

## Provider Requirements

[Revised: July 21, 2021](#)

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Minnesota Health Care Programs (MHCP) requires all enrolled providers to follow applicable state and federal regulations.

### Enrollment with Minnesota Health Care Programs

See the [Enrollment with MHCP](#) section for details about enrolling for each provider type.

### Federal and State Exclusions Lists

The federal Health and Human Services–Office of Inspector General (OIG) has the authority to exclude individuals and entities from participation in Medicare, Medicaid and other federal health care programs. MHCP also excludes individuals and entities from participation in MHCP if they are on either the federal or state excluded provider list.

See complete requirements in the [Enrollment with MHCP](#) and the [Excluded Provider Lists](#) sections.

### Use of Billing Agents

If a provider uses a [billing agent or organization](#) (person or entity that submits a claim or receives MHCP payment on behalf of a provider), the provider must also list the name and address of the billing agent on the enrollment application. Notify MHCP Provider Enrollment in writing if you hire a billing agent after enrollment. The notification must include the provider name, the National Provider Identifier (NPI) or Unique Minnesota Provider Identifier (UMPI), office address, and billing agent's name and address. Send the notice to:

#### DHS – MHCP Provider Enrollment

PO Box 64987  
St. Paul, MN 55164-0987  
Fax 651-431-7425

### Payment to Provider or Billing Agent

MHCP must make all payments to the provider. However, MHCP may mail payment to a billing agent (such as an accounting firm or billing service) that furnishes statements and receives payments in the name of the provider if the agent's compensation for these services is any of the following:

- Related to the cost of processing the billing
- Not related on a percentage (or other basis) to the amount that is billed or collected
- Not dependent on collection of the payment

## Payment Reversals for Terminated Providers

MHCP pulls monthly reports to identify claims paid with dates of service on and after the effective date of the pay-to provider's or rendering provider's termination. MHCP will reprocess and reverse payments retroactive to six years following federal [Required Provider Agreement](#) regulations and Minnesota's [Covered Services](#) rule that prohibits payment of a service to non-enrolled providers. Providers will see reversed claims as adjustments on their remittance advices.

## Sale or Transfer of a Provider Entity

An MHCP provider who sells or transfers ownership or control of a provider entity enrolled in MHCP must notify MHCP Provider Enrollment no later than 30 days before the effective date of the sale or transfer by submitting a [Provider Entity Sale or Transfer Addendum \(DHS-5550\) \(PDF\)](#). MHCP may stop or withhold payments effective the date the sale or transfer takes place if the new entity's enrollment is not complete.

A new owner of an entity enrolled in MHCP must complete and comply with all provider screening and enrollment requirements and conditions. They must also submit a new Provider Agreement, a [Disclosure of Ownership and Control Interest Statement for Participating Providers \(DHS-5259\) \(PDF\)](#), and any other required enrollment documentation to Provider Enrollment no later than the effective date of the sale or transfer. MHCP must process and approve the new entity owner's enrollment before we can pay claims for services they provide.

DHS retains the right to pursue monetary recovery, or civil or criminal action against the seller or transferor.

If a new owner agrees to keep the NPI established for an entity (provider), as of the effective date of the sale or transfer of the provider the following apply:

- The previous owner authorizes and the new owner accepts all claims payments; claims adjustments will accrue to the new owner, without regard to the date of service, date of submission to MHCP, or adjudication date.
- MHCP will not recognize or enforce any agreement between the previous owner and the new owner. This does not limit the right of the previous owner and new owner to pursue other legal remedies.
- The previous owner's access to MN-ITS, all future RAs and 835 transactions will transfer to the new owner; MHCP will not give information to the previous owner about adjustments; the previous owner must obtain any such information from the new owner.
- Any provider agreements, including addendums, executed by the previous owner on behalf of the provider will terminate.

## Impact for home care and waived services

Advance notification to MHCP Provider Enrollment is critical for providers of home care and waived services due to the impact of a provider number change on service agreements through which they bill. See additional requirements in [Home Care Services](#) and [HCBS Waiver Programs](#) and [AC Program](#).

## DHS Review and Notice to Provider

MHCP Provider Enrollment reviews the provider's application and notifies the provider of its determination in writing within 30 days of receipt of the application. Provider Enrollment will notify the provider and ask for additional information if it is unable to make a determination. If Provider Enrollment denies an initial provider enrollment application, the provider may not appeal the decision. If Provider Enrollment terminates a provider, the provider has a right to an administrative appeal at the [Office of Administrative Hearings \(OAH\)](#).

## Duration of MHCP Participation

MHCP participation remains in effect until any of the following occur:

- The ending date specified in the agreement
- The provider fails to comply with the terms of participation
- The provider sells or transfers ownership, assets, or control of an entity that has been enrolled to provide MHCP services
- Thirty days following the date of DHS' request to the provider to sign a new provider agreement, if the provider has not signed the new agreement
- The provider requests to end the agreement

## Violating Provider Agreement

A provider who fails to comply with the terms of participation in the provider agreement or with requirements of the rules governing MHCP is subject to monetary recovery, [Minnesota Rules, part 9505](#) program sanctions, or civil or criminal action. Unless otherwise provided by law, no provider of health care services will be declared ineligible without prior notice and an opportunity for a hearing under [Minnesota Statute 14](#).

## Limits on Recipient Services

[Minnesota Rules 9505.0195](#), subp. 10 states in part:

"A provider shall not place restrictions or criteria on the services it will make available, the type of health conditions it will accept, or the persons it will accept for care or treatment, unless the provider applies those restrictions or criteria to all individuals seeking the provider's services. A provider shall render to recipients services of the same scope and quality as would be provided to the general public. Furthermore, a provider who has such restrictions or criteria shall disclose the restrictions or criteria to DHS so DHS can determine whether the provider complies with the requirements of this subpart."

For example, providers cannot deny treatment for a certain diagnosis (for example, pregnancy) to MHCP recipients unless treatment for that diagnosis is also not available for other clients. Requirements regarding the need for a referral, or which days are available for treatment, etc., are legitimate requirements for MHCP recipients only if they are also applied to other clients.

## Nondiscrimination Notice

All MHCP enrolled providers must post a notice of nondiscrimination practices that is clearly visible in all of the following locations:

- Physical locations where you interact with the public
- The home page of your company's website (in an easily accessible location)
- In any significant publications and communications that target MHCP members or the public

The nondiscrimination notice must include all of the following information:

- Your organization does not discriminate on the basis of race, color, national origin, sex, age, or disability
- You provide appropriate accommodations for people with disabilities in a timely manner and free of charge, when they are needed to perform services. Appropriate accommodations include assistive devices and services, interpreters and information in alternate formats
- You provide timely language assistance services for people with limited English proficiency (LEP) free of charge, when they are needed to perform services. Language assistance services include translated documents and oral language interpretation
- How someone can obtain accommodations or language assistance services from you
- The name and contact information of an employee of your organization someone can contact to file a complaint about any of the items covered in the nondiscrimination notice
- Information about filing a complaint with the Office for Civil Rights (OCR)
- Taglines in at least the top 15 languages spoken by people with LEP in the state in which you operate, indicating that language assistance services are free of charge

For small publications or communications, such as postcards or tri-fold brochures, the nondiscrimination statement may contain no less than the following information:

- Statement that your organization does not discriminate on the basis of race, color, national origin, sex, age, or disability
- Taglines in at least the top two languages spoken by people with LEP in the state in which you operate indicating that language assistance services are free of charge

## Prohibited Practices

### Nursing Homes

A nursing home is not eligible to receive Medical Assistance (MA) payments unless it refrains from requiring any resident of the nursing facility to use a vendor of health care services chosen by the nursing facility. (Minnesota Statute [256B.48](#), subd. 1)

Payment agreements between nursing homes and providers of ancillary medical care: A nursing home is not eligible to receive MA payments unless it refrains from requiring any vendor of medical care who is reimbursed by MA under a separate fee schedule, to pay any portion of the provider's fee to the nursing home. Exceptions to this are as payment for renting or leasing space or equipment or purchasing support services from the nursing facility. (Minnesota Statutes [256B.02](#), [256B.433](#), [256B.48](#) subd. 1)

Payment rates and special services for nursing homes and its private pay residents: A nursing home is not eligible to receive MA payments unless it refrains from requiring its residents to pay more than its MA rate for similar services.

Exceptions are made for:

- Private paying residents in private or single bedrooms
- Special services not included in the daily rate, if MA residents are charged the same rate for the same service

In addition, a nursing facility participating in the demonstration project may charge private pay residents up to the Medicare rate for the first 100 days after admission only if the private pay resident's stay is less than 101 days. Refer to these statutes for additional details of these provisions. (Minnesota Statutes [256B.48](#), subd. 1; [256B.434](#))

## Federal Anti-Fraud Statutes

Federal anti-fraud and abuse provisions prohibit certain types of business transactions or arrangements. A pertinent provision of these statutes is: Whoever knowingly and willfully offers; pays or solicits; or receives any compensation (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind:

- To refer, or in return for referring, an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under the MHCP program or
- To refer, or in return for purchasing, leasing, ordering, or arranging for or recommending, purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years or both.

The following practices are prohibited:

Offering or transferring remuneration to any individual eligible for benefits under this program, that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner or supplier any item or service for which payment may be made in whole or in part by this program. Examples of benefits include, but are not limited to such items as coupons providing discounts, cash, merchandise or other goods or services of value in exchange for utilizing services or obtaining goods from a particular provider.

## Factors

**Factor:** An individual or organization that advances money to a provider for their accounts receivable for an added fee or a deduction of the accounts receivable worth. Payment for any covered service furnished to a recipient by a provider may not be made to or through a factor, either directly or indirectly.

## Advance Directives

### Background

Inpatient hospitals, nursing facilities, providers of home health and personal care services, hospice programs and managed care plans are required by federal and state law to inform all adult patients about their rights to accept or refuse medical or surgical treatment, and the right to execute an advance directive. Out-of-state providers must comply with all terms of this section and follow laws of the state in which the provider is located.

### Definitions

**Advance Directive:** A written instruction such as a living will or durable power of attorney for health care, recognized under state law and relating to the provision of care when the patient is incapacitated. The intent of an advance directive is to enhance a patient's control over medical treatment decisions.

**Patient:** Any adult resident, patient, recipient, or client receiving medical care from or through the provider.

### Requirements

Inpatient hospitals, nursing facilities, providers of home health and personal care services, hospice programs and managed care plans must maintain written policies and procedures as well as the following:

- Give updated, written information to all patients about their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and to execute an advance directive. Providers may contract with other entities to furnish this information but are still legally responsible for ensuring this requirement.
- Give written information to patients regarding the provider's policies and procedures concerning implementation of these rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive based on conscience. At a minimum, the provider's statement of limitation should include the following:
- Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians
- Identify the state legal authority permitting such objection
- Describe the range of medical conditions or procedures affected by the conscientious objection
- Within limited circumstances, only if allowed under state law, a facility or physician may conscientiously object to an advance directive. If state law is silent regarding conscientious objection, the facility or physician may not conscientiously object to an advance directive that is permissible in that state
- Document in the patient's medical record whether or not the patient has executed an advance directive

- Refrain from conditioning the provision of care, or otherwise discriminating against the patient, based on whether or not the patient has executed an advance directive
- Comply with state law governing advance directives
- Provide for educational campaigns, individually or with other providers and organizations, to educate staff and the community on issues concerning advance directives. This requirement may be met by making copies of the required documents available in reception areas

Providers are encouraged to work with associations and advocacy groups to further educate the community on these issues. Providers must be able to document their community education efforts.

### When Providers Must Inform Patients

According to federal law, the following providers must give written information on state laws regarding the patient's right to make decisions and the provider's policies concerning implementation of those rights at the following times:

- **Inpatient hospitals**, at the time of the person's admission as an inpatient
- **Nursing facilities**, at the time of the person's admission as a resident
- **Home health or personal care services providers**, in advance of the person coming under the care of the provider (this means on or before the initial visit)
- **Hospice programs**, at the time of the person's initial receipt of hospice care
- **HMOs**, at the time the person enrolls with the organization

### Patient Incapacity

If a patient is incapacitated at one of the above times, and if the provider issues materials about policies and procedures to families, surrogates, or other concerned persons, the provider must include in those materials the information about advance directives. Document in the medical record that the patient was unable to receive the information or was unable to articulate whether he or she has executed an advance directive. Once the patient is no longer incapacitated, give the information on advance directives to the individual. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

### Executed Advance Directives

Document in the patient's medical record whether the patient has executed an advance directive. If the patient has an advance directive and has given the provider a copy, the provider must comply with the terms of the advance directive, to the extent allowed under state law.

### Objection Based on Conscience

Federal law does not affect the rights a provider may have under state law to object, based on conscience, to the treatment or withdrawal of an advance directive.

### Informed Consent

Federal law does not affect a provider's obligation to obtain informed consent to treatment.

### Forms Available

Although providers are not required by law to assist patients in formulating advance directives, providers may wish to have copies of the Minnesota Health Care Declaration (living will) form or the Durable Power of Attorney for Health Care form available for patients who request one. The Minnesota Health Care Directive suggested form is found in [Minnesota Statutes 145C](#).

### Mandatory Reporting

#### Adult maltreatment

As a professional or professional's delegate engaged in social services and the care of vulnerable adults, MHCP enrolled providers are mandated reporters under Minnesota Statute [626.557](#). Under Minnesota law all enrolled providers are required to report all suspected maltreatment including abuse, neglect or financial exploitation of a vulnerable adult to the common entry point following the requirements in [Minnesota Statutes 626.557, subd. 4](#).

#### Child maltreatment

MHCP providers are also mandated by law to report suspected maltreatment, abuse or neglect of children. Refer to [child protection programs and services](#) for more information. Report concerns about abuse or neglect to your [county or tribal agency](#).

### Surveillance & Integrity Review Section (SIRS)

#### Background

Minnesota Rules [9505.2160 to 9505.2245](#) (enacted June 10, 1991; amended March 18, 1995) establish a program of surveillance, integrity, review and control. They authorize a post-payment review process to ensure compliance with MHCP requirements by monitoring the use of health services by recipients and the delivery of health services by vendors. Within DHS, the SIRS section is responsible for identifying and investigating suspected fraud, theft, and abuse. SIRS is authorized to seek monetary recovery, to impose administrative sanctions, and to seek civil or criminal action through the office of Attorney General (AG). Referrals are made both to the Medicaid Fraud Control Unit (MFCU), and to the civil section of the AG's office. Information about the monitoring of recipient use of health services is found in [Health Care Programs and Services](#).

## Definitions

**Abuse:** In the case of a vendor, a pattern of practice inconsistent with sound fiscal, business, or health service practices, and that results in unnecessary costs to MHCP or in reimbursement for services not medically necessary, or that fail to meet professionally recognized standards for health services. The following practices are deemed to be abuse by a provider:

- Submitting repeated claims as follows:
  - With missing or incorrect information
  - Using procedure codes that overstate the level or amount of health service provided
  - For health services that are not reimbursable by MHCP
  - For the same health service provided to the same recipient
  - For health services that do not comply with the requirements to be a covered service under Minnesota Rules [9505.0210](#) and, if applicable, [9505.0215](#)
  - For services not medically necessary
  - Failing to develop and maintain health service records as required under Minnesota Rules [9505.2175](#)
  - Failing to use generally accepted accounting principles or other accounting methods which relate entries on the recipient's health service record to corresponding entries on the billing invoice, unless another accounting method or principle is required by federal or state law or rule
  - Failing to disclose or make available to DHS the recipient's health service records or the vendor's financial records as defined under Minnesota Rules [9505.2180](#)
  - Repeatedly failing to report duplicate payments from third-party payers for covered services provided to MHCP recipients and billed to DHS
  - Failing to obtain information and assignment of benefits as specified in Minnesota Rules [9505.0070](#), subp. 3, or
  - Failing to bill Medicare as required by Minnesota Rules [9505.0440](#);
  - Failing to keep financial records as defined under Minnesota Rules [9505.2180](#)
  - Repeatedly submitting or causing repeated submission of false information for the purpose of obtaining (prior) authorization, inpatient hospital admission certification, or a second medical opinion
  - Knowingly and willfully submitting a false or fraudulent application for provider status
  - Soliciting, charging, or receiving payments from recipients or non-Medical Assistance sources, in violation of Code of Federal Regulations, title 42, section 447.15, or Minnesota Rules [9505.0225](#), for services for which the vendor has received reimbursement from, or should have billed to, MHCP
  - Payment of program funds by a vendor to another vendor whom the vendor knew or had reason to know was suspended or terminated from MHCP participation
  - Repeatedly billing MHCP for health services after entering into an agreement with a third-party payer to accept an amount in full satisfaction of the payer's liability
  - Repeatedly failing to comply with the requirements of the provider agreement that relate to the programs covered by Minnesota Rules [9505.2160 to 9505.2245](#)

**Electronically Stored Data:** Data stored in a typewriter, word processor, computer, existing or pre-existing computer system or computer network, magnetic tape, or computer disk.

**Fraud:** Acts which constitute a crime against any program, or attempts or conspiracies to commit those crimes including the following:

- Theft, perjury, forgery and aggravated forgery, MA fraud, or financial transaction card fraud
- Making a false statement, claim, or representation to a program where the person knows or should reasonably know the statement, claim, or representation is false
- A felony listed in United States Code, title 42, section 1320a-7b(b)(3)(D) subject to any safe harbors established in Code of Federal Regulations, title 42, part 1001, section 952

**Health Plan:** A managed care organization that contracts with DHS to provide health services to recipients under a prepaid contract.

**Health Services:** Goods and services eligible for MHCP payment under Minnesota Statutes [256B.02](#), subd. 8 and [256B.0625](#).

**Health Service Record:** Electronically stored data, and written or diagrammed documentation of the nature, extent, and evidence of the medical necessity of a health service provided to a recipient by a vendor and billed to MHCP.

**Investigative Costs:** Investigative costs are subject to the provisions of Minnesota Statutes [256B.064](#), subd. 1d, and means the sum of the following expenses incurred by a DHS investigator on a particular case:

- Hourly wage multiplied by the number of hours spent on the case
- Employee benefits
- Travel
- Lodging
- Meals
- Photocopying costs, paper, computer data storage or diskettes, and computer records and printouts

**Medically Necessary or Medical Necessity:** A health service that is consistent with the recipient's diagnosis and condition and:

- Is recognized as the prevailing standard or current practice by the provider's peer group
- Is rendered in response to a life-threatening condition or pain; to treat an injury, illness, or infection; to treat a condition that could result in physical or mental disability; to care for a mother and child through the maternity period; or to achieve a level of physical or mental function or
- Is a preventive health service

**Ownership or Control Interest:** Has the meaning given in Code of Federal Regulations, title 42, part 455, sections 101 and 102.

**Pattern:** An identifiable series of more than one event or activity.

**MHCP (Minnesota Health Care Programs):** The Medical Assistance (MA) Program, MinnesotaCare, Behavioral Health Fund (BHF) Program, Prepaid Medical Assistance Program (PMAP), home and community-based services under a waiver from CMS, or any other DHS administered health service program.

**Provider:** An individual, organization, or entity that has entered into an agreement with DHS for the provision of health services, including a personal care assistant.

**Restriction:** In the case of a vendor, excluding or limiting the scope of the health services for which a vendor may receive a payment through a program for a reasonable time.

**Suspending Participation or Suspension:** Making a vendor ineligible for reimbursement through MHCP funds for a stated period.

**Suspending Payments:** Stopping any or all program payments for health services billed by a provider pending resolution of the matter in dispute between the provider and DHS.

**Terminating Participation or Termination:** Making a vendor ineligible for reimbursement through MHCP funds.

**Theft:** The act defined in Minnesota Statutes [609.52](#), subd. 2, clause (3)(c).

**Third Party Payer:** The term defined in Minnesota Rules [9505.0015](#), subp. 46, and, additionally, Medicare.

**Vendor:** The meaning given to "vendor of medical care" in Minnesota Statute [256B.02](#), subd. 7. The term vendor includes a provider and also a personal care assistant.

**Withholding Payments:** Reducing or adjusting the amounts paid to a provider to offset overpayments previously made to the provider.

## Health Service Records

**Documentation:** [Health service records](#) must be developed and maintained as a condition of payment by MHCP.

Document each occurrence of a health service in the recipient's health record. MHCP funds paid for health care not documented in the health service record are subject to monetary recovery.

Health Service Records: In addition to those listed here, there may be other record obligations located throughout this manual specific to vendors of a particular service. Records must contain the following information when applicable:

- The record must be legible at a minimum to the individual providing care
- The recipient's name must be on each page of the recipient's record
- Each entry in the health service record must contain:
  - The date on which the entry is made
  - The date or dates on which the health service is provided
  - The length of time spent with the recipient, if the amount paid for the service depends on time spent
  - The signature and title of the person from whom the recipient received the service
  - Reportage of the recipient's progress or response to treatment, and changes in the treatment or diagnosis
  - When applicable, the countersignature of the vendor or the supervisor as required under Minnesota Rules [9505.0170 to 9505.0475](#)
  - Documentation of supervision by the supervisor
- The record must state:
  - The recipient's case history and health condition as determined by the vendor's examination or assessment
  - The results of all diagnostic tests and examinations
  - The diagnosis resulting from the examination
- The record must contain reports of consultations that are ordered for the recipient
- The record must contain the recipient's plan of care, individual treatment plan, or individual program plan
- The record of a laboratory or x-ray service must document the provider's order for service

### Health Service Records of Specific Providers

These vendors must follow additional requirements in their health service records:

**Pharmacy service record** must comply with Minnesota Rules relating to pharmacy licensing and operations and electronic data processing of pharmacy records. The pharmacy service record must be a hard copy made at the time of the request for service and must be kept for five years.

**Medical transportation record** must document:

- The origin, destination, and distance traveled in providing the service to the recipient
- The type of transportation
- If applicable, a physician's certification for nonemergency, ancillary, or special transportation services as defined in Minnesota Rules [9505.0315](#), subp. 1

**Medical supplies and equipment record** must:

- Document that the medical supply or equipment is eligible for payment
- Contain the physician's order or prescription, including the name and amount of the medical supply or equipment provided for the recipient. The physician's order or prescription maintained by the medical supplier may be a photocopy or fax image, electronically maintained, or original "pen-and-ink" document. Follow the requirements for electronically maintained records as stated in Minnesota Rules [9505.2190](#) Subpart 1 and [9505.2197](#).

**Rehabilitative and therapeutic service records** must comply with requirements listed in [Rehabilitative Services](#).

**Personal care provider records** must comply with additional documentation requirements in the [PCA](#) section of this Manual.

### Record Keeping

Financial records, including written and electronically stored data, of a vendor who receives payment for a recipient's services under MHCP must contain:

- Payroll ledgers, canceled checks, bank deposit slips and any other accounting records prepared by or for the vendor
- Contracts for services or supplies relating to the vendor's costs and billings to MHCP for the recipient's health services
- Evidence of the vendor charges to MHCP recipients and to persons who are not MHCP recipients, consistent with the requirements of Minnesota Government Data Practices Act
- Evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to third party payers or programs
- The vendor's appointment books for patient appointments and the provider's schedules for patient supervision, if applicable;
- Billing transmittal forms
- Records showing all persons, corporations, partnerships, and entities with an ownership or controlling interest in the vendor

- Employee records for those persons currently employed by the vendor (or who have been employed by the vendor at any time within the previous five years) which, under the Minnesota Government Data Practices Act, would be considered public data for a public employee, such as employee name, salary, qualifications, position description, job title, and dates of employment. In addition, employee records must include the current home address of the employee or the last known address of any former employee
- Nursing or board and care homes must, in addition to the foregoing, maintain purchase invoices, records of deposits, expenditures for patient personal needs and allowance accounts

### Record Keeping [9505.2185](#)

Subpart 1. **Recipient's consent to access.** A recipient of Medical Assistance is deemed to have authorized in writing a vendor or others to release to DHS for examination according to Minnesota Statutes [256B.27](#), subd. 4, upon request, the Medical Assistance recipient's health service records related to services under a program. The Medical Assistance recipient's authorization of the release and review of health service records for services provided while the person is a Medical Assistance recipient shall be presumed competent if given in conjunction with the person's application for Medical Assistance. This presumption shall exist regardless of whether the application was signed by the person or the person's guardian or authorized representative as defined in Minnesota Rules [9505.0015](#), subp. 8.

Subp. 2. **Department access to records.** A vendor shall grant DHS access during the vendor's regular business hours to examine health service and financial records related to a health service billed to a program. Access to a recipient's health service records shall be for the purposes in Minnesota Rules [9505.2200](#), subp. 1. DHS shall notify the vendor no less than 24 hours before obtaining access to a health service or financial record, unless the vendor waives notice.

### Retention of Records [9505.2190](#)

Subp. 1. **Retention required, general.** A vendor shall retain all health service and financial records related to a health service for which payment under a program was received or billed for at least five years after the initial date of billing. Microfilm records satisfy the recordkeeping requirements of this subpart and Minnesota Rules [9505.2175](#), subp. 3, in the fourth and fifth years after the date of billing.

Records may be maintained electronically in an Electronic Health Records (EHR) system for all or part of the five-year record keeping period. You must ensure that the electronically stored records meet all of the general record keeping requirements, including the ability for DHS to access and copy the records when required and any other requirement of Minnesota Rule [9505.2197](#).

Subp. 2. **Record retention after vendor withdrawal or termination.** A vendor who withdraws or is terminated from a program must retain or make available to DHS on demand the health service and financial records as required under subpart 1.

Subp. 3. **Record retention under change of ownership.** If the ownership of a long-term care facility or vendor service changes, the transferor, unless otherwise provided by law or written agreement with the transferee, is responsible for maintaining, preserving, and making available to DHS on demand the health service and financial records related to services generated before the date of the transfer as required under subpart 1 and Minnesota Rules [9505.2185](#), subp. 2.

Subp. 4. **Record retention in contested cases.** In the event of a contested case, the vendor must retain health service and financial records as required by subpart 1 or for the duration of the contested case proceedings, whichever period is longer.

### Copying Records [9505.2195](#)

DHS, at its own expense, may photocopy or otherwise duplicate any health service or financial record related to a health service for which a claim or payment is made under a MHCP program. Photocopying shall be done on the vendor's premises unless removal is specifically permitted by the vendor. If a vendor fails to allow DHS to use the department's equipment to photocopy or duplicate any health service or financial record on the premises, the vendor must furnish copies at the vendor's expense within two weeks of a request for copies by DHS.

### Investigative Process

- SIRS has the authority to conduct routine audits of vendors to monitor compliance with program requirements.
- SIRS is authorized to use information from sources including:
  - Government agencies; Third-party payers including Medicare
  - Professional review organizations
  - Consultants under contract in Minnesota Rules [9505.0185](#)
  - Recipients and their responsible relatives
  - Vendors and persons employed by or under contract to vendors

- Professional associations of vendors and their peers; Recipient advocacy organizations and recipients
- Members of the public
- A SIRS investigation may include:
  - Examination of health service and financial records
  - Examination of equipment, materials, prescribed drugs, or other items used in or for a recipient's health service under MHCP
  - Examination of prescriptions written for MHCP recipients
  - Interviews of contacts
  - Verification of the professional credentials of a vendor, the vendor's employees and entities under contract with the vendor
  - Consultation with DHS peer review mechanisms
  - Determination of whether the health care provided was medically necessary

### Monetary Recovery and Sanctioning

- Following completion of the investigation, DHS will determine whether:
  - The vendor is in compliance with the requirements of a program
  - Insufficient evidence exists that fraud, theft, or abuse has occurred or
  - The evidence of fraud, theft, or abuse supports administrative, civil, or criminal action
- After completing the determination, DHS will take one or more of the actions specified in items listed below:
  - Close the investigation when no further action is warranted
  - Impose administrative sanctions
  - Seek monetary recovery
  - Refer the investigation to the appropriate state regulatory agency
  - Refer the investigation to the attorney general or, if appropriate, to a county attorney for possible civil or criminal legal action
- Issue a warning that states the practices are potentially in violation of program laws or regulations
- Seek monetary recovery from a vendor if payment for a recipient's health service under MHCP was the result of fraud, theft, abuse or error on the part of the provider, DHS or local agency. The commissioner is authorized to calculate the amount of monetary recovery based on estimation from systematic random samples of claims submitted and paid. The commissioner will recover money by the following means:
  - Permitting voluntary repayment of money, either in lump sum payment or installment payments
  - Deducting or withholding from MHCP payments
  - Withholding payments to a provider under Code of Federal Regulations, title 42, section 447.31
  - Using any legal collection process

If DHS permits use of installment payments, DHS shall assess interest on the funds, unless the overpayment occurred because of department error. The Department of Revenue establishes the rate under Minnesota Statute [270.75](#).

- If a vendor willfully submits a claim for reimbursement for medical care or services the vendor knows or reasonably should have known is a false representation and which results in payments for which the vendor is ineligible, DHS may seek recovery of investigative costs
- Administrative sanctions may be imposed for any of the following:
  - Fraud, theft, or abuse in connection with health care services billed to MHCP
  - Refusal to grant DHS access to records
- For a vendor, the sanctions that may be imposed are:
  - Referral to the appropriate peer review mechanism or licensing board
  - Suspending or terminating the provider's or vendor's participation
  - Suspending or terminating the participation of any person or corporation with whom the provider or vendor has any ownership or control interest
  - Requiring attendance at education sessions provided by DHS
  - Requiring authorization of services
  - Restricting the vendor's participation in MHCP
- For a provider, the sanctions that may be imposed are those described in previous, as well as:
  - Requiring a provider agreement of limited duration
  - Requiring a provider agreement which stipulates specific conditions of participation
  - Review of the provider's claims before payment
- DHS has the authority to simultaneously seek monetary recovery and to administer sanctions
- DHS will notify vendors in writing of any intent to recover money or impose sanctions
- A vendor may meet with DHS informally to discuss the matter in dispute

- A vendor has the right to appeal DHS' proposed action. An appeal is considered timely if written notice of appeal is filed with the commissioner within 30 days of the date that the notice of proposed action was mailed. The appeal request must specify:
  - Each disputed item
  - The reason for the dispute
  - An estimate of the dollar amount involved, if any, for each disputed item
  - The computation or other disposition that the appealing party believes is correct
  - The authority in statute or rule upon which the appealing party relies for each disputed item
  - The name and address of the person or firm with whom contracts may be made regarding the appeal
  - Other information required by the commissioner
- The appeal shall be a contested case proceeding under the provisions of the Minnesota Administrative Procedure Act
- Under certain conditions, DHS has the authority to withhold payments to vendor prior to notice or to a hearing
- A vendor who has been suspended or terminated from MHCP may not submit claims personally, nor may any clinic, group, corporation, or association submit claims on behalf of a vendor who has been suspended or terminated from MHCP. Claims for health care provided prior to the suspension or termination may be submitted, but will be subject to review.
- The vendor who is restricted from participation may not submit a claim for payment under MHCP for services or charges specified in the notice of action, either through a claim as an individual or through a claim submitted by a clinic, group, corporation, or professional association, except in the case of claims for payment for health services otherwise eligible for payment and provided before the restriction. No payments may be made to a vendor either directly or indirectly, for restricted services or charges specified in the notice of action.
- A vendor who is convicted of a crime related to the provision, management, or administration of MHCP related health services will be suspended from participation effective on the date of conviction. The commissioner will notify the vendor of the date and duration of the suspension.

### **Fraud or Abuse of Medicare Program**

DHS will suspend or terminate any vendor who has been suspended or is currently under suspension or termination from participation in the Medicare program because of fraud or abuse.

### **Reporting Suspected Fraud or Abuse**

If you suspect either a treating or rendering provider, or a provider group or agency, of fraud, abuse or improper billing, contact SIRS.

SIRS Hotline: 651-431-2650 or 800-657-3750 (anonymous)

Fax: 651-431-7569

Email: [DHS.SIRS@state.mn.us](mailto:DHS.SIRS@state.mn.us)

### **Kickbacks and Other Criminal Activities**

A vendor who commits any of the following acts may be convicted of a felony and fined up to \$25,000 or imprisoned for up to five years, or both:

- Makes a statement known to be false in an application for payment or for use in determining rights to such payment
- Fails to disclose a fact affecting the vendor's initial or continuing right to receive payments with the intent to wrongfully obtain such payments
- Receives payments for the benefit of another and knowingly uses them for a purpose other than on behalf of the beneficiary
- Receives, solicits, offers, or pays in any manner and in any form in return for:
  - Referring, or inducing another to refer, a recipient for the furnishing of benefits for which payment may be made under this program or
  - Obtaining, or inducing another to obtain, in any manner, goods or services for which payment may be made under this program

This does not apply to:

- A properly disclosed reduction in price that is reflected in cost claimed by the provider or
- Salaries paid by an employer to an employee
- Makes a statement known to be false so that a facility may qualify, or continue to qualify, as a hospital, skilled nursing facility, intermediate care facility, or home health agency
- Requests or receives from a recipient payment in excess of reimbursement received from the program; or charges or accepts value in excess of rates established by DHS under this program as a condition precedent to admitting a patient to a hospital, skilled nursing facility, intermediate care facility, or as a requirement for a patient's continued stay in such facility

## Crimes Related to MHCP

**Convicted:** A judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from the judgment is pending, and includes a plea of guilty or nolo contendere.

- A vendor convicted of an MHCP-related crime is automatically suspended from participation in MHCP. The effective date of the suspension is the date of the conviction. The commissioner will notify the vendor of the date and duration of the suspension.
- Suspension and termination sanctions are applicable to vendors who share ownership or control interest with a vendor convicted of a crime related to MHCP. The determination of ownership or control interest will be made using the definitions in Code of Federal Regulations, title 42, sections 455.101 and 455.102. A provider suspended under this provision may seek reinstatement as a provider when the convicted provider ceases ownership or control interest in the other provider.
- A vendor will be notified in writing of DHS' intent to suspend the vendor from MHCP participation, the reasons for the suspension, and the effective date and duration of the suspension.

## Additional Resources

[HITECH Act](#)

[Health Information Privacy – HIPAA](#)

## Legal References

[Minnesota Statutes 14](#) – Administrative Procedure

[Minnesota Statutes 145C](#) – Health Care Directives

[Minnesota Statutes 62D.04](#), subd. 5 – Issuance of Certificate of Authority

[Minnesota Statutes 256B.02](#) – Policy

[Minnesota Statutes 246B.03](#) – Definitions

[Minnesota Statutes 256B.04](#) – Duties of State Agency

[Minnesota Statutes 256B.27](#) – MA; Cost Reports

[Minnesota Statutes 256B.48](#) – Conditions for Participation

[Minnesota Statutes 256B.0625](#) – Covered Services

[Minnesota Statutes 256B.064](#) – Sanctions; Monetary Recovery

[Minnesota Statutes 256B.0644](#) – Vendor Request for Contested Case Proceeding

[Minnesota Statutes 256B.0655](#) – Authorization and Review of Home Care Services

[Minnesota Statutes 256B.434](#) – Alternative Payment Demonstration Project

[Minnesota Statutes 270C.40](#) – Interest Payable to Commissioner

[Minnesota Statutes 363A.36](#) – Certificates of Compliance for Public Contracts

[Minnesota Statutes 609.52](#), subd. 2 – Acts constituting theft

Minnesota Rules [9505](#) – Health Care Programs

Minnesota Rules [9505.0015](#) – Definitions

Minnesota Rules [9505.0070](#) – Third-Party Liability

Minnesota Rules [9505.0140](#) – Payment for Access to Medically Necessary Services

Minnesota Rules [9505.0170 to 9505.0475](#) – Medical Assistance Payments

Minnesota Rules [9505.0185](#)

Minnesota Rules [9505.0195](#) – Provider Participation

Minnesota Rules [9505.0210](#) – Covered Services; General Requirements

Minnesota Rules [9505.0215](#) – Covered Services; Out-of-State Providers

Minnesota Rules [9505.0225](#) – Request to Recipient to Pay

Minnesota Rules [9505.0315](#) – Medical Transportation

Minnesota Rules [9505.0440](#) – Medicare Billing Required

Minnesota Rules [9505.2160 to 9505.2245](#) – Surveillance and Integrity Review Program

Minnesota Rules [9505.2175](#) – Health Care Records

Minnesota Rules [9505.2180](#) – Financial Records

Minnesota Rules [9505.2185](#) – Access to Records

Minnesota Rules [9505.2190](#) – Retention of Records

Minnesota Rules [9505.2195](#) – Copying Records

Minnesota Rules [9505.2197](#) – Vendor's Responsibility for Electronic Records

Minnesota Rules [9505.2200](#) – Identifying Fraud, Theft, Abuse, or Error

Minnesota Rules [9505.5200 to 9505.5240](#) – Department Health Care Program Participation Requirements for Vendors and Health Maintenance Organizations

Section 504 of the Rehabilitation Act of 1973

Title XI, section [1128\(b\)](#) (formerly Title XIX, section 1909) of the Social Security Act

Title XVIII, section [1877\(b\)](#) of the Social Security Act

[42 CFR 431.53](#) – Assurance of transportation  
[42 CFR 431.107](#) – Required provider agreement  
[42 CFR 447.10](#) – Prohibition against reassignment of provider claims  
[42 CFR 455](#) – Program Integrity: Medicaid  
Stipulated Settlement Agreement Day v. Noot