

Chapter 1

Requirements for Providers

Requirements All Providers Must Meet

Providers who choose to participate in PrimeWest Health must meet professional requirements and/or licensure requirements as set forth in applicable state and federal laws and regulations.

Eligible Providers

The following providers of health care may be eligible for enrollment in PrimeWest Health:

- Advanced Practice Registered Nurse (APRN)
- Ambulatory Surgical Center (ASC)
- Audiologist
- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Chemical Dependency
- Child and Teen Checkup Clinic (C&TC)
- Chiropractor
- Clinical Nurse Specialist (CNS)
- Community Health Clinic
- Community Mental Health Center
- County Case Manager
- County Contracted Mental Health Rehabilitative Services
- County Human Services Agency
- Day Training and Habilitation Center (DT & H)
- Day Treatment Program
- Dental Lab
- Dentist/Dental Group
- Dental Hygienist
- Federally Qualified Health Center (FQHC)
- Hearing Aid Dispenser
- Home Health Agency
- Hospice
- Hospital
- Intermediate Care Facility for the Mentally Retarded (ICF/MR)
- Independent Diagnostic Testing Facility
- Independent Laboratory
- Indian Health Service (IHS)
- Institution for Mental Disease (IMD)
- Licensed Independent Clinical Social Worker (LICSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Nutritionist
- Licensed Psychological Practitioner (LPP)

Licensed Registered Dietician
Medical Supply/Durable Medical Equipment
Medical Therapy Management Services
Medical Transportation
Mental Health Targeted Case Management for SPMI/SED
Nursing Home
Nurse Practitioner (NP)
Occupational Therapist (OT)
Optical Company
Optometrist
PCA Choice
Personal Care Provider Organization (PCPO)
Personal Care Assistant, Independent (PCA)
Pharmacy
Physical Therapist (PT)
Physician/Clinic (Group)
Physician Assistant
Podiatrist
Private Duty Nurse/Private Duty Nursing Agency (PDN)
Psychiatrist
Psychologist
Public Health Clinic
Public Health Nursing Agency
Regional Treatment Center (RTC)
Registered Nurse (RN)/Licensed Practical Nurse (LPN)
Rehabilitation Agency
Renal Dialysis
Rural Health Clinic (RHC)
School District
Speech Language Pathologist
Elderly Waiver (Home & Community-Based) Services
Women, Infants, & Children (WIC) Program
X-Ray

Enrollment Process for Providers

Providers who choose to participate must complete, sign and return a PrimeWest Health Participation Agreement, Network Information Request and necessary credentialing forms. The Provider Agreement includes a statement of terms for participation. To initiate please call PrimeWest Health.

Change of Enrollment Information

PrimeWest Health Provider Services must be notified in writing of any change in information (including address changes) provided on the [Network Information Request \(NIR\)](#).

Practitioner Rights

PrimeWest Health Provider Services requires practitioners to submit a written request to review information regarding the credentialing process. For further information regarding practitioner rights, please access our website at www.primewest.org and click on Partners and Providers to access the Practitioner Rights policy and Credentialing Plan.

Use of Billing Agents

If a billing agent (person or entity that submits a claim or receives PrimeWest Health payment on behalf of a provider) is used, the name and address of the billing agent must also be listed on the [Network Information Request](#). PrimeWest Health Provider Services must be notified in writing if a billing agent is hired after enrollment. The notification must include the provider name, NPI/UMPI/PrimeWest Health provider ID number, office address, and billing agent's name and address. Send the notice to:

PrimeWest Health
Provider Services
2209 Jefferson Street, Suite 101
Alexandria, MN 56308
Fax: 320-762-8750

Payment to Provider or Billing Agent

All PrimeWest Health payments must be made to the provider. However, PrimeWest Health payment may be mailed 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:

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

Sale or Transfer of an Entity

A PrimeWest Health provider who sells or transfers ownership or control of an entity that is enrolled in PrimeWest Health must notify PrimeWest Health Provider Services by Fax: 320-762-8750 or call toll-free 888-588-4420, no later than 30 days before the effective date of the sale or transfer. PrimeWest Health has the right to pursue monetary recovery, or civil or criminal action against the seller or transferor.

Advance notification to PrimeWest Health Provider Services is critical for providers of home care and/or waived services due to the impact of a provider number change on service agreements through which they bill. See additional requirements in the [Home Care Services chapter](#) (Ch. 24A)

and the [HCBS Waiver Programs](#) and the [Elderly Waiver \(EW\)](#) (Chs. 26 & 26A).

Affirmative Action Plan Requirement

A provider applying for PrimeWest Health participation that has employed more than 40 full-time employees at any time during the past year, and who anticipates reimbursement in excess of \$100,000 in a one-year period, must have an affirmative action plan for the employment of minority persons, women, and the disabled that is approved by the Commissioner of Human Rights. As part of the enrollment process, PrimeWest Health may ask providers to submit documents showing compliance with, or exemption from, the affirmative action requirement plan of the Minnesota Human Rights Act.

Duration of PrimeWest Health Participation

PrimeWest Health participation remains in effect until:

- Either party terminates in accordance with terms 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 PrimeWest Health services;

For additional information, provider should refer to the Participation Agreement.

Violating Participation Agreement

A provider, who fails to comply with the terms of participation in the participation agreement or with requirements of the rules governing PrimeWest Health, is subject to monetary recovery. The provider may also be subject to Minnesota Rules [9505.2160-9505.2245](#) 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 MS [14.57 to 14.62](#). See MN Rules – Chapter 9505 at:

<https://www.revisor.leg.state.mn.us/rules/?id=9505>

Limits on Member 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 members 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 PrimeWest Health so PrimeWest Health can determine whether the provider complies with the requirements of this subpart.”

For example, providers cannot deny treatment for a certain diagnosis (e.g., pregnancy) to PrimeWest Health members unless treatment for that diagnosis is also not available to other patients. Requirements regarding the need for a referral, or which days are available for treatment, etc., are legitimate requirements for PrimeWest Health members **only** if they are also applied to other members.

Provider Participation Requirements - Rule 101

Rule 101 (MS [256B.0644](#)) establishes requirements for provider participation in PrimeWest Health. In order for a provider to be reimbursed for other state-sponsored health care programs, the provider must also participate in MHCP and accept, on a continuous basis, new patients who are members in these programs.

Other state-sponsored health care programs include:

- State employees' health insurance plans;
- Workers' compensation insurance;
- Public employees' insurance program;
- Insurance plans provided through the Minnesota Comprehensive Health Association; and
- Health insurance plans offered to local statutory or home rule charter city, county, and school district employees.

PrimeWest Health uses the Current Procedural Terminology (CPT) definition of a new patient: "A new patient is one who has not received any professional service from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years." A member who changes from another payer source to PrimeWest Health eligibility is not a "new patient" simply because of that change.

Rule 101 Non-Compliance

If PrimeWest Health has reason to believe a provider is not in compliance with the participation requirements, PrimeWest Health will notify the provider. The provider will have 30 days to provide PrimeWest Health with evidence of participation compliance. After the response period expires, those who have not submitted evidence of compliance will be reported to the Department of Human Services.

Limiting PrimeWest Health Caseload Rule 101

A non-dental provider may limit acceptance of new PrimeWest Health recipients if the PrimeWest Health recipient caseload is at least 20% of the provider's annual active caseload (the total number of patient encounters that result in a billing during the provider's most recent fiscal year).

A dental provider meets the obligation of PrimeWest Health members when at least 10% of the provider's patients are covered by medical assistance (MA), general assistance medical care (GAMC), and MinnesotaCare as their primary source of coverage, or effective for dates of service on and or after July 1, 2007, the provider accepts new medical assistance and MinnesotaCare patients who are children with special health care needs. For purposes of this provision, children with special health care needs are children up to age 18 years who:

- Require health and related services beyond that required by children generally
- Have or are at risk for chronic physical, developmental, behavioral, or emotional condition, including:
 - Autism
 - Bleeding and coagulation disorders

- Cancer
- Developmental disabilities
- Down syndrome and other genetic disorders
- Epilepsy, cerebral palsy, and other neurological diseases
- Endocrinopathy
- Fetal alcohol syndrome
- Immunodeficiency disorders
- Visual impairment or deafness
- Other conditions as designated by the commissioner after consultation with representatives of pediatric dental providers and consumers

A medical provider may limit acceptance of new PrimeWest Health members if the member caseload is 20% (10% for dental) of the provider's annual active caseload (the total number of patient encounters that result in a billing during the provider's most recent fiscal year).

An encounter is one patient encounter per patient, per day, regardless of the number of service sites. However, patient encounters from all service sites enrolled under the provider's ID number may be included in the total caseload count.

Encounters involving patients enrolled in either fee-for-service or managed care organizations count toward the calculation of a caseload.

If at least 20% (10% for dentists or the dentist accepts new PrimeWest Health who are children with special health care needs) of the provider's annual active patient caseload is, and continues to be, Minnesota Health Care Program members, the provider may refuse to accept new PrimeWest Health members for the remainder of the provider's fiscal year only after submitting patient encounter data to Provider Enrollment as outlined below.

Providers that wish to limit acceptance of new patients must notify PrimeWest Health Provider Services in writing at least 10 days before limiting the acceptance of new PrimeWest Health patients. The notice must include the provider's name, NPI/PrimeWest Health provider ID number, fiscal period, total number of patient encounters for the last fiscal year, and the total number of PrimeWest Health patient encounters. Contact PrimeWest Health Provider Services for additional information at 320-335-5213 or 888-588-4420

Provider Services will notify the provider in writing whether its notice to limit PrimeWest Health caseload has been accepted. This acceptance will be effective 10 days after the provider is notified by PrimeWest Health, and will remain in effect for the remainder of the provider's fiscal year. If a provider wishes to continue limiting PrimeWest Health caseload, it must file a new notice each year. In addition, a provider who has a contract with a PrimeWest Health must also notify the Minnesota Department of Human Services of its intention to limit acceptance of new PrimeWest Health members.

Prohibited Practices

Nursing Homes

MS [256B.48](#), subd. 1, provides that a nursing home is not eligible to receive Medical Assistance

(MA) payments unless it refrains from requiring any resident of the nursing facility to utilize a vendor of health care services chosen by the nursing facility.

MS [256B.48](#), subd. 1, addresses payment agreements between nursing homes and providers of ancillary medical care. It provides that a nursing home is not eligible to receive Medical Assistance payments unless it refrains from requiring any vendor of medical care (as defined by section [256B.02](#), subd. 7), who is reimbursed by Medical Assistance under a separate fee schedule, to pay any portion of the provider's fee to the nursing home except as payment for renting or leasing space or equipment or purchasing support services from the nursing facility as limited by section [256B.433](#).

MS [256B.48](#), subd. 1, addresses payment rates and special services for nursing homes and its private pay residents. It provides that a nursing home is not eligible to receive Medical Assistance payments unless it refrains from requiring its residents to pay more than its Medical Assistance rate for similar services.

Exceptions are made for:

- Private paying residents in private/single bedrooms; and
- Special services not included in the daily rate, if Medical Assistance residents are charged the same rate for the same service.

In addition, a nursing facility participating in the demonstration project under MS [256B.434](#) 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 this statute for additional details of these provisions. Legal References are also included at the end of this chapter.

Federal Anti-Fraud and Abuse Provisions

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/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 PrimeWest Health.
- 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 member by a provider may not be made to or through a factor, either directly or indirectly.

See C.F.R. U.S.C. 1320a.-7b.

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 and:

- 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 on the basis of conscience.

At a minimum, the provider's statement of limitation should:

- 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; and

- 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;
- Shall not condition the provision of care, or otherwise discriminate against the patient, based on whether or not the patient has executed an advance directive, including not conditioning the provision of care on that basis;
- Comply with state law governing advance directives; and
- 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

In accordance with federal law, written information on state laws regarding the patient’s right to make decisions and the provider’s policies concerning implementation of those rights must be given by the following providers at the following times:

- **Inpatient hospitals**, at the time of the individual’s admission as an inpatient.
- **Nursing facilities**, at the time of the individual’s admission as a resident.
- **Home health or personal care services providers**, in advance of the individual coming under the care of the provider (this means on or before the initial visit).
- **Hospice programs**, at the time of the individual’s initial receipt of hospice care.
- **MCOs (PrimeWest Health)**, at the time the individual 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 concerning advance directives. The provider must document in the medical record that the patient was unable to receive the information and/or was unable to articulate whether he/she has executed an advance directive. Once the patient is no longer incapacitated, the provider must 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

The provider must document in the patient's medical record whether or not the patient has executed an advance directive. If the patient has an advance directive, and the provider has been given 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 MS [145C](#).

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 PrimeWest Health state and federal requirements by monitoring the use of health services by members and the delivery of health services by vendors. Within PrimeWest Health, the Compliance Department is responsible for investigating suspected fraud, theft, and abuse. PrimeWest Health may seek monetary recovery, or refer the case to the State, to impose administrative sanctions, or to seek civil or criminal remedies. Information concerning the monitoring of member use of health services is found in the [Health Care Programs and Services chapter](#) Ch. 2.

Definitions

Abuse: In the case of a vendor, a pattern of practice that is inconsistent with sound fiscal, business, or health service practices, and that result in unnecessary costs to PrimeWest Health 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:
 - 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 PrimeWest Health;
- For the same health service provided to the same member;
- 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 member'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 PrimeWest Health the member'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 members and billed to PrimeWest Health;
- 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 members 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, PrimeWest Health;
- Payment of program funds by a vendor to another vendor whom the vendor knew or had reason to know was suspended or terminated from PrimeWest Health participation;
- Repeatedly billing PrimeWest Health 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; and
- 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, Medical Assistance 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; and

- 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: An HMO, MCO or other organization that contracts with DHS to provide health services to members under a prepaid contract.

Health Services: Goods and services eligible for PrimeWest Health payment under MS [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 member by a vendor and billed to PrimeWest Health.

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

- Hourly wage multiplied by the number of hours spent on the case;
- Employee benefits;
- Travel;
- Lodging;
- Meals; and
- 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 member'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.

Minnesota Health Care Programs: The Medical Assistance (MA) Program, General Assistance Medical Care (GAMC) Program, MinnesotaCare, Consolidated Chemical Dependency Treatment Fund (CCDTF) 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 PrimeWest Health 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 PrimeWest Health funds for a stated period of time.

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 PrimeWest Health.

Terminating Participation or Termination: Making a vendor ineligible for reimbursement through PrimeWest Health funds.

Theft: The act defined in MS [609.52](#), subd. 2 (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 MS [256B.02](#), subd. 7. The term vendor includes a provider and also a personal care assistant.

Health Service Records

Documentation: Health service records must be developed and maintained as a condition of payment by PrimeWest Health. Each occurrence of a health service must be documented in the recipient’s health record. PrimeWest Health funds paid for health care not documented in the health service record are subject to monetary recovery.

Health Service Records: Must contain the following information when applicable. There may also be other record obligations located throughout this manual specific to vendors of a particular service:

- 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 member, 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 member’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](#); and
 - Documentation of supervision by the supervisor.
- The record must state:
 - The member’s case history and health condition as determined by the vendor’s

- examination or assessment;
- The results of all diagnostic tests and examinations; and
- 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
- Documentation as to whether or not the recipient has executed an advance directive (members 18 years and older)
- The record of a laboratory or x-ray service must document the provider's order for service.
- Refer to PrimeWest Health Medical Record Policy CC19 Policies and Procedures section.

These are the basic medical record requirements for DHS. For further information regarding medical records requirements, see PrimeWest Health Policy CC19 available on the PrimeWest web site at www.primewest.org.

Health Service Records of Specific Providers

The following 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 ten years.

Medical transportation record must document:

- The origin, destination, and distance traveled in providing the service to the member;
- The type of transportation; and
- If applicable, a physician's certification for non-emergency, 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; and
- Contain a hard copy of the physician's order or prescription, including the name and amount of the medical supply or equipment provided for the member.

Rehabilitative and therapeutic service records must comply with requirements listed in the [Rehabilitative Services chapter](#) (Ch. 17).

Personal care provider records must document:

- The physician's initial statement of need for personal care services, must be received by PrimeWest Health prior to the start of services;
- The statement of need has been reviewed by the physician at least once every 365 days;
- PrimeWest Health care plan completed by the supervising registered nurse which details the nurse's instruction to the personal care assistant;
- PrimeWest Health notice of prior authorization which identifies the amount of personal care service and registered nurse supervision authorized for the member;

- Whether or not the member is in a shared care arrangement.

In a shared care arrangement, the documentation requirements must be met separately for each recipient.

The following daily documentation must be made by each personal care assistant of services provided to the recipient:

- Recipient's name;
- Name of the personal care assistant providing services;
- Day, month, and year the personal care services were provided;
- Total number of hours spent providing personal care services;
- Time of arrival and the time of departure of the personal care assistant at the site where services were provided;
- Personal care services provided;
- Notes by the personal care assistant regarding changes in the recipient's condition, documentation of calls to the supervising nurse, and other notes as required by the supervising nurse;
- Personal care assistant's signature; and
- Recipient's signature, stamp, mark, or the responsible party's signature, if the recipient requires a responsible party.

Each recipient record must also document:

- Authorization by the member's responsible party, if any, for personal care services provided outside the member's residence;
- Authorization by the responsible party, who is a parent of a minor member or a guardian of member, which is approved and signed by the supervising nurse, to delegate to another adult the responsible party function for absences of at least 24 hours but not more than six days; and
- Supervision by the supervising nurse, including the date of the provision of supervision of personal care services as specified in Minnesota Statute [256B0655](#), Subd 1h, if supervision by the supervising nurse is requested.

Record Keeping

Financial records, including written and electronically stored data, of a vendor who receives payment for a member's services under PrimeWest Health 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 PrimeWest Health for the member's health services;
- Evidence of the vendor charges to PrimeWest Health members and to persons who are not PrimeWest Health members, 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 shall include the current home address of the employee or the last known address of any former employee; and
- Nursing/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

Subp. 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 PrimeWest Health for examination according to MS [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 member 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. **PrimeWest Health access to records.** A vendor shall grant PrimeWest Health 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. PrimeWest Health 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 ten (10) years after the initial date of billing (42 C.F.R. 422.504(d)). 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.

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 PrimeWest Health on demand the health service and financial records as required under subp. 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 PrimeWest Health on demand the health service and financial records related to services generated before the date of the transfer as required under subp. 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 subp. 1 or for the duration of the contested case proceedings, whichever period is longer.

Copying Records 9505.2195

PrimeWest Health, 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 PrimeWest Health program. Photocopying shall be done on the vendor's premises unless removal is specifically permitted by the vendor. If a vendor fails to allow PrimeWest Health 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 PrimeWest Health.

Investigative Process

- **Quality and Compliance** have the authority to conduct routine audits of vendors to monitor compliance with program requirements.
- **Quality and Compliance** are authorized to use information from sources including:
 - Government agencies;
 - Professional review organizations;
 - Consultants under contract in Minnesota Rules part [9505.0185](#);
 - Recipients and their responsible relatives;
 - Vendors and persons employed by or under contract to vendors;
 - Professional associations of vendors and their peers;
 - Site Visits; and
 - Quality Initiative (QI) studies completed by provider organizations.
- A **Quality and Compliance** investigation may include:
 - Examination of health service and financial records;
 - Examination of equipment, materials, prescribed drugs, or other items used in or for a member's health service under PrimeWest Health;
 - Examination of prescriptions written for PrimeWest Health members;
 - Interviews of contacts;
 - Verification of the professional credentials of a vendor, the vendor's employees and entities under contract with the vendor;
 - Consultation with PrimeWest Health peer review mechanisms;
 - Site Visits;
 - Quality Initiative (QI) studies completed by provider organizations; and
 - Determination of whether the health care provided was medically necessary.

Monetary Recovery and Sanctioning

- Following completion of the investigation, PrimeWest Health 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, PrimeWest Health 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; and/or
- PrimeWest Health will seek monetary recovery from a vendor if payment for a member's health service under PrimeWest Health was the result of fraud, theft, abuse, or error on the part of the provider, PrimeWest Health, or local agency. PrimeWest Health is authorized to calculate the amount of monetary recovery based on estimation from systematic random samples of claims submitted and paid. PrimeWest Health will recover money by the following means:
 - Permitting voluntary repayment of money, either in lump sum payment or installment payments;
 - Deducting or withholding from PrimeWest Health System payments;
 - Withholding payments to a provider under 42 C.F.R 447.31; or
 - Using any legal collection process.

If PrimeWest Health permits use of installment payments, PrimeWest Health shall assess interest on the funds, unless the overpayment occurred because of PrimeWest Health error. The rate will be established by the Department of Revenue.

- 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, PrimeWest Health 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 PrimeWest Health; and
 - Refusal to grant PrimeWest Health access to records.
- For a vendor, the sanctions which 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 PrimeWest Health or DHS;
- Requiring authorization of services; and
- Restricting the vendor’s participation in PrimeWest Health.
- For a provider, the sanctions which may be imposed are those described previously, as well as:
 - Requiring a provider agreement of limited duration;
 - Requiring a provider agreement which stipulates specific conditions of participation; and
 - Review of the provider’s claims before payment.
- PrimeWest Health has the authority to simultaneously seek monetary recovery and to administer sanctions.
- PrimeWest Health will notify vendors in writing of any intent to recover money or impose sanctions.
- A vendor may meet with PrimeWest Health informally to discuss the matter in dispute.
- A vendor has the right to appeal PrimeWest Health’s proposed action. An appeal is considered timely if written notice of appeal is filed with the PrimeWest Health 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; and
 - Other pertinent information as may be required by PrimeWest Health.
- The appeal shall be a contested case proceeding under the provisions of the Minnesota Administrative Procedure Act.
- Under certain conditions, PrimeWest Health has the authority to withhold payments to vendor prior to notice or to a hearing.
- No claims may be submitted personally by a vendor who has been suspended or terminated from PrimeWest Health, nor may claims be submitted by any clinic, group, corporation, or association on behalf of a vendor who has been suspended or terminated from PrimeWest Health. 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 PrimeWest Health 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 PrimeWest Health related health services will be suspended from participation effective on the date of conviction. PrimeWest Health will notify the vendor of the date and duration of the suspension.

Fraud or Abuse of Medicare Program

PrimeWest Health 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

To report suspected fraud or abuse by a provider, call the PrimeWest Health Compliance Hotline at 1-866-763-2952 (toll free).

Kickbacks and Other Criminal Activities

The federal government has broad authority to penalize vendors who engage in fraud and abuse.

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

- 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 member 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; or
- 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 PrimeWest Health 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 PrimeWest Health. The effective date of the suspension is the date of the conviction. DHS will notify the vendor of the date and duration of the suspension. PrimeWest Health will enforce the action of DHS.
- 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 PrimeWest Health's intent to suspend the vendor from PrimeWest Health participation, the reasons for the suspension, and the effective date and duration of the suspension.

Access Services

Transportation

- Transportation and other related travel services are covered when the services are necessary to enable a recipient to obtain a covered health service from a participating provider. Transportation to nonparticipating providers shall also be paid if:
 - The service is covered under the PrimeWest Health;
 - It results in proper and efficient administration of Minnesota Health Care Programs due to cost effectiveness.
 - A service authorization has been obtained prior to the services being rendered.
- Medical Assistance covers the cost of the most appropriate and cost-effective forms of transportation incurred by an ambulatory recipient. Funded completely by state and federal funds, this program is administered by counties who reimburse the recipient or the provider directly for costs incurred. Examples of services and expenses for which reimbursement is, or may be, available: Mileage and parking expenses incurred by a recipient or recipient's driver; bus or taxi fare; food and lodging expenses; and sign language interpreters.
- Local human service agencies must assist members in finding necessary transportation whenever transportation is not available to obtain covered health services. Each local human service agency has a plan detailing how it will assure that a member obtains necessary transportation services. Local human service agencies may require authorization for the transportation services they provide or reimburse. Refer to the [Health Care Programs and Services chapter](#) (Ch. 2) for information about services provided by managed care organizations.

Sign Language Interpreter Services

All providers are required to provide sign language interpreter services when such services are

necessary to enable deaf or hard of hearing members to obtain covered services. Provider responsibility for paying for the interpreter services depends on the number of persons the provider employs. When 15 or more persons are employed, the provider must pay for the service. When fewer than 15 persons are employed, the local county human services agency must pay for the sign language interpreter services. In both cases the local county human service agency is responsible for establishing fees appropriate to the situation and the certification level of the interpreter. The rate should be agreed upon before services begin. If services are needed for four or more hours per week, it may be beneficial to negotiate a reduced rate and a contract for services. The [County Phone Numbers](#) Web page lists contact information for county human services agencies.

PrimeWest Health Member Services (866-431-0801) can assist with questions about sign language interpreter referral services or hiring freelance sign language interpreters.

Limited English Proficiency (LEP)

Federal law requires that providers who receive federal funds must provide oral language interpreter services to all patients who have limited English proficiency (LEP) at no cost to the patient, whether the patient is a member of PrimeWest Health or not.

Legal Requirements

Title VI of the Civil Rights Act of 1964 (Title VI) requires health care providers who receive federal funds (such as physicians, hospitals, nursing homes, home health agencies, managed care organizations, and universities and other entities with health or social service research programs) to *take reasonable steps to provide meaningful access to services* for people with LEP. This obligation applies whether or not an enrolled provider's patient is PrimeWest Health eligible. Failure to comply with this requirement can result in the loss of federal funding for the providers.

In August 2003, the U.S. Department of Health and Human Services published in the Federal Register its own guidance document designed to help human services providers understand the extent of their obligation to provide interpretation and translation services to LEP patients. The document is called *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* <http://www.hhs.gov/ocr/lep/revisedlep.html>.

A patient has LEP when he/she is not able to speak, read, write or understand English at a level that allows him/her to interact effectively with human services staff from DHS, county and provider agencies. Enrolled providers must take reasonable steps to provide effective oral language interpreter services when such services are necessary to enable any LEP patient to obtain medical services.

Reasonable Steps

To know what *reasonable steps* to take, the Guidance instructs providers to start by conducting an individualized assessment that balances four factors:

1. The number/proportion of people with LEP eligible to be serviced or likely to be encountered by the provider;
2. How often people with LEP come in contact with the provider's services;
3. The nature and importance of the services in people's lives; and
4. The language assistance resources available to the provider and what it will cost to provide those services to the public.

The results of this four-factor analysis help the provider determine the mix of language assistance services it should provide. For example, in most cases, interpreter services will be the most effective type of language assistance available to patients. However, other forms of language assistance may be appropriate in certain situations, such as using translated application forms and other documents, or using bilingual staff members who are proficient in both English and a non-English language. The *right mix* of language assistance services should be based on what is both reasonable and necessary given the results of the four-factor analysis (refer to the *Guidance* pages 47314-16).

LEP Plan

PrimeWest Health strongly recommends that providers develop a written LEP Plan. An LEP Plan is a written policy and procedure that describes how the provider will offer *free and timely* interpreter and/or other language assistance services to communicate effectively with non- or limited-English speaking patients. An LEP Plan does not have to be lengthy or complicated. It may be as simple as being prepared to use a commercial telephone interpreter service or identifying bilingual staff members within the office who are proficient enough in both English and a non-English language to communicate directly with a patient in his/her primary language (refer to the *Guidance* pages 47319-20).

The following model LEP Plans can be used as a template for your LEP Plan:

LEP Model Plan #1 & LEP Model Plan #2

Both located at: <http://www.hhs.gov/ocr/lep/reviseblep.html>.

Providers serving very few people with LEP or those with very limited resources may choose not to develop a written LEP Plan. However, all providers are responsible for providing meaningful access to services for their LEP patients and they must have a plan, written or not, to do so. Providers who decide to not develop an LEP Plan may want to consider *alternative reasonable ways* to show how they are providing meaningful access in compliance with Title VI. Should a complaint arise, all providers must be able to show intent to comply with the law and have documentation sufficient to show what happened in the particular case.

Quality Standards for Language Assistance Services

Providers have two ways to provide language assistance services: oral interpretation either in person or through a telephone interpretation service, including the use of bilingual staff, and written translation. In some cases, language assistance services should be made available on an expedited/emergency basis.

Regardless of the type of language assistance provided, the services must be an accurate and quality service. For example, under the *Guidance*, an interpreter must be *competent* to provide interpreter services. Competent interpreters:

- Demonstrate proficiency in both English and another language;

- Use the appropriate mode of interpreting given the situation at hand (e.g., consecutive, simultaneous, summarization, or sight translation);
- Have received appropriate interpreter training that includes instruction in the skills and ethics of interpreting, and rules of confidentiality and/or data privacy
- Understand their role as interpreters without deviating into other roles, such as counselor or legal advisor;
- Have fundamental knowledge in both languages of any specialized health care terms or concepts;
- Are sensitive to the member's culture; and
- Understand and follow confidentiality and impartiality rules to the same extent as the staff person involved (refer to the *Guidance* page 473-16).

Using Minor Children or Family and Friends as Interpreters

Minor children should never be used as interpreters. Providers may not require an LEP person to use a family member or friend as an interpreter. However, some people may feel more comfortable when a family member or friend acts as an interpreter. Providers must initiate an offer to provide free and timely language assistance when patients are having difficulty communicating in English or when patients ask for language assistance.

Although providers should not plan to rely on an LEP person's family members, friends, or other informal interpreters to provide meaningful access to its services, providers should respect an LEP person's desire to use an interpreter of his/her own choosing in place of the language services they offer. Providers may use a patient's family member or friend as an interpreter in emergency situations (refer to the *Guidance* pages 47317-18).

Oral Language Interpreter Services

Oral language interpreter services are a covered benefit for PrimeWest Health members.

Billing Sign and Oral Language Interpreter Services

PrimeWest Health covers sign and oral language interpreter services.

Bill PrimeWest Health using the following guidelines:

- All enrolled providers *except inpatient hospitals and special transportation providers** may bill PrimeWest Health for language interpreter services. Providers are responsible for arranging the interpretation service through PrimeWest Health Member Services or directly contracting with the interpreter. If services are directly contracted through the interpreter, provider is responsible for paying the interpreter. Use the same principles that you normally use when hiring, contracting, or arranging with a person to provide services to your patients.
- Three people must be present for the service to be covered: the provider, the patient and the interpreter.
 - For sign language interpreter services, the interpreter may be on a video screen when using video remote interpreter services
 - For oral language interpreter services, the interpreter may be on the phone

- The patient's friend or family member cannot act as the interpreter and receive reimbursement from PrimeWest Health.
- Other staff members at the provider's office who are qualified in sign language or competent in oral language interpretation may interpret the medical service. This interpreter service is billable.
- Bill only for the direct face-to-face/video/phone service time. If the patient fails to show up for the appointment, then the interpreter service cannot be billed to PrimeWest Health.
- Use HCPCS code T1013 (1 unit = 15 minutes) to bill for the sign or oral language interpreter service. The MHCP payment rate is the lower of \$12.50, or your usual and customary charge, for each 12-minute unit. When applicable, bill the patient's Third Party Liability (TPL) insurance prior to billing PrimeWest Health.
- Interpreter services performed must be billed on CMS-1500 claim format to allow billing the number of units.
- Translating documents (paper to paper) is not a covered oral language interpreter service.

PrimeWest Health provides sign language services when such services are required for the recipient to receive or understand the health care services provided.

* Language interpreter services are part of the inpatient hospital DRG payment and cannot be billed separately during an inpatient stay. Special transportation providers cannot bill due to the nature of the service performed. The service of transporting a patient does not require interpreting.

Legal References

[MS 14](#)

[MS 145C](#)

[MS 62D.04, subd.5](#)

[MS 145C](#)

[MS 256B.02](#)

[MS 246B.03](#)

[MS 256B.04](#)

[MS 256B.27](#)

[MS 256B.48](#)

[MS 256B.064](#)

[MS 256B.0625, subd. 18d](#)

[MS 256B.0625, subd. 39](#)

[MS 256B.064, subd. 1d](#)

[MS 256B.0644](#)

[MS 256B0655 subd 1h](#)

[MS 256B.27, subd. 4](#)

[MS 256B.434](#)

[MS 256B.48, subd. 1](#)

[MS 270.75](#)

[MS 363.073](#)

[MS 609.52, subd. 2](#)

[Minnesota Rules 9505](#)

[Minnesota Rules 9505.0015](#), subp. 8; subp. 46

[Minnesota Rules 9505.0070](#), subp. 3

[Minnesota Rules 9505.0140](#)

[Minnesota Rules 9505.0170 to 9505.0475](#)

[Minnesota Rules 9505.0185](#)

[Minnesota Rules 9505.0195](#), subp. 10

[Minnesota Rules 9505.0210](#)

[Minnesota Rules 9505.0215](#)

[Minnesota Rules 9505.0225](#)

[Minnesota Rules 9505.0315](#), subp. 1

[Minnesota Rules 9505.0440](#)

[Minnesota Rules 9505.0455 to 0475](#)

[Minnesota Rules 9505.2160 to 9505.2245](#)

[Minnesota Rules 9505.2175](#), subp.3

[Minnesota Rules 9505.2180](#)

[Minnesota Rules 9505.2185](#)

[Minnesota Rules 9505.2190](#)

[Minnesota Rules 9505.2195](#)

[Minnesota Rules 9505.2200](#), subp. 1

[Minnesota Rules 9505.5200 to 9505.5240](#)

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 422.504\(d\)](#)

[42 CFR 431.53](#)

[42 CFR 431.107](#)

[42 CFR 447.10](#)

[42 CFR 455](#)

Stipulated Settlement Agreement, *Day v. Noot*