive content of this item is in subpart 10, item E of the current rule. Placing it in subpart 11 is part of the restructuring of the rule. It is reasonable to move it because the content refers to a payment adjustment, the subject matter of subpart 11. The proposed language explains in more detail how diagnostic category validation is conducted. The revision is reasonable as it clarifies the purpose, and possible outcome, of the validation. It is important to note that the diagnostic category validation designates the medical record to be the controlling document on which the diagnostic category is based. Therefore, any deviation of the diagnostic category assigned to the claim from the information in the medical record is considered a discrepancy that may require a payment adjustment.

Item D. (Proposed rule) Item E of the current rule is being relettered as Item D. The length of time for complying with the medical review agent's request for the medical record or other required information is being lengthened from 20 days to 30 days. 30 days is consistent with other provisions in the rule allowing 30 days for submitting requested information. The change is reasonable as it avoids confusion and thereby is administratively efficient.

Subitems 1 to 3, present item E, are being deleted because it is not necessary to iterate the reasons why the medical record is being requested. A provider's failure to submit medical records is contrary to the intent and purpose of parts 9505.0500 to 9505.0540, which is to rely on a recipient's medical records to determine the medical necessity of the recipient's inpatient hospital services. (See Minnesota Statutes, section 256B.04, subdivision 15 which prohibits medical assistance payment for health care services that are not medically necessary.) Thus, it is reasonable to deny or recover all or part of the payment if the provider fails to submit the record which is the basis for the determination of medical necessity.

Item E. (Proposed rule) This item, formerly in present part 9505.0521, prohibits a provider from seeking payment from a recipient for inpatient hospital services if a certification number, authorizing payment, is not issued or is withdrawn. Its content remains the same. It is reasonable to combine provisions of similar content into the same subpart.

This item is consistent with part 9505.0225, subpart 3 which prohibits providers from requesting a recipient to pay for an

inpatient hospital service not covered by medical assistance unless the provider informed the recipient about the recipient's potential liability before providing the inpatient hospital service.

Subp. 12 (Current rule) Reconsideration of denial or withdrawal of admission certification. This subpart is being deleted because it repeats the reconsideration process set forth in detail in subparts 9 to 9c. It is reasonable to delete repetitive material to shorten the rule and to avoid possible confusion.

Subp. 13 (Current rule) Information used for determination. This subpart is being deleted as it repeats information found in other rule parts. See subparts 8 item I; 9; and 10, item B.

Subp. 14 (Current rule) Retroactive admission certification. This subpart is being deleted in its entirety. The amendment to 9505.0520, subpart 1, removes any deadlines for a provider's request of admission certification. Thus, this provision, which permits a provider to request admission certification within 30 days after the recipient's discharge is not necessary.

Subp. 15 (Current rule) Recovery of payment after withdrawal of admission certification. This subpart is being deleted because authority to recover payments is provided in other state and federal laws and rules. See Minnesota Statutes, sections 256.969, subdivision 5a, and 256B.064, subdivision 1c and proposed subpart 11.

9505.0521 PROHIBITION OF RECOVERY FROM RECIPIENT

The substance of this part is being moved to part 9505.0520, subpart 11, item E as one of the series of items addressing payment adjustments that are necessary when a recipient has received inpatient hospital services for which an admission certification number is denied or withdrawn.

9505.0522 RECIPIENT'S RIGHT TO APPEAL.

Provisions about appeals by the provider and the recipient have been consolidated in proposed part 9505.0545. Thus, part 9505.0522 is not necessary and its deletion is reasonable in order to avoid repetition and possible confusion. It is reasonable to place provisions about similar actions close together because it assists the reader to locate them.

9505.0530 INCORPORATION BY REFERENCE OF CRITERIA TO DETERMINE MEDICAL NECESSITY

Subpart 1. Determinations using medical necessity criteria.

This subpart sets out the types of determinations the medical review agent is to make. Subitems 1 to 4 were moved to this rule part from part 9505.0540, subpart 1 to restructure the rule for clarification. It is logical to place in the same rule part the medical necessity criteria and the types of determinations the criteria apply to.

Subparts 2 and 3 are designations for paragraphs 1 and 2 of present part 9505.0530. Designating them by number is reasonable because the designation assists the reader. Their content remains unchanged, except that the addresses where the material can be obtained has changed. The Health Data Institute is no longer listed as a source, because the book is out of print and the Health Data Institute appears to be out of business. The address of the state law library in subpart 3 has been updated to reflect its move from the Ford Building to Minnesota Judicial Center. It is reasonable to use the corrected addresses for obtaining publications incorporated by reference so that interested persons can find a source for the publications which meets the requirements of Minnesota Statutes, section 14.07, subdivision 4.

9505.0540 CRITERIA FOR READMISSIONS

Subpart 1 (Current rule) Determination for admission for purpose other than chemical dependency treatment. This subpart is being deleted as its content is being placed in part 9505.0530, proposed subpart 1. See the SNR of part 9505.0530, subpart 1.

Subp. 2. (Current rule) Determination for admission for chemical dependency treatment. This subpart is being deleted. Admission for chemical dependency treatment is **not** subject to admission certification under parts 9505.0500 to 9505.0545. Therefore, is reasonable and necessary to delete this subpart from this rule.

Subp. 3, renumbered as proposed subpart 1. Readmission considered as a second admission. There is only one minor change to this subpart. The reference to the criteria for medical necessity has been revised as a result of reorganization of part 9505.0530. There is no change to the content or meaning of this subpart.

Subp. 4, renumbered as proposed subpart 2. Readmission considered as continuous with admission. There is only one minor change to the introductory paragraph of this subpart. The reference to the criteria for medical necessity has been revised as a result of reorganization of part 9505.0530. There is no change to the content or meaning of this subpart.

Items A and C. There is the same minor change in each of these

items. The change is necessary to reflect a revision to subpart 5, item A which is referenced in items A and C of subpart 4. See subpart 5 and its SNR below.

Subp. 5, renumbered as proposed subpart 3. Admission and readmission eligible for transfer payment. Subpart 5 addresses readmission situations that are considered to be transfers and are eligible for transfer payment. A minor change has been made. The word "admission" has been added as a clarification. Under the circumstances defined in this subpart, both the admission and readmission will be considered transfers and eligible for transfer payments.

Items A, B and C. The citations in items A,B, and C which refer to transfer payments are being revised to be consistent with adopted amendments of parts 9500.1128, the hospital payment rule.

Subp. 6. Physician adviser's review of readmission. This subpart is being deleted because it is no longer necessary. The procedure described in this subpart is reflected in the medical record review process in subpart 5 of the proposed rule. Deleting of repetition is reasonable as it avoids possible confusion and shortens the rule.

9505.0545 APPEALS

This part was created to inform providers and recipients of their right to appeal the decision to deny, or withdraw all or part of, an admission certification.

Subpart 1. Appeal by admitting physician or hospital. As discussed under subparts 8 and 9, proposed rule, reconsideration is an internal appeal process focused on the medical necessity of an admission. It is an additional part of the admission certification process available at the request of the admitting physician or hospital. Following a denial or withdrawal of an admission certification in a reconsideration, a provider may appeal to the commissioner as set forth in Minnesota Statutes, section 256.9685, subdivisions 1b to 1d. Thus, this subpart is necessary to inform providers of the statutory provision enabling them to appeal.

The proposed subpart clarifies what the provider who wants to appeal must do. Requiring the appeal request to be in writing is reasonable as it is consistent with the statute. It is necessary to clarify the basis the commissioner will use in reviewing the appeal to determine medical necessity of the inpatient hospital admission. Minnesota Statutes, section 256.9685, subdivision 1b specifies that the "commissioner shall review the medical record and information submitted during the reconsideration process and the medical review agent's basis for the determination that the services were not medically necessary." Thus the proposed rule

reflects the statutory language.

A time limit for appealing to the commissioner is necessary to conclude the determination procedure in a timely manner. A limit of 30 days is reasonable as it affords the physician and hospital time to discuss the matter with each other and also with the recipient and reach a decision in the recipient's interest.

Subp. 1a. Judicial review. As discussed under subpart 1, proposed rule, an admitting physician or hospital may seek further review of a denial or withdrawal of an admission certification. The appeal procedure is set out in Minnesota Statutes, section 256.9685, subdivisions 1c and 1d. The proposed subpart clarifies what the provider who wants to seek judicial review must do. This information is necessary and reasonable to enable the provider to exercise this option in an effective manner.

Subp. 2. Recipient appeal. Prior to the rules' reorganization, this provision about the recipient's right to appeal was in a separate part (9505.0522). It is reasonable to place it in the part about appeal processes because of similar subject matter. The content of the provision remains the same.

Expert Witnesses

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

Date: _____

_____
JOHN PETRABORG
Commissioner