

**256.9685 ESTABLISHMENT OF INPATIENT HOSPITAL PAYMENT SYSTEM.**

Subdivision 1. **Authority.** The commissioner shall establish procedures for determining medical assistance payment rates under a prospective payment system for inpatient hospital services in hospitals that qualify as vendors of medical assistance. The commissioner shall establish, by rule, procedures for implementing this section and sections 256.9686, 256.969, and 256.9695. Services must meet the requirements of section 256B.04, subdivision 15, to be eligible for payment.

Subd. 1a. **Administrative reconsideration.** Notwithstanding section 256B.04, subdivision 15, the commissioner shall establish an administrative reconsideration process for appeals of inpatient hospital services determined to be medically unnecessary. A physician or hospital may request a reconsideration of the decision that inpatient hospital services are not medically necessary by submitting a written request for review to the commissioner within 30 days after receiving notice of the decision. The reconsideration process shall take place prior to the procedures of subdivision 1b and shall be conducted by the medical review agent that is independent of the case under reconsideration.

Subd. 1b. **Appeal of reconsideration.** Notwithstanding section 256B.72, the commissioner may recover inpatient hospital payments for services that have been determined to be medically unnecessary after the reconsideration and determinations. A physician or hospital may appeal the result of the reconsideration process by submitting a written request for review to the commissioner within 30 days after receiving notice of the action. The commissioner shall review the medical record and information submitted during the reconsideration process and the medical review agent's basis for the determination that the services were not medically necessary for inpatient hospital services. The commissioner shall issue an order upholding or reversing the decision of the reconsideration process based on the review.

Subd. 1c. **Judicial review.** A hospital or physician aggrieved by an order of the commissioner under subdivision 1b may appeal the order to the district court of the county in which the physician or hospital is located by:

(1) serving a written copy of a notice of appeal upon the commissioner within 30 days after the date the commissioner issued the order; and

(2) filing the original notice of appeal and proof of service with the court administrator of the district court. The appeal shall be treated as a dispositive motion under the Minnesota General Rules of Practice, rule 115. The district court scope of review shall be as set forth in section 14.69.

Subd. 1d. **Transmittal of record.** Within 30 days after being served with the notice of appeal, the commissioner shall transmit to the district court the original or certified copy of the entire record considered by the commissioner in making the final agency decision. The district court shall not consider evidence that was not included in the record before the commissioner.

Subd. 2. **Federal requirements.** If it is determined that a provision of this section or section 256.9686, 256.969, or 256.9695 conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare limitations.

**History:** 1989 c 282 art 3 s 36; 1991 c 292 art 4 s 22; 1992 c 513 art 7 s 22; 1Sp1993 c 1 art 5 s 17; 1995 c 207 art 6 s 16-18; 1997 c 187 art 1 s 19; 1998 c 407 art 4 s 8; 1999 c 245 art 4 s 24; 2002 c 277 s 7; 2014 c 312 art 24 s 3,4; 1Sp2017 c 6 art 4 s 5,6