

CHAPTER 144

DEPARTMENT OF HEALTH

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144.122 LICENSE, PERMIT, AND SURVEY FEES.

(a) The state commissioner of health, by rule, may prescribe procedures and fees for filing with the commissioner as prescribed by statute and for the issuance of original and renewal permits, licenses, registrations, and certifications issued under authority of the commissioner. The expiration dates of the various licenses, permits, registrations, and certifications as prescribed by the rules shall be plainly marked thereon. Fees may include application and examination fees and a penalty fee for renewal applications submitted after the expiration date of the previously issued permit, license, registration, and certification. The commissioner may also prescribe, by rule, reduced fees for permits, licenses, registrations, and certifications when the application therefor is submitted during the last three months of the permit, license, registration, or certification period. Fees proposed to be prescribed in the rules shall be first approved by the Department of Finance. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be in an amount so that the total fees collected by the commissioner will, where practical, approximate the cost to the commissioner in administering the program. All fees collected shall be deposited in the state treasury and credited to the state government special revenue fund unless otherwise specifically appropriated by law for specific purposes.

(b) The commissioner may charge a fee for voluntary certification of medical laboratories and environmental laboratories, and for environmental and medical laboratory services provided by the department, without complying with paragraph (a) or chapter 14. Fees charged for environment and medical laboratory services provided by the department must be approximately equal to the costs of providing the services.

(c) The commissioner may develop a schedule of fees for diagnostic evaluations conducted at clinics held by the services for children with handicaps program. All receipts generated by the program are annually appropriated to the commissioner for use in the maternal and child health program.

(d) The commissioner shall set license fees for hospitals and nursing homes that are not boarding care homes at the following levels:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA) hospitals
 Non-JCAHO and non-AOA hospitals
 Nursing home

\$7,555 plus \$13 per bed
 \$5,180 plus \$247 per bed
 \$183 plus \$91 per bed

The commissioner shall set license fees for outpatient surgical centers, boarding care homes, and supervised living facilities at the following levels:

Outpatient surgical centers	\$3,349
Boarding care homes	\$183 plus \$91 per bed
Supervised living facilities	\$183 plus \$91 per bed.

(e) Unless prohibited by federal law, the commissioner of health shall charge applicants the following fees to cover the cost of any initial certification surveys required to determine a provider's eligibility to participate in the Medicare or Medicaid program:

Prospective payment surveys for hospitals	\$ 900
Swing bed surveys for nursing homes	\$1,200
Psychiatric hospitals	\$1,400
Rural health facilities	\$1,100
Portable x-ray providers	\$ 500
Home health agencies	\$1,800
Outpatient therapy agencies	\$ 800
End stage renal dialysis providers	\$2,100
Independent therapists	\$ 800
Comprehensive rehabilitation outpatient facilities	\$1,200
Hospice providers	\$1,700
Ambulatory surgical providers	\$1,800
Hospitals	\$4,200
Other provider categories or additional resurveys required to complete initial certification	Actual surveyor costs: average surveyor cost x number of hours for the survey process.

These fees shall be submitted at the time of the application for federal certification and shall not be refunded. All fees collected after the date that the imposition of fees is not prohibited by federal law shall be deposited in the state treasury and credited to the state government special revenue fund.

(f) The commissioner shall charge the following fees for examinations, registrations, licenses, and inspections:

Plumbing examination	\$ 50
Water conditioning examination	\$ 50
Plumbing bond registration fee	\$ 40
Water conditioning bond registration fee	\$ 40
Master plumber's license	\$120
Journeyman plumber's license	\$ 55
Apprentice registration	\$ 25
Water conditioning contractor license	\$ 70
Water conditioning installer license	\$ 35
Residential inspection fee (each visit)	\$ 50

Public, commercial, and industrial inspections	Inspection fee
25 or fewer drainage fixture units	\$ 300
26 to 50 drainage fixture units	\$ 900
51 to 150 drainage fixture units	\$1,200
151 to 249 drainage fixture units	\$1,500
250 or more drainage fixture units	\$1,800
Callback fee (each visit)	\$ 100

History: 2005 c 85 s 1; 1Sp2005 c 4 art 6 s 7

144.1222 PUBLIC POOLS; ENCLOSED SPORTS ARENAS.

[For text of subds 1 to 2b, see M.S.2004]

Subd. 2c. **Pools used for adult-only recreation.** Notwithstanding Minnesota Rules, part 4717.1850, a pool with a zero-depth area may be used without a lifeguard present if access to the pool area is prohibited to individuals under the age of 18 years during the time a lifeguard is not present.

Subd. 2d. **Hot tubs on rental houseboats.** (a) A hot water pool intended for seated recreational use, including a hot tub or whirlpool, that is located on a houseboat that is rented to the public is not a public pool and is exempt from the requirements for public pools under Minnesota Rules, chapter 4717.

(b) A hot water pool under this subdivision must be conspicuously posted with the following notice to renters:

“NOTICE

This spa is exempt from state and local sanitary requirements that prevent disease transmission.

USE AT YOUR OWN RISK

This notice is required under Minnesota Statutes, section 144.1222, subdivision 2d.”

[For text of subd 3, see M.S.2004]

History: 2005 c 50 s 1; 2005 c 130 s 1

144.147 RURAL HOSPITAL PLANNING AND TRANSITION GRANT PROGRAM.

Subdivision 1. **Definition.** “Eligible rural hospital” means any nonfederal, general acute care hospital that:

- (1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;
- (2) has 50 or fewer beds; and
- (3) is not for profit.

Subd. 2. **Grants authorized.** The commissioner shall establish a program of grants to assist eligible rural hospitals. The commissioner shall award grants to hospitals and communities for the purposes set forth in paragraphs (a) and (b).

(a) Grants may be used by hospitals and their communities to develop strategic plans for preserving or enhancing access to health services. At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what health services are needed and desired by the community. The assessment must include interviews with or surveys of area health professionals, local community leaders, and public hearings;

(2) an assessment of the feasibility of providing needed health services that identifies priorities and timeliness for potential changes; and

(3) an implementation plan.

The strategic plan must be developed by a committee that includes representatives from the hospital, local public health agencies, other health providers, and consumers from the community.

(b) The grants may also be used by eligible rural hospitals that have developed strategic plans to implement transition projects to modify the type and extent of services provided, in order to reflect the needs of that plan. Grants may be used by hospitals under this paragraph to develop hospital-based physician practices that integrate hospital and existing medical practice facilities that agree to transfer their practices, equipment, staffing, and administration to the hospital. The grants may also be used by the hospital to establish a health provider cooperative, a telemedicine system, an electronic health records system, or a rural health care system or to cover expenses associated with being designated as a critical access hospital for the Medicare rural hospital flexibility program. Not more than one-third of any grant shall be used to offset losses incurred by physicians agreeing to transfer their practices to hospitals.

[For text of subs 3 to 5, see M.S.2004]

History: *1Sp2005 c 4 art 6 s 8,9*

RURAL PHARMACY PLANNING AND TRANSITION GRANT PROGRAM

144.1476 RURAL PHARMACY PLANNING AND TRANSITION GRANT PROGRAM.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the following definitions apply.

(b) "Eligible rural community" means:

(1) a Minnesota community that is located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041; or

(2) a Minnesota community that has a population of less than 10,000, according to the United States Bureau of Statistics, and that is outside the seven-county metropolitan area, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(c) "Health care provider" means a hospital, clinic, pharmacy, long-term care institution, or other health care facility that is licensed, certified, or otherwise authorized by the laws of this state to provide health care.

(d) "Pharmacist" means an individual with a valid license issued under chapter 151 to practice pharmacy.

(e) "Pharmacy" has the meaning given under section 151.01, subdivision 2.

Subd. 2. **Grants authorized; eligibility.** (a) The commissioner of health shall establish a program to award grants to eligible rural communities or health care providers in eligible rural communities for planning, establishing, keeping in operation, or providing health care services that preserve access to prescription medications and the skills of a pharmacist according to sections 151.01 to 151.40.

(b) To be eligible for a grant, an applicant must develop a strategic plan for preserving or enhancing access to prescription medications and the skills of a pharmacist. At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what pharmacy services are needed and desired by the community. The assessment must include interviews with or surveys of area and local health professionals, local community leaders, and public officials;

(2) an assessment of the feasibility of providing needed pharmacy services that identifies priorities and timelines for potential changes; and

(3) an implementation plan.

(c) A grant may be used by a recipient that has developed a strategic plan to implement transition projects to modify the type and extent of pharmacy services provided, in order to reflect the needs of the community. Grants may also be used by recipients:

(1) to develop pharmacy practices that integrate pharmacy and existing health care provider facilities; or

(2) to establish a pharmacy provider cooperative or initiatives that maintain local access to prescription medications and the skills of a pharmacist.

Subd. 3. **Consideration of grants.** In determining which applicants shall receive grants under this section, the commissioner of health shall appoint a committee comprised of members with experience and knowledge about rural pharmacy issues including, but not limited to, two rural pharmacists with a community pharmacy background, two health care providers from rural communities, one representative from a statewide pharmacist organization, and one representative of the Board of Pharmacy. A representative of the commissioner may serve on the committee in an ex officio status. In determining who shall receive a grant, the committee shall take into account:

(1) improving or maintaining access to prescription medications and the skills of a pharmacist;

(2) changes in service populations;

(3) the extent community pharmacy needs are not currently met by other providers in the area;

(4) the financial condition of the applicant;

(5) the integration of pharmacy services into existing health care services; and

(6) community support.

The commissioner may also take into account other relevant factors.

Subd. 4. **Allocation of grants.** (a) The commissioner shall establish a deadline for receiving applications and must make a final decision on the funding of each application within 60 days of the deadline. An applicant must apply no later than March 1 of each fiscal year for grants awarded for that fiscal year.

(b) Any grant awarded must not exceed \$50,000 a year and may not exceed a one-year term.

(c) Applicants may apply to the program each year they are eligible.

(d) Project grants may not be used to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

Subd. 5. **Evaluation.** The commissioner shall evaluate the overall effectiveness of the grant program and may collect progress reports and other information from grantees needed for program evaluation. An academic institution that has the expertise in evaluating rural pharmacy outcomes may participate in the program evaluation if asked by a grantee or the commissioner. The commissioner shall compile summaries of successful grant projects and other model community efforts to preserve access to prescription medications and the skills of a pharmacist, and make this information available to Minnesota communities seeking to address local pharmacy issues.

History: 1Sp2005 c 4 art 6 s 10

144.148 RURAL HOSPITAL CAPITAL IMPROVEMENT GRANT PROGRAM.

Subdivision 1. **Definition.** (a) For purposes of this section, the following definitions apply.

(b) "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

(c) "Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital, including establishing an electronic health records system.

[For text of subs 2 to 9, see M.S.2004]

History: *1Sp2005 c 4 art 6 s 11*

144.1483 RURAL HEALTH INITIATIVES.

The commissioner of health, through the Office of Rural Health, and consulting as necessary with the commissioner of human services, the commissioner of commerce, the Higher Education Services Office, and other state agencies, shall:

(1) develop a detailed plan regarding the feasibility of coordinating rural health care services by organizing individual medical providers and smaller hospitals and clinics into referral networks with larger rural hospitals and clinics that provide a broader array of services;

(2) develop recommendations regarding health education and training programs in rural areas, including but not limited to a physician assistants' training program, continuing education programs for rural health care providers, and rural outreach programs for nurse practitioners within existing training programs;

(3) develop a statewide, coordinated recruitment strategy for health care personnel and maintain a database on health care personnel as required under section 144.1485;

(4) develop and administer technical assistance programs to assist rural communities in: (i) planning and coordinating the delivery of local health care services; and (ii) hiring physicians, nurse practitioners, public health nurses, physician assistants, and other health personnel;

(5) study and recommend changes in the regulation of health care personnel, such as nurse practitioners and physician assistants, related to scope of practice, the amount of on-site physician supervision, and dispensing of medication, to address rural health personnel shortages;

(6) support efforts to ensure continued funding for medical and nursing education programs that will increase the number of health professionals serving in rural areas;

(7) support efforts to secure higher reimbursement for rural health care providers from the Medicare and medical assistance programs;

(8) coordinate the development of a statewide plan for emergency medical services, in cooperation with the Emergency Medical Services Advisory Council;

(9) establish a Medicare rural hospital flexibility program pursuant to section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, by developing a state rural health plan and designating, consistent with the rural health plan, rural nonprofit or public hospitals in the state as critical access hospitals. Critical access hospitals shall include facilities that are certified by the state as necessary providers of health care services to residents in the area. Necessary providers of health care services are designated as critical access hospitals on the basis of being more than 20 miles, defined as official mileage as reported by the Minnesota Department of Transportation, from the next nearest hospital, being the sole hospital in the county, being a hospital located in a county with a designated medically underserved area or health professional shortage area, or being a hospital located in a county contiguous to a county with a medically underserved area or health professional shortage area. A critical access hospital located in a county with a designated medically underserved area or a health professional shortage area or in a county contiguous to a county with a

medically underserved area or health professional shortage area shall continue to be recognized as a critical access hospital in the event the medically underserved area or health professional shortage area designation is subsequently withdrawn; and

(10) carry out other activities necessary to address rural health problems.

History: 1Sp2005 c 4 art 6 s 12

144.1486 [Repealed, 1Sp2005 c 4 art 6 s 58]

144.1501 HEALTH PROFESSIONAL EDUCATION LOAN FORGIVENESS PROGRAM.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Dentist" means an individual who is licensed to practice dentistry.

(c) "Designated rural area" means:

(1) an area in Minnesota outside the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or

(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).

(d) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

(e) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(f) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

(g) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

(h) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

(i) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse practitioners.

(j) "Pharmacist" means an individual with a valid license issued under chapter 151.

(k) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(l) "Physician assistant" means a person registered under chapter 147A.

(m) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

(n) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach for at least 20 hours per week in the nursing field in a postsecondary program;

(3) for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions or to teach for at least 20 hours per week in the nursing field in a postsecondary program;

(4) for other health care technicians agreeing to teach for at least 20 hours per week in their designated field in a postsecondary program. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists who agree to practice in designated rural areas; and

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51, chapter 303.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Subd. 3. **Eligibility.** (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical or dental resident, a licensed pharmacist or be enrolled in a dentist, midlevel practitioner, registered nurse, or a licensed practical nurse training program; and

(2) submit an application to the commissioner of health. If fewer applications are submitted by dental students or residents than there are dentist participant slots available, the commissioner may consider applications submitted by dental program graduates who are licensed dentists.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

Subd. 4. **Loan forgiveness.** The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area, facility type, teaching area, patient group, or specialty type specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that 75 percent of the funds available are used for rural physician loan forgiveness and 25 percent of the funds available are used for underserved urban communities and pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for any eligible profession, the remaining funds may be allocated proportionally among the other eligible professions according to the vacancy rate for each profession in the required geographic area, patient group, or facility type specified in subdivision 2. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area or facility type specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment

disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Subd. 5. Penalty for nonfulfillment. If a participant does not fulfill the required minimum commitment of service according to subdivision 3, the commissioner of health shall collect from the participant the total amount paid to the participant under the loan forgiveness program plus interest at a rate established according to section 270C.40. The commissioner shall deposit the money collected in the health care access fund to be credited to the health professional education loan forgiveness program account established in subdivision 2. The commissioner shall allow waivers of all or part of the money owed the commissioner as a result of a nonfulfillment penalty if emergency circumstances prevented fulfillment of the minimum service commitment.

[For text of subd 6, see M.S.2004]

History: 2005 c 151 art 2 s 17; 1Sp2005 c 4 art 6 s 13-16

144.1502 [Repealed, 1Sp2005 c 4 art 6 s 58]

144.212 DEFINITIONS.

[For text of subds 1 to 7, see M.S.2004]

Subd. 8. Vital record. "Vital record" means a record or report of birth, stillbirth, death, marriage, dissolution and annulment, and data related thereto. The birth record is not a medical record of the mother or the child.

[For text of subds 9 to 11, see M.S.2004]

History: 2005 c 60 s 2

144.214 LOCAL REGISTRARS OF VITAL STATISTICS.

[For text of subds 1 to 3, see M.S.2004]

Subd. 4. [Repealed, 2005 c 106 s 68]

144.2151 RECORD OF BIRTH RESULTING IN STILLBIRTH.

Subdivision 1. Filing. A record of birth for each birth resulting in a stillbirth in this state, on or after August 1, 2005, for which a fetal death report is required under section 144.222, subdivision 1, shall be filed with the state registrar within five days after the birth if the parent or parents of the stillbirth request to have a record of birth resulting in stillbirth prepared.

Subd. 2. Information to parents. The party responsible for filing a fetal death report under section 144.222, subdivision 1, shall advise the parent or parents of a stillbirth:

- (1) that they may request preparation of a record of birth resulting in stillbirth;
- (2) that preparation of the record is optional; and
- (3) how to obtain a certified copy of the record if one is requested and prepared.

Subd. 3. Preparation. (a) Within five days after delivery of a stillbirth, the parent or parents of the stillbirth may prepare and file the record with the state registrar if the parent or parents of the stillbirth, after being advised as provided in subdivision 2, request to have a record of birth resulting in stillbirth prepared.

(b) If the parent or parents of the stillbirth do not choose to provide a full name for the stillbirth, the parent or parents may choose to file only a last name.

(c) Either parent of the stillbirth or, if neither parent is available, another person with knowledge of the facts of the stillbirth shall attest to the accuracy of the personal data entered on the record in time to permit the filing of the record within five days after delivery.

Subd. 4. **Retroactive application.** Notwithstanding subdivisions 1 to 3, if a birth that occurred in this state at any time resulted in a stillbirth for which a fetal death report was required under section 144.222, subdivision 1, but a record of birth resulting in stillbirth was not prepared under subdivision 3, a parent of the stillbirth may submit to the state registrar, on or after August 1, 2005, a written request for preparation of a record of birth resulting in stillbirth and evidence of the facts of the stillbirth in the form and manner specified by the state registrar. The state registrar shall prepare and file the record of birth resulting in stillbirth within 30 days after receiving satisfactory evidence of the facts of the stillbirth.

Subd. 5. **Responsibilities of state registrar.** The state registrar shall:

(1) prescribe the form of and information to be included on a record of birth resulting in stillbirth, which shall be as similar as possible to the form of and information included on a record of birth;

(2) prescribe the form of and information to be provided by the parent of a stillbirth requesting a record of birth resulting in stillbirth under subdivisions 3 and 4 and make this form available on the Department of Health's Web site;

(3) issue a certified copy of a record of birth resulting in stillbirth to a parent of the stillbirth that is the subject of the record if:

(i) a record of birth resulting in stillbirth has been prepared and filed under subdivision 3 or 4; and

(ii) the parent requesting a certified copy of the record submits the request in writing; and

(4) create and implement a process for entering, preparing, and handling stillbirth records identical or as close as possible to the processes for birth and fetal death records when feasible, but no later than the date on which the next reprogramming of the Department of Health's database for vital records is completed.

History: 2005 c 60 s 1

144.221 DEATH REGISTRATION.

Subdivision 1. **When and where to file.** A death record for each death which occurs in the state shall be filed with the state registrar within five days after death and prior to final disposition.

[For text of subs 2 and 3, see M.S.2004]

History: 2005 c 106 s 56

144.222 REPORTS OF FETAL OR INFANT DEATH.

Subdivision 1. **Fetal death report required.** A fetal death report must be filed within five days of the death of a fetus for whom 20 or more weeks of gestation have elapsed, except for abortions defined under section 145.4241. A fetal death report must be prepared in a format prescribed by the state registrar and filed in accordance with Minnesota Rules, parts 4601.0100 to 4601.2600 by:

(1) a person in charge of an institution or that person's authorized designee if a fetus is delivered in the institution or en route to the institution;

(2) a physician, certified nurse midwife, or other licensed medical personnel in attendance at or immediately after the delivery if a fetus is delivered outside an institution; or

(3) a parent or other person in charge of the disposition of the remains if a fetal death occurred without medical attendance at or immediately after the delivery.

[For text of subd 2, see M.S.2004]

History: 2005 c 60 s 3

144.225 DISCLOSURE OF INFORMATION FROM VITAL RECORDS.

[For text of subds 1 to 6, see M.S.2004]

Subd. 7. **Certified birth or death record.** (a) The state or local registrar shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner:

(1) to a person who has a tangible interest in the requested vital record. A person who has a tangible interest is:

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) if the requested record is a death record, a sibling of the subject;

(vii) the party responsible for filing the vital record;

(viii) the legal custodian or guardian or conservator of the subject;

(ix) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(x) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

(xi) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

(xii) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

(xiii) adoption agencies in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties. An authorized governmental agency includes the Department of Human Services, the Department of Revenue, and the United States Immigration and Naturalization Service;

(3) to an attorney upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state or local registrar shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to (vii), if, on behalf of the individual, a licensed mortician furnishes the registrar with a properly completed attestation in the form provided by the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

[For text of subd 8, see M.S.2004]

History: 2005 c 23 s 1; 2005 c 106 s 57

144.226 FEES.

Subdivision 1. **Which services are for fee.** The fees for the following services shall be the following or an amount prescribed by rule of the commissioner:

(a) The fee for the issuance of a certified vital record or a certification that the vital record cannot be found is \$9. No fee shall be charged for a certified birth, stillbirth, or death record that is reissued within one year of the original issue, if an amendment is made to the vital record and if the previously issued vital record is surrendered. The fee is nonrefundable.

(b) The fee for processing a request for the replacement of a birth record for all events, except when filing a recognition of parentage pursuant to section 257.73, subdivision 1, is \$40. The fee is payable at the time of application and is nonrefundable.

(c) The fee for processing a request for the filing of a delayed registration of birth, stillbirth, or death is \$40. The fee is payable at the time of application and is nonrefundable. This fee includes one subsequent review of the request if the request is not acceptable upon the initial receipt.

(d) The fee for processing a request for the amendment of any vital record when requested more than 45 days after the filing of the vital record is \$40. No fee shall be charged for an amendment requested within 45 days after the filing of the vital record. The fee is payable at the time of application and is nonrefundable. This fee includes one subsequent review of the request if the request is not acceptable upon the initial receipt.

(e) The fee for processing a request for the verification of information from vital records is \$9 when the applicant furnishes the specific information to locate the vital record. When the applicant does not furnish specific information, the fee is \$20 per hour for staff time expended. Specific information includes the correct date of the event and the correct name of the registrant. Fees charged shall approximate the costs incurred in searching and copying the vital records. The fee is payable at the time of application and is nonrefundable.

(f) The fee for processing a request for the issuance of a copy of any document on file pertaining to a vital record or statement that a related document cannot be found is \$9. The fee is payable at the time of application and is nonrefundable.

[For text of subd 2, see M.S.2004]

Subd. 3. **Birth record surcharge.** In addition to any fee prescribed under subdivision 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or stillbirth record and for a certification that the vital record cannot be found. The local or state registrar shall forward this amount to the commissioner of finance for deposit into the account for the children's trust fund for the prevention of child abuse established under section 256E.22. This surcharge shall not be charged under those circumstances in which no fee for a certified birth or stillbirth record is permitted under subdivision 1, paragraph (a). Upon certification by the commissioner of finance that the assets in that fund exceed \$20,000,000, this surcharge shall be discontinued.

Subd. 4. **Vital records surcharge.** (a) In addition to any fee prescribed under subdivision 1, there is a nonrefundable surcharge of \$2 for each certified and noncertified birth, stillbirth, or death record, and for a certification that the record cannot be found. The local or state registrar shall forward this amount to the commissioner of finance to be deposited into the state government special revenue fund. This surcharge shall not be charged under those circumstances in which no fee for a birth, stillbirth, or death record is permitted under subdivision 1, paragraph (a).

(b) Effective August 1, 2005, to June 30, 2009, the surcharge in paragraph (a) shall be \$4.

Subd. 5. **Electronic verification.** A fee for the electronic verification of a vital event, when the information being verified is obtained from a certified birth or death record, shall be established through contractual or interagency agreements with interested local, state, or federal government agencies.

Subd. 6. **Alternative payment methods.** Notwithstanding subdivision 1, alternative payment methods may be approved and implemented by the state registrar or a local registrar.

History: 2005 c 60 s 4-6; 2005 c 98 art 1 s 24; 1Sp2005 c 4 art 6 s 17-20

144.335 ACCESS TO HEALTH RECORDS.

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meanings given them:

(a) "Patient" means a natural person who has received health care services from a provider for treatment or examination of a medical, psychiatric, or mental condition, the surviving spouse and parents of a deceased patient, or a person the patient appoints in writing as a representative, including a health care agent acting pursuant to chapter 145C, unless the authority of the agent has been limited by the principal in the principal's health care directive. Except for minors who have received health care services pursuant to sections 144.341 to 144.347, in the case of a minor, patient includes a parent or guardian, or a person acting as a parent or guardian in the absence of a parent or guardian.

(b) "Provider" means (1) any person who furnishes health care services and is regulated to furnish the services pursuant to chapter 147, 147A, 147B, 147C, 147D, 148, 148B, 148C, 148D; 150A, 151, 153, or 153A, or Minnesota Rules, chapter 4666; (2) a home care provider licensed under section 144A.46; (3) a health care facility licensed pursuant to this chapter or chapter 144A; (4) a physician assistant registered under chapter 147A; and (5) an unlicensed mental health practitioner regulated pursuant to sections 148B.60 to 148B.71.

(c) "Individually identifiable form" means a form in which the patient is or can be identified as the subject of the health records.

[For text of subs 2 to 6, see M.S.2004]

History: 2005 c 147 art 1 s 3

144.3351 IMMUNIZATION DATA.

Providers as defined in section 144.335, subdivision 1, group purchasers as defined in section 62J.03, subdivision 6, elementary or secondary schools or child care facilities as defined in section 121A.15, subdivision 9, public or private postsecondary educational institutions as defined in section 135A.14, subdivision 1, paragraph (b), a board of health as defined in section 145A.02, subdivision 2, community action agencies as defined in section 256E.31, subdivision 1, and the commissioner of health may exchange immunization data with one another, without the patient's consent, if the person requesting access provides services on behalf of the patient. For purposes of this section immunization data includes:

- (1) patient's name, address, date of birth, gender, parent or guardian's name; and
- (2) date vaccine was received, vaccine type, lot number, and manufacturer of all immunizations received by the patient, and whether there is a contraindication or an adverse reaction indication.

This section applies to all immunization data, regardless of when the immunization occurred.

History: 2005 c 98 art 1 s 24

144.3831 FEES.

Subdivision 1. **Fee setting.** The commissioner of health may assess an annual fee of \$6.36 for every service connection to a public water supply that is owned or operated by a home rule charter city, a statutory city, a city of the first class, or a town. The commissioner of health may also assess an annual fee for every service connection served by a water user district defined in section 110A.02.

[For text of subds 2 and 3, see M.S.2004]

History: 1Sp2005 c 4 art 6 s 21

NOTE: The amendment to subdivision 1 by Laws 2005, First Special Session chapter 4, article 6, section 21, is effective July 1, 2006. Laws 2005, First Special Session chapter 4, article 6, section 21, the effective date.

144.419 ISOLATION AND QUARANTINE OF PERSONS.

Subdivision 1. **Definitions.** For purposes of sections 144.419 to 144.4196, the following definitions apply:

(1) "bioterrorism" means the intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, infectious substance, or biological product, to cause death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism in order to influence the conduct of government or to intimidate or coerce a civilian population;

(2) "communicable disease" means a disease caused by a living organism or virus and believed to be caused by bioterrorism or a new or novel or previously controlled or eradicated infectious agent or biological toxin that can be transmitted person to person and for which isolation or quarantine is an effective control strategy, excluding a disease that is directly transmitted as defined under section 144.4172, subdivision 5;

(3) "isolation" means separation, during the period of communicability, of a person infected with a communicable disease, in a place and under conditions so as to prevent direct or indirect transmission of an infectious agent to others; and

(4) "quarantine" means restriction, during a period of communicability, of activities or travel of an otherwise healthy person who likely has been exposed to a communicable disease to prevent disease transmission during the period of communicability in the event the person is infected.

[For text of subds 2 to 5, see M.S.2004]

History: 2005 c 149 s 1

144.4195 DUE PROCESS FOR ISOLATION OR QUARANTINE OF PERSONS.

Subdivision 1. **Ex parte order for isolation or quarantine.** (a) Before isolating or quarantining a person or group of persons, the commissioner of health shall obtain a written, ex parte order authorizing the isolation or quarantine from the District Court of Ramsey County, the county where the person or group of persons is located, or a county adjoining the county where the person or group of persons is located. The evidence or testimony in support of an application may be made or taken by telephone, facsimile transmission, video equipment, or other electronic communication. The court shall grant the order upon a finding that probable cause exists to believe isolation or quarantine is warranted to protect the public health.

(b) The order must state the specific facts justifying isolation or quarantine, must state that the person being isolated or quarantined has a right to a court hearing under this section and a right to be represented by counsel during any proceeding under this section, and must be provided immediately to each person isolated or quarantined. The commissioner of health shall provide a copy of the authorizing order to the commissioner of public safety and other peace officers known to the commissioner to have jurisdiction over the site of the isolation or quarantine. If feasible, the commissioner of health shall give each person being isolated or quarantined an estimate of the expected period of the person's isolation or quarantine.

(c) If it is impracticable to provide individual orders to a group of persons isolated or quarantined, one order shall suffice to isolate or quarantine a group of persons believed to have been commonly infected with or exposed to a communicable disease. A copy of the order and notice shall be posted in a conspicuous place:

(1) in the isolation or quarantine premises, but only if the persons to be isolated or quarantined are already at the isolation or quarantine premises and have adequate access to the order posted there; or

(2) in another location where the group of persons to be isolated or quarantined is located, such that the persons have adequate access to the order posted there.

If the court determines that posting the order according to clause (1) or (2) is impractical due to the number of persons to be isolated or quarantined or the geographical area affected, the court must use the best means available to ensure that the affected persons are fully informed of the order and notice.

(d) Any peace officer, as defined in section 144.4803, subdivision 16, may use force as described by sections 609.06 and 609.066 to apprehend, hold, transport, quarantine, or isolate a person subject to the order if the person flees or forcibly resists the officer. This subdivision is authority to carry out enforcement duties under this section. The commissioner or an agent of a local board of health authorized under section 145A.04 shall advise the peace officer on request of protective measures recommended to protect the officer from possible transmission of the communicable disease. The peace officer may act upon telephone, facsimile, or other electronic notification of the order from the court, commissioner of health, agent of a local board of health, or commissioner of public safety. This paragraph expires August 1, 2009.

(e) No person may be isolated or quarantined pursuant to an order issued under this subdivision for longer than 21 days without a court hearing under subdivision 3 to determine whether isolation or quarantine should continue. A person who is isolated or quarantined may request a court hearing under subdivision 3 at any time before the expiration of the order.

Subd. 2. Temporary hold upon commissioner's directive. (a) Notwithstanding subdivision 1, the commissioner of health may by directive isolate or quarantine a person or group of persons without first obtaining a written, ex parte order from the court if a delay in isolating or quarantining the person or group of persons would significantly jeopardize the commissioner of health's ability to prevent or limit the transmission of a communicable or potentially communicable life-threatening disease to others. The directive shall specify the known period of incubation or communicability or the estimated period under the commissioner's best medical judgment when the disease is unknown. The directive remains in effect for the period specified unless amended by the commissioner or superseded by a court order. The commissioner must provide the person or group of persons subject to the temporary hold with notice that the person has a right to request a court hearing under this section and a right to be represented by counsel during a proceeding under this section. If it is impracticable to provide individual notice to each person subject to the temporary hold, notice of these rights may be posted in the same manner as the posting of orders under subdivision 1, paragraph (c). Immediately upon executing the directive and initiating notice of the parties subject to it, the commissioner shall initiate the process to apply for a written, ex parte order pursuant to subdivision 1 authorizing the isolation or quarantine. The court must rule within 24 hours of receipt of the application or sooner if practicable or necessary. If the person is under a temporary hold, the person may not be held in isolation or quarantine after the temporary hold expires unless the court issues an ex parte order under subdivision 1. If the court does not rule within 36 hours after the execution of the directive, the directive shall expire.

(b) At the same time the commissioner initiates the process to apply for a written, ex parte order under paragraph (a), the commissioner shall notify the governor, the majority and minority leaders of the senate, the speaker and majority and minority leaders of the house, and the chairs and the ranking minority members of the senate and house committees having jurisdiction over health policy that a directive for a temporary hold has been issued under this subdivision. Notice under this paragraph is governed by the data privacy provisions of subdivision 6.

(c) Any peace officer, as defined in section 144.4803, subdivision 16, may assist a public health official to apprehend, hold, transport, quarantine, or isolate a person

subject to the commissioner's directive. The peace officer may use force as described by sections 609.06 and 609.066. The commissioner or an agent of a local board of health authorized under section 145A.04 shall advise the peace officer on request of protective measures recommended to protect the officer from possible transmission of the communicable disease. The peace officer may act upon telephone, facsimile, or other electronic notification of the commissioner's directive or upon the request of an agent of a local board of health.

(d) If a person subject to a commissioner's directive under paragraph (a) is already institutionalized in an appropriate health care facility, the commissioner of health may direct the facility to continue to hold the person. The facility shall take all reasonable measures to prevent the person from exposing others to the communicable disease.

(e) This subdivision expires August 1, 2009.

[For text of subs 3 and 4, see M.S.2004]

Subd. 5. **Judicial procedures and decisions.** (a) Court orders issued pursuant to subdivision 3 or 4 shall be based upon clear and convincing evidence and a written record of the disposition of the case shall be made and retained.

(b) Any person subject to isolation or quarantine has the right to be represented by counsel. Persons not otherwise represented may request the court to appoint counsel at the expense of the Department of Health or of a local public health board that has entered into a written delegation agreement with the commissioner under subdivision 7. The court shall appoint counsel when so requested and may have one counsel represent a group of persons similarly situated. The appointments shall be only for representation under subdivisions 3 and 4 and for appeals of orders under subdivisions 3 and 4. On counsel's request, the commissioner or an agent of a local board of health authorized under section 145A.04 shall advise counsel of protective measures recommended to protect counsel from possible transmission of the communicable disease. Appointments shall be made and counsel compensated according to procedures developed by the Supreme Court. The procedures shall provide standards for determining indigency for purposes of appeal. A person seeking an appeal who does not meet the indigency standard may, upon motion by the commissioner of health or local public health board and subsequent court order, reimburse the Department of Health or local public health board for the attorney fees and costs incurred in the person's appeal. Counsel appointed for a respondent must be allowed to withdraw from representation and is not required to pursue an appeal if, in the opinion of counsel, there is insufficient basis for proceeding.

(c) The court may choose to conduct a hearing under subdivision 3 or 4 by telephonic, interactive video, or other electronic means to maintain isolation or quarantine precautions and reduce the risk of spread of a communicable disease. Otherwise, the manner in which the request for a hearing is filed and acted upon shall be in accordance with the existing laws and rules of the courts of this state or, if the isolation or quarantine occurs during a national security or peacetime emergency, any rules that are developed by the courts for use during a national security or peacetime emergency.

[For text of subs 6 and 7, see M.S.2004]

History: 2005 c 149 s 2-4

144.4196 EMPLOYEE PROTECTION.

Subdivision 1. **Definitions.** For purposes of this section:

(1) "qualifying employee" means a person who performs services for hire in Minnesota and who has been subject to isolation or quarantine for a communicable disease as defined in section 144.419, subdivision 1, clause (2). The term applies to persons who comply with isolation or quarantine restrictions because of:

- (i) a commissioner's directive;
- (ii) an order of a federal quarantine officer;

(iii) a state or federal court order; or
 (iv) a written recommendation of the commissioner or designee that the person enter isolation or quarantine; and

(2) "employer" means any person having one or more employees in Minnesota and includes the state and any political subdivision of the state.

Subd. 2. **Protections.** (a) An employer shall not discharge, discipline, threaten, or penalize a qualifying employee, or otherwise discriminate in the work terms, conditions, location, or privileges of the employee, because the employee has been in isolation or quarantine.

(b) A qualifying employee claiming a violation of paragraph (a) may bring a civil action for recovery of lost wages or benefits, for reinstatement, or for other relief within 180 days of the claimed violation or 180 days of the end of the isolation or quarantine, whichever is later. A qualifying employee who prevails shall be allowed reasonable attorney fees fixed by the court.

(c) Nothing in this subdivision is intended to alter sick leave or sick pay terms of the employment relationship.

Subd. 3. **Limitations.** The protections of subdivision 2 do not apply to work absences due to isolation or quarantine for periods longer than 21 consecutive work days. However, absences due to isolation or quarantine for periods longer than 21 consecutive work days resulting in loss of employment shall be treated for purposes of unemployment compensation in the same manner as loss of employment due to a serious illness.

History: 2005 c 149 s 5

144.4197 EMERGENCY VACCINE ADMINISTRATION AND LEGEND DRUG DISPENSING.

(a) When a mayor, county board chair, or legal successor to such official has declared a local emergency under section 12.29 or the governor has declared an emergency under section 12.31, subdivision 1 or 2, the commissioner of health may authorize any person, including, but not limited to, any person licensed or otherwise credentialed under chapters 144E, 147 to 148, 150A, 151, 153, or 156, to administer vaccinations or dispense legend drugs if the commissioner determines that such action is necessary to protect the health and safety of the public. The authorization shall be in writing and shall contain the categories of persons included in the authorization, any additional training required before performance of the vaccination or drug dispensing by such persons, any supervision required for performance of the vaccination or drug dispensing, and the duration of the authorization. The commissioner may, in writing, extend the scope and duration of the authorization as the emergency warrants. Any person authorized by the commissioner under this section shall not be subject to criminal liability, administrative penalty, professional discipline, or other administrative sanction for good faith performance of the vaccination or drug dispensing duties assigned according to this section.

(b) This section expires August 1, 2009.

History: 2005 c 149 s 6

144.55 LICENSES; ISSUANCE, SUSPENSION AND REVOCATION BY COMMISSIONER.

[For text of subs 1 to 1b, see M.S.2004]

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given:

(a) "Outpatient surgical center" or "center" means a freestanding facility organized for the specific purpose of providing elective outpatient surgery for preexamined, prediagnosed, low-risk patients. Admissions are limited to procedures that utilize general anesthesia or conscious sedation and that do not require overnight inpatient

care. An outpatient surgical center is not organized to provide regular emergency medical services and does not include a physician's or dentist's office or clinic for the practice of medicine, the practice of dentistry, or the delivery of primary care.

(b) "Approved accrediting organization" means the Joint Commission on Accreditation of Health Care Organizations or the American Osteopathic Association.

[For text of subd 3, see M.S.2004]

Subd. 4. Routine inspections; presumption. Any hospital surveyed and accredited under the standards of the hospital accreditation program of an approved accrediting organization that submits to the commissioner within a reasonable time copies of (a) its currently valid accreditation certificate and accreditation letter, together with accompanying recommendations and comments and (b) any further recommendations, progress reports and correspondence directly related to the accreditation is presumed to comply with application requirements of subdivision 1 and the standards requirements of subdivision 3 and no further routine inspections or accreditation information shall be required by the commissioner to determine compliance. Notwithstanding the provisions of sections 144.54 and 144.653, subdivisions 2 and 4, hospitals shall be inspected only as provided in this section. The provisions of section 144.653 relating to the assessment and collection of fines shall not apply to any hospital. The commissioner of health shall annually conduct, with notice, validation inspections of a selected sample of the number of hospitals accredited by an approved accrediting organization, not to exceed ten percent of accredited hospitals, for the purpose of determining compliance with the provisions of subdivision 3. If a validation survey discloses a failure to comply with subdivision 3, the provisions of section 144.653 relating to correction orders, reinspections, and notices of noncompliance shall apply. The commissioner shall also conduct any inspection necessary to determine whether hospital construction, addition, or remodeling projects comply with standards for construction promulgated in rules pursuant to subdivision 3. Pursuant to section 144.653, the commissioner shall inspect any hospital that does not have a currently valid hospital accreditation certificate from an approved accrediting organization. Nothing in this subdivision shall be construed to limit the investigative powers of the Office of Health Facility Complaints as established in sections 144A.51 to 144A.54.

Subd. 5. Coordination of inspections. Prior to conducting routine inspections of hospitals and outpatient surgical centers, a state agency shall notify the commissioner of its intention to inspect. The commissioner shall then determine whether the inspection is necessary in light of any previous inspections conducted by the commissioner, any other state agency, or an approved accrediting organization. The commissioner shall notify the agency of the determination and may authorize the agency to conduct the inspection. No state agency may routinely inspect any hospital without the authorization of the commissioner. The commissioner shall coordinate, insofar as is possible, routine inspections conducted by state agencies, so as to minimize the number of inspections to which hospitals are subject.

[For text of subds 6 to 11, see M.S.2004]

History: 2005 c 85 s 2-4

144.551 HOSPITAL CONSTRUCTION MORATORIUM.

Subdivision 1. Restricted construction or modification. (a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves adolescents and that receives more than 70 percent of its patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a combined licensed capacity of 130 beds or less if: (i) the new hospital site is located within five miles of the current site; and (ii) the total licensed capacity of the replacement hospital, either at the time of construction of the initial building or as the result of future expansion, will not exceed 70 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an existing state facility operated by the commissioner of human services to a new or existing facility, building, or complex operated by the commissioner of human services; from one regional treatment center site to another; or from one building or site to a new or existing building or site on the same campus;

(12) the construction or relocation of hospital beds operated by a hospital having a statutory obligation to provide hospital and medical services for the indigent that does not result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(13) a construction project involving the addition of up to 31 new beds in an existing nonfederal hospital in Beltrami County;

(14) a construction project involving the addition of up to eight new beds in an existing nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20 new hospital beds used for rehabilitation services in an existing hospital in Carver County serving the southwest suburban metropolitan area. Beds constructed under this clause shall not be eligible for reimbursement under medical assistance, general assistance medical care, or MinnesotaCare;

(16) a project for the construction or relocation of up to 20 hospital beds for the operation of up to two psychiatric facilities or units for children provided that the operation of the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County;

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds; or

(19) a critical access hospital established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law.

[For text of subs 2 to 4, see M.S.2004]

History: *1Sp2005 c 4 art 6 s 22*

144.562 SWING BED APPROVAL; ISSUANCE OF LICENSE CONDITIONS; VIOLATIONS.

[For text of subd 1, see M.S.2004]

Subd. 2. Eligibility for license condition. (a) A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66.

(b) Except for those critical access hospitals established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, eligible hospitals are allowed a total of 2,000 days of swing bed use per year. Critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, are allowed swing bed use as provided in federal law.

(c) Except for critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, the commissioner of health may approve swing bed use beyond 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient. Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available that are willing to admit the patient.

(d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking approval from the commissioner or being in violation of this subdivision. These six swing bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals subject to this limit.

(e) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year.

[For text of subds 3 to 6, see M.S.2004]

History: *1Sp2005 c 4 art 6 s 23*

144.574 EDUCATION ABOUT DANGERS OF SHAKING INFANTS AND YOUNG CHILDREN.

Subdivision 1. Education by hospitals. (a) A hospital licensed under sections 144.50 to 144.56 shall make available for viewing by the parents of each newborn baby delivered in the hospital a video presentation on the dangers associated with shaking infants and young children.

(b) A hospital shall use a video obtained from the commissioner or approved by the commissioner. The commissioner shall provide to a hospital and any interested individuals, at cost, copies of an approved video. The commissioner shall review other video presentations for possible approval upon the request of a hospital. The commissioner shall not require a hospital to use videos that would require the hospital to pay royalties for use of the video, restrict viewing in order to comply with public viewing or other restrictions, or be subject to other costs or restrictions associated with copyrights.

(c) A hospital shall, whenever possible, request both parents to view the video.

(d) The showing or distribution of the video shall not subject any person or facility to any action for damages or other relief provided the person or facility acted in good faith.

Subd. 2. Education by health care providers. The commissioner shall establish a protocol for health care providers to educate parents and primary caregivers about the dangers associated with shaking infants and young children. The commissioner shall request family practice physicians, pediatricians, and other pediatric health care providers to review these dangers with the parents and primary caregivers of infants and young children up to the age of three at each well-baby visit.

History: *1Sp2005 c 4 art 6 s 24*

STATEWIDE TRAUMA SYSTEM

144.602 DEFINITIONS.

Subdivision 1. Applicability. For purposes of sections 144.601 to 144.608, the terms defined in this section have the meanings given them.

Subd. 2. Commissioner. "Commissioner" means the commissioner of health.

Subd. 3. Major trauma. "Major trauma" means a sudden severe injury or damage to the body caused by an external force that results in potentially life-threatening injuries or that could result in the following disabilities:

- (1) impairment of cognitive or mental abilities;
- (2) impairment of physical functioning; or
- (3) disturbance of behavioral or emotional functioning.

Subd. 4. Trauma hospital. "Trauma hospital" means a hospital that voluntarily meets the commissioner's criteria under section 144.603 and that has been designated as a trauma hospital under section 144.605.

History: *1Sp2005 c 4 art 6 s 25*

144.603 STATEWIDE TRAUMA SYSTEM CRITERIA.

Subdivision 1. **Criteria established.** The commissioner shall adopt criteria to ensure that severely injured people are promptly transported and treated at trauma hospitals appropriate to the severity of injury. Minimum criteria shall address emergency medical service trauma triage and transportation guidelines as approved under section 144E.101, subdivision 14, designation of hospitals as trauma hospitals, interhospital transfers, a trauma registry, and a trauma system governance structure.

Subd. 2. **Basis; verification.** The commissioner shall base the establishment, implementation, and modifications to the criteria under subdivision 1 on the department-published Minnesota comprehensive statewide trauma system plan. The commissioner shall seek the advice of the Trauma Advisory Council in implementing and updating the criteria, using accepted and prevailing trauma transport, treatment, and referral standards of the American College of Surgeons, the American College of Emergency Physicians, the Minnesota Emergency Medical Services Regulatory Board, the national Trauma Resources Network, and other widely recognized trauma experts. The commissioner shall adapt and modify the standards as appropriate to accommodate Minnesota's unique geography and the state's hospital and health professional distribution and shall verify that the criteria are met by each hospital voluntarily participating in the statewide trauma system.

Subd. 3. **Rule exemption and report to legislature.** In developing and adopting the criteria under this section, the commissioner of health is exempt from chapter 14, including section 14.386. By September 1, 2009, the commissioner must report to the legislature on implementation of the voluntary trauma system, including recommendations on the need for including the trauma system criteria in rule.

History: *1Sp2005 c 4 art 6 s 26*

144.604 TRAUMA TRIAGE AND TRANSPORTATION.

Subdivision 1. **Transport requirement.** Unless the Emergency Medical Services Regulatory Board has approved a licensed ambulance service's deviation from the guidelines under section 144E.101, subdivision 14, the ambulance service must transport major trauma patients from the scene to the highest state-designated trauma hospital within 30 minutes' transport time.

Subd. 2. **Ground ambulance exceptions.** Notwithstanding subdivision 1, ground ambulances must comply with the following:

- (1) patients with compromised airways must be transported immediately to the nearest designated trauma hospital; and
- (2) level II trauma hospitals capable of providing definitive trauma care must not be bypassed to reach a level I trauma hospital.

Subd. 3. **Undesignated hospitals.** No major trauma patient shall be transported to a hospital not participating in the statewide trauma system unless no trauma hospital is available within 30 minutes' transport time.

History: *1Sp2005 c 4 art 6 s 27*

NOTE: This section, as added by Laws 2005, First Special Session chapter 4, article 6, section 27, is effective July 1, 2009. Laws 2005, First Special Session chapter 4, article 6, section 27, the effective date.

144.605 DESIGNATING TRAUMA HOSPITALS.

Subdivision 1. **Naming privileges.** Unless it has been designated a trauma hospital by the commissioner, no hospital shall use the term trauma center or trauma hospital in its name or its advertising or shall otherwise indicate it has trauma treatment capabilities.

Subd. 2. **Designation; reverification.** The commissioner shall designate four levels of trauma hospitals. A hospital that voluntarily meets the criteria for a particular level of trauma hospital shall apply to the commissioner for designation and, upon the commissioner's verifying the hospital meets the criteria, be designated a trauma hospital at the appropriate level for a three-year period. Prior to the expiration of the

three-year designation, a hospital seeking to remain part of the voluntary system must apply for and successfully complete a reverification process, be awaiting the site visit for the reverification, or be awaiting the results of the site visit. The commissioner may extend a hospital's existing designation for up to 18 months on a provisional basis if the hospital has applied for reverification in a timely manner but has not yet completed the reverification process within the expiration of the three-year designation and the extension is in the best interest of trauma system patient safety. To be granted a provisional extension, the hospital must be:

- (1) scheduled and awaiting the site visit for reverification;
- (2) awaiting the results of the site visit; or
- (3) responding to and correcting identified deficiencies identified in the site visit.

Subd. 3. ACS verification. The commissioner shall grant the appropriate level I, II, or III trauma hospital designation to a hospital that successfully completes and passes the American College of Surgeons (ACS) verification standards at the hospital's cost, submits verification documentation to the Trauma Advisory Council, and formally notifies the Trauma Advisory Council of ACS verification.

Subd. 4. Level III designation; not ACS verified. (a) The commissioner shall grant the appropriate level III trauma hospital designation to a hospital that is not ACS verified but that successfully completes the designation process under paragraph (b).

(b) The hospital must complete and submit a self-reported survey and application to the Trauma Advisory Council for review, verifying that the hospital meets the criteria as a level III trauma hospital. When the Trauma Advisory Council is satisfied the application is complete, the commissioner shall arrange a site review visit. Upon successful completion of the site review, the review team shall make written recommendations to the Trauma Advisory Council. If approved by the Trauma Advisory Council, a letter of recommendation shall be sent to the commissioner for final approval and designation.

Subd. 5. Level IV designation. (a) The commissioner shall grant the appropriate level IV trauma hospital designation to a hospital that successfully completes the designation process under paragraph (b).

(b) The hospital must complete and submit a self-reported survey and application to the Trauma Advisory Council for review, verifying that the hospital meets the criteria as a level IV trauma hospital. When the Trauma Advisory Council is satisfied the application is complete, the council shall review the application and, if the council approves the application, send a letter of recommendation to the commissioner for final approval and designation. The commissioner shall grant a level IV designation and shall arrange a site review visit within three years of the designation and every three years thereafter, to coincide with the three-year reverification process.

Subd. 6. Changes in designation. Changes in a trauma hospital's ability to meet the criteria for the hospital's level of designation must be self-reported to the Trauma Advisory Council and to other regional hospitals and local emergency medical services providers and authorities. If the hospital cannot correct its ability to meet the criteria for its level within six months, the hospital may apply for redesignation at a different level.

Subd. 7. Higher designation. A trauma hospital may apply for a higher trauma hospital designation one time during the hospital's three-year designation by completing the designation process for that level of trauma hospital.

Subd. 8. Loss of designation. The commissioner may refuse to designate or redesignate or may revoke a previously issued trauma hospital designation if a hospital does not meet the criteria of the statewide trauma plan, in the interests of patient safety, or if a hospital denies or refuses a reasonable request by the commissioner or the commissioner's designee to verify information by correspondence or an on-site visit.

History: *1Sp2005 c 4 art 6 s 28*

144.606 INTERHOSPITAL TRANSFERS.

Subdivision 1. **Written procedures required.** A level III or IV trauma hospital must have predetermined, written procedures that direct the internal process for rapidly and efficiently transferring a major trauma patient to definitive care, including:

- (1) clearly identified anatomic and physiologic criteria that, if met, will immediately initiate transfer to definitive care;
- (2) a listing of appropriate ground and air transport services, including primary and secondary telephone contact numbers; and
- (3) immediately available supplies, records, or other necessary resources that will accompany a patient.

Subd. 2. **Transfer agreements.** (a) A level III or IV trauma hospital may transfer patients to a hospital with which the trauma hospital has a written transfer agreement.

(b) Each agreement must be current and with a trauma hospital or trauma hospitals capable of caring for major trauma injuries.

(c) A level III or IV trauma hospital must have a current transfer agreement with a hospital that has special capabilities in the treatment of burn injuries and a transfer agreement with a second hospital that has special capabilities in the treatment of burn injuries, should the primary transfer hospital be unable to accept a burn patient.

History: *1Sp2005 c 4 art 6 s 29*

144.607 TRAUMA REGISTRY.

Subdivision 1. **Registry participation required.** A trauma hospital must participate in the statewide trauma registry.

Subd. 2. **Trauma reporting.** A trauma hospital must report major trauma injuries as part of the reporting for the traumatic brain injury and spinal cord injury registry required in sections 144.661 to 144.665.

Subd. 3. **Application of other law.** Sections 144.661 to 144.665 apply to a major trauma reported to the statewide trauma registry, with the exception of sections 144.662, clause (2), and 144.664, subdivision 3.

History: *1Sp2005 c 4 art 6 s 30*

144.608 TRAUMA ADVISORY COUNCIL.

Subdivision 1. **Trauma Advisory Council established.** (a) A Trauma Advisory Council is established to advise, consult with, and make recommendations to the commissioner on the development, maintenance, and improvement of a statewide trauma system.

(b) The council shall consist of the following members:

(1) a trauma surgeon certified by the American College of Surgeons who practices in a level I or II trauma hospital;

(2) a general surgeon certified by the American College of Surgeons whose practice includes trauma and who practices in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(3) a neurosurgeon certified by the American Board of Neurological Surgery who practices in a level I or II trauma hospital;

(4) a trauma program nurse manager or coordinator practicing in a level I or II trauma hospital;

(5) an emergency physician certified by the American College of Emergency Physicians whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

(6) an emergency room nurse manager who practices in a level III or IV trauma hospital;

(7) a family practice physician whose practice includes emergency room care in a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(8) a nurse practitioner, as defined under section 144.1501, subdivision 1, paragraph (h), or a physician assistant, as defined under section 144.1501, subdivision 1, paragraph (j), whose practice includes emergency room care in a level IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(9) a pediatrician certified by the American Academy of Pediatrics whose practice includes emergency room care in a level I, II, III, or IV trauma hospital;

(10) an orthopedic surgeon certified by the American Board of Orthopaedic Surgery whose practice includes trauma and who practices in a level I, II, or III trauma hospital;

(11) the state emergency medical services medical director appointed by the Emergency Medical Services Regulatory Board;

(12) a hospital administrator of a level III or IV trauma hospital located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b);

(13) a rehabilitation specialist whose practice includes rehabilitation of patients with major trauma injuries or traumatic brain injuries and spinal cord injuries as defined under section 144.661;

(14) an attendant or ambulance director who is an EMT, EMT-I, or EMT-P within the meaning of section 144E.001 and who actively practices with a licensed ambulance service in a primary service area located in a designated rural area as defined under section 144.1501, subdivision 1, paragraph (b); and

(15) the commissioner of public safety or the commissioner's designee.

(c) Council members whose appointment is dependent on practice in a level III or IV trauma hospital may be appointed to an initial term based upon their statements that the hospital intends to become a level III or IV facility by July 1, 2009.

Subd. 2. Council administration. (a) The council must meet at least twice a year but may meet more frequently at the call of the chair, a majority of the council members, or the commissioner.

(b) The terms, compensation, and removal of members of the council are governed by section 15.059, except that the council expires June 30, 2015.

(c) The council may appoint subcommittees and workgroups. Subcommittees shall consist of council members. Workgroups may include noncouncil members. Noncouncil members shall be compensated for workgroup activities under section 15.059, subdivision 3, but shall receive expenses only.

Subd. 3. Regional trauma advisory councils. (a) Up to eight regional trauma advisory councils may be formed as needed.

(b) Regional trauma advisory councils shall advise, consult with, and make recommendation to the state Trauma Advisory Council on suggested regional modifications to the statewide trauma criteria that will improve patient care and accommodate specific regional needs.

(c) Each regional advisory council must have no more than 15 members. The commissioner, in consultation with the Emergency Medical Services Regulatory Board, shall name the council members.

(d) Regional council members may receive expenses in the same manner and amount as authorized by the plan adopted under section 43A.18, subdivision 2.

History: 1Sp2005 c 4 art 6 s 31

144.6501 NURSING HOME ADMISSION CONTRACTS.

Subdivision 1. Definitions. For purposes of this section, the following terms have the meanings given them.

(a) "Facility" means a nursing home licensed under chapter 144A or a boarding care facility licensed under sections 144.50 to 144.58.

(b) "Contract of admission," "admission contract," or "admission agreement," includes, but is not limited to, all documents that a resident or resident's representative must sign at the time of, or as a condition of, admission to the facility. Oral representations and statements between the facility and the resident or resident's representative are not part of the contract of admission unless expressly contained in writing in those documents. The contract of admission must specify the obligations of the resident or the responsible party.

(c) "Legal representative" means an attorney-in-fact under a valid power of attorney executed by the prospective resident, or a conservator or guardian appointed for the prospective resident, or a representative payee appointed for the prospective resident, or other agent of limited powers.

(d) "Responsible party" means a person who has access to the resident's income and assets and who agrees to apply the resident's income and assets to pay for the resident's care or who agrees to make and complete an application for medical assistance on behalf of the resident.

[For text of subs 2 to 10, see M.S.2004]

History: 2005 c 10 art 4 s 1

144.9504 SECONDARY PREVENTION.

[For text of subd 1, see M.S.2004]

Subd. 2. **Lead risk assessment.** (a) An assessing agency shall conduct a lead risk assessment of a residence according to the venous blood lead level and time frame set forth in clauses (1) to (4) for purposes of secondary prevention:

(1) within 48 hours of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 60 micrograms of lead per deciliter of whole blood;

(2) within five working days of a child or pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than 45 micrograms of lead per deciliter of whole blood;

(3) within ten working days of a child in the residence being identified to the agency as having a venous blood lead level equal to or greater than 15 micrograms of lead per deciliter of whole blood; or

(4) within ten working days of a pregnant female in the residence being identified to the agency as having a venous blood lead level equal to or greater than ten micrograms of lead per deciliter of whole blood.

(b) Within the limits of available local, state, and federal appropriations, an assessing agency may also conduct a lead risk assessment for children with any elevated blood lead level.

(c) In a building with two or more dwelling units, an assessing agency shall assess the individual unit in which the conditions of this section are met and shall inspect all common areas accessible to a child. If a child visits one or more other sites such as another residence, or a residential or commercial child care facility, playground, or school, the assessing agency shall also inspect the other sites. The assessing agency shall have one additional day added to the time frame set forth in this subdivision to complete the lead risk assessment for each additional site.

(d) Within the limits of appropriations, the assessing agency shall identify the known addresses for the previous 12 months of the child or pregnant female with venous blood lead levels of at least 15 micrograms per deciliter for the child or at least ten micrograms per deciliter for the pregnant female; notify the property owners, landlords, and tenants at those addresses that an elevated blood lead level was found in a person who resided at the property; and give them primary prevention information. Within the limits of appropriations, the assessing agency may perform a risk assessment

and issue corrective orders in the properties, if it is likely that the previous address contributed to the child's or pregnant female's blood lead level. The assessing agency shall provide the notice required by this subdivision without identifying the child or pregnant female with the elevated blood lead level. The assessing agency is not required to obtain the consent of the child's parent or guardian or the consent of the pregnant female for purposes of this subdivision. This information shall be classified as private data on individuals as defined under section 13.02, subdivision 12.

(e) The assessing agency shall conduct the lead risk assessment according to rules adopted by the commissioner under section 144.9508. An assessing agency shall have lead risk assessments performed by lead risk assessors licensed by the commissioner according to rules adopted under section 144.9508. If a property owner refuses to allow a lead risk assessment, the assessing agency shall begin legal proceedings to gain entry to the property and the time frame for conducting a lead risk assessment set forth in this subdivision no longer applies. A lead risk assessor or assessing agency may observe the performance of lead hazard reduction in progress and shall enforce the provisions of this section under section 144.9509. Deteriorated painted surfaces, bare soil, and dust must be tested with appropriate analytical equipment to determine the lead content, except that deteriorated painted surfaces or bare soil need not be tested if the property owner agrees to engage in lead hazard reduction on those surfaces. The lead content of drinking water must be measured if another probable source of lead exposure is not identified. Within a standard metropolitan statistical area, an assessing agency may order lead hazard reduction of bare soil without measuring the lead content of the bare soil if the property is in a census tract in which soil sampling has been performed according to rules established by the commissioner and at least 25 percent of the soil samples contain lead concentrations above the standard in section 144.9508.

(f) Each assessing agency shall establish an administrative appeal procedure which allows a property owner to contest the nature and conditions of any lead order issued by the assessing agency. Assessing agencies must consider appeals that propose lower cost methods that make the residence lead safe. The commissioner shall use the authority and appeal procedure granted under sections 144.989 to 144.993.

(g) Sections 144.9501 to 144.9509 neither authorize nor prohibit an assessing agency from charging a property owner for the cost of a lead risk assessment.

[For text of subds 3 to 10, see M.S.2004]

History: 1Sp2005 c 4 art 6 s 32

144.98 CERTIFICATION OF ENVIRONMENTAL LABORATORIES.

[For text of subds 1 and 2, see M.S.2004]

Subd. 3. **Fees.** (a) An application for certification under subdivision 1 must be accompanied by the biennial fee specified in this subdivision. The fees are for:

- (1) base certification fee, \$1,600;
- (2) sample preparation techniques fees, \$100 per technique; and
- (3) test category certification fees:

Test Category	Certification Fee
Clean water program bacteriology	\$800
Safe drinking water program bacteriology	\$800
Clean water program inorganic chemistry	\$800
Safe drinking water program inorganic chemistry	\$800
Clean water program chemistry metals	\$1,200
Safe drinking water program chemistry metals	\$1,200
Resource conservation and recovery program chemistry metals	\$1,200
Clean water program volatile organic compounds	\$1,500

Safe drinking water program	
volatile organic compounds	\$1,500
Resource conservation and recovery program	
volatile organic compounds	\$1,500
Underground storage tank program	
volatile organic compounds	\$1,500
Clean water program other organic compounds	\$1,500
Safe drinking water program other organic compounds	\$1,500
Resource conservation and recovery program	
other organic compounds	\$1,500
Clean water program radiochemistry	\$2,500
Safe drinking water program radiochemistry	\$2,500
Resource conservation and recovery program	
agricultural contaminants	\$2,500
Resource conservation and recovery program	
emerging contaminants	\$2,500

(b) Laboratories located outside of this state that require an on-site inspection shall be assessed an additional \$3,750 fee.

(c) The total biennial certification fee includes the base fee, the sample preparation techniques fees, the test category fees, and, when applicable, the on-site inspection fee.

(d) Fees must be set so that the total fees support the laboratory certification program. Direct costs of the certification service include program administration, inspections, the agency's general support costs, and attorney general costs attributable to the fee function.

(e) A change fee shall be assessed if a laboratory requests additional analytes or methods at any time other than when applying for or renewing its certification. The change fee is equal to the test category certification fee for the analyte.

(f) A variance fee shall be assessed if a laboratory requests and is granted a variance from a rule adopted under this section. The variance fee is \$500 per variance.

(g) Refunds or credits shall not be made for analytes or methods requested but not approved.

(h) Certification of a laboratory shall not be awarded until all fees are paid.

[For text of subds 4 and 5, see M.S.2004]

History: *1Sp2005 c 4 art 6 s 33*