

Chapter 1

Requirements for Providers

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 results in unnecessary costs to IMCare 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:

1. Submitting repeated claims or causing a claim to be submitted:
 - a. With missing or incorrect information;
 - b. Using procedure codes that overstate the level or amount of health service provided;
 - c. For health services that are not reimbursable by IMCare;
 - d. For the same health service provided to the same member;
 - e. For health services that do not comply with the requirements to be a covered service under [MN Rules part 9505.0210](#) and, if applicable, [MN Rules part 9505.0215](#);
 - f. For services not medically necessary.
2. Failing to develop and maintain health service records as required under [MN Rules part 9505.2175](#);
3. Failing to use generally accepted accounting principles or other accounting methods that 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;
4. Failing to disclose or make available to IMCare the member's health service records or the vendor's financial records as defined under [MN Rules part 9505.2180](#);
5. Repeatedly failing to report duplicate payments from third party payers for covered services provided to IMCare members and billed to IMCare;
6. Failing to obtain information and assignment of benefits as specified in [MN Rules part 9505.0070, subp. 3](#), or failing to bill Medicare as required by [MN Rules part 9505.0440](#);
7. Failing to keep financial records as defined under [MN Rules part 9505.2180](#);
8. Repeatedly submitting or causing repeated submission of false information for the purpose of obtaining Service Authorization, inpatient hospital admission certification, or a second medical opinion;
9. Knowingly and willfully submitting a false or fraudulent application for provider status;
10. Soliciting, charging, or receiving payments from members or non-Medical Assistance (Medicaid) sources, in violation of [Title 42 Code of Federal Regulations \(CFR\) Part 447.15](#) or [MN Rules part 9505.0225](#), for services for which the vendor has received reimbursement from, or should have billed to, IMCare;
11. Payment of program funds by a vendor to another vendor whom the vendor knew or had reason to know was suspended or terminated from IMCare participation;
12. Repeatedly billing IMCare 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;
13. Repeatedly failing to comply with the requirements of the provider agreement that relate to the programs covered by [MN Rules parts 9505.2160 –9505.2245](#);
14. Failing to comply with the ownership and control information disclosure requirements of [42 CFR 422.455](#);
15. Billing for services that were provided to a member without the request or consent of the member, the member's guardian, or the member's responsible party; and
16. Billing for the services that were outside the scope of the vendor's license, or in the case of a provider that is not required to hold a license, billing by a provider for services that the provider is not authorized to provide under applicable regulatory agency requirements.

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 that constitute a crime against any program, or attempts or conspiracies to commit those crimes, including the following:

1. Theft in violation of [MN Stat. sec. 609.52](#)
2. Perjury in violation of [MN Stat. sec. 609.48](#)
3. Forgery and aggravated forgery in violation of [MN Stat. sec. 609.625](#) and [MN Stat. sec. 609.63](#)
4. Financial transaction card fraud in violation of [MN Stat. sec. 609.821](#)
5. Medicare/Medicaid fraud
6. 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
7. A felony listed in [Title 42 United States Code \(USC\) Section 1320a-7b\(b\)\(3\)\(D\)](#) subject to any safe harbors established in [42 CFR 1001.952](#)

Health Care 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 a Health Care Directive is to enhance a patient's control over medical treatment decisions. Health Care Directives are sometimes called Advance Directives.

Health Plan: A health maintenance organization (HMO), Managed Care Organization (MCO), or other organization that contracts with the Minnesota Department of Human Services (DHS) to provide health services to members under a prepaid contract.

Health Services: Goods and services eligible for IMCare payment under [MN Stat. sec. 256B.02, subd. 8](#) and [MN Stat. sec. 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 IMCare.

Interpretation: The oral replacement of one spoken language (source language) into another spoken language (target language). Four modes of interpretation exist: consecutive, simultaneous, summarization, and sight translation (when the interpreter reads text in one language and speaks it in another language).

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

1. Hourly wage multiplied by the number of hours spent on the case;
2. Employee benefits;
3. Travel;
4. Lodging;
5. Meals; and
6. Photocopying costs, paper, computer data storage or diskettes, and computer records and printouts.

Medical Necessity: A health service that is consistent with the member's diagnosis or condition and is:

1. Recognized as the prevailing medical community standard or current practice by the provider's peer group; and

2. Rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve community standards for diagnosis or condition; or
3. A preventive health service as defined in [MN Rules part 9505.0355](#).

Minnesota Health Care Programs (MHCP): The Medical Assistance (Medicaid) Program, MinnesotaCare, Consolidated Chemical Dependency Treatment Fund (CCDTF), Prepaid Medical Assistance Program (PMAP), Home and Community Based Services (HCBS) under a waiver from the Centers for Medicare & Medicaid Services (CMS), or any other DHS-administered health service program.

Ownership or Control Interest: Has the meaning given in [42 CFR 455, subp. B](#).

1. Physician-owned hospitals are required to disclose to their patients the names of the physician owners and the names of immediate family members of the physician who have an ownership or investment interest in the hospital.
2. Physicians are required to disclose to their patients at the time of referral if they (or their immediate family members) have an ownership or investment interest in the hospitals to which they refer patients for treatment.
3. Hospitals that fail to disclose this information to patients may lose their provider agreements to participate in the Medicare program, and physicians who fail to disclose this information to patients may lose their hospital medical staff memberships.
4. As part of the credentialing process and at any other time upon request of IMCare, contracted providers shall provide the name, address, Social Security Number, and date of birth of all persons and businesses or organizations that meet the following criteria:
 - a. Have an ownership or control interest of 5 percent or more in the disclosing entity
 - b. Have an ownership or control interest in a subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more
 - c. Are a managing employee of the disclosing entity

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

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

Person with Limited English Proficiency (LEP): A person not able to speak, read, write, or understand English at a level that allows him/her to effectively interact.

Provider: An individual, organization, or entity that has entered into an agreement with IMCare for the provision of health services, including a Personal Care Assistant (PCA).

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 IMCare 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 IMCare.

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

Theft: The act defined in [MN Stat. sec. 609.52, subd. 2 \(3\)\(iii\)](#).

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

Translation: The written replacement of text from one language (source language) into an equivalent text in another language (target language).

Vendor: The meaning given to “vendor of medical care” in [MN Stat. sec. 256B.02, subd. 7](#). The term vendor includes a provider and also a PCA.

Requirements All Providers Must Meet

Providers who choose to participate in IMCare 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 IMCare. Provider types marked with an asterisk (*) may not receive direct payment for the services they provide; they must bill through an agency.

1. Advanced practice registered nurse (APRN)
2. Ambulatory Surgical Center (ASC)
3. Audiologist
4. Certified mental health rehab professional*
5. Certified nurse midwife (CNM)
6. Certified Registered Nurse Anesthetist (CRNA)
7. Certified traditional midwife (CPM)
8. Chemical dependency (CD)
9. Children’s residential treatment*
10. Child and Teen Checkup (C&TC) clinic
11. Chiropractor
12. Clinical Nurse Specialist (CNS)
13. Community health clinic (CHC)
14. Community health worker*
15. Community mental health center (CMHC)
16. County case manager
17. County Contracted Mental Health Rehabilitative Services
18. County human services agency
19. Customized Living (CL)
20. Day Training and Habilitation (DT&H) day activity center
21. Day treatment program
22. Dental lab
23. Dentist/dental group
24. Dental hygienist
25. Elderly Waiver (EW)/Home and Community Based Services (HCBS)
26. Family planning agency
27. Federally Qualified Health Center (FQHC)
28. Freestanding birth center
29. Head Start Agency
30. Health care case coordinator
31. Hearing aid dispenser
32. Home health agency
33. Hospice
34. Hospital

35. Intermediate Care Facility for the Developmentally Disabled (ICF/DD)
36. Independent diagnostic testing facility
37. Independent laboratory
38. Indian Health Service (IHS)
39. Institution for Mental Disease (IMD)*
40. Licensed Independent Clinical Social Worker (LICSW)
41. Licensed Marriage and Family Therapist (LMFT)
42. Licensed nutritionist
43. Licensed Professional Clinical Counselor (LPCC)
44. Licensed Psychologist (LP)
45. Licensed registered dietician
46. Long-term care facility (nursing home)
47. Medical supply/Durable Medical Equipment (DME)
48. Medication Therapy Management (MTM) services
49. Medical transportation
50. Mental Health Targeted Case Management (MH-TCM) for Serious and Persistent Mental Illness (SPMI)/Severe Emotional Disturbance (SED)
51. Nurse practitioner (NP)
52. Occupational therapist (OT)
53. Optical company
54. Optometrist
55. Personal Care Assistant (PCA) Choice
56. Personal Care Provider Organization (PCPO)
57. Personal Care Assistant (PCA), Independent*
58. Pharmacy
59. Physical Therapist (PT)
60. Physician/Clinic (Group)
61. Physician Assistant (PA)*
62. Podiatrist
63. Private Duty Nurse (PDN)/PDN Agency
64. Psychiatrist
65. Psychologist
66. Public Health Clinic
67. Public Health Nursing Agency
68. Regional Treatment Center (RTC)
69. Registered Nurse (RN)/Licensed Practical Nurse (LPN)
70. Rehabilitation Agency
71. Renal Dialysis
72. Rural Health Clinic (RHC)
73. Skilled Nursing Facility (SNF)
74. Speech-Language Pathologist (SLP)
75. Waiver (Home and Community Based Services Provider)
76. X-ray

Enrollment Process for Providers

Providers who choose to participate must complete, sign, and return the IMCare the necessary credentialing forms. The [**MN Uniform Credentialing Application**](#) includes a statement of terms for participation. To request a contract with IMCare, interested parties should complete a [**MN Uniform Credentialing Application**](#), which can be found on the IMCare website.

Fax the completed [MN Uniform Credentialing Application](#) to IMCare at 218-327-5545. Call IMCare member service and ask for person in charge of credentialing if you have any questions. IMCare will send you a letter confirming your Credentialing application.

Please note, submitting the [MN Uniform Credentialing Application](#) does not guarantee approval as an IMCare network provider.

Enrollment Requirements

All providers that wish to enroll with Itasca Medical Care **must** be enrolled as a Minnesota Health Care Programs (MHCP) provider through the Minnesota Department of Human Services (DHS) and must provide the following:

1. **Disclosure of Ownership and Control Interest**
2. [W-9 form](#)
3. National Provider Identifier (NPI) number or Unique Minnesota Provider Identifier (UMPI) number
4. Proof of applicable insurance coverage
5. All applicable license(s) for services they provide
6. DHS enrollment verification letter

To procure and maintain professional liability insurance consistent with amount determined by IMCare or Itasca County. Providers shall provide a certificate of such insurance to IMCare, which document the following minimum coverage amounts:

- a) \$1,500,000 when the claim is one for death by wrongful act or omission and \$1,500,000 to any claimant in any other case; and
- b) \$3,000,000 aggregate for any number of claims arising out of a single occurrence for the protection of the interest and property of the Medical Provider, the Medical Provider's employees or Beneficiaries, and IMCare, the Dental Director, the Medical Director, the Pharmacy Director and the County of Itasca.

This information is collected when contracting/re-contracting is done. IMCare also request to be named as a certificate holder so that if when the policy is renewed (or canceled) IMCare will receive notice.

For MN Department of Human Services provider enrollment and revalidation, there is a new option to use the online web-based application the Minnesota Provider Screening and Enrollment (MPSE) portal. This new provider portal is an easy to use, interactive, on-line tool. This new tool streamlines the process and gives you real-time responses. Please see the below links for additional information.

MPSE webpage:

<https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/mpse/>

MHCP Provider Manual Provider Basics (includes a section on enrollment and Managed Care Organizations):

https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_147613

MHCP Provider Manual - Enrollment with MHCP (includes a list of all eligible provider types):

https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ENROLL-HOME

MPSE Training webpage:

<https://mn.gov/dhs/partners-and-providers/training-conferences/minnesota-health-care-programs/provider-training/mpse-portal-training.jsp>

MPSE User Manual:

https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=MPSE-HOME

Provider News and Updates (where we post current provider news):

<https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/provider-news/>

MHCP Provider Call Center (for any questions providers might have about MPSE or MHCP):

<https://mn.gov/dhs/partners-and-providers/contact-us/minnesota-health-care-programs/providers/>

MN-ITS Log In Page (MPSE Link is located on this page under “MN-ITS Administration”):

<https://mn-its.dhs.state.mn.us/GatewayWebUnprotected/index.faces>

Checking the 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. IMCare also excludes individuals and entities from participation in IMCare. IMCare cannot enroll and pay providers that either the Federal OIG or MHCP have excluded.

Federal Exclusions List

The OIG publishes a list of excluded providers and may impose civil monetary penalties against providers who employ or enter into contracts with excluded individuals or entities to provide services or items to recipients.

Providers who choose to enroll with IMCare must check all owners, managing employees, board members, employees, or anyone else who works for the provider against the [OIG list of excluded individuals and entities \(LEIE\)](#). The LEIE provides information to the health care industry, patients, and the public about individuals and entities currently excluded.

The effect of an exclusion is that no payment will be made by any Federal health care program for any items or services furnished, ordered or prescribed by an excluded individual or entity. This payment withholding applies

to the excluded person and anyone who employs or contracts with the excluded person. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

Providers must report to IMCare any individual or entity they find on the exclusion list. Provider enrollment will also verify the entity and individuals listed above against the LEIE on an ongoing basis to identify and remove any person added to the Federal list of exclusions.

Minnesota Excluded Providers

In addition to the Federal exclusion list, IMCare maintains and publishes two lists of all people suspended or terminated from receiving payment from Medicaid funds who IMCare has excluded—one for excluded group providers and one for excluded individual providers. Besides checking the LEIE, providers must also check the Minnesota Excluded Provider lists when employing or entering into contracts with individuals or entities to provide services or items to recipients. IMCare will deny claims for services or items rendered, ordered, referred, or prescribed by excluded providers.

Providers must verify that all people they employ are not on an exclusion list before hire and on an ongoing basis (at least monthly). Anyone who is on the list is excluded from employment with an entity who receives reimbursement from IMCare.

Owner information is not included on the individual provider list unless the owner is also enrolled as an individual provider of services.

For individual providers, the list shows the following:

1. Provider type description
2. Last name, first name, middle name
3. Effective date of exclusion
4. Address line 1 (This is the last known practice, organization, or provider where the person was working)
5. Address line 2

For group or organization providers, the list shows the following:

1. Provider type description
2. Agency name
3. Effective date of exclusion
4. Address line 1
5. Address line 2

The MHCP [Excluded Provider Lists](#) are updated monthly.

Providers named on the excluded providers list have been terminated due to fraud, theft, abuse, error, or noncompliance in connection with a Minnesota health care program. IMCare cannot pay providers on an excluded provider list for services they provide to IMCare members. Providers are notified that they are being terminated before they are named on the published list. The effective date of nonpayment is the date of the notification. Excluded providers are not prohibited from providing services for private-pay clients.

IMCare will not pay for services that providers or individual staff members provide to IMCare members after they have been terminated. If IMCare has already paid for services and then finds that a provider on an exclusion list performed the service, IMCare will recover all funds paid.

Contact the IMCare to verify information that may not be clear on the list, such as a person with a similar name, or a person with the same name who is shown as a different provider type.

Change of Enrollment Information

IMCare must be notified in writing no later than 45 days before the effective date of any change of information regarding the provider's facility.

To notify IMCare of any changes, send a written notification signed by the person who executed the contract with IMCare and mail to:

Attn: Contracting
Itasca Medical Care
1219 Southeast 2nd Avenue
Grand Rapids, Minnesota 55744

Practitioner Rights

IMCare Credentialing requires practitioners to submit a written request via mail, email, or fax to review information submitted to support their credentialing application, correct erroneous information, and receive the status of their credentialing or re-credentialing application.

Use of Billing Agents

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

Attention: Claims
Itasca Medical Care
1219 Southeast 2nd Avenue
Grand Rapids, Minnesota 55744

Fax: 1-218-327-5545

Payment to Provider or Billing Agent

All IMCare payments must be made to the provider. However, IMCare 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 all of the following:

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

Sale or Transfer of an Entity

An IMCare contracted provider who sells or transfers ownership or control of an entity that is enrolled in IMCare must notify IMCare Director in writing no later than 45 days before the effective date of the sale or transfer via mail or fax:

Attn: Itasca Medical Care
1219 Southeast 2nd Avenue
Grand Rapids, Minnesota 55744
Fax: 1-218-327-5545

IMCare has the right to pursue monetary recovery or civil or criminal action against the seller or transferor.

Affirmative Action Plan Requirement

A provider applying for IMCare 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, IMCare 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 IMCare Participation

IMCare participation remains in effect until one of the following occurs:

1. Either party terminates in accordance with terms specified in the agreement
2. The provider fails to comply with the terms of participation
3. The provider sells or transfers ownership, assets, or control of an entity that has been enrolled to provide IMCare services

For additional information, the provider should refer to their *Credentialing Packet*.

Noninterference with Medical Care

IMCare will not interfere in any manner in the methods or means by which a provider renders health care services or provides health care supplies to members. IMCare does not require providers to take any action inconsistent with professional judgment concerning the medical care and treatment rendered to members. Providers may freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Providers and IMCare Health Quality Initiatives

Contracted providers agree to cooperate with IMCare quality management initiatives and programs. This includes providing IMCare, upon request, information needed to assess quality and to participate, cooperate, and assist with audit procedures and access standards.

Providers also agree to allow IMCare to obtain and use provider and provider's practitioners' performance data. Performance data on providers may include facility utilization data, Healthcare Effectiveness Data and Information Set (HEDIS) production and performance evaluation, member satisfaction, overall compliance with the National Committee for Quality Assurance (NCQA) or other comparable quality standards, and data required for compliance with applicable State and Federal requirements.

IMCare Member Confidentiality

All medical records and other protected health information (PHI) of IMCare members created or maintained by or in possession of IMCare and the provider shall be maintained in an accurate and confidential manner in accordance with applicable State and Federal laws, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). All medical records shall belong to the provider consistent with the dictates of medical ethics.

Member Access to Care

In compliance with [MN Stat. 62D sec. 124](#), IMCare-contracted providers must ensure IMCare members have access to covered health care services to the same extent available to the general population. Primary care and specialty service providers, including mental health service providers, must provide or arrange for the provision of covered services to members 24 hours a day, 7 days a week, 365 days a year. The provision of services may include the following:

1. Regularly scheduled appointments during normal business hours
2. After-hours clinics
3. Use of 24-hour answering service with standards for maximum allowable call-back times based on what is medically appropriate to each situation
4. Back-up coverage by another participating primary care or specialty care provider. This on-call provider, or an alternative provider, shall be available to members whenever the primary provider is not available.
5. Referrals to urgent care centers, where available, and to hospital emergency care ([MN Rules part 4685.1010, sub 2.A\(1\) \(a – e\)](#))

Providers should have normal business hours and instructions for after-hours care posted so members can see the instructions from outside the clinic. The notice should include office hours and phone numbers for after-hours service. The clinic should also have a recorded telephone message after clinic hours instructing members how to access after-hours care and directing members with a life-threatening situation to hang up and dial **911**. (MN Rules part 4685.1010; 42 CFR Part 422.111)

Violating Provider Contract

A provider who fails to comply with the terms of contract or with requirements of the rules governing IMCare is subject to monetary recovery. The provider may also be subject to [MN Rules parts 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 [MN Stat.secs. 14.57 – 14.62](#). See [MN Rules Chap. 9505](#).

Distribution of Written Materials to Practitioners

From time to time, IMCare distributes written materials or information to practitioners. In cases where IMCare has contracted with the facility or clinic in which the practitioner practices, the written materials or information will be sent to the clinic or facility administrator, office manager, or other designated office staff member. The administrator, office manager, or other designated office staff member is responsible for distributing such written materials or information to the practitioners.

Notification to IMCare

IMCare requires providers to report to IMCare within five days any information regarding individuals or entities within their organization who have been convicted of a criminal offense related to the involvement in any program established under Medicare, Medicaid, the programs under Title XX of the Social Security Act, or that have been excluded from participation in Medicaid under Sections 1128 or 1128A of the Social Security Act.

Discharging a IMCare Member

If a provider chooses to discontinue care for an IMCare member, the provider must notify IMCare and the member in writing, providing a 30-day notice that includes the effective date and reason care will be discontinued. IMCare is obligated to ensure that members have access to medical care. IMCare will furnish the member with names, addresses, and telephone numbers of other participating providers in the same area of medical specialty, and an IMCare care coordinator will assist the member in locating a new medical home.

A provider may discharge a member for any of the following reasons:

1. The member behaves in a manner that seriously impairs the provider or the provider's ability to furnish health care services to the member or to other members
2. The member is uncooperative or abusive toward the provider
3. The member incurred unpaid bills before enrollment with IMCare
4. The inability of the member and the provider to agree on a course of treatment
5. Written notifications of member discharge should be mailed to:
Attn: Itasca Medical Care
1219 Southeast 2nd Avenue
Grand Rapids, Minnesota 55744

Limits on Member Services

[MN 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 IMCare so IMCare 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 IMCare 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 IMCare members **only** if they are also applied to other members. Providers must offer to IMCare members hours of operation that are no less (in number or scope) than the hours of operation offered to non-IMCare members.

Provider Participation Requirements – Rule 101

Rule 101 ([MN Stat. sec. 256B.0644](#)) establishes requirements for provider participation in IMCare. In order for a provider to be reimbursed for other State-sponsored health care programs, the provider must accept, on a continuous basis, new patients who are members in these programs.

Other State-sponsored health care programs include the following:

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

IMCare 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 IMCare eligibility is not a "new patient" simply because of that change.

Rule 101 Non-Compliance

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

A provider who fails to comply with the requirements of Rule 101 will be excluded from State-sponsored health care programs. DHS provides lists of providers who comply with participation requirements on a quarterly basis to the State Departments of Commerce, Employee Relations, and Labor and Industry.

Limiting IMCare Caseload – Rule 101

A non-dental provider may limit acceptance of **new** IMCare members if the MHCP recipient caseload is at least 20 percent 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 IMCare members when at least 10 percent of the provider's patients are covered by MHCP as their primary source of coverage, or effective for dates of service on and or after July 1, 2007, the provider accepts new MHCP patients who are children with special health care needs. For purposes of this provision, children with special health care needs are children up to 21 years of age who:

1. Require health and related services beyond that required by children generally; or
2. Have or are at risk for chronic physical, developmental, behavioral, or emotional condition, including:
 - a. Autism
 - b. Bleeding and coagulation disorders
 - c. Cancer
 - d. Developmental disabilities
 - e. Down syndrome and other genetic disorders
 - f. Epilepsy, cerebral palsy, and other neurological diseases
 - g. Endocrinopathy
 - h. Fetal alcohol syndrome (FAS)
 - i. Immunodeficiency disorders
 - j. Visual impairment or deafness
 - k. Other conditions as designated by the commissioner after consultation with representatives of pediatric dental providers and consumers

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 NPI/UMPI may be included in the total caseload count.

Encounters involving patients enrolled in either fee-for-service (FFS) or MCOs count toward the calculation of a caseload.

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

Providers wishing to limit acceptance of new patients must notify IMCare Member Services in writing at least 10 days before limiting the acceptance of new IMCare patients. The notice must include the provider's name, NPI, fiscal period, total number of patient encounters for the last fiscal year, and the total number of MHCP patient encounters. Fax this information to IMCare at **1-218-327-5545**. Contact IMCare for additional information at **1-800-843-9536** (toll free).

IMCare will notify the provider in writing whether its notice to limit IMCare caseload has been accepted. This acceptance will be effective 10 days after the provider is notified by IMCare and will remain in effect for the

remainder of the provider's fiscal year. If a provider wishes to continue limiting IMCare caseload, it must file a new notice each year. In addition, a provider who has a contract with IMCare must also notify DHS of its intention to limit acceptance of new IMCare members.

Provider Liability

IMCare shall assume the provider, physician, or supplier should have known about a policy or rule if any of the following are true:

1. The policy or rule is in the provider, physician, or supplier manual or in Federal regulations;
2. The Centers for Medicare & Medicaid Services (CMS) or a CMS contractor provided general notice to the medical community concerning the rule;
3. CMS, a CMS contractor, or the Office of Inspector General (OIG) gave written notice of the policy or rule to the particular provider/physician/supplier;
4. The provider, physician, or supplier was previously investigated or audited as a result of not following the policy or rule;
5. The provider, physician, or supplier previously agreed to a Corporate Integrity Agreement as a result of not following the policy or rule;
6. The provider, physician, or supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements which are related to the policy or rule; or
7. The provider, physician, or supplier previously received documented training/outreach from CMS or one of its contractors related to the same policy rule.

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:

1. 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 IMCare Medicaid and Medicare programs; or
2. 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
3. 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 practice is 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.

See [42 USC 1320a-7b](#).

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.

Health Care Directives

Background

Inpatient hospitals, NFs, SNFs, 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 a Health Care 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.

Requirements

Inpatient hospitals, NFs, SNFs, providers of home health and personal care services, hospice programs, and managed care plans must maintain written policies and procedures and:

1. 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 a Health Care Directive. Providers may contract with other entities to furnish this information but are still legally responsible for ensuring this requirement;
2. 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 a Health Care Directive on the basis of conscience. At a minimum, the provider's statement of limitation should:
 - a. Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians;
 - b. Identify the State legal authority permitting such objection; and
 - c. Describe the range of medical conditions or procedures affected by the conscientious objection.
3. Within limited circumstances, only if allowed under State law, a facility or physician may conscientiously object to a Health Care Directive. If State law is silent regarding conscientious objection, the facility or physician may not conscientiously object to a Health Care Directive that is permissible in that state;
4. Document in the patient's medical record whether or not the patient has executed a Health Care Directive;
5. Shall not condition the provision of care, or otherwise discriminate against the patient, based on whether or not the patient has executed a Health Care Directive, including not conditioning the provision of care on that basis;
6. Comply with State law governing Health Care Directives; and
7. Provide for educational campaigns, individually or with other providers and organizations, to educate staff and the community on issues concerning Health Care 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:

1. **Inpatient hospitals**, at the time of the individual's admission as an inpatient
2. **Nursing Facilities**, at the time of the individual's admission as a resident

3. **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)
4. **Hospice programs**, at the time of the individual's initial receipt of hospice care
5. **MCOs (IMCare)**, 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 Health Care 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 a Health Care Directive. Once the patient is no longer incapacitated, the provider must give the information on Health Care Directives to the individual. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

Executed Health Care Directives

The provider must document in the patient's medical record whether or not the patient has executed a Health Care Directive. If the patient has a Health Care Directive, and the provider has been given a copy, the provider must comply with the terms of the Health Care 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 a Health Care 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 Health Care 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 [MN Stat. Chap. 145C](#).

Surveillance & Integrity Review Section (SIRS)

Background

[MN Rules parts 9505.2160 – 9505.2245](#) established a program of surveillance, integrity, review, and control. They authorize a post-payment review process to ensure compliance with State and Federal requirements by monitoring the use of health services by members and the delivery of health services by vendors. Within IMCare, the Compliance department is responsible for investigating suspected fraud, theft, and abuse. IMCare 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 Chapter 2, Health Care Programs and Services.

Health Service Records

Documentation: Health service records must be developed and maintained as a condition of payment by IMCare. Each occurrence of a health service must be documented in the member's health record. IMCare 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.

1. The record must be legible, at a minimum, to the individual providing care.
2. The member's name must be on each page of the member's record.
3. Each entry in the health service record must contain:
 - a. The date on which the entry is made;
 - b. The date or dates on which the health service is provided;
 - c. The length of time spent with the member, if the amount paid for the service depends on time spent;
 - d. The signature and title of the person from whom the member received the service;
 - e. Report of the member's progress or response to treatment, and changes in the treatment or diagnosis;
 - f. When applicable, the countersignature of the vendor or the supervisor as required under [MN Rules parts 9505.0170 – 9505.0475](#); and
 - g. Documentation of supervision by the supervisor.
4. The record must state:
 - a. The member's case history and health condition as determined by the vendor's examination or assessment;
 - b. The results of all diagnostic tests and examinations; and
 - c. The diagnosis resulting from the examination.
5. The record must contain reports of consultations that are ordered for the member.
6. The record must contain the member's plan of care, individual treatment plan, or individual program plan.
7. The record must contain documentation as to whether or not the member has executed a Health Care Directive (members 18 years and over).
8. The record of a laboratory or X-ray service must document the provider's order for service.
9. Refer to IMCare Medical Record Policy 024-005 in the *Policies and Procedures* section of the [IMCare website](#). These are the basic medical record requirements for DHS.

Health Service Records of Specific Providers

The following vendors must follow additional requirements **in their health service records**:

Pharmacy service records 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 10 years.

Medical transportation records must document:

1. The origin, destination, and distance traveled in providing the service to the member;
2. The type of transportation; and
3. If applicable, a physician's certification for non-emergency, ancillary, or special transportation services (STS) as defined in [MN Rules part 9505.0315, subp. 1](#).

Medical supplies and equipment records must:

1. Document that the medical supply or equipment is eligible for payment; and
2. 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 Chapter 17,

Rehabilitative Services.

Record Keeping

Financial records, including written and electronically stored data, of a vendor who receives payment for a member's services under IMCare must contain the following:

1. Payroll ledgers, cancelled checks, bank deposit slips, and any other accounting records prepared by or for the vendor
2. Contracts for services or supplies relating to the vendor's costs and billings to IMCare for the member's health services
3. Evidence of the vendor charges to IMCare members and to persons who are not IMCare members, consistent with the requirements of the Minnesota Government Data Practices Act
4. Evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to third party payers or programs
5. The vendor's appointment books for patient appointments and the provider's schedules for patient supervision, if applicable
6. Billing transmittal forms
7. Records showing all persons, corporations, partnerships, and entities with an ownership or controlling interest in the vendor
8. 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.
9. 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 ([MN Rules part 9505.2185](#))

Recipient's consent to access ([MN Rules part 9505.2185, subp. 1](#)): A recipient of Medical Assistance (Medicaid) is deemed to have authorized in writing a vendor or others to release to IMCare for examination according to [MN Stat. sec. 256B.27, subd. 4](#), upon request, the Medical Assistance (Medicaid) recipient's health service records related to services under a program. The Medical Assistance (Medicaid) recipient's authorization of the release and review of health service records for services provided while the person is a Medical Assistance (Medicaid) member shall be presumed competent if given in conjunction with the person's application for Medical Assistance (Medicaid). 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 [MN Rules part 9505.0015, subp. 8](#).

IMCare access to records ([MN Rules part 9505.2185, subp. 2](#)): A vendor shall grant IMCare or any business associate of IMCare 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 member's health service records shall be for the purposes in [MN Rules part 9505.2200, subp. 1](#). IMCare 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 ([MN Rules part 9505.2190](#))

Retention required, general ([MN Rules part 9505.2190, subp. 1](#)): 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 10 years after the initial date of billing ([42 CFR 422.504\[d\]](#)). Microfilm records satisfy the recordkeeping requirements of this subpart and [MN Rules part 9505.2175, subp. 3](#), in the fourth and fifth years after the date of

billing.

Record retention after vendor withdrawal or termination ([MN Rules part 9505.2190, subp. 2](#)): A vendor who withdraws or is terminated from a program must retain or make available to IMCare on demand the health service and financial records as required under [MN Rules part 9505.2190, subp. 1](#).

Record retention under change of ownership ([MN Rules part 9505.2190, subp. 3](#)): 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 IMCare on demand the health service and financial records related to services generated before the date of the transfer as required under [MN Rules part 9505.2190, subp. 1](#) and [MN Rules part 9505.2185, subp. 2](#).

Record retention in contested cases ([MN Rules 9505.2190, subp. 4](#)): In the event of a contested case, the vendor must retain health service and financial records as required by [MN Rules part 9505.2190, subp. 1](#) or for the duration of the contested case proceedings, whichever period is longer.

Copying Records ([MN Rules part 9505.2195](#))

IMCare or any contracted IMCare business associate, 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 IMCare program. Photocopying shall be done on the vendor's premises unless removal is specifically permitted by the vendor. If a vendor fails to allow IMCare 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 IMCare.

Investigative Process

Quality and Compliance staff has the authority to conduct routine audits of vendors to monitor compliance with program requirements.

1. **Quality and Compliance** staff are authorized to use information from sources including the following:
 - a. Government agencies
 - b. Professional review organizations
 - c. Consultants under contract
 - d. Members and their responsible relatives
 - e. Vendors and persons employed by or under contract to vendors
 - f. Professional associations of vendors and their peers
 - g. Site visits
 - h. Quality Initiative (QI) studies completed by provider organizations. This includes full cooperation with HEDIS chart abstractions and allowing abstractors full access to medical records and the right to copy/scan supporting documentation from the chart.
2. A **Quality and Compliance** investigation may include the following:
 - a. Examination of health service and financial records
 - b. Examination of equipment, materials, prescribed drugs, or other items used in or for a member's health service under IMCare
 - c. Examination of prescriptions written for IMCare members
 - d. Interviews of contacts
 - e. Verification of the professional credentials of a vendor, the vendor's employees, and entities under contract with the vendor
 - f. Consultation with IMCare peer review mechanisms
 - g. Site visits
 - h. QI studies completed by provider organizations and HEDIS chart abstractions

- i. Determination of whether the health care provided was medically necessary

Quality Improvement

LIVANTA BFCC-QIO Program (<https://livantaqio.com>) (is the Quality Improvement Organization (QIO) authorized by the Medicare program to review medical services provided to Medicare beneficiaries in Regions 2, 3, 5, 7 and 9. (Minnesota is located in Region5). LIVANTA BFCC-QIO Program reviews medical records to determine whether services delivered to beneficiaries meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting. In addition, LIVANTA BFCC-QIO Program reviews written complaints from Medicare beneficiaries about the quality of Medicare services they have received and conducts quality improvement projects to make measurable improvements in beneficiary health status or satisfaction.

In order to participate in the Medicare program, certain providers are required under Federal law to have a Memorandum of Agreement (MOA) with a QIO. MOAs outline the QIO's and provider's responsibilities during the review process.

1. Section 1866 (a)(1)(E) of the Social Security Act requires providers of services to have an MAO with QIOs to release data related to patients when a QIO requests it.
2. Section 1866 (a)(1)(F)(i) of the Social Security Act requires hospitals that provide inpatient hospital services paid under the Prospective Payment System (PPS) to maintain an MAO with QIOs to review the validity of diagnostic information provided by such hospitals; the completeness, adequacy and quality of care provided; the appropriateness of admissions and discharges; and the appropriateness of care provided for which additional payments are sought.
3. Section 1866 (a)(1)(F)(ii) of the Social Security Act requires hospitals, critical access hospitals (CAHs), Skilled Nursing Facilities (SNFs), hospices, long-term acute care (LTAC) facilities, comprehensive outpatient rehabilitation facilities (CORFs), and home health agencies (HHAs) to maintain an MOA with a QIO to perform certain functions.

The MOA with LIVANTA BFCC-QIO Program describes the following:

1. LIVANTA BFCC-QIO Program procedures with respect to certain contract obligations
2. The review and Appeal rights providers have with respect to these obligations
3. Opportunities providers have to partner with LIVANTA BFCC-QIO Program in local and national quality improvement projects

Cooperation with Healthcare Effectiveness Data and Information Set (HEDIS) Chart Abstractions

HEDIS is an annual performance measurement created by NCQA and used to help establish accountability and improve the quality of health care. IMCare is required by our contracts with the CMS and DHS to report HEDIS measurements. Medical record data abstraction is used to improve the measurement rates by supplementing administrative data mined through claims. IMCare requires all providers to help complete this process in the most efficient manner possible. Participating in quality management activities is specified in your provider contract with IMCare; you do not need to get special patient permission for the chart data abstraction process.

IMCare contracts with chart abstractors to perform HEDIS medical record data abstraction on our behalf. These individuals serve IMCare as a "Business Associate," a role defined and covered by HIPAA. As such, the abstraction company is ethically and legally bound to protect, preserve, and maintain the confidentiality of any PHI it gleans from clinical records provided by IMCare providers. Providers may rest assured the chart abstractors will treat patients' PHI with the highest level of protection and confidentiality.

The HEDIS medical record data abstraction process usually begins the first quarter of each year. Before conducting its on-site review, IMCare will contact your office to schedule a visit. IMCare will then send you

information about the scheduled visit and explain its data collection process. The abstractors may also request that you either mail or fax copies of certain chart components for off-site review. The number of charts reviewed will be proportionate to the number of IMCare members receiving care at your facility.

IMCare requires all providers to cooperate with HEDIS chart abstraction. We expect that chart abstractors will be given full access to medical charts and will be allowed to copy/scan appropriate supporting documentation. Without this supporting documentation, it is impossible to follow the NCQA HEDIS Compliance standards that are required of IMCare.

Monetary Recovery and Sanctioning

1. Following completion of the investigation, IMCare will determine whether:
 - a. The vendor is in compliance with the requirements of a program;
 - b. Insufficient evidence exists that fraud, theft, or abuse has occurred; or
 - c. The evidence of fraud, theft, or abuse supports administrative, civil, or criminal action.
2. After completing the determination, IMCare will take one or more of the actions specified in items listed below:
 - a. Close the investigation when no further action is warranted
 - b. Impose administrative sanctions
 - c. Seek monetary recovery
 - d. Refer the investigation to the appropriate State regulatory agency
 - e. Refer the investigation to the attorney general or, if appropriate, to a county attorney for possible civil or criminal legal action
3. IMCare will issue a warning that states the practices are potentially in violation of program laws or regulations; and/or
4. IMCare will seek monetary recovery from a vendor if payment for a member's health service under IMCare was the result of fraud, theft, abuse, or error on the part of the provider, IMCare, or local agency. IMCare is authorized to calculate the amount of monetary recovery based on estimation from systematic random samples of claims submitted and paid. IMCare will recover money by the following means:
 - a. Permitting voluntary repayment of money, either in lump sum payment or installment payments;
 - b. Recapturing or offsetting from claims on future remittance advices from IMCare payments;
 - c. Withholding payments to a provider under [42 CFR 447.31](#); or
 - d. Using any legal collection process.

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

1. 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, IMCare may seek recovery of investigative costs.
2. Administrative sanctions may be imposed for any of the following:
 - a. Fraud, theft, or abuse in connection with health care services billed to IMCare.
 - b. Refusal to grant IMCare access to records
3. For a vendor, the sanctions that may be imposed are:
 - a. Referral to the appropriate peer review mechanism or licensing board;
 - b. Suspending or terminating the provider's or vendor's participation;
 - c. Suspending or terminating the participation of any person or corporation with whom the provider or vendor has any ownership or control interest;
 - d. Requiring attendance at education sessions provided by IMCare or DHS;
 - e. Requiring authorization of services; and
 - f. Restricting the vendor's participation in IMCare.

4. For a provider, the sanctions which may be imposed are those described previously, as well as:
 - a. Requiring a ***Provider Participation Contract*** of limited duration;
 - b. Requiring a ***Provider Participation Contract*** that stipulates specific conditions of participation; and
 - c. Review of the provider's claims before payment.
5. IMCare has the authority to simultaneously seek monetary recovery and to administer sanctions.
6. IMCare will notify vendors in writing of any intent to recover money or impose sanctions.
7. A vendor may meet with IMCare informally to discuss the matter in dispute.
8. A vendor has the right to Appeal IMCare's proposed action. An Appeal is considered timely if written notice of Appeal is filed with IMCare within 30 days of the date that the notice of proposed action was mailed. The Appeal request must specify:
 - a. Each disputed item;
 - b. The reason for the dispute;
 - c. An estimate of the dollar amount involved, if any, for each disputed item;
 - d. The computation or other disposition that the appealing party believes is correct;
 - e. The authority in Statute or Rule upon which the appealing party relies for each disputed item;
 - f. The name and address of the person or firm with whom contracts may be made regarding the Appeal; and
 - g. Other pertinent information as may be required by IMCare.
9. The Appeal shall be a contested case proceeding under the provisions of the Minnesota Administrative Procedure Act.
10. Under certain conditions, IMCare has the authority to withhold payments to vendor prior to notice or to a hearing.
11. No claims may be submitted personally by a vendor who has been suspended or terminated from IMCare, nor may claims be submitted by any clinic, group, corporation, or association on behalf of a vendor who has been suspended or terminated from IMCare. Claims for health care provided prior to the suspension or termination may be submitted, but will be subject to review.
12. The vendor who is restricted from participation may not submit a claim for payment under IMCare 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.
13. A vendor who is convicted of a crime related to the provision, management, or administration of IMCare related health services will be suspended from participation effective on the date of conviction. IMCare will notify the vendor of the date and duration of the suspension.

Fraud or Abuse of Medicare Program

IMCare 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, waste, or abuse.

Reporting Suspected Fraud or Abuse

To report suspected fraud, waste, or abuse by a provider, call the IMCare Compliance Hotline at 1-866-269-0584 or the Itasca County Health and Human Services Fraud Hotline at 1-800-422-0312 ext. 2191 (toll free) or report to imcarecompliance.co.itasca.mn.us.

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:

1. Makes a statement known to be false in an application for payment or for use in determining rights to such payment
2. Fails to disclose a fact affecting the vendor's initial or continuing right to receive payments with the intent to wrongfully obtain such payments
3. Receives payments for the benefit of another and knowingly uses them for a purpose other than on behalf of the beneficiary
4. Receives, solicits, offers, or pays in any manner and in any form in return for:
 - a. Referring, or inducing another to refer, a member for the furnishing of benefits for which payment may be made under this program; or
 - b. 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. A properly disclosed reduction in price that is reflected in cost claimed by the provider; or
 - b. Salaries paid by an employer to an employee.
5. Makes a statement known to be false so that a facility may qualify, or continue to qualify, as a hospital, SNF, ICF, or home health agency
 6. Requests or receives from a member payment in excess of reimbursement received from the program, or charges or accepts value in excess of rates established by IMCare under this program as a condition precedent to admitting a patient to a hospital, SNF, ICF, or as a requirement for a patient's continued stay in such facility.

Crimes Related to Minnesota Health Care Programs (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*.

1. A vendor convicted of an MHCP-related crime is automatically suspended from participation in IMCare. 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. IMCare will enforce the action of DHS.
2. 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 [42 CFR 455.101](#) and [42 CFR 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 IMCare's intent to suspend the vendor from IMCare participation, the reasons for the suspension, and the effective date and duration of the suspension.

Language Interpreter Services

All providers are required to provide language interpreter services as follows:

1. Sign language interpreter services when such services are necessary to help deaf or hard of hearing member get covered services
2. Foreign spoken language interpreter services to all patients with LEP, whether or not the patient is a member of IMCare

IMCare covers sign and foreign spoken language interpreter service with the following conditions if the provider cannot communicate with the member:

1. Providers are responsible for arranging the interpreter service and 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.
2. Providers must verify that the spoken language interpreter being used for covered face-to-face spoken language interpreter services is listed in the Minnesota Department of Health's (MDH) [Spoken Language Health Care Interpreter Roster](#). IMCare does not contract with or enroll interpreters. Providers must document the following in the member's medical record:
 - a. That an interpreter was used
 - b. The date and time the interpreter was used
 - c. The name of the interpreter and agency.
3. Three people must be present for the service to be covered: the provider, the patient, and the interpreter.
4. For sign language interpreter services, the interpreter may be on a video screen when using video remote interpreter services.
5. For foreign spoken language interpreter services, the interpreter may be on the phone.
6. Staff members at the provider's office who are qualified in sign language or competent in foreign spoken language interpretation may interpret the medical service.
7. Minor children should never be used as interpreters. Providers may not require a patient 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.
8. Providers must initiate an offer to provide free and timely language assistance when patients and staff are having difficulty understanding each other or when patients ask for language (sign or foreign spoken) assistance.

IMCare also covers language interpreter services for the parent/guardian when the patient is a minor.

In some cases, interpreter services need to be made available on an expedited/emergency basis.

Translating documents (paper to paper) is not a covered foreign spoken language interpreter service.

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 to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons \("Guidance"\)](#), an interpreter must be *competent* to provide interpreter services. Competent interpreters:

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

Eligible Providers

All enrolled providers can bill for interpreter services except for the following:

1. Community health workers (CHW) – included in CHW service rates
2. Federally Qualified Health Centers (FQHCs) for Federally funded encounter rate recipients – included in the encounter rate
3. Inpatient hospitals – included in the inpatient hospital DRG payment
4. Nursing facilities – included in the per diem rate
5. Rural Health Clinics (RHCs) for Federally funded encounter rate recipients – included in the encounter rate
6. Transportation providers – the service of transporting a member; does not include interpreter service reimbursements

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 473-17 through 473-18](#)).

Sign Language Interpreters

DHS Deaf and Hard of Hearing Services Division (DHHSD) [regional staff](#) located throughout Minnesota can assist with questions about [sign language interpreter referral services](#) or hiring freelance sign language interpreters. Refer to the [DHHSD](#) and [Sign Language Interpreter Referral](#) web sites for additional information and resources.

Oral Language Interpreter Services

Oral language interpreter services are a covered benefit for IMCare members. Providers must verify that the spoken language interpreter being used for covered face-to-face spoken language interpreter services is listed in MDH's [Spoken Language Health Care Interpreter Roster](#).

IMCare does not contract with or enroll interpreters. Continue to document interpreter information (such as name, agency, etc.). IMCare will only reimburse for provision of face-to-face oral interpretation services by interpreters who are listed on the [MDH Roster](#).

Limited English Proficiency (LEP)

Federal law requires that providers who receive Federal funds must provide oral language interpreter services to all patients who have LEP at no cost to the patient, whether or not the patient is a member of IMCare.

In August 2003, the United States Department of Health and Human Services (HHS) 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.

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 IMCare and/or 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 473-14 through 473-16](#)).

Limited English Proficiency (LEP) Plan

IMCare 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 473-19 through 473-20](#)).

The DHS [LEP Model Plan \(DHS-4210\)](#) can be used as a template for your LEP Plan.

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.

Interpreter Unit Authorizations

Submit an authorization request only after the allowed 8 units (1 unit = 15 minutes) of interpreter services per date of service have been used.

The prior authorization must include, but is not limited to, the following:

1. Name and provider number of the enrolled IMCare provider delivering the covered service that requires the additional interpreter service units
2. Name, date of birth (DOB), and IMCare member ID number requiring the additional interpreter service units

3. Service code or description of the service being provided requiring the additional interpreter service units
4. Brief explanation of why this service will require additional interpreter service units
5. Self-attestation by the provider that none of the interpreter service units include time or consideration for reimbursement for any of the following:
 - a. Travel time
 - b. Wait time (includes time waiting in the lobby, exam room, or any office space when a medical service is not being delivered)
 - c. Mileage
 - d. No-shows or cancellations
 - e. Form translation activities
 - f. Form completion activities
 - g. Time when all three people required for interpreter services (provider, member, interpreter) are not involved in the discussion or delivery of the member's covered service(s) provided during the appointment

Do not include the initial 8 units as part of the additional interpreter units being requested.

Billing Sign and Oral Language Interpreter Services

IMCare covers sign and oral language interpreter services.

Bill IMCare using the following guidelines:

1. All enrolled providers *except inpatient hospitals and special transportation providers** may bill IMCare for language interpreter services. If services are directly contracted through the interpreter, the 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.
2. The names of oral interpreters are required on all claims submitted to IMCare for reimbursement of face-to-face oral interpretation services. This is a change from the previous requirement, which stated only that names be noted in the medical record. Claims submitted without the interpreter name in the correct field or with the name of an interpreter that does not appear on the [MDH Roster](#) will be denied. The SV1 segment, element SV101-7 of the 5010 claim format, effective January 1, 2012, is designated for the inclusion of the interpreter name. Upon claim submission to IMCare, the interpreter listed on the claim will be validated against the [MDH Roster](#).
3. Three people must be present for the service to be covered: the provider, the patient, and the interpreter.
 - a. For sign language interpreter services, the interpreter may be on a video screen when using video remote interpreter services.
 - b. For oral language interpreter services, the interpreter may be on the phone.
4. The patient's friend or family member cannot act as the interpreter and receive reimbursement from IMCare.
5. 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.
6. 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 IMCare.
7. When applicable, bill the patient's Third Party Liability (TPL) insurance prior to billing IMCare.
8. Interpreter services performed must be billed on the 837P electronic claim format to allow billing the number of units.
9. Translating documents (paper to paper) is not a covered oral language interpreter service.

IMCare provides sign language services when such services are required for the member to receive or understand the health care services provided.

*Language interpreter services are part of the inpatient hospital Diagnosis Related Group (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.

Effective January 1, 2011, IMCare implemented the Minnesota Administrative Uniformity Committee (AUC) recommendation to use modifiers when billing interpreter services.

Code	Modifier	Description
T1013		Face-to-face oral language interpreter service
T1013	U3	Face-to-face sign language interpreter service
T1013	GT	Telemedicine interpreter service
T1013	U4	Interactive audio and video telecommunications systems interpreter services
T1013	UN	UN-2 patients served.
	UP	UP- 3 patients served.
	UO	UO-4 patients served.
	UR	UR-5 patients served.
	US	US-6 or more patients served.

When billing interpreter services for multiple recipients in a group setting, billing should include the appropriate modifier to indicate the number of patients served. This modifier should be submitted secondary to the type of interpretation provided (e.g., sign, telemedicine, etc.).

IMCare does not cover any of the following for the interpreter:

1. Travel time
2. Wait time
3. Mileage
4. No show/cancellations

Report one unit of T1013 per 15 minutes (at least eight minutes must be spent to report one unit). Use only the 837P or 837I formats to submit interpreter service claims.

Bill only for the direct face-to-face/video/phone service time.

Interpreter services are not covered by Medicare but are covered under the member's Medicaid benefit.

Additional Resources

[eXchange](#): A resource for providers about language and cultural competency.

The eXchange, a Minnesota-based collaboration of health care related organizations, offers translated materials and resources for better health communication. Translated materials include vital documents (such as surgical consent forms) and health education materials (such as information about diabetes management, asthma, etc.).

MHCP-enrolled providers may download or print these translated materials from the eXchange and use them with patients with LEP. To access these materials, select the [Translation Library](#) link from the [eXchange home page](#). When prompted, enter *DHS* (upper- or lowercase) as the login ID and as the password.

Legal References

[MN Stat. Chap. 14](#) – Administrative Procedure

[MN Stat. secs. 14.57 – 14.62](#) – Contested Case Procedures

[MN Stat. sec. 62D.04, subd. 5](#) – Issuance of Certificate Authority: Participation; government programs

[MN Stat. Chap. 145C](#) – Health Care Directives

[MN Stat. sec. 256B.02](#) – Definitions

[MN Stat. sec. 256B.02, subd. 7](#) – Definitions: Vendor of medical care

[MN Stat. sec. 256B.02, subd. 8](#) – Definitions: Medical assistance; medical care

[MN Stat. sec. 256B.03](#) – Payments to Vendors

[MN Stat. sec. 256B.04](#) – Duties of State Agency

[MN Stat. sec. 256B.0625](#) – Covered Services

[MN Stat. sec. 256B.0625, subd. 39](#) – Covered Services: Childhood immunizations

[MN Stat. sec. 256B.064](#) – Sanctions; Monetary Recovery

[MN Stat. sec. 256B.064, subd. 1d](#) – Sanctions; Monetary Recovery: Investigative costs

[MN Stat. sec. 256B.0644](#) – Reimbursement under Other State Health Care Programs

[MN Stat. sec. 256B.27](#) – Medical Assistance; Cost Reports

[MN Stat. sec. 256B.27, subd. 4](#) – Medical Assistance; Cost Reports: Authorization of commissioner to examine records

[MN Stat. sec. 256B.433](#) – Ancillary Services

[MN Stat. sec. 256B.434](#) – Alternative Payment Demonstration Project

[MN Stat. sec. 256B.48](#) – Conditions for Participation

[MN Stat. sec. 256B.48, subd. 1](#) – Conditions for Participation: Prohibited practices

[MN Stat. sec. 363A.36](#) – Certificates of Compliance for Public Contracts

[MN Stat. sec. 609.48](#) – Perjury

[MN Stat. sec. 609.52, subd. 2](#) – Theft: Acts constituting theft

[MN Stat. sec. 609.625](#) – Aggravated Forgery

[MN Stat. sec. 609.52, subd. 2 \(3\)\(iii\)](#) – Theft: Acts constituting theft

[MN Stat. sec. 609.63](#) – Forgery

[MN Stat. sec. 609.821](#) – Financial Transaction Card Fraud

[MN Rules part 4685.1010](#) – Availability and Accessibility

[MN Rules Chap. 9505](#) – Health Care Programs

[MN Rules part 9505.0015, subp. 8](#) – Definitions: Authorized representative

[MN Rules part 9505.0015, subp. 46](#) – Definitions: Third-party payer

[MN Rules part 9505.0070, subp. 3](#) – Third-Party Liability: Provider responsibility to obtain information and assignment of benefits

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

[MN Rules parts 9505.0170 – 9505.0475](#) – Medical Assistance Payments

[MN Rules part 9505.0195, subp. 10](#) – Provider Participation: Condition of participation

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

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

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

[MN Rules part 9505.0315, subp. 1](#) – Medical Transportation: Definitions

[MN Rules part 9505.0440](#) – Medicare Billing Required

[MN Rules parts 9505.0455 – 9505.0475](#) – Billing Procedure; Business Agent; Consequences of a False Claim; Recovery of Payment to Provider; Provider Responsibility for Billing Procedure; Suspension of Provider Convicted of Crime Related to Medicare or Medicaid

[MN Rules parts 9505.2160 – 9505.2245](#) – Surveillance and Integrity Review Program

[MN Rules part 9505.2175](#) – Health Service Records

[MN Rules part 9505.2175, subp. 3](#) – Health Service Records: Requirements for pharmacy service records

[MN Rules part 9505.2180](#) – Financial Records

[MN Rules part 9505.2185](#) – Access to Records

[MN Rules part 9505.2185, subp. 2](#) – Access to Records: Department access to records

[MN Rules part 9505.2190](#) – Retention of Records

[MN Rules part 9505.2195](#) – Copying Records

[MN Rules part 9505.2200, subp. 1](#) – Identifying Fraud, Theft, Abuse, or Error: Department investigation

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

[42 CFR 422.455](#) – Special Rules for MA Regional Plans

[42 CFR 422.504\(d\)](#) – Contract provisions: Maintenance of records

[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 447.15](#) – Acceptance of State payment as payment in full

[42 CFR 447.31](#) – Withholding Medicare payments to recover Medicaid overpayments

[42 CFR 455](#) – Program Integrity: Medicaid

[42 CFR 455.101](#) – Disclosure of Information by Providers and Fiscal Agents: Definitions

[42 CFR 455.102](#) – Disclosure of Information by Providers and Fiscal Agents: Determination of ownership or control percentages

[42 CFR 455, subp. B](#) – Disclosure of Information by Providers and Fiscal Agents

[42 CFR 1001.952](#) – Exceptions

[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](#) – Limitation on Certain Physician Referrals: General Exceptions to Both Ownership and Compensation Arrangement Prohibitions

Stipulated Settlement Agreement, *Day v. Noot*

[42 USC 1320a-7b](#) – Criminal penalties for acts involving Federal health care programs

[42 USC 1320a-7b\(b\)\(3\)\(D\)](#) – Criminal penalties for acts involving Federal health care programs: Illegal remunerations