

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the SIRS Appeal of Maple
Grove Hospital

**FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND RECOMMENDATION**

The above-entitled matter came before Administrative Law Judge Barbara J. Case for a hearing on June 3, 2015. The record closed on July 7, 2015, with the filing of post-hearing briefs.

Stephanie Hilstrom, Assistant Attorney General, appeared on behalf of the Department of Human Services (Department). Katherine B. Iiten, Frederikson & Byron, P.A., appeared on behalf of Maple Grove Hospital (Hospital).

STATEMENT OF THE ISSUE

Did the Department correctly determine that it overpaid the Hospital \$4,449.72 in medical assistance benefits for inpatient services provided to [Patient] from [redacted], 2011?

SUMMARY OF CONCLUSIONS

The Administrative Law Judge concludes that, because the Department's medical reviewers did not apply the required protocol to determine if [Patient's] inpatient treatment was medically necessary, the Department has failed to demonstrate that it overpaid \$4,449.72 in medical assistance benefits to Maple Grove Hospital.

The Administrative Law Judge concludes that Melanie Kirkland's testimony shall not be stricken from the record.

Based on the evidence in the hearing record, the Administrative Law Judge makes the following:

FINDINGS OF FACT

Background Information

1. In [redacted] 2011, [Patient] started having back pain.¹ [Patient] visited her primary care physician, who prescribed a muscle relaxer and 400 mg of Ibuprofen every six hours.²

2. On [redacted], 2011, [Patient] went to urgent care for her back pain.³ The attending physician prescribed Prednisone and Hydrocodone.⁴

3. On [redacted], 2011, [Patient] again visited her primary care physician due to increased back pain.⁵ [Patient's] primary care physician recommended an MRI, which showed narrowing of areas in the spine around the nerves.⁶ [Patient's] primary care physician advised her to go to the emergency room for pain management if necessary.⁷

4. On [redacted], 2011, [Patient] went to the Hospital's emergency room with severe lower back pain radiating into her right leg.⁸ [Patient] rated her pain level 10/10, and stated that she was unable to sit or lay without discomfort.⁹ She further indicated that she was experiencing some numbness, but no weakness.¹⁰ [Patient] informed the nurse that she had taken three Vicodin without any relief.¹¹

5. The attending physician decided to admit [Patient] in an effort to manage her pain.¹² [Patient] is covered by the Minnesota Medical Assistance (MA) Program, which includes Medicaid.¹³

6. In the emergency room, the doctors gave [Patient] Dilaudid, an intravenous pain medication; Solumedrol, an intravenous anti-inflammatory; Toradol, a non-steroidal anti-inflammatory; and Flexeril, an oral muscle relaxant.¹⁴

¹ Ex. 4 at DHS 150; Testimony (Test.) of Eric Shore.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ Ex. 2 at DHS 18.

⁶ *Id.*; Test. of E. Shore; Test. of Muhammed Emran.

⁷ Ex. 2 at DHS 18; Test. of E. Shore.

⁸ *Id.*

⁹ Ex. 2 at DHS 18, Ex. 4 at DHS 151; Test. of E. Shore.

¹⁰ Ex. 2 at DHS 18.

¹¹ *Id.*

¹² Ex. 4 at DHS 151; Test. of M. Emran.

¹³ Test. of Penny Cell.

¹⁴ Ex. 4 at DHS 151; Test. of E. Shore; Test. of M. Emran.

7. By 10:50 p.m., [Patient's] pain level was down to 2/10.¹⁵ Following a "spine consult," the physician recommended continued pain management and a follow-up appointment after discharge.¹⁶

8. On [redacted], 2011, [Patient's] pain varied from 2/10 to 10/10.¹⁷ In addition to the medications previously listed, the doctors gave [Patient] Celebrex, a nonsteroidal anti-inflammatory; Neurontin, an anti-epileptic used to treat nerve pain; Liboderm patches; a local anesthetic; and Percocet, an opioid pain medication.¹⁸

9. On [redacted], 2011, [Patient's] pain was under control, and she was discharged from the Hospital after scheduling a follow-up appointment with a spine specialist.¹⁹

Procedural Posture

10. The Hospital submitted a claim for [Patient's] care to the Department for reimbursement.²⁰ The Department paid the Hospital \$4,449.72 in MA benefits.²¹

11. On August 30, 2013, the Surveillance and Integrity Review Section (SIRS) of the Department notified the Hospital that Health Management Systems, Inc. (HMS), the state of Minnesota's Recovery Audit Contractor (RAC), would be auditing its "provider claims and associated medical and financial records."²²

12. HMS notified the Hospital that it had been hired by SIRS to "complete a post-payment review and verify that claims have been paid according to Minnesota Medicaid Policy."²³ HMS requested certain medical records for review, including [Patient's] hospital admission records from [redacted], 2011.²⁴ The Hospital provided those records to HMS.²⁵

13. On October 25, 2013, HMS issued an Initial Physician Review denying reimbursement for [Patient's] hospitalization.²⁶ The reviewing physician stated that [Patient] "could have been managed with outpatient pain control with observational status while obtaining above referenced work up."²⁷

14. On November 15, 2013, HMS issued preliminary results of the review and an audit detail report, which indicated an overpayment of \$4,449.72 for [Patient's]

¹⁵ Ex. 4 at DHS 151; Test. of M. Emran.

¹⁶ Ex. 4, at DHS 151; Test. of E. Shore.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ See Test. of P. Cell.

²¹ See *id.*

²² Ex. 1 at DHS 8.

²³ *Id.* at DHS 9.

²⁴ *Id.* at DHS 11.

²⁵ Ex. 2.

²⁶ Ex. 3, at DHS 3.

²⁷ *Id.*

inpatient care.²⁸ The audit report stated that a “[r]eview of medical records showed the patient should have received lower level of care.”²⁹

15. On November 27, 2013, the Hospital requested an appeal of the reimbursement denial.³⁰

16. On January 5, 2014, HMS issued a Reconsideration Physician Review.³¹ The second physician likewise denied reimbursement because [Patient] “should have been admitted to observation as the presentation and medical necessity did not warrant inpatient.”³²

17. On January 28, 2014, the Department issued a Notice of Agency Action, stating that “[b]ased on a thorough review of the additional records and any other information you may have provided, HMS has concluded that its overpayment determination was accurate.”³³ The Department therefore stated that it would seek to recover \$4,449.72 in overpaid funds for [Patient’s] inpatient care.³⁴ HMS also provided the Hospital with a new audit report, stating that an outpatient or observational setting would have been appropriate for [Patient’s] treatment and that, as a result, [Patient’s] admission to the Hospital was not medically necessary.³⁵

18. The Hospital appealed the Department’s overpayment determination, and on February 19, 2015, the Department issued a Notice and Order for Prehearing Conference and Hearing.³⁶

Hearing

19. The Administrative Law Judge held an evidentiary hearing on June 3, 2015. At the evidentiary hearing, the parties stipulated that the Department does not have a copy of the Appropriateness Evaluation Protocol (AEP), a screening tool used to determine whether hospital admission is medically necessary and referenced in the Department’s administrative rules.³⁷

20. At the hearing, Ms. Melanie Kirkland, a nurse employed by HMS, testified that InterQual is a “screening tool” used by HMS nurses to determine whether a patient’s treatment was medically necessary.³⁸ InterQual provides “evidence based sets of criteria that are utilized for screening cases for medical necessity of admission to an inpatient

²⁸ *Id.* at DHS 146.

²⁹ *Id.* at DHS 148.

³⁰ Ex. 4, at DHS 150-53.

³¹ Ex. 5, at DHS 4.

³² *Id.*

³³ *Id.* at DHS 285.

³⁴ *Id.*

³⁵ *Id.* at DHS 287.

³⁶ Notice and Order for Prehearing Conference and Hearing (Feb. 19, 2015).

³⁷ See Minn. R. 9505.0530 (2015).

³⁸ Test. of Melanie Kirkland.

level of care.”³⁹ Ms. Kirkland further testified that if a patient does not meet the criteria for inpatient admission, the patient should be treated at a lower level of care, such as observation.⁴⁰

21. Ms. Kirkland testified that, based on her review of [Patient’s] medical records, [Patient’s] hospital admission was not medically necessary under the InterQual criteria.⁴¹

22. Ms. Kirkland testified that HMS’s “arrangement” with the Department requires them to apply the InterQual criteria when determining medical necessity for inpatient care.⁴² The Department does not have access to the InterQual criteria used by HMS to evaluate patient records because it is proprietary.

23. Ms. Kirkland testified that another screening tool, the Milliman Care Guidelines, is generally accepted in the medical industry.⁴³ Ms. Kirkland stated that a decision as to whether or not a patient should be admitted to the hospital could depend on which of these two screening tools is applied.⁴⁴

24. The Hospital applied the Milliman Guidelines when determining whether to admit [Patient]⁴⁵

25. Ms. Kirkland testified that she had never heard of the AEP.⁴⁶

26. Dr. Muhammed Emran testified that, based on his review of [Patient’s] medical records, [Patient’s] hospital admission was not medically necessary.⁴⁷ Dr. Emran did not use a screening tool to make his determination, instead relying on medical articles and his own expertise.⁴⁸ Dr. Emran testified that he had never heard of the AEP.⁴⁹

27. Dr. Eric Shore testified that there are two tissues in the human body that do not heal once damaged: teeth and nerve tissue.⁵⁰ It is therefore important to treat potential nerve damage quickly to avoid permanent damage.⁵¹ Moreover, Dr. Shore testified that the medications given to [Patient] could have caused drowsiness (creating

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ Ex. 4 at DHS 151.

⁴⁶ *Id.*

⁴⁷ Test. of M. Emran.

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ Test. of E. Shore.

⁵¹ *Id.*

a fall risk) and suppressed respiration.⁵² Dr. Shore therefore concluded that [Patient's] hospital admission was medically necessary.⁵³

28. Ms. Penny Cell, a senior investigator for SIRS, also testified at the evidentiary hearing.⁵⁴ Ms. Cell testified that the Department did not apply the AEP in this case.⁵⁵ In fact, she testified that she does not believe the AEP still exists because she "could not find it."⁵⁶ She stated she has worked for the state for 20 years and has "never seen it."⁵⁷ Ms. Cell stated that application of the AEP is no longer appropriate as it does not fit "the prevailing community standards."⁵⁸

29. The Department's provider manual, which is to be used by providers in applying the Department's coverage rules, referenced the AEP until very recently.⁵⁹

30. Ms. Cell testified that the Department relies on Minn. R. 9505.0210 (2015) to apply the guidelines that conform to the prevailing community standards rather than the AEP.⁶⁰

31. Ms. Cell further testified that the medical review contractors hired by the Department use InterQual or Milliman's Guidelines.⁶¹ She stated that HMS used the InterQual guidelines in this case, but that the Department tells HMS to use whatever criteria they think is most appropriate.⁶²

32. Ms. Cell acknowledged that the Department and HMS are required to follow the Minnesota administrative rules.⁶³ Ms. Cell testified that hospitals know which protocol to follow because they use the "prevailing community standards."⁶⁴

33. On July 7, 2015, the parties submitted post-hearing briefs. The record closed on that date.

Based on these Findings of Fact, the Administrative Law Judge makes the following:

⁵² *Id.*; see also, Ex. 100.

⁵³ Test. of E. Shore; see also, Ex. 100.

⁵⁴ Test. of P. Cell.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

CONCLUSIONS OF LAW

1. The Administrative Law Judge and the Commissioner of Human Services have jurisdiction to consider this matter pursuant to Minn. Stat. §§ 14.50, 256B.04, subd. 15(c), .064, subd. 2 (2014).

2. The Department has complied with all relevant procedural requirements of statute and rule.

Regulatory Framework

3. Medicaid is a jointly-financed federal and state program established under Title XIX of the United States Social Security Act.⁶⁵ Its purpose is to provide necessary medical assistance to eligible persons who have insufficient income and resources to pay for the cost of their medical care.⁶⁶

4. The federal government shares the cost of providing medical assistance with states that elect to participate in the Medicaid program.⁶⁷ In return, the states must comply with federal statutes and the rules issued by the Centers for Medicare and Medicaid (CMS) of the U.S. Department of Health and Human Services.⁶⁸ CMS regulations require states to have surveillance and utilization control programs in order to guard against the “unnecessary or inappropriate use of Medicaid services and . . . excess payments.”⁶⁹ In order to discover and correct inappropriate use of Medicaid payments and excess payments, states must conduct post-payment reviews.⁷⁰

5. The Medicaid program in Minnesota is administered by the Department and is a Minnesota Health Care Program (MHCP), commonly referred to as Medical Assistance (MA).⁷¹ Because the Department receives and administers federal funds, it must establish and maintain a program of utilization review in order to prevent the unnecessary or inappropriate use of MA, and to determine whether excess MA payments are being made.⁷² If the Department discovers that a provider has inappropriately billed MA or erroneously received excess payments, state law permits the Department to impose sanctions on the provider and/or recover the excess payments.⁷³

⁶⁵ 42 U.S.C. §§ 1396-1396w-5 (2014).

⁶⁶ See 42 U.S.C. § 1396-1; see also *Atkins v. Rivera*, 477 U.S. 154, 156 (1986) (“In Massachusetts, persons who lack sufficient income, measured on a monthly basis, to meet their basic needs automatically qualify for Medicaid.”).

⁶⁷ See 42 U.S.C. §§ 1396a, b.

⁶⁸ See 42 U.S.C. § 1396a; 42 C.F.R. § 430.10 (2014); see also *Atkins*, 477 U.S. at 156-57 (“The Federal Government shares the costs of Medicaid with States that elect to participate in the program. In return, participating States are to comply with requirements imposed by the Act and by the Secretary of Health and Human Services.”).

⁶⁹ 42 C.F.R. § 456.3(a) (2014).

⁷⁰ 42 C.F.R. § 456.23 (2014).

⁷¹ See Minn. Stat. §§ 256B.01-.85 (2014).

⁷² Minn. Stat. § 256B.04, subd. 15(a); see also 42 C.F.R. §§ 456.1-.725 (2014).

⁷³ See Minn. Stat. §§ 256B.064, .0641.

6. In order to safeguard against inappropriate use of MA and excess MA payments, the Department created SIRS and promulgated rules to monitor providers' compliance with federal and state rules, regulations, and statutes.⁷⁴ SIRS conducts post-payment reviews or audits of claims submitted for MA payments.⁷⁵ These investigations are necessary to prevent fraud and abuse, as well as to detect instances of improper payment of MA funds due to error or inadvertence.⁷⁶

7. The Department bears the burden of demonstrating, by a preponderance of evidence, an overpayment of MA funds under Minn. Stat. § 256B.064.⁷⁷

8. The Department is entitled to recover from a provider funds improperly paid "for services not medically necessary."⁷⁸

9. The Department's administrative rules state that "[i]npatient hospital admission and services are not eligible for payment under the medical assistance program if they are not medically necessary under parts 9505.0501 to 9505.0545."⁷⁹

10. Medically necessary "means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in part 9505.0530 cannot be provided on an outpatient or other basis."⁸⁰

11. Minnesota Rules part 9505.0530 provides that "[t]he medical review agent⁸¹ shall follow the medical necessity criteria specified in subparts 2 and 3 in determining . . . whether a recipient's admission is medically necessary." Subpart 2, which is the relevant provision here, states that "[t]he most recent edition of the Appropriateness Evaluation Protocol of the National Institutes of Health is incorporated by reference. The book was published in 1984 by the Health Data Institute . . . and it is available through the Minitex interlibrary loan system. The book is not subject to change."

12. HMS served as the Department's medical review agent for this case.

13. Because HMS did not utilize the AEP, and the Department failed to demonstrate that [Patient's] care would not have been found medically necessary under any of the review tools currently in use, the Department is therefore unable to prove that it overpaid MA benefits to the Hospital for [Patient's] inpatient care.

⁷⁴ See Minn. R. 9505.2160-.2245 (2015).

⁷⁵ See 42 CFR § 456.23 (requiring post-payment reviews); Minn. Stat. § 256B.04, subd. 15(a) (requiring post-payment reviews).

⁷⁶ See Minn. R. 9505.2200, subp. 1, .2215, subp. 1(A).

⁷⁷ Minn. R. 1400.7300, subp. 5 (2015)

⁷⁸ Minn. Stat. § 256B.064, subd. 1c(a) (2014).

⁷⁹ Minn. R. 9505.0300, subp. 5 (2015).

⁸⁰ Minn. R. 9505.0505, subp. 19 (2015).

⁸¹ A medical review agent is "the representative of the commissioner who is authorized by the commissioner to administer procedures for admission certifications, medical record reviews and reconsideration, and perform other functions as stipulated in the terms of the agent's contract with the department." *Id.*, subp. 18 (2015).

Based on these Conclusions of Law, and for the reasons set out in the accompanying Memorandum, the Administrative Law Judge makes the following:

RECOMMENDATION

The Administrative Law Judge recommends that the Department's Notice of Agency Action seeking to recover \$4,449.72 from the Maple Grove Hospital be reversed.

Dated: August 25, 2015

s/Barbara J. Case

BARBARA J. CASE
Administrative Law Judge

Reported: Digitally recorded; no transcript prepared.

NOTICE

This Report is a recommendation, not a final decision. The Commissioner of Human Services (the Commissioner) will make the final decision after a review of the record. Under Minn. Stat. § 14.61 (2014), the Commissioner shall not make a final decision until this Report has been made available to the parties for at least ten calendar days. The parties may file exceptions to this Report and the Commissioner must consider the exceptions in making a final decision. Parties should contact Debra Schumacher, Administrative Law Attorney, PO Box 64998, St. Paul, MN 55164, (651) 431-4319 to learn the procedure for filing exceptions or presenting argument.

The record closes upon the filing of exceptions to the Report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and Administrative Law Judge of the date the record closes. If the Commissioner fails to issue a final decision within 90 days of the close of the record, this Report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a (2014). In order to comply with this statute, the Commissioner must then return the record to the Administrative Law Judge within ten working days to allow the Judge to determine the discipline imposed.

Under Minn. Stat. § 14.62, subd. 1 (2014), the Commissioner is required to serve her final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

MEMORANDUM

Background

In [redacted] 2011, [Patient] was admitted to Maple Grove Hospital for severe lower back pain.⁸² The Hospital applied the Milliman Guidelines and determined that [Patient] should be admitted for inpatient care.⁸³ The Department thereafter paid the Hospital \$4,449.72 in MA funds for [Patient's] inpatient care.

Following a routine audit, the Department issued a Notice of Agency Action seeking to recover the \$4,449.72 relating to [Patient's] inpatient care from the Hospital.⁸⁴ HMS, the Department's medical review agent, informed the Hospital that an outpatient or observational setting would have been appropriate for [Patient's] treatment and that, as a result, [Patient's] admission to the Hospital was not medically necessary.⁸⁵ HMS applied InterQual when making its determination that [Patient's] inpatient treatment was not medically necessary.⁸⁶

The Department's administrative rules state that "[i]npatient hospital admission and services are not eligible for payment under the medical assistance program if they are not medically necessary under parts 9505.0501 to 9505.0545."⁸⁷ Medically necessary "means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in part 9505.0530 cannot be provided on an outpatient or other basis."⁸⁸ Minnesota Rule 9505.0530 provides that "[t]he medical review agent⁸⁹ shall follow the medical necessity criteria specified in subparts 2 and 3 in determining . . . whether a recipient's admission is medically necessary." Subpart 2, which is the relevant provision here, states that "[t]he most recent edition of the Appropriateness Evaluation Protocol of the National Institutes of Health is incorporated by reference. The book was published in 1984 by the Health Data Institute . . . and it is available through the Minitex interlibrary loan system. The book is not subject to change."

It is undisputed that HMS did not apply the AEP to the facts of this case. In fact, neither HMS nor the Department even have a copy of the AEP. Rather, HMS applied one of two protocols commonly used in the industry: InterQual.⁹⁰ But the plain language of the rule required HMS to apply the AEP when determining whether [Patient's] hospital

⁸² Ex. 4, at DHS 150-51.

⁸³ *Id.*

⁸⁴ Ex. 5, at DHS 285.

⁸⁵ *Id.*, at DHS 287.

⁸⁶ Test. of M. Kirkland.

⁸⁷ Minn. R. 9505.0300, subp. 5.

⁸⁸ Minn. R. 9505.0505, subp. 19.

⁸⁹ A medical review agent is "the representative of the commissioner who is authorized by the commissioner to administer procedures for admission certifications, medical record reviews and reconsideration, and perform other functions as stipulated in the terms of the agent's contract with the department." *Id.*, subp. 18.

⁹⁰ Test. of M. Kirkland.

admission was medically necessary.⁹¹ And the Department failed to introduce any evidence indicating that, had HMS applied the AEP, its conclusions as to medical necessity would have been the same. It is therefore not possible for the Administrative Law Judge to conclude that the Department's failure to apply the AEP was harmless error.⁹²

The Department argues that because "the current community standard is not the AEP," it was unnecessary to apply it to the facts of this case.⁹³ The Department states that "[t]he testimony in this case clearly established that the AEP is not the prevailing community standard, but rather the doctors in this case relied on the current community standards of care, and customary practice."⁹⁴ The Department relies on Minn. R. 9505.0210 to support its argument, which states that "the medical assistance program shall pay for a covered service provided to a recipient To be eligible for payment, a health service must . . . be determined by prevailing community standards or customary practice and usage to . . . be medically necessary."

First, the Department's reliance is misplaced because this argument runs counter to the principle of statutory construction that a more specific law prevails over the general.⁹⁵ And despite Ms. Cell's testimony that application of the AEP is "no longer appropriate," rule 9505.0530 clearly states that AEP's status as the applicable criteria "is not subject to change." Lastly, although the Department's assertion that the AEP is not the prevailing community standard may be correct, this fact is irrelevant because Minn. R. 9505.0530 requires the Department's medical review agent to apply the AEP, regardless of its prevalence in the community.

In the alternative, even assuming that the "prevailing community standard" approach is appropriate, HMS applied InterQual to the facts of this case, whereas the Hospital used the Milliman Guidelines. The Department does not dispute that both standards are commonly used in the industry. In fact, Ms. Cell testified that the medical review contractors hired by the Department use either InterQual or the Milliman Guidelines.⁹⁶ And the Department's witness, Ms. Kirkland, testified that the outcome of a case might depend on which screening tool is used.⁹⁷ Yet, the Department presented

⁹¹ See *Hy-Vee Food Stores, Inc. v. Minn. Dep't of Health*, 705 N.W.2d 181, 189 (Minn. 2005) (stating that "it is unnecessary to look beyond the plain language of administrative rules where, as here, their meaning is unambiguous"); see also *St. Joseph's Med. Ctr. v. Dep't of Human Servs.*, Nos C0-98-2172, C8-98-2260, 1999 WL 391613, at *4 (Minn. Ct. App. 1999) (stating that "[w]hether inpatient psychiatric hospitalization is 'medically necessary' is based on criteria referenced at Minn. R. 9505.0530 (1997)").

⁹² See Minn. R. Civ. P. 61 ("The court at every stage of the proceeding must disregard any error or defect in the proceeding which does not affect the substantial rights of the parties.").

⁹³ Closing Argument of the Minnesota Department of Human Services (July 7, 2015).

⁹⁴ *Id.*

⁹⁵ See Minn. Stat. § 645.26, subd. 1 (2014) ("When a general provision in a law is in conflict with a special provision in the same or another law, the two shall be construed, if possible, so that effect may be given to both. If the conflict between the two provisions be irreconcilable, the special provision shall prevail and shall be construed as an exception to the general provision, unless the general provision shall be enacted at a later session and it shall be the manifest intention of the legislature that such general provision shall prevail.").

⁹⁶ Test. of P. Cell.

⁹⁷ Test. of M. Kirkland.

no evidence demonstrating that, under the Milliman Guidelines, [Patient's] inpatient admission was not medically necessary. Therefore, even assuming that the Department is correct and the proper standard to be applied is the "prevailing community standard," the Milliman Guidelines fall within that definition, and the Department has failed to carry its burden to demonstrate that it overpaid MA funds because [Patient's] hospitalization was not medically necessary.

Moreover, the Department's "prevailing community standard" argument lacks some credibility because there are *two* generally accepted screening tools in the industry. The logical purpose for designating an applicable protocol is predictability and transparency. It seems logical that hospitals might be able to minimize MA overpayments by applying the same criteria to hospital admission as those used by medical review agents. This result would be advantageous to providers and the Department alike and might explain the Department's decision to promulgate one protocol in its administrative rules. Nonetheless, the hearing testimony indicates that there are two commonly used standards in the industry, the result might be affected by which one is applied, and the Department instructs HMS to use the standard it deems best.⁹⁸ This approach decreases predictability and weakens the Department's assertion that the prevailing community standard is the appropriate criteria, not the AEP.

Lastly, the Administrative Law Judge notes that the Department promulgated Minn. R. 9505.0530. The Department likewise has the authority to change that rule to reflect the criteria that it would like its medical review agents to apply. The Hospital cannot be held accountable for the Department's decision to leave its applicable rule unaltered despite the AEP's current irrelevancy in the industry.

In sum, HMS failed to use the AEP, which is the required protocol under the Department's administrative rules. Therefore, the Department's Notice of Agency Action, which relied on HMS's determination, should be reversed.

B. J. C.

⁹⁸ Test. of M. Kirkland; Test. of P. Cell.