CHAPTER 9505
DEPARTMENT OF HUMAN SERVICES
HEALTH CARE PROGRAMS

HOSPITAL ADMISSIONS CERTIFICATION

9505.0500 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9505.0500 to 9505.0540, the following terms have the meanings given them.

Subp. 2. **Admission.** "Admission" means the act that allows the recipient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Subp. 3. **Admission certification.** "Admission certification" means the determination of the medical review agent that inpatient hospitalization is medically necessary and that medical assistance or general assistance medical care funds may be used to pay the admitting physician, hospital, and other vendors of inpatient hospital services for providing medically necessary services, subject to parts 9500.0750 to 9500.1080, 9505.5000 to 9505.5020 [Emergency], and 9505.1000 to 9505.1040.

Subp. 4. **Admitting physician.** "Admitting physician" means the physician who orders the recipient's admission to the hospital and who is a party to a written provider agreement with the department.

Subp. 5. **Certification number.** "Certification number" means the number issued by the medical review agent.

Subp. 6. **Clinical evaluator.** "Clinical evaluator" means a person who is employed by or under contract with the medical review agent and who is either licensed by the Minnesota Board of Nursing to practice professional nursing under Minnesota Statutes, section 148.171, or a physician.

Subp. 7. **Commissioner.** "Commissioner" means the commissioner of human services or an authorized representative of the commissioner.

Subp. 8. **Concurrent review.** "Concurrent review" means a review and determination performed while the recipient is in the hospital and focused on the medical necessity of inpatient hospital services. The review consists of admission review, continued stay review, and, when appropriate, procedure review.

Subp. 9. **Continued stay review.** "Continued stay review" means a review and determination, after the admission certification and during a patient's hospitalization, of the medical necessity of continuing the recipient's stay at a hospital level of care.

Subp. 10. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 11. **Emergency.** "Emergency" means a medical condition that if not immediately diagnosed or treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death.

Subp. 12. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the health services provided to a recipient under the general assistance medical care program according to Minnesota Statutes, section 256D.03, and applicable rules adopted by the commissioner as either may from time to time be amended and enforced.

Subp. 13. **Hospital.** "Hospital" means an institution that is approved to participate as a hospital under Medicare and that is maintained primarily for the treatment and care of patients with disorders other than mental diseases and tuberculosis.

Subp. 14. **Inpatient hospital service.** "Inpatient hospital service" means a service provided under the supervision of a physician and furnished in a hospital for the care and treatment of a recipient. The inpatient hospital service may be furnished by a hospital, physician, or a vendor of an ancillary service prescribed by a physician that may be paid for under medical assistance or general assistance medical care.

Subp. 15. **Local agency.** "Local agency" means a county or multicounty agency authorized under Minnesota statutes as the agency responsible for determining eligibility for the medical assistance and general assistance medical care programs.

Subp. 16. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 17. **Medical record.** "Medical record" means the information required in part 9505.1800, subpart 3.

Subp. 18. **Medical review agent.** "Medical review agent" means the representative of the commissioner who is authorized by the commissioner to make decisions about admission certifications, concurrent reviews, continued stay reviews, and retrospective reviews.

Subp. 19. **Medically necessary.** "Medically necessary" means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in part 9505.0540 cannot be provided on an outpatient basis.

Subp. 20. **Medicare.** "Medicare" means the federal health insurance program for the aged and disabled under title XVIII of the Social Security Act.

Subp. 21. **Physician.** "Physician" means a person licensed to provide services within the scope of the profession as defined in Minnesota Statutes, chapter 147.

Subp. 22. **Physician adviser.** "Physician adviser" means a physician who practices in the specialty area of the recipient's primary diagnosis or a specialty area related to the primary diagnosis.

Subp. 23. **Prior authorization.** "Prior authorization" means the prior approval for medical services by the department as required under applicable rules and regulations adopted by the commissioner.

Subp. 24. **Readmission.** "Readmission" means admission for an inpatient hospital service for the same diagnosis or a related condition or the treatment of a condition which grew out of the previous diagnosis which occurs within seven days of a prior discharge of the recipient from a hospital.

Subp. 25. **Recipient.** "Recipient" means a person who has applied to the local agency and has been determined eligible for the medical assistance or general assistance medical care program.

Subp. 26. **Reconsideration.** "Reconsideration" means a review of a denial or withdrawal of admission certification according to part 9505.0520, subpart 9.

Subp. 27. **Retrospective review.** "Retrospective review" means a review conducted after inpatient hospital services are provided to a recipient. The review is focused on determining the medical necessity of the admission, the medical necessity of any inpatient hospital services provided, and whether all medically necessary inpatient hospital services were provided.

Statutory Authority: *MS s 256B.04 subd 15; 256B.503; 256D.03 subd 7*

History: *9 SR 2296*

9505.0510 APPLICABILITY.

Parts 9505.0500 to 9505.0540 establish the standards and procedures for admission certification to be followed by admitting physicians and hospitals seeking medical assistance or general assistance medical care payment for inpatient hospital services provided to medical assistance or general assistance medical care recipients under Minnesota Statutes, chapters 256B and 256D. Parts 9505.0500 to 9505.0540 are to be read in conjunction with Code of Federal Regulations, title 42, and titles XVIII and XIX of the Social Security Act. The department retains the authority to approve prior authorizations established under parts 9505.5000 to 9505.5020 [Emergency]. Parts 9505.0500 to 9505.0540 do not apply to out-of-state hospitals and admitting physicians who seek medical assistance or general assistance medical care program payment for inpatient hospital services provided to recipients who are Minnesota residents. Instate admitting physicians who admit a Minnesota resident who is a recipient to an out-of-state hospital must comply with parts 9505.0500 to 9505.0540. Out-of-state admitting physicians who admit a Minnesota resident who is a recipient to an in-state hospital must comply with parts 9505.0500 to 9505.0540.

Statutory Authority: *MS s 256B.04 subd 15; 256B.503; 256D.03 subd 7*

History: *9 SR 2296*

9505.0520 INPATIENT ADMISSION CERTIFICATION.

Subpart 1. **Requirement for admission certification.** Except as provided in subpart 2, an admission providing inpatient hospital service to a recipient must receive admission certification prior to the recipient's admission in order for the admitting physician, the hospital, or other vendor of an inpatient hospital service to receive medical assistance or general assistance medical care program payment for the inpatient hospital service.

Subp. 2. **Exclusions from admission certification or prior admission certification.** Admission for inpatient hospital services under items A and B shall be excluded from the requirement in subpart 1.

A. An emergency admission may occur without prior admission certification and shall be subject to subpart 4, item B.

B. Admission certification is not required for delivery of a newborn, inpatient dental procedures, or inpatient hospital services for which a recipient has been approved under Medicare. However, denial of an inpatient hospital service under Medicare because the service is not medically necessary shall also constitute sufficient grounds for denying payment for the service under medical assistance.

Subp. 3. **Admitting physician responsibilities.** The admitting physician who seeks medical assistance or general assistance medical care program payment for an inpatient hospital service to be provided to a recipient shall:

A. Obtain prior authorization from the department for any service requiring prior authorization. Medical assistance and general assistance medical care payment shall be denied when a required prior authorization is not obtained prior to admission.

B. Request admission certification by contacting the medical review agent either by phone or in writing and providing the information in subitems (1) to (8):

(1) hospital's medical assistance provider number and name;

(2) recipient's name, medical assistance or general assistance medical care identification number, and date of birth;

(3) admitting physician's name and medical assistance provider number;

(4) primary procedure code according to the most recent edition of Current Procedural Terminology published by the American Medical Association or the International Classification of Diseases--Clinical Modification, published by the Commission on Professional and Hospital Activities, Green Road, Ann Arbor, Michigan 48105 which are incorporated by reference. These books are available through the Minitex interlibrary loan system and are subject to change;

(5) expected date of admission;

(6) whether the admission is a readmission;

(7) admitting diagnosis by diagnostic code according to the most recent edition of the International Classification of Diseases--Clinical Modification; and

(8) information from the plan of care and the reason for admission as necessary for the medical review agent to determine if admission is medically necessary.

C. Provide the following information when applicable:

(1) surgeon's name and medical assistance provider number;

(2) expected date of surgery; and

(3) affirmation that a second surgical opinion and prior authorization have been received.

D. Inform the hospital of the certification number.

E. For purposes of billing, enter the certification number on, and attach a copy of a necessary prior authorization form and a second or third surgical opinion to all invoices submitted to the department for payment.

Subp. 4. **Hospital responsibilities.** A hospital that seeks medical assistance or general assistance medical care program payment for inpatient hospital services provided to a recipient shall:

A. Obtain from the admitting physician the certification number.

B. In an emergency admission, inform, by phone, the medical review agent of the emergency admission and provide the information required in subpart 3, items B and C, if applicable, within 48 hours of the emergency admission exclusive of weekends and holidays. If the hospital fails to notify the medical review agent within 48 hours excluding weekends and holidays, the hospital shall submit, at its own expense, a copy of the complete medical record to the medical review agent within 30 days after the recipient's discharge. Failure to submit the record within the 30 days shall result in denial of the certification number.

C. For billing purposes, enter the certification number on all invoices submitted to the department for payment.

Subp. 5. **Retroactive eligibility.** A hospital may seek admission certification for a person found retroactively eligible for medical assistance or general assistance medical care program benefits after the date of admission. The hospital shall inform the admitting physician of the admission certification number of a retroactively eligible recipient. An admitting physician and a hospital shall not seek admission certification for a person whose application for the medical assistance or general assistance medical care program is pending. The medical review agent may require the hospital to submit, at its own expense, a copy of the complete medical record to substantiate the medical necessity of

the admission. Failure to submit a requested record within 30 days of the request shall result in denial of admission certification.

Subp. 6. **Medical review agent responsibilities.** The medical review agent shall:

A. obtain and review the information required in subpart 3, items B and C, if applicable;

B. determine within 24 hours of receipt of the information, exclusive of weekends and holidays, whether admission is medically necessary;

C. inform the admitting physician and the hospital of the determination, by phone, within 24 hours of receipt of the information, exclusive of weekends and holidays;

D. mail a written notice of the admission certification determination to the admitting physician and the hospital within five days of the determination, exclusive of weekends and holidays;

E. determine if admission of a retroactively eligible recipient was medically necessary;

F. provide for a reconsideration of a denial or withdrawal of admission certification;

G. recruit and coordinate the work of the physician advisers;

H. notify the admitting physician and the person responsible for the hospital's utilization review, by phone, of a reconsideration decision within 24 hours of the decision, exclusive of weekends and holidays; and

I. mail a written notice of the reconsideration decision to the admitting physician, the person responsible for the hospital's utilization review, and the department within five days of the determination, exclusive of weekends and holidays.

Subp. 7. **Ineligibility to serve as physician adviser.** A physician shall not be eligible to serve as a physician adviser if:

A. the physician is the admitting physician; or

B. during the previous 12 months, the physician issued treatment orders or participated in the formulation or execution of the treatment plan for the recipient for whom admission certification is requested; or

C. the physician and the physician's family, which means the physician's spouse, child, grandchild, parent, or grandparent, has an ownership interest of five percent or more in the hospital for which admission certification is being requested; or

D. the physician can obtain a financial benefit from the admission of the recipient.

Subp. 8. **Procedure for admission certification.** The procedure for admission certification shall be as in items A to H.

A. Upon receipt of the information requested in subpart 3, items B and C, if applicable, the clinical evaluator shall review the information and determine whether the admission is medically necessary.

B. If the clinical evaluator determines the admission is medically necessary, the medical review agent shall issue a certification number.

C. If the clinical evaluator is unable to determine that the admission is medically necessary, the evaluator shall contact a physician adviser.

D. If the physician adviser determines that the admission is medically necessary, the medical review agent shall issue a certification number.

E. If the physician adviser is unable to determine that the admission is medically necessary, the physician adviser shall notify the clinical evaluator by phone, the clinical evaluator shall notify the admitting physician by phone, and the admitting physician may request a second physician adviser's opinion.

F. If the admitting physician requests a second physician adviser's opinion, the clinical evaluator shall contact a second physician adviser.

G. If the second physician adviser determines that the admission is medically necessary, the medical review agent shall issue a certification number.

H. If the second physician adviser is unable to determine that the admission is medically necessary, the medical review agent shall deny the admission certification and shall not issue a certification number.

Subp. 9. **Reconsideration.** The admitting physician or the hospital may request reconsideration of a decision to deny or withdraw an admission certification. The admitting physician or the hospital shall submit the request in writing to the medical review agent within 30 days of the date of receipt of the letter denying or withdrawing admission certification. Upon receipt of the request, the medical review agent shall appoint at least three physician advisers, none of whom shall have been involved previously in the procedure for the recipient's admission certification, to hear the reconsideration. The reconsideration may be conducted by means of a telephone conference call. The admitting physician or the hospital may submit additional facts at their own expense to support the request for admission certification. The physician advisers may seek additional facts and medical advice as necessary to decide whether the admission is medically necessary. The reconsideration shall be completed within 30 days of the receipt of the request. Any party may appeal the determination of the physician advisers according to the contested case provisions of Minnesota Statutes, chapter 14, by filing a written notice of appeal with the commissioner within 20 days of the date of receipt of the notice of the determination.

Subp. 10. **Medical record review and determination.** The medical review agent shall be authorized to conduct a concurrent, continued stay, or retrospective review of a recipient's medical record to determine whether the admission was medically necessary, whether the inpatient hospital services were medically necessary, whether a continued stay will be medically necessary, or whether all medically necessary services were provided. The procedure for concurrent, continued stay, and retrospective reviews shall be as in items A to D.

A. A clinical evaluator shall review the medical record and may review the bills, invoices, and all supporting documentation pertaining to a request for medical assistance and general assistance medical care payment.

B. If the clinical evaluator is unable to determine that the recipient's admission was medically necessary, that the recipient's continued stay will be medically necessary, or that all medically necessary services were provided, the clinical evaluator shall request additional information from the admitting physician or the hospital as necessary to clarify the medical record.

C. If, after additional information is submitted, the clinical evaluator is unable to determine that the recipient's admission was medically necessary, that the recipient's continued stay will be medically necessary, or that all medically necessary services were provided, a physician adviser shall be consulted.

D. If a physician adviser determines that the recipient's admission was not medically necessary, that the recipient's continued stay will not be medically necessary, or that all medically necessary services were not provided, the medical review agent shall withdraw the previously issued certification number and shall notify the admitting physician and hospital by telephone within 24 hours of the determination and by written notice mailed within 24 hours.

Subp. 11. **Consequences of withdrawal of admission certification.** If the medical review agent determines that the admission was not medically necessary or that all medically necessary inpatient hospital services were not provided or that some or all of the inpatient hospital services were not medically necessary, the department shall withdraw the certification number and may take action as specified in items A to E.

A. For hospitals receiving payments on a per admission basis, the entire payment shall be debited for an admission that was not medically

necessary. If the admission was medically necessary but some or all of the inpatient hospital services were not medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150. If the hospital failed to provide services that were medically necessary, the matter shall be referred to the department which may take action under parts 9505.1750 to 9505.2150.

B. For hospitals receiving per diem payment, no payment shall be made if the admission was not medically necessary. If the stay or a portion of the stay was not medically necessary, no payment shall be made for the portion of the stay that was not medically necessary.

C. If the medical review agent determines that additional inpatient hospital services will not be medically necessary, the medical review agent shall notify the hospital, admitting physician, and the recipient or the person designated by the recipient in the hospital record that no payment will be made for additional hospital services.

D. If the admission was not medically necessary or the medical record does not adequately document that the admission was medically necessary, the department may seek to recover payments made to physicians and other vendors of inpatient hospital services under parts 9505.1750 to 9505.2150.

E. If an inpatient hospital service is not medically necessary, payment for a service not medically necessary shall be denied to the vendor of the service except as provided in items A and B.

Subp. 12. **Appeal of withdrawal of admission certification.** The withdrawal of admission certification may be appealed to the medical review agent through the reconsideration process in subpart 9.

Subp. 13. **Information used for determination.** At any stage of the admission certification process, including reconsideration, the person or persons making the determination may do so on the information provided by the admitting physician, or in their sole discretion may refer to additional facts submitted by the admitting physician.

Statutory Authority: *MS s 256B.04 subd 15; 256B.503; 256D.03 subd 7*

History: *9 SR 2296*

9505.0530 ADOPTION OF THE APPROPRIATENESS EVALUATION PROTOCOL BY REFERENCE.

The most recent edition of the Appropriateness Evaluation Protocol of the National Institutes of Health is incorporated by reference. The book is available at the Health Data Institute, 7 Wells Avenue, Newton, Massachusetts, 02159, and it is also available through the Minitex interlibrary loan system. The book is subject to change.

Statutory Authority: *MS s 256B.04 subd 15; 256B.503; 256D.03 subd 7*

History: *9 SR 2296*

9505.0540 CRITERIA TO DETERMINE MEDICAL NECESSITY.

The medical review agent shall follow the Appropriateness Evaluation Protocol in determining whether a recipient's admission is medically necessary, whether the inpatient hospital services provided to the recipient were medically necessary, whether the recipient's continued stay will be medically necessary, and whether all medically necessary inpatient hospital services were provided to the recipient.

Statutory Authority: *MS s 256B.04 subd 15; 256B.503; 256D.03 subd 7*

History: *9 SR 2296*

GENERAL ASSISTANCE MEDICAL CARE

9505.1000 STATUTORY AUTHORITY FOR GENERAL ASSISTANCE MEDICAL CARE PROGRAM.

This rule establishes a statewide general assistance medical care program and governs state financial participation in county welfare medical costs as authorized by Laws of Minnesota 1975, chapter 437, article II.

Statutory Authority: *MS s 256D.03 subds 3,4,5*

9505.1010 PURPOSE OF RULES.

The purposes of parts 9505.1010 to 9505.1040 are to provide medical services to persons financially unable to provide it for themselves, and whose medical needs are not otherwise provided for by law; and to provide property tax relief by providing state financing for some medical costs historically financed by county property tax levies.

Statutory Authority: *MS s 256D.03 subds 3,4,5*

9505.1020 DEFINITIONS.

Subpart 1. **Scope.** The terms defined in this part shall have the meanings given them unless otherwise provided or indicated by the context.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of human services or his/her designee.

Subp. 3. **Department.** "Department" means the Department of Human Services.

Subp. 4. **General assistance medical care.** "General assistance medical care" means payment of part or all of the cost of the following care and services not provided by titles XVIII, XIX, or XX of the Social Security Act for eligible individuals whose income and resources are insufficient to meet all such costs:

A. inpatient hospital services;

B. skilled nursing home and intermediate care facility services;

C. physician's services;

D. outpatient hospital or clinic services;

E. home health care services;

F. private duty nursing service;

G. physical therapy and related services;

H. dental services;

I. laboratory and X-ray services;

J. the following, if prescribed by a licensed practitioner: drugs, eyeglasses, dentures, and prosthetic devices;

K. diagnostic, screening, and preventive services;

L. transportation costs incurred solely for obtaining medical care; and

M. any other medical or remedial care licensed and recognized under state law to the extent that such services are provided for in the medical assistance program.

To be excluded from the services above are the following:

N. jejuno-ileal bypass surgery;

O. cosmetic surgery;

P. contact lenses unless prescribed for Kerotoconus or where functional vision is impossible to achieve by other means;

Q. orthodontia unless prior authorization has been obtained from the local agency subject to review by the state dental advisory committee;

R. psychiatric and psychological services unless the need for them has been preauthorized by the local agency in accordance with the conditions and limitations prevailing in the medical assistance program;

S. autopsies; and

T. air conditioners, humidifiers, dehumidifiers, and orthopedic mattresses even though they may have some health treatment values.

Subp. 5. **Income.** "Income" means earned and unearned income from any source whatsoever, (including windfalls, income tax refunds, and rebates) reduced by amounts paid or withheld for federal and state income taxes, federal social security taxes, and employment expenses. The local agency may adopt a standardized allowance schedule for usual employment expenses.

Subp. 6. **Local agency.** "Local agency" means the county welfare boards in the several counties of the state except that it may also include any multi-county welfare boards of departments where those have been established in accordance with law.

Subp. 7. **Provider of medical care.** "Provider of medical care" means any persons or facility furnishing, within the scope of his or its respective license, any or all of the services or goods recited in subpart 4.

Subp. 8. **Relatives' responsibility.** "Relatives' responsibility" means that the financial responsibility of a relative for an applicant or recipient of general assistance medical care shall not extend beyond the relationship of a spouse, or a parent of an applicant or recipient who is a child under the age of 18 years.

Statutory Authority: *MS s 256D.03 subds 3,4,5*

History: *L 1984 c 654 art 5 s 58*

9505.1030 ELIGIBILITY REQUIREMENTS.

General assistance medical care benefits shall be granted to any person or family who has all of the following qualifications:

A. Who is currently receiving general assistance in accordance with Minnesota Statutes, sections 256D.01 to 256D.22; or

B. Who is not eligible for or receiving medical care through the programs of Aid to Families with Dependent Children, or emergency assistance-AFDC, or medical assistance, or cost-of-care for mentally retarded, epileptic, or emotionally handicapped children, or state reimbursement for state wards per Minnesota Statutes, section 260.38, or social services under title XX of the Social Security Act, but who otherwise meets eligibility requirements for this general assistance medical care program; and

C. Whose net equity in real and personal property does not exceed the maximum standards established in the medical assistance program according to Minnesota Statutes, sections 256B.06 and 256B.07; and

D. Who does not own or have an equivalent to ownership of more than one family automobile; and

E. Who has not transferred property without receiving reasonable consideration for the purpose of qualifying for general assistance medical care; and

F. Who has or anticipates receiving an annual income not in excess of $2,600 for a single person, or $3,264 for two family members (husband and wife, parent and child, or two siblings), or $3,960 for three family members, or $4,620 for four family members, or $5,184 for five family members, plus $625 for each additional legal dependent, or who has income in excess of these maxima and in the month of application (or during the three months prior to the month of application) incurs expenses for medical care that total more than one-half of the annual excess income in accordance with the rules of the department. In such excess income cases, eligibility shall be limited to a period of six months beginning with the first of the month in which these medical obligations are first incurred; and

G. Who has or agrees to apply all proceeds received or receivable by him or his spouse from private health care coverage or the Minnesota no-fault auto insurance law to the costs of medical care for himself, his spouse, and legal

dependents. The local agency or the department may require from any applicant or recipient of general assistance medical care the assignment of any rights accruing under such health and accident care coverage. Any rights or amounts so assigned shall be applied against the cost of medical care paid for by the general assistance medical care program.

Statutory Authority: *MS s 256D.03 subds 3,4,5*

9505.1040 APPLICATION FOR GENERAL ASSISTANCE MEDICAL CARE.

Subpart 1. **Forms and determinations.** Applications for general assistance medical care shall be reduced to writing on forms prescribed by the department and be filed with the local agency of the county wherein the applicant is residing. The determination of the county of financial responsibility shall be made in accordance with Minnesota Statutes, section 256D.18 and the procedures prescribed therein for referral of applications to other counties shall be followed.

Subp. 2. **Written notice of agency action.** The local agency shall, within 45 days thereafter, selectively ascertain the facts supporting the application and inform the applicant by written notice of the action taken on his application. Any applicant or recipient aggrieved by any order or determination of the local agency may appeal therefrom to the commissioner in accordance with Minnesota Statutes, section 256D.12.

Subp. 3. **Selection of medical providers.** Upon approval of such application for a period of eligibility not to exceed six months, the local agency shall advise the recipient whether he may select the medical providers which are to provide him with the necessary medical services and goods or if the local agency is reserving the right to designate the medical providers for him.

Subp. 4. **Delegation of determination of eligibility.** Upon prior approval from the commissioner, a local agency may delegate its responsibility for determining an applicant's eligibility for benefits of this program to other legally established units of county government.

Subp. 5. **Notice to commissioner regarding medical provider.** Each local agency shall notify the commissioner whether it will: pay the medical providers directly and claim state reimbursement (90 percent) in accordance with procedures established by the commissioner, or require that all medical providers submit their claims to the department's central disbursement center for state payment directly to the providers after which the department will bill the local agency for the county share (ten percent) of the payments thus made.

In selecting this alternative, the local agency also agrees to:

A. accept all reimbursement standards and edits of the system which are applied to title XIX payments;

B. maintain current eligibility records on all recipients of general assistance medical care on the title XIX recipient subsystem through the use of form DPW-106; and

C. reimburse 50 percent of the department's costs of processing these medical provider claims.

Subp. 6. **Payments for noneligible persons.** Any local agency may, from its own resources, make payments for medical care for persons not otherwise eligible for this general assistance medical care program.

Subp. 7. **Administration of program.** The local agencies shall administer the general assistance medical program in their respective counties under the supervision of the department, and shall make such reports, prepare such statistics, and keep such records and accounts as the commissioner may require.

Subp. 8. **Limit to payment amounts.** The local agency shall not allow payment of medical provider claims which exceed the fee schedules established by the commissioner for the medical assistance program.

Statutory Authority: *MS s 256D.03 subds 3,4,5*

CATASTROPHIC HEALTH EXPENSE PROTECTION

9505.1100 SCOPE AND STATUTORY AUTHORITY FOR CHEPP.

Parts 9505.1100 to 9505.1380 govern administration of the catastrophic health expense protection program (CHEPP, CHEP program) in Minnesota. It is issued pursuant to Minnesota Statutes, section 62E.54, subdivision 1. They provide the basis for implementation of Minnesota Statutes, sections 62E.51 to 62E.55.

Statutory Authority: *MS s 62E.54 subd 1*

9505.1110 PERSONS REGULATED.

Parts 9505.1100 to 9505.1380 are binding on the Department of Human Services, on all county welfare and human services boards (hereinafter called local welfare agencies), on all persons and organizations contracting to perform functions under the CHEPP act, on providers of health services who are paid or who request payment under the act, and on people who apply for or receive benefits under the act.

Statutory Authority: *MS s 62E.54 subd 1*

History: *L 1984 c 654 art 5 s 58*

9505.1120 UNIFORM IMPLEMENTATION.

The commissioner of human services shall issue handbooks and informational materials to local welfare agencies, to persons and organizations that contract to perform functions required under the CHEPP act, to providers of health services which may be paid for under the act, and to people who apply for or receive benefits under the act, so that the act and parts 9505.1100 to 9505.1380 are put into effect in an orderly and uniform way.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1130 CIVIL RIGHTS PROTECTIONS.

The CHEP program shall be administered so as not to deny people who apply for or receive benefits their individual and civil rights. The program shall give due regard to the rights of its beneficiaries as to privacy of their personal medical records. No disclosure shall be made of such records or of personally identifiable data from them except as permitted by law and then only such pertinent data as is clearly required for proper administration of the program by those persons and organizations responsible for it.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1140 SUBORDINATION OF RULES TO STATE AND FEDERAL LAWS.

Any provision of these parts which is inconsistent with any state or federal law applicable to the CHEP program is superseded thereby.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1150 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 9505.1100 to 9505.1380, the terms defined in this part have the meanings given them.

Subp. 2. **Adjustment.** "Adjustment" means a payment by or to the state of Minnesota intended to change the net amount of an earlier payment made by the CHEP program.

Subp. 3. **Applicant.** "Applicant" means a person who has directly, or through his attorney, guardian, or personally designated representative, made application for benefits from the CHEP program with his local welfare agency. Additionally, an applicant may be a deceased person's estate, on behalf of which

an application is filed by the personal representative of the estate, subject to the restrictions in part 9505.1160, subpart 2.

Subp. 4. **CHEPP beneficiary.** "CHEPP beneficiary" means an eligible or formerly eligible person or his dependent, someone on whose behalf CHEPP benefits have been or may be paid.

Subp. 5. **CHEPP deductible.** "CHEPP deductible" means the sum of qualified expenses which an applicant must have incurred an obligation to pay in order to become an eligible person, as defined in subpart 11.

Subp. 6. **Catastrophic health expense protection program coverage 1 (CHEPP 1).** "Catastrophic health expense protection program coverage 1 (CHEPP 1)" means the set of CHEPP benefits available to persons who have become eligible under the provisions of subpart 11, item A. This coverage is the regular and broad coverage of the CHEP program. It makes no restrictions on benefits on account of age, except as regards defining who may be included in a single family group.

Subp. 7. **Catastrophic health expense protection program coverage 2 (CHEPP 2).** "Catastrophic health expense protection program coverage 2 (CHEPP 2)" means the coverage of some part of the routine per diem costs of nursing home care for persons less than 65 years of age who have become eligible under the provisions of subpart 11, item B.

Subp. 8. **Commissioner.** "Commissioner" means the commissioner of human services, or, as applicable, the commissioner's designated agent in the Department of Human Services, a local welfare agency, or a person or organization contracting to perform functions required for administration of the CHEP program.

Subp. 9. **Copayment.** "Copayment" means the ten percent share of a reasonable charge or qualified expense, in excess of a CHEPP deductible, for which an eligible person remains liable to a provider of health services after payment of the 90 percent share by the commissioner under the provisions of the CHEPP act and parts 9505.1100 to 9505.1380.

Subp. 10. **Dependent.** "Dependent" means a spouse, unmarried child under the age of 19 years, a child who is a student under the age of 25 and financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent, provided such spouse or child is not currently eligible for benefits under the medical assistance program or the general assistance medical care program. The term "child" as used here includes legally adopted children, and it also includes financially dependent stepchildren, foster children, and children under the guardianship of the applicant or his spouse. Eligibility for benefits of children reaching age 19 or 25 shall end on the last day of the birthdate month, in the eligibility year.

Subp. 11. **Eligible person.** "Eligible person" means any person who is a resident of Minnesota and who, while a resident of Minnesota, has been found by the commissioner to have incurred an obligation to pay:

A. qualified expenses for himself and any dependents in any 12 consecutive months exceeding:

(1) 40 percent of his household income up to $15,000, plus 50 percent of his household income between $15,000 and $25,000, plus 60 percent of his household income in excess of $25,000; or

(2) $2,500, whichever is greater; or

B. qualified nursing home expenses for himself and any dependents in any 12 consecutive months exceeding 20 percent of his household income.

Where clearly indicated by the context, "eligible person" shall also mean the dependents of an eligible person as defined in subpart 10.

Subp. 12. **General assistance medical care (GAMC).** "General assistance medical care (GAMC)" means that program of medical assistance for the poor and needy established by Minnesota Statutes, chapter 256D.

Subp. 13. **Gross income.** "Gross income" means income as defined in Minnesota Statutes, section 290A.03, subdivision 3. Cash benefits paid to eligible persons in lieu of payments to providers of health services shall not be included in gross income as defined here, but payments made by the United States Veterans' Administration for "aid and attendance" shall be considered to be a part of gross income rather than medical benefits.

Subp. 14. **Health maintenance organization (HMO).** "Health maintenance organization (HMO)" means an organization offering prepaid health services, as defined in Minnesota Statutes, chapter 62D.

Subp. 15. **Home health agency.** "Home health agency" means a public or private agency which specializes in giving nursing and other therapeutic and rehabilitative services in patients' homes and which is eligible for enrollment as such in the Minnesota medical assistance program.

Subp. 16. **Hospital services.** "Hospital services" means any and all reasonable and medically appropriate services provided on an inpatient or outpatient basis on the direction of a physician or under his supervision by a hospital which meets the requirements for reimbursement as such by the medical assistance program. Hospital services do not include outpatient mental or dental health services, drugs dispensed on an outpatient basis for consumption at some other location, home health services, outpatient oral surgery, prostheses for outpatient use, or durable medical equipment for use outside the hospital, to the extent that such services are not covered under the other provisions of the CHEP program. Ambulance services and other medical transportation are not hospital services, per se, unless they lead to an inpatient hospital admission and are chargeable as hospital services under the rules and procedures of the Minnesota medical assistance program.

Subp. 17. **Household income.** "Household income" means the gross income of an eligible person and all his dependents 23 years of age or older for the calendar year preceding the year in which an application is filed for CHEPP benefits. A dependent's age, for the purposes of this subpart, shall be his age on the last day of the calendar year preceding the year in which application is filed for CHEPP benefits. Income paid to the applicant or his spouse on behalf of children included in the application shall be considered the applicant's income rather than the children's unless an accounting must be made for its use to some person outside the applicant family; this interpretation of children's income applies in particular to social security survivors' benefits. Child support legally required to be paid to a custodial parent by an absent parent shall be considered income of the custodial parent if and only if the custodial parent is not entitled to claim the child(ren) as tax dependents.

Subp. 18. **Illness.** "Illness" means disease, injury, or a condition involving bodily or mental disorder of any kind, including pregnancy and fertility, and also including the state of reasonable personal concern for maintenance of individual health.

Subp. 19. **Medical assistance program.** "Medical assistance program" means that program of medical assistance to the poor and needy established by title XIX of the federal Social Security Act as of July 1, 1977, and, in Minnesota, by Minnesota Statutes, chapter 256B.

Subp. 20. **Medically necessary.** "Medically necessary" means reasonable and prudent according to commonly accepted standards of medical practice as applied to a particular case at a particular point in time in the light of such information as is or could reasonably be available to the treating physician.

Subp. 21. **Medicare.** "Medicare" means that program of payment for health services for the aged and disabled established by title XVIII of the federal Social Security Act as of July 1, 1977.

Subp. 22. **Nursing home.** "Nursing home" means an institution which is licensed as a nursing home by the state in which it is located. The term includes facilities which meet the standards of the Minnesota medical assistance program for enrollment as skilled nursing facilities or as intermediate care facilities (I), but it excludes facilities (or beds, in the case of multi-level facilities) which are classified as intermediate care facilities (II) or as intermediate care facilities (mental retardation).

Subp. 23. **Out-of-pocket.** "Out-of-pocket" means the personal liability of an applicant, eligible person, or a dependent of one of these. A charge or expense for a service covered by CHEPP must be an out-of-pocket expense for the applicant or eligible family. Except as provided below, this means that no third party is legally liable to pay it, and no third party has been liable to pay it and has then paid it to or on behalf of the family. If part of an expense for a covered service is paid by a liable third party or is the liability of a third party, that part is not a qualified expense under the CHEP program and may not be used to satisfy the CHEPP deductible and may not be reimbursed by CHEPP. However, expenses for covered services actually paid by liable health insurance companies may be considered eligible out-of-pocket expenses for the purpose of satisfying the CHEPP deductible to the extent that the applicant or one of his dependents actually paid or contributed toward the insurance premiums, the contributions were made during the deductible period, and the services for which the insurance payments were made were received during the deductible period.

Subp. 24. **Physical therapist.** "Physical therapist" means an individual who meets the requirements for enrollment as such in the Minnesota medical assistance program.

Subp. 25. **Physician.** "Physician" means a medical doctor or osteopath, a chiropractor, or a dentist acting within the scope of CHEPP coverage of dental services, licensed in the state in which he practices and acting within the scope of his license. The term does not include podiatrists, optometrists, or psychologists. The inclusion of chiropractors here within the definition of physician shall not imply any authority within the CHEP program for chiropractors to prescribe other health services for coverage under the program if prescribing such services would constitute the prescribing of internal drugs, the practice of medicine, or the practice of physical therapy.

Subp. 26. **Private health care coverage.** "Private health care coverage" means any plan regulated by Minnesota Statutes, chapters 62A, 62C, 62D, or 64A, or sections 62E.01 to 62E.17. Private health care coverage also includes any self-insurance plan providing health care benefits.

Subp. 27. **Provider.** "Provider" means a provider of health services to an applicant for CHEPP benefits or to a CHEPP beneficiary.

Subp. 28. **Qualified expense.** "Qualified expense" means any charge incurred subsequent to July 1, 1977, for a health service which is included in the list of covered services described in Minnesota Statutes, section 62E.06, subdivision 1, and for which no third party is liable. Such qualified expenses shall include the usual and customary charges for the following services and articles when prescribed by a physician:

A. hospital services;

B. professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;

C. drugs requiring a physician's prescription;

D. services of a skilled nursing facility which meets the requirements for participation as such in the medicare program or the medical assistance

program, for not more than 120 days in an individual eligible person's year-long eligibility period, if the services would qualify as reimbursable services under medicare, and if the services do not fall into the class of "qualified nursing home expenses" defined in subpart 29, and if, in addition, the patient's attending physician certifies in writing that the services are not primarily of a custodial or residential nature;

E. services of a home health agency if the services would qualify as reimbursable services under medicare;

F. use of ionizing radiation or radioisotopes for therapeutic or diagnostic purposes;

G. oxygen;

H. anesthetics;

I. prostheses other than dental, but including cataract lenses;

J. rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;

K. diagnostic X-rays and laboratory tests;

L. oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;

M. services of a physical therapist; and

N. transportation provided by licensed ambulance service to the nearest facility qualified to treat a condition, if such ambulance transportation is medically necessary.

Subp. 29. **Qualified nursing home expense.** "Qualified nursing home expense" means any per diem charge (as "per diem charge" is defined by the Minnesota medical assistance program) incurred subsequent to July 1, 1977, for nursing home services after 36 months of continuous care provided to a person less than 65 years of age in a licensed nursing home bed certified at the skilled nursing facility (SNF) or intermediate care facility 1 (ICF-1) level. Periods of inpatient hospital care and short periods of therapeutic leave from nursing home care which occur after the initial admission to nursing home care shall count as part of the 36 months.

Subp. 30. **Reasonable charge.** "Reasonable charge" means the charge for a service or supply which would be allowable for payment under the medical assistance program as administered by the Department of Human Services, except that customary charge audits by provider may be omitted uniformly for practitioners and that determinations of the reasonableness of charges which require professional review may be contracted to a review organization.

Subp. 31. **Regular provider.** "Regular provider" means a provider of health services to a CHEPP applicant or beneficiary who (which) wishes to be reimbursed for such services directly by the CHEP program.

Subp. 32. **Resident of Minnesota.** "Resident of Minnesota" means a person who is presently residing in Minnesota, having there his principal and permanent abode, and having no intent to return to some other state to live upon completion of a course of medical care. In deciding whether an applicant for CHEPP benefits is a resident of Minnesota, all important aspects of the applicant's situation shall be considered, and the decision shall be made on the preponderance of the evidence. In doubtful cases, the following forms of evidence of residence may be included in those examined:

A. the place of residence of the applicant's family members who would be eligible for CHEPP benefits;

B. the number of months that the applicant has lived in Minnesota, and, in the case of retired persons who maintain residences in two or more states, the proportion of each of the past two years which the applicant has spent in Minnesota;

C. the state in which the applicant and his spouse are:

(1) registered to vote;

(2) licensed to drive;

(3) registering their car(s);

(4) claiming a homestead for property tax relief;

(5) employed;

(6) doing their banking; and

D. the state in which the applicant lived for a substantial period before retiring and establishing residences in two or more states.

Subp. 33. **Residual spend-down amount.** "Residual spend-down amount" means any portion of the CHEPP deductible which for administrative convenience is arranged to be deducted from CHEPP payments after an applicant has been accepted as an eligible person.

Subp. 34. **Review organization.** "Review organization" means a professional standards review organization as defined in the federal Social Security Act as of July 1, 1977, or a similar organization as defined in Minnesota Statutes, section 145.61.

Subp. 35. **Subsequent to July 1, 1977.** "Subsequent to July 1, 1977," means on or after July 1, 1977.

Subp. 36. **Third party.** "Third party" means any person other than the eligible person or his dependents.

Subp. 37. **Usual and customary charge.** "Usual and customary charge" means a provider's normal charge, in the absence of insurance or other plan of health coverage, for a service or supply, but not more than the prevailing charge in the state for a like service or supply.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1160 APPLICATION.

Subpart 1. **Where to apply.** Applications for benefits from the catastrophic health expense protection program shall be taken by the local welfare agency responsible for the county in which the applicant makes his home.

Subp. 2. **Who may apply.** Applications for CHEPP benefits may be made by a single adult person, by either spouse of a family, or by an individual's attorney, guardian, or personally designated representative, or by the administrator or court-appointed representative of a deceased individual's estate. A personally designated representative shall present written proof of his designation and shall not be an employee of or a contractor with any provider of medical services which has provided services to the applicant. No application may be made on behalf of a deceased person's estate unless the apparent heirs of the estate include the decedent's children, spouse, former spouse, or parents and these do not qualify to apply for CHEPP benefits because of age or relationship to the decendent. An applicant (that is, the person on whose behalf application is made) must be a resident of Minnesota at the time of application.

Subp. 3. **Filing and processing applications.** Application forms and records of applicants' income and expenses for health services shall be kept in the local welfare agency for at least as long as such records are required to be kept by the medical assistance program. Local agencies shall provide copies of CHEPP applications, applicants' medical bills, and other documents submitted at application, to the Department of Human Services as required by the commissioner. Local agencies shall determine whether an applicant is eligible

for CHEPP benefits within 30 days of receiving all information and documents needed to determine eligibility. When an applicant has been found eligible, the local agency shall take whatever action is necessary to establish the applicant family as an eligible case in the state computerized welfare information system, the case information system; this updating of the case information system shall be completed within ten work days of determining the applicant's eligibility.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1170 DELEGATION OF AUTHORITY.

The director of each local welfare agency is designated as the commissioner's agent authorized to review and determine applicants' eligibility for CHEPP benefits. This authority may be further delegated to the supervisor of the administrative unit within each agency which is responsible for processing CHEPP applications.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1180 PROVISION OF INFORMATION BY LOCAL WELFARE AGENCIES.

Local welfare agencies shall answer questions from the public about the CHEP program, using information and literature supplied by the commissioner. Local agencies shall explain the program's benefits and requirements to people who apply or who are eligible for benefits. Local agencies shall explain the state's privacy protection law to people who apply for CHEPP benefits.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1190 CONSIDERATION OF ALTERNATIVE WELFARE PROGRAMS.

Local welfare agencies shall request from CHEPP applicants enough information to decide whether they can qualify for medical assistance, general assistance medical care, or some other form of welfare medical assistance such as certification of need for care at the University Hospitals. Applicants entitled to benefits under such other welfare programs shall be considered ineligible for CHEPP benefits if such other benefits are clearly equal to or greater than those available under CHEPP. If an applicant becomes eligible for CHEPP in preference to some other welfare program to which he is entitled, justification of the selection shall be recorded in the case record.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1200 INFORMATION AND DOCUMENTS TO BE SUPPLIED BY CHEPP APPLICANTS.

Applicants for CHEPP benefits shall provide such information and documents as are needed to establish their eligibility for the program, including as applicable the following:

A. Application data:

(1) full names of family members included in the application;

(2) birthdates of all family members;

(3) current addresses of all family members included in the application;

(4) the main address of the household one month before the date of the first service offered in satisfaction of the CHEPP deductible;

(5) the social security number of each family member whose income would be relevant to determining the family's eligibility for CHEPP benefits;

(6) the amount of the family's household income in the previous year, including an itemization of all such income not reported on a state or

federal income tax return or on an application for the Minnesota renter's credit, income-adjusted homestead tax credit, or senior citizen's property tax freeze credit;

(7) the health insurance claim number of each medicare-eligible member of the applicant family;

(8) the names of all private or public plans or programs of health coverage from which one or more family members are entitled to benefits, the addresses of such plans, the policy numbers or beneficiary identification numbers for each plan, and the name of the plan group if necessary for claim filing;

(9) the names of all automobile insurance companies with which family members have no-fault medical coverages, the policy numbers, and the addresses of the companies;

(10) the names of any other third parties who are or may be liable for the cost of health services or health insurance for any family member, and current information about the status of any actions pending or contemplated for recovery of damages or benefits for health services;

(11) the medical assistance program, general assistance medical care, or CHEPP identification number of each family member who has been eligible for one of those programs within the two years before the current application for CHEPP;

(12) the telephone number of the family's main home and the telephone number at work of the employed head of household; and

(13) the sex and marital status of all adult family members.

B. A signed warranty by the applicant that the information supplied is true and complete, to the best of his knowledge and ability to make it such.

C. A signed assignment of third party benefits to the extent of the state's payments on the eligible family's behalf; an assignment shall be signed by the competent family member for each separate set of entitlements; each assignment shall include an authorization to release pertinent medical information for purposes of collecting health plan and other third party benefits for health services.

D. A signed authorization from each family member, other than dependent children under age 23 years, for the commissioner to inspect tax returns and applications for tax credits submitted to the Minnesota Department of Revenue, and for the commissioner to receive copies of such documents pertinent to verifying the income reported by the applicant family; the authority to inspect and receive copies of documents shall extend also to data from microforms and computer storage devices.

E. Copies of invoices from the providers of all health services whose charges are offered in satisfaction of the CHEPP deductible or for CHEPP payment, together with current information as to which charges have been billed to third parties and the extent to which such third parties have paid or are expected to pay for the charges, information as to which charges have been paid by the family out of pocket (with proof of payment), and a signed statement that no insurance company or other third party payment has been received or is expected to be received for charges offered in satisfaction of the CHEPP deductible or for which CHEPP payment is requested, except as explained above.

F. Proof of out-of-pocket payments for prepaid health coverages used to justify partial inclusion of payments by such prepaid plans in the eligible expenses used to satisfy the CHEPP deductible.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1210 CHEPP DEDUCTIBLE.

The CHEPP deductible is out-of-pocket. Eligible expenses offered in satisfaction of the CHEPP deductible must be out-of-pocket expenses and/or liabilities as defined in part 9505.1150, subpart 23. Eligible expenses attributed to the CHEPP deductible need not have been paid in advance of CHEPP eligibility, and failure of an applicant to pay them shall not affect the applicant's eligibility. Payment of such deductible expenses by relatives, friends, or other persons having no legal duty to pay shall not defeat the out-of-pocket character of the expenses. If a payment by a liable third party is not available within a reasonable period of time (normally 120 days from the date of application), and if the applicant cannot otherwise qualify for the CHEP program, the charges whose payment is in question may be treated as eligible expenses for satisfaction of the CHEPP deductible, provided all required assignments of benefits are signed by the member of the applicant family who appears to be entitled to the delayed or disputed third party payment.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1220 SATISFACTION OF THE CHEPP DEDUCTIBLE.

The applicant for CHEPP benefits may select which of his qualified expenses for services received subsequent to July 1, 1977, is to be the earliest for satisfaction of the CHEPP deductible. Having selected a beginning date, the applicant shall then offer his remaining qualified expenses incurred after that date in satisfaction of the deductible, in the order in which such remaining expenses were incurred. The date of an expense shall be deemed to be the date of the earliest service occasioning any part of the expense or charge. Applicants must be Minnesota residents at the time each service is received whose charge is used to satisfy the CHEPP deductible, but the services may be received in other states.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1230 INCOME CONSIDERED IN SPECIAL CASES.

If a widow or widower applies for CHEPP benefits, the income received prior to death by the deceased spouse which was paid during the calendar year preceding the application year shall be disregarded in determining the CHEPP deductible which must be met by the applicant. Similarly, if an applicant or the applicant's spouse has petitioned for a dissolution of marriage and there exists a temporary decree or other legally binding agreement specifying the terms of separation, the gross income of the nonapplicant spouse shall not be considered in computing the amount of the applicant's CHEPP deductible, provided the applicant is in fact separated from and living apart from the nonapplicant spouse.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1240 DURATION OF ELIGIBILITY.

Subpart 1. **CHEPP 1 benefits.** Eligibility for CHEPP 1 benefits shall run for 12 calendar months, beginning on the first day of the month and year of the earliest service occasioning a qualified expense offered in satisfaction of the CHEPP deductible. Such eligibility shall not cover the portion of any qualified expense offered in satisfaction of the deductible, but it may cover other qualified expenses incurred during the deductible period if such expenses were not known to be qualified at the time of application. Children who reach an age at which they become ineligible for CHEPP benefits during the 12-month period shall remain covered until the last day of the month in which they reach that age.

Subp. 2. **CHEPP 2 benefits.** Eligibility for CHEPP 2 benefits shall run from the date of satisfaction of the CHEPP 2 deductible until the last day of the state fiscal year, this being currently June 30. CHEPP 2 eligibility shall end,

however, not later than the last day of the month in which the eligible nursing home patient reaches the age of 65 years.

Subp. 3. **Change of residence.** Eligible persons who establish residence in another state shall be eligible for CHEPP payments for services they receive after their change in residence.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1250 ELIGIBILITY FOR PAYMENT OF QUALIFIED NURSING HOME EXPENSES.

A CHEPP applicant's eligibility for payment of qualified nursing home expenses as defined in part 9505.1150, subpart 29 shall be figured separately from eligibility for other CHEPP benefits. Qualified nursing home expenses as defined in part 9505.1150, subpart 29 shall not be used to satisfy the CHEPP deductible for other CHEPP benefits, and other qualified expenses shall not be used to satisfy the CHEPP deductible for reimbursement of qualified nursing home expenses.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1260 APPLICATION FOR PAYMENT OF QUALIFIED NURSING HOME EXPENSES.

Persons desiring CHEPP payment of qualified nursing home expenses shall apply for payment in a timely way. Application shall be made not later than 60 days after the end of the earliest month for which payment will be requested. Applications for payments for the last month of the state fiscal year, i.e. June, shall be made not later than the last day of the following month.

Persons who wish per diem charges of nursing homes to be limited to those allowed by medical assistance must establish eligibility for CHEPP reimbursement in the month before the month in which the limitation on charges is claimed against the nursing home.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1270 TERMINATION OF ELIGIBILITY.

Subpart 1. **Third party payments.** Eligibility for CHEPP benefits may be terminated or interrupted by the commissioner if third party payments are made for services whose expenses were offered in satisfaction of the CHEPP deductible, regardless of whether they are made to the beneficiary, a provider of care, or the state. If a third party payment interrupts a family's CHEPP eligibility, the commissioner shall notify the family by letter. If the amount of deductible the family must reincur to become eligible for CHEPP again is small, it shall be entered into the computerized central payments system as a residual spend-down amount. Then the family shall be permitted to continue to have medical claims billed to the CHEP program, but amounts payable by the state shall be used to satisfy that residual spend-down before any actual payment is made on a family's behalf. Families which choose to reestablish eligibility for CHEPP benefits in this way are liable to providers of care for both their own copayment amounts and for state-share payments held back to satisfy the residual spend-down. Such families shall tell providers of health services of their interrupted CHEPP eligibility at the time of receiving health services.

Subp. 2. **Fraud.** Eligibility for CHEPP benefits may also be terminated by the commissioner upon a clear determination by the commissioner that incorrect or fraudulent data was submitted by an applicant in order to become eligible. Such a determination shall not be made until 14 days have passed from notice to the family by letter that it is being considered and that the matter may be discussed with a designated representative of the commissioner. If eligibility is terminated because of errors made in good faith in figuring a family's deductible or its satisfaction, the family may be allowed to continue in the CHEP program

with the unsatisfied deductible amount being treated as a residual spend-down amount as provided in subpart 1.

Subp. 3. **Return of identification cards.** Families whose CHEPP eligibility is terminated or interrupted to satisfy additional deductible amounts shall return their CHEPP eligibility identification cards to the Department of Human Services, which shall issue replacement cards for families on interrupted eligibility.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1280 APPEALS.

The final decision of the commissioner denying an application for status as an eligible person, suspending it, or revoking it, or denying all or part of the charges for a health service may be appealed by any interested party pursuant to Minnesota Statutes, chapter 14.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1290 BENEFITS PAYABLE.

Subpart 1. **Formula.** Except for qualified nursing home expenses, the Department of Human Services shall pay 90 percent of the reasonable charge for an eligible person's qualified expenses in excess of his CHEPP deductible. The eligible person shall remain liable to the provider of health services for the remaining ten percent of the reasonable charge for each service.

Subp. 2. **Exception.** For qualified nursing home expenses, the Department of Human Services shall pay, at the end of each state fiscal year, an amount for each eligible person calculated as follows, unless some other formula is set by law:

+ (Reasonable cost of eligible person's qualified nursing home care during the state's fiscal year)

- (20 percent of the eligible person's household income in the calendar year before the year application is filed for CHEPP)

= Eligible person's raw entitlement

The CHEP program will not pay more than the raw entitlement, but if there are insufficient funds earmarked for qualified nursing home expenses, the program's payments will be calculated as follows:

$$\text{Payable Amount} = \left(\begin{array}{c}\text{State Appropriation}\\ \text{for qualified}\\ \text{nursing home}\\ \text{expenses}\end{array}\right) \times \left(\frac{\text{Eligible person's raw entitlement}}{\text{The sum of all eligible persons' raw entitlements}}\right)$$

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1300 FORGIVENESS OF DISALLOWED CHARGES.

Subpart 1. **Unconscionable fee.** If a charge for a covered service to an eligible person is billed to CHEPP, any part of the charge determined by the Department of Human Services to be more than a reasonable charge, or the entire charge if the service is determined to have been not medically necessary, shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed. Charges for qualified nursing home expenses shall be considered billed to CHEPP and subject to limitation on the first day of the month following written notice to the nursing home of a patient's eligibility.

Subp. 2. **Nursing home care.** In the case of nursing home care which occasions qualified nursing home expenses, any per diem charge for qualified nursing home care given to a person eligible for CHEPP benefits shall be deemed to be a reasonable charge if it is not more than the charge per diem allowed in that section of that facility for that level of care of the Minnesota medical assistance program.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1310 PERSONS TO WHOM PAYMENTS ARE MADE.

CHEPP 1 benefits shall be paid only to providers of health services, and then only after receipt of a proper billing for review and adjudication; provided, however, that benefits shall be paid to eligible persons directly if the eligible person has already paid the provider and the services were received before the date of the eligible person's application for CHEPP. CHEPP 2 benefits shall be paid to the eligible nursing home resident or on his behalf to his spouse or guardian.

Statutory Authority: *MS s 62E.54 subd 1*

9505.1320 POSTPAYMENT ADJUSTMENTS.

Adjustments to amounts paid by the CHEPP program shall be settled between the provider and the Department of Human Services at 100 percent, with no payment or collection of copayments to or from CHEPP beneficiaries.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1330 ENROLLMENT OF REGULAR PROVIDERS.

Regular providers of services to CHEPP beneficiaries shall give the Department of Human Services the same enrollment information and provider agreements that are required for enrollment in the medical assistance program, if these have not been given already to the program. Providers already enrolled in the medical assistance program will be enrolled automatically as providers of services for CHEPP beneficiaries unless they ask in writing not to be. Acceptance of payments on behalf of CHEPP beneficiaries by providers enrolled in the medical assistance program shall be deemed to be an acceptance of the terms of parts 9505.1100 to 9505.1380 and to extend the provider's agreement with the medical assistance program to cover services to CHEPP beneficiaries.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1340 INVOICING PROCEDURES.

Subpart 1. **Direct billing to CHEPP.** Regular providers of service to CHEPP beneficiaries shall bill the CHEP program directly, using approved Minnesota medial assistance program invoices and forms. This requirement for billing by providers may be waived by the Department of Human Services for services provided and billed before the date an applicant for CHEPP benefits is told that he or she is eligible.

Subp. 2. **Collection of charges by provider.** If a provider of health services knows that a patient is eligible for CHEPP benefits, other than qualified nursing home expenses, he shall not try to collect charges from the patient or his family for services which are to be billed to CHEPP until the amount of the CHEPP beneficiary's copayment liability has been reported to the provider by the Department of Human Services. A provider may, however, seek third party

payments for services to CHEPP beneficiaries, provided that any third party recoveries of charges for services paid for in part by CHEPP are reported to the CHEP program.

Subp. 3. **Prohibition to providers.** Providers who bill the CHEP program shall accept the program's determination of what will constitute reasonable charges for services to CHEPP beneficiaries, and they shall not attempt to collect from beneficiaries any charges disallowed by the program as excessive or as being for services deemed not medically necessary.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1350 THIRD PARTY INSURANCE CLAIMS.

Providers shall bill third parties known to be liable for health services provided to CHEPP beneficiaries or shall supply sufficient information to the Department of Human Services to allow the department to claim reimbursement under its rights of assignment or subrogation. Providers shall not supply known CHEPP beneficiaries with invoices requesting payment for services to be billed to the CHEP program unless such invoices are prominently marked to indicate that payment by the CHEP program will be or has been requested.

Statutory Authority: *MS s 62E.51 to 62E.55*

History: *L 1984 c 654 art 5 s 58*

9505.1360 CHEPP BENEFICIARY IDENTIFICATION CARDS.

CHEPP beneficiaries shall be provided with identification cards giving the dates of their eligibility and their identification numbers. Beneficiaries shall show these cards to providers of health services before they receive services for which they expect part payment by CHEPP. CHEPP beneficiaries eligible only for part payment of qualified nursing home expenses shall receive separate and distinct identification cards or letters.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1370 NONQUALIFYING EXPENSES.

Charges for the following shall be considered to be not qualified expenses, not covered by the CHEP program:

A. Cosmetic surgery, except to repair an injury or birth defect.

B. Private hospital or nursing home rooms, to the extent that the charges exceed the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician. If an institution has no semiprivate rooms, its most common semiprivate room charge shall be deemed to be 90 percent of its lowest private room charge.

C. Transsexual surgery.

D. Artificial insemination.

E. Reversals of sterilizations entered into originally with free and informed consent.

F. Autopsies.

G. Missed appointments.

H. Costs of billing.

I. Inpatient psychiatric care substituted for outpatient care primarily to acquire reimbursability of the services under the CHEP program.

Procedures used by the Minnesota medical assistance program for review of the appropriateness or medical necessity of health services shall be used for the review of claims for CHEPP payments to the extent that they are not incompatible with this rule or with the catastrophic health expense protection act. Providers of care shall observe such procedures, including prior authorization procedures, as a condition of receiving payments from the CHEP

program.

Statutory Authority: *MS s 62E.51 to 62E.55*

9505.1380 TERMINATION OF PROVIDER ENROLLMENTS.

Providers may be terminated from enrollment as eligible payees under the CHEP program according to the procedures established for such termination in the Minnesota medical assistance program. Providers terminated from the medical assistance program for misconduct shall be simultaneously terminated from the CHEP program.

Statutory Authority: *MS s 62E.51 to 62E.55*

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

9505.1500 SCOPE AND STATUTORY AUTHORITY FOR EPSDT.

Parts 9505.1500 to 9505.1690 govern the administration of the early and periodic screening, diagnosis, and treatment program (hereinafter referred to as the EPSDT program). This program is mandated by section 1905(a)(4)(B) of the Social Security Act.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1510 PURPOSE OF EPSDT PROGRAM.

The purpose of the EPSDT program is to identify potentially handicapping conditions in children eligible for medical assistance, to provide diagnosis and treatment for conditions identified, and to encourage the entrance of children into the health care system.

Note: It is the intention of the department, in order to ensure effective delivery of EPSDT services, that parents be involved with the child throughout the screening, diagnosis, and treatment process. However, since the program includes "children" through age 20, the department recognizes that some children, including teenagers and adults who are 18 through 20, may be able to supply requested information themselves and may not wish to have their parents involved in the screening process. To allow for such cases, references in parts 9505.1500 to 9505.1690 are made to "parent/child." In using this language, the department intends that health providers and local welfare agencies involve the parent whenever possible in the program, but also recognize the right of the child to privacy.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1520 DEFINITIONS.

Subpart 1. **Child.** For purposes of this rule, "child" means any individual from birth through 20 years of age who is eligible for medical assistance.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of human services.

Subp. 3. **Department.** "Department" means the Department of Human Services.

Subp. 4. **Diagnosis.** "Diagnosis" means the determination of the nature or cause of physical or developmental disease or abnormality through the use of health history; physical, developmental, and psychological examination; laboratory tests and X rays.

Subp. 5. **EPSDT equivalent clinic.** "EPSDT equivalent clinic" means a facility which provides screening services according to Minnesota Department of Health EPS standards, provides follow-up services, and is monitored by the Minnesota Department of Health. Such facilities provide comprehensive care in a sequence incompatible with the completion of the EPSDT billing form.

Subp. 6. **EPSDT provider agreement.** "EPSDT provider agreement" means an agreement between a provider of screening services and the department that the provider, in order to qualify for medical assistance reimbursement, will

screen each medical assistance child according to the appropriate screening standards specified in parts 9505.1550 and 9505.1560, will report all findings on the EPSDT billing form, and will refer children according to procedures specified in part 9505.1590, subpart 2.

Subp. 7. **Follow-up.** "Follow-up" means efforts by local agencies to ensure that the screening, diagnosis, and treatment services needed by a child are obtained.

Subp. 8. **Local agency.** "Local agency" means the county welfare board, multi-county welfare board, or human service agency established in accordance with state law and responsible for the administration of the EPSDT program at the county level.

Subp. 9. **Medical assistance.** "Medical assistance" means the program authorized under title XIX of the Social Security Act to provide medical care for individuals whose resources do not enable them to purchase such care.

Subp. 10. **Minnesota Department of Health approved EPS clinic.** "Minnesota Department of Health approved EPS clinic" means an agency which provides screening services according to Minnesota Department of Health screening and administrative standards; which operates under the supervision of a registered nurse, public health nurse, or pediatric/family nurse practitioner; and which qualifies for medical assistance and other public third party reimbursement.

Subp. 11. **Nurse-supervised EPSDT clinic.** "Nurse-supervised EPSDT clinic" means a facility or individual which provides screening services according to Minnesota Department of Health screening standards and Department of Human Services administrative standards. Such clinics operate under the supervision of a registered nurse, public health nurse, or pediatric/family nurse practitioner, and qualify for medical assistance reimbursement.

Subp. 12. **Outreach.** "Outreach" means efforts by the department or local agencies to inform and encourage persons to avail themselves of services which they might not otherwise request without such assistance.

Subp. 13. **Periodic.** "Periodic" means at regular, fixed intervals established for screening by health care experts to assure that disease or abnormality is not incipient or has not appeared since the child's last evaluation.

Subp. 14. **Physician-supervised EPSDT clinic.** "Physician-supervised EPSDT clinic" means a facility or individual which provides screening services according to physician screening standards, which operates under the supervision of a licensed physician, and which qualifies for medical assistance reimbursement.

Subp. 15. **Screening.** "Screening" means the use of quick, simple procedures to sort apparently well children from those who need more definitive study of possible physical or developmental problems.

Subp. 16. **Treatment.** "Treatment" means the use of medical care and services to prevent, correct, or ameliorate disease or abnormalities detected by screening and diagnostic procedures.

Statutory Authority: *MS s 256B.04 subd 2*

History: *L 1984 c 654 art 5 s 58*

9505.1530 ELIGIBILITY FOR EPSDT PROGRAM.

All persons from birth through age 20 who are eligible for medical assistance are eligible for the EPSDT program.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1540 TERMINATION OF ELIGIBILITY.

Eligibility for the EPSDT program terminates when medical assistance eligibility terminates, regardless of the child's status in the EPSDT process.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1550 PHYSICIAN SCREENING STANDARDS.

Subpart 1. **Requirement.** A licensed physician must provide the following components in order for an examination to be reimbursed as a screening under the EPSDT program.

Subp. 2. **Health history.** A health and developmental history must be obtained from the child, the parent, and/or another responsible adult who is familiar with the child's health history and must include information on lead and tuberculosis exposure, nutrition intake, and seizure history.

Subp. 3. **Assessment of physical growth.** The child's height and weight must be measured and compared with the ranges considered normal for children of that age. Head circumference measurements must be taken for children under three years of age.

Subp. 4. **Physical examination.** The following areas must be checked according to accepted medical procedures: pulse, respiration, blood pressure, head, eyes, ears, nose, mouth, pharynx, neck, chest, heart, lungs, abdomen, spine, genitals, extremities, joints, muscle tone, skin, and neurological examination.

Subp. 5. **Dental inspection.** The mouth must be examined for any obvious dental problems. A child who is three years of age or older must be referred to a dentist for preventive care if she/he has never been to a dentist or if it has been one year since the last dental appointment.

Subp. 6. **Vision of children under the age of three years.** Children under the age of three years:

A. must be checked for a history of maternal and/or neonatal infection; family history of ocular abnormalities;

B. must be observed for:

(1) pupils and light following reflex;

(2) presence/absence of nystagmus;

(3) muscle balance: examination for esotropia, exotropia, large phorias;

(4) external examination of eyes, including lids, conjuctiva, and cornea; and

(5) parental concern regarding child's vision.

Subp. 7. **Vision of children over the age of three years.** Children over the age of three years:

A. Must be checked for all of the items contained in subpart 6, item A.

B. Must, in addition, be checked for visual acuity. A test such as the STYCAR, the Snellen E Cube, the Snellen E Chart, and the Snellen Alphabet Chart, or their equivalent, must be used.

Subp. 8. **Hearing of children under the age of three years.** Children under the age of three years must be observed for:

A. retardation of language acquisition or history of such retardation;

B. failure to directionalize to sounds;

C. history of repeated otitis media during early life; and

D. parental concern regarding child's hearing.

Subp. 9. **Hearing of children over the age of three years.** Children over the age of three years:

A. must be observed for all of the items contained in subpart 8, items A to D; and

B. must receive a pure tone audiometric test or referral for pure tone audiometric testing if subpart 8, items A to D indicate the need for audiometric testing.

Subp. 10. **Developmental screening.** For children ages birth through five years, the Denver Prescreening Developmental Questionnaire (PDQ) must be completed. All children who fail the PDQ must be screened further by use of the Denver Developmental Screening Test (DDST). If the screener does not provide the DDST, referral must be made to an agency that does provide it.

For children ages six through 20 years, the provider must screen for the following areas according to his/her standard procedures: fine/gross motor development, speech, and socialization. Developmental questions must be included on the health history for this age group.

Subp. 11. **Sexual development.** Sexual development appropriate to the child's age must be checked for all children, with special emphasis given to children who have reached puberty.

At the request of the parent/child, counseling on normal development, birth control and venereal disease, as well as appropriate prescriptions and testing, must be provided by the screener, or referral to appropriate resources must be made.

The option to receive a pelvic examination with appropriate testing (GC, Pap Smear, other tests at provider's discretion) must be offered to all females who have reached puberty.

Subp. 12. **Nutritional status.** A child having any detectable nutritional deficiencies must receive nutritional counseling or must be referred for such counseling.

When a child's history reveals that his/her diet regularly lacks two or more daily servings from one of the four basic food groups, the parent/child must receive nutritional counseling or must be referred for nutritional counseling even if there are no objective signs of poor nutrition.

Subp. 13. **Immunizations.** The immunization status of all children must be checked. Needed immunizations must be offered and provided if requested. Immunizations must be administered according to the Recommended Schedule of Immunizations developed by the Minnesota Department of Health and approved by the Minnesota State Medical Association.

Subp. 14. **Laboratory tests.** Laboratory tests include:

A. Tuberculin testing must be performed for all children once at 15 months of age or at their first screening, if this screening occurs later than 15 months. A child may receive additional tuberculin testing at later ages if his/her history indicates the possibility of exposure.

B. Lead absorption testing must be performed on all children whose history and physical findings indicate the possibility of exposure to undue levels of lead in the environment or atmosphere.

C. Urine testing: all children over the age of two years must be tested at their first screening for the presence of glucose, ketones, protein, and other abnormalities in the urine. Females at or near the ages of four and ten must be tested for bacteriuria.

D. Anemia testing: all children must be tested for anemia by use of either a microhematocrit determination or a hemoglobin concentration. This test should be done near the ages of six months, one year, two years, four years, and 15 years.

E. Sickle cell testing: tests for sickle cell disease or trait must be offered to all children known to be at risk and must be provided if requested by the parent/child. Only one sickle cell test is needed. If sickle cell trait is found, parent/child must be referred for genetic counseling if they so desire.

F. Other laboratory tests: tests for cervical cancer, venereal disease, pregnancy, and parasites should be performed when indicated and charged as part of the screening examination.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1560 VARIATION FROM SCREENING PROCEDURES.

If a provider wishes to substitute other procedures for those contained in part 9505.1550, or wishes to omit any of the required procedures, written application must be made to the EPSDT section in the department. All such requests shall be reviewed by a physician advisory committee and a decision on the request shall be made by the committee in writing within 30 days of the receipt of the request.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1570 NURSE SCREENING STANDARDS.

The department will recognize as screening providers all nurse-supervised EPS and EPSDT clinics which follow the screening standards and periodicity schedule devised by the Minnesota Department of Health. Screenings performed by these providers will be reimbursed under the EPSDT program.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1580 PERIODICITY SCHEDULE.

The department will offer all children who have been screened the opportunity for rescreening at the following ages: six months, nine months, one year, 18 months, two years, four years, and every three years thereafter. The department will notify all eligible recipients of the availability of screening services at least once a year if they have not received an initial screening.

For physician-supervised EPSDT clinics, screening components must be provided according to the physician EPSDT periodicity schedule below.

INTERVALS	MONTHS						YEARS					
	0-5	6-7	8-11	12-15	16-19	20-35	3-4	5-7	8-10	11-13	14-17	18-21
Health History	X	X	X	X	X	X	X	X	X	X	X	X
Assessment of Physical Growth:												
-Height	X	X	X	X	X	X	X	X	X	X	X	X
-Weight	X	X	X	X	X	X	X	X	X	X	X	X
-OFC	X	X	X	X	X	X						
Physical Examination	X	X	X	X	X	X	X	X	X	X	X	X
Dental Inspection	X	X	X	X	X	X	X	X	X	X	X	X
Vision	X	X	X	X	X	X	X	X	X	X	X	X
Hearing	X	X	X	X	X	X	X	X	X	X	X	X
Developmental:												
-PDQ/DDST	X	X	X	X	X	X	X					
-Interview/History Only								X	X	X	X	X
Sexual Development	X	X	X	X	X	X	X	X	X	X	X	X
Nutrition Review	X	X	X	X	X	X	X	X	X	X	X	X
Immunization Review	X	X	X	X	X	←	←	X	←	←	X	←
Tuberculin				X	←	←	←	←	←	←	←	←
Lead Absorption Testing				IF HISTORY INDICATES								
Urine						X	←	←	←	←	←	←
Bacteriuria (females)							X	←	X	←	←	←
Anemia Testing		X	←	X	←	X	X	←	←	←	X	←
Sickle Cell	AT PARENT'S OR CHILD'S REQUEST											
Other Lab Tests					AS INDICATED							

← Procedure to be completed if not done at the previous visit, or on the first visit.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1590 CONDITIONS OF SCREENING PROVIDER PARTICIPATION IN THE EPSDT PROGRAM.

Subpart 1. **Billing.** All screening providers must complete the EPSDT billing form with one total charge submitted for the complete screening package.

The parent/child must be provided with a copy of the billing form.

Screening providers which are designated as EPSDT equivalent programs by the department need not complete the billing form. In order to receive such a designation, a facility must screen children according to Minnesota Department of Health standards, must provide follow-up services to those children, and must be monitored by the Minnesota Department of Health. EPSDT equivalent programs may submit screening statistics in aggregate form.

Subp. 2. **Screening referral form.** All screening providers must complete a screening referral form, supplied by the department, and provide this form to the parent/child in every instance when a child is referred for further diagnosis and treatment.

Subp. 3. **Provider agreement.** All screening providers must sign an EPSDT provider agreement whereby they agree to the provisions of subparts 1 and 2.

Subp. 4. **Medical assistance.** In order to qualify for medical assistance reimbursement, screening providers must follow all requirements for medical assistance program participation as specified in parts 9500.0750 to 9500.1080

Subp. 5. **Maximum fees.** All screening providers shall be reimbursed according to their usual and customary fee until six months after parts 9505.1500 to 9505.1690 are published. At that time, the department will establish one maximum screening fee for physician supervised clinics and another maximum screening fee for nurse supervised clinics.

Each of these maximum fees shall be equal to the 75th percentile of all screening charges submitted by each group during that six month period. After the maximum fees are established, screening providers shall be reimbursed according to their usual and customary fee or the department's maximum fee, whichever is lower. The maximum fee shall be updated yearly.

Subp. 6. **Health maintenance organizations.** Health maintenance organizations which participate in the medical assistance program must provide EPSDT services as part of their contract with the department for their enrollees at no extra charge to the department, and must complete the EPSDT billing form for each child screened.

Subp. 7. **Referrals.** Screening providers may, after notifying the department, elect to provide one or more of the screening components by referral to other providers. In such cases, the screening provider must ensure that the child receives the components for which he/she was referred before the screening is billed.

Subp. 8. **Outreach.** Screening providers may provide an outreach component as part of the screening and may charge for the extra outreach service after they have submitted a budget to the department which justifies the outreach charge.

Subp. 9. **Training and assistance.** The department must provide:

A. training on screening components to all providers who sign the EPSDT provider agreement and who request such training; and

B. assistance in obtaining the forms and materials needed in the screening process.

Subp. 10. **Choice of provider.** The parent/child who requests screening services has free choice of all local screening providers who have signed EPSDT provider agreements.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1600 CONDITIONS OF DIAGNOSIS AND TREATMENT PROVIDER PARTICIPATION IN THE EPSDT PROGRAM.

Subpart 1. **Eligibility.** Any health care provider licensed under state law who has signed a medical assistance provider agreement is eligible to provide appropriate diagnostic and treatment services to a child who has been screened.

Subp. 2. **Billing.** Diagnosis and treatment providers must bill according to regular medical assistance procedures as outlined in parts 9500.0750 to 9500.1080. In addition, providers who diagnose or treat a child who has been screened, pursuant to parts 9505.1550 to 9505.1570 must complete the billing invoice so as to indicate that this child is being diagnosed or treated as part of the EPSDT program. The department will make payments according to regular medical assistance procedures as specified in parts 9500.0750 to 9500.1080.

Subp. 3. **Compliance with medical assistance program.** Diagnosis and treatment providers must follow all requirements for medical assistance program participation as specified in parts 9500.0750 to 9500.1080.

Subp. 4. **Choice of provider.** The child or parent of the child who is referred for diagnosis and treatment as a result of a screening has free choice of all local diagnosis and treatment providers who are enrolled in the medical assistance program.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1610 OUTREACH.

Subpart 1. **Screening eligibility.** The local agency must notify all applicants for programs which include medical assistance eligibility about the EPSDT program if the applicant or any of his/her children are under 21 years of age. The notification must include an oral and written explanation of the program. The notification must take place within 30 days of the date of application. The local agency must obtain a definite response in writing from each applicant for each child in the family within 30 days of the date of notification.

Subp. 2. **Rescreening eligibility.** The department will notify, in writing, parents, whose children have been screened, of their eligibility for rescreening at periodic intervals. The department will also renotify parents whose children have never been screened of their continuing eligibility for an initial screening. The local agency will receive the response and must handle the response per parts 9505.1620 to 9505.1660.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1620 RESPONSE TO A SCREENING REQUEST.

Subpart 1. **Written list.** The local agency must provide each parent/child who accepts EPSDT services with a written list of screening providers in the area.

Subp. 2. **Transportation.** The local agency must, in writing, offer transportation to each parent/child who accepts EPSDT services and must provide transportation to the screening site to each child who requests such transportation or for whom such transportation is requested.

Subp. 3. **Other assistance.** The local agency must, in writing, offer assistance in making the screening appointment to each parent/child who accepts EPSDT services and must provide such assistance to each child who requests it or for whom such assistance is requested.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1630 FOLLOW-UP AFTER A SCREENING REQUEST.

The local agency must make one additional offer of assistance to each parent/child who accepted screening services and was not screened within 60 days. This offer of assistance may be done by a home visit, telephone call, or letter.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1640 FOLLOW-UP FOR DIAGNOSIS AND TREATMENT.

Subpart 1. **Written notification.** The department, through the screening provider, will notify each parent/child who is referred for diagnosis and treatment, in writing, that the local agency will provide assistance, including transportation, in obtaining the needed diagnosis and treatment. If requested, the local agency must provide names and addresses of providers of the needed diagnostic and treatment services. If requested, the local agency must provide transportation to the diagnostic and treatment site.

Subp. 2. **Final notification required.** The local agency must make one additional contact, within 60 days of the screening, with each parent/child who was referred for diagnosis and treatment in order to ascertain if needed diagnosis and treatment has been obtained. This contact must be made by either a home visit or telephone call. If a diagnosis and treatment has not been obtained, the local agency must offer assistance, including transportation and/or a list of diagnosis and treatment providers, and must provide such assistance if requested. If the local agency has previously been informed that the child has received the needed diagnosis and treatment, this contact need not be made.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1650 FURTHER NOTIFICATION REQUIREMENT.

Local agencies must provide EPSDT notification and follow-up services to non-English-speaking, illiterate, and disabled applicants and recipients by a mode of communication which will enable them to fully understand and utilize the program.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1660 CHILDREN IN FOSTER CARE ELIGIBLE FOR MEDICAL ASSISTANCE.

Subpart 1. **Requirement.** The local agency must accept EPSDT services for all foster children who are dependent/neglected state wards and who are eligible for medical assistance, except when such acceptance would not be in the best interests of the child.

Subp. 2. **Parental consultation.** The local agency must discuss the availability of EPSDT services with the parents of all foster children who are eligible for medical assistance and who are under the legal custody of the local agency or whose parents have entered into a voluntary placement agreement with the local agency except when the natural parents are not available for such a discussion. If the parent is not consulted, the local agency must decide whether or not to accept EPSDT services for the child and must document the reasons for such a decision. The local agency must assist the parent in deciding whether to accept EPSDT services.

Subp. 3. **Case management services.** The local agency must provide the case management services defined in parts 9505.1620 to 9505.1640 to all foster children for whom EPSDT services are accepted.

Subp. 4. **Rescreening notification.** The department will notify the local agency in writing when foster children who are eligible for medical assistance are eligible for periodic rescreenings. The local agency must handle these notifications as specified in subparts 1 and 2.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1670 DOCUMENTATION.

Local agencies must document the completion of requirements in parts 9505.1610 to 9505.1640 on forms prescribed by the department.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1680 INTERAGENCY COORDINATION.

Local agencies must cooperate, whenever possible, with other agencies which provide health services to children so that duplication of services is avoided. Examples of such agencies are local nursing services, local head start agencies, and local school districts.

Statutory Authority: *MS s 256B.04 subd 2*

9505.1690 REIMBURSEMENT FOR EPSDT STAFF.

Local agencies which intend to claim title XIX federal financial participation at 75 percent for salaries and expenses of EPSDT administrative support staff must obtain written authorization from the department by submittal of a plan that meets state and federal program requirements.

Local agencies which intend to claim title XIX federal financial participation at 75 percent for contracts with outside agencies to perform EPSDT administrative support services must obtain written authorization from the department by submittal of a plan that meets state and federal program requirements.

Statutory Authority: *MS s 256B.04 subd 2*

SURVEILLANCE AND UTILIZATION REVIEW PROGRAM

9505.1750 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 9505.1750 to 9505.2150, the following terms shall be defined as indicated.

Subp. 2. **Abuse.** "Abuse" means a pattern of practice by a provider, or a pattern of health care utilization by a recipient which is inconsistent with sound fiscal, business, or medical practices, and results in unnecessary costs to the programs, or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Abuse is characterized by, but not limited to, the presence of one of the following conditions:

A. The repeated submission of claims by a provider from which required material data is missing or incorrect. Examples include but are not limited to: incorrect or missing procedure or diagnosis codes, incorrect mathematical entries, incorrect third party liability information, incorrect use of procedure code modifiers.

B. The repeated submission of claims by a provider presenting procedure codes which overstate the level or amount of health care provided.

C. The repeated submission of claims by a provider for health care which is not reimbursable under the programs, or the repeated submission of duplicate claims.

D. Failure of a provider to develop and maintain patient care records which document the nature, extent, and evidence of the medical necessity of health care provided.

E. Failure of a provider to use generally accepted accounting principles, or other accounting methods which relate entries on the medical or health care record to corresponding entries on the billing invoice, unless otherwise indicated by federal or state law or rule.

F. The repeated submission of claims by a provider for health care which is not medically necessary, or which is of an unacceptable quality.

G. The repeated submission of claims by a provider for health care which exceeds that requested or agreed to by the recipient or his responsible relative or guardian or that otherwise required by federal or state law or rule; services, prescriptions, or devices deemed unnecessary or excessive under the generally accepted practice of providers of such services, prescriptions, or devices is abusive.

H. The recipient permitting the use of his/her medical identification card by any unauthorized individual for the purpose of obtaining health care through any of the programs.

I. Obtaining unneeded equipment, supplies, or pharmaceuticals by a recipient for the purpose of resale or the disposal of equipment, supplies, or pharmaceuticals obtained with program moneys without authorization of the local welfare agency.

J. Obtaining duplicate services by a recipient, from a multiple number of providers, for the same health care condition excluding confirmation for diagnosis, evaluation, or assessment.

Subp. 3. **Commissioner.** "Commissioner" means the commissioner of human services or his designee.

Subp. 4. **Health care.** "Health care" means services, equipment, or supplies provided by any individual, organization, or entity that participates in the medical assistance, general assistance medical care, and/or catastrophic health expense protection programs.

Subp. 5. **Health care record.** "Health care record" means written or diagrammed documentation of the nature, extent, and evidence of the medical necessity of health care provided to the program recipients by a provider other than a medical doctor and billed to the programs.

Subp. 6. **Medicaid management information system (MMIS).** "Medicaid management information system (MMIS)" means a centralized automated processing and payment system certified by the United States Department of Health and Human Services and implemented in Minnesota to administer the title XIX program.

Subp. 7. **Medical record.** "Medical record" means written documentation of the nature, extent, and evidence of the medical necessity of health care provided to program recipients by or under the authority of a medical doctor and billed to the programs.

Subp. 8. **Medically necessary.** "Medically necessary" means health care which is rendered pursuant to the provider's authority under state law and within the scope of his/her license, if any, and is:

A. provided in response to life threatening conditions;

B. provided in response to pain;

C. provided to treat injuries, illness, or infections; or

D. provided in compliance with the provisions of parts 9500.0750 to 9500.1080; 9505.1000 to 9505.1040; or 9505.1100 to 9505.1380 regarding services reimbursable under the programs.

Subp. 9. **Pattern.** "Pattern" means an identifiable series of events or activities.

Subp. 10. **Programs.** "Programs" means the Minnesota medical assistance program, the general assistance medical care program, and/or catastrophic health expense protection program.

Subp. 11. **Provider.** "Provider" means an individual, organization, or entity that has entered into an agreement with the state agency to be reimbursed by Minnesota medical assistance, general assistance medical care, and/or catastrophic health expense protection programs for health care provided to a recipient.

Subp. 12. **Recipient.** "Recipient" means an individual who has established eligibility to receive health care paid by Minnesota medical assistance, general assistance medical care, and/or catastrophic health expense protection programs.

Subp. 13. **Records.** "Records" means medical, health care, and financial records pertaining to health care provided program recipients and billed to the programs.

Subp. 14. **State agency.** "State agency" means the Department of Human Services.

Subp. 15. **Surveillance and utilization review (SUR).** "Surveillance and utilization review (SUR)" means the section of the Department of Human Services responsible for the identification and investigation of suspected fraud and abuse by providers and recipients participating in the programs. For the purpose of parts 9505.1750 to 9505.2150, this definition specifically excludes the utilization control activity of the SUR section.

Subp. 16. **Suspending participation.** "Suspending participation" means making a provider ineligible for reimbursement by the programs for a stated period of time.

Subp. 17. **Suspension of payments.** "Suspension of payments" means stoppage of any or all program payments for services billed by a provider pending resolution of the matter in dispute between the provider and the state agency.

Subp. 18. **Terminating participation.** "Terminating participation" means making a provider ineligible for reimbursement by the programs.

Subp. 19. **Utilization control.** "Utilization control" means the activity within the state agency responsible for the ongoing evaluation of the necessity for and the quality and timeliness of services provided in long term care facilities not under the responsibility of a professional standards review organization.

Subp. 20. **Withholding of payments.** "Withholding of payments" means a reduction or adjustment of the amounts paid to a provider for purposes of offsetting overpayments previously made to the provider, or of recovering payments made to a provider for services not documented in the recipient's medical or health care record.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 2; 256D.04 cl (2)*

History: *L 1984 c 654 art 5 s 58*

9505.1760 PURPOSE.

Parts 9505.1750 to 9505.2150 govern procedures to be used by the Surveillance and Utilization Review (SUR) section, Department of Human Services in the identification and investigation of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by a provider or recipient of health care in the Minnesota medical assistance, general assistance medical care, and/or catastrophic health expense protection programs.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

History: *L 1984 c 654 art 5 s 58*

9505.1770 STATUTORY AUTHORITY.

The provisions of parts 9505.1750 to 9505.2150 are to be read in conjunction with titles XVIII and XIX of the federal Social Security Act; Code of Federal Regulations, title 42; Minnesota Statutes, chapters 62E, 256, 256B, 256D and 609; Laws of Minnesota 1980, chapter 349; and other rules of the Minnesota Department of Human Services.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

History: *L 1984 c 654 art 5 s 58*

9505.1780 BULLETINS, MANUALS, AND FORMS.

The Department of Human Services, as the state agency responsible for the administration of the Minnesota medical assistance, general assistance medical care, and catastrophic health expense protection programs, will issue instructional bulletins, manual materials, and forms to assist others in complying with parts 9505.1750 to 9505.2150.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

History: *L 1984 c 654 art 5 s 58*

9505.1790 SCOPE.

Parts 9505.1750 to 9505.2150 are binding on all county welfare boards (hereinafter referred to as local welfare agencies) in the state of Minnesota administering the programs, on all providers of health care participating in the programs, on all recipients under the programs, and on the state agency.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1800 MEDICAL AND HEALTH CARE RECORDS.

Subpart 1. **Documentation requirement.** Medical and health care records must be developed and maintained as a condition for reimbursement by the programs. Program funds paid for health care not documented in the medical and health care record shall be subject to monetary recovery.

Subp. 2. **Legibility.** Medical and health care records shall be legible throughout to at least the individuals providing care.

Subp. 3. **Contents.** Medical and health care records shall contain the following information:

A. Each page of the record shall name or otherwise identify the patient.

B. Each entry in the record shall be signed and dated by the individual providing health care. Record entries for health care provided by an individual under the supervision of an individual licensed provider, and which is billed directly to the programs by the provider, shall be countersigned by the provider. Institutional providers shall not be required to countersign record entries for health care provided in the facility by an individual provider; however, the institutional providers shall be responsible for monitoring the provision of such health care.

C. Diagnoses, assessments, or evaluations.

D. The patient case history and results of oral or physical examination.

E. The plan of treatment or patient care plan shall be entered in the physical record or shall be otherwise available on site.

F. Quantities and dosages of any prescribed drugs ordered and/or administered shall be entered in the record.

G. The results of all diagnostic tests and examinations.

H. The record shall indicate the patient's progress, response to treatment, any change in treatment, and any change in diagnosis.

I. Copies of consultation reports relating to a particular recipient.

J. Dates of hospitalization relating to service provided by a particular provider.

K. A copy of the summary of surgical procedures billed to the programs by the provider.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1810 RECORDS EXCEPTION.

Subpart 1. **Applicability.** The requirements of item C shall not apply to pharmacies, laboratories, ambulance services, and medical transportation providers, or suppliers of medical equipment and nondurable supplies.

Subp. 2. **Records required.** For the purpose of parts 9505.1750 to 9505.2150, provider groups mentioned in this part shall develop and maintain the following records:

A. Pharmacies:

(1) Prescriptions or equivalent computer record.

(2) This part shall not require the development and maintenance of a recipient drug profile; however, if available, the state agency shall be authorized to review such a record.

B. Laboratories:

(1) Documentation of provider orders for laboratory tests or procedures.

(2) Documentation of test results.

C. Ambulance service and medical transportation providers:

(1) Documentation of physician authorization for nonemergency medical transportation.

(2) Trip tickets.

(3) Documentation of durable and nondurable supplies expended on a recipient.

D. Suppliers of medical equipment and nondurable supplies:

(1) Prescriptions.

(2) Documentation of physician orders related to the provision of equipment and supplies.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1820 FINANCIAL RECORDS.

Subpart 1. **Requirement.** Financial records pertaining to the provider's costs, if the provider is reimbursed on a cost basis, and charges for health care provided to program recipients shall be developed and maintained.

Subp. 2. **Contents of records for all providers.** Financial records for all providers, other than nursing homes and board and care homes certified by the Department of Health, shall include:

A. purchase invoices;

B. all accounting records including, but not limited to, payroll ledgers, canceled checks, and bank deposit slips;

C. all contracts for supplies and services which relate to the provider's costs and charges for health care billed to the programs;

D. evidence of the provider's usual and customary charges and written evidence of charges to nonrecipient patients without violating nonrecipient patient rights to confidentiality; and

E. evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to other third party payers of health care.

For the purposes of parts 9505.1750 to 9505.2150, third parties shall include other governmental programs, insurance companies, no-fault auto insurers, and other payers of health care who may be financially responsible for services rendered a recipient.

Subp. 3. **Contents of records for nursing homes and board and care homes.** Financial records for nursing homes and board and care homes certified by the Department of Health, shall include all records identified in subpart 2 and

records of deposits and expenditures for patient personal needs allowance accounts.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1830 ACCESS TO RECORDS.

For the purposes of parts 9505.1750 to 9505.2150, as set forth in part 9505.1760, providers shall grant the state agency access during regular business hours to examine medical, health care, and financial records related to health care billed to the programs. Access to a recipient's personal medical and health care record shall be for the purpose of investigating whether or not a provider has submitted a claim for reimbursement, a cost report, or a rate application which may be false in whole or in part or whether or not the health care was medically necessary. The SUR section shall notify the provider at least 24 hours before gaining access to such records. Upon the request of the provider, the SUR section shall present a copy of the recipient's written authorization to examine personal medical records unless the provider already has received written authorization from the recipient. A provider's refusal to grant the state agency access to examine records when authorized shall be grounds for sanction.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1840 COPYING RECORDS.

The state agency, at its own expense, is authorized to photocopy or otherwise duplicate any medical or financial record which it is authorized to examine. Photocopying shall be limited to the provider's premises unless removal is specifically permitted by the provider.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1850 RETENTION OF RECORDS.

Providers shall retain all records for at least five years. Records may be microfilmed after the third year.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1860 CHANGE OF OWNERSHIP.

In the event of a change of ownership of a facility or practice the seller, unless otherwise provided by law or by written agreement, shall be responsible for maintaining and preserving all records generated prior to the date of sale. Responsibility for making records available for inspection after the date of sale is on the seller and the seller must take reasonable steps by contract or otherwise to maintain a right of access to those records which is necessary to substantiate his billings, cost reports, or rate applications.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1870 PROVIDER WITHDRAWAL OR TERMINATION.

In the event a provider withdraws or is terminated from the programs, all records developed during participation in the programs, and not subject to the provisions of part 9505.1860, shall be retained by the provider for a period of five years and shall be available for review by the state agency. Providers must retain records for at least five years after the date of billing.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1880 RECIPIENT CONSENT TO REVIEW OF RECORDS.

A recipient's consent to the state agency's review of his or her medical or health care records shall be presumed competent if given in conjunction with an application for coverage under the programs. This presumption shall be

rebuttable, and shall exist regardless of whether the application was signed by a recipient or a guardian.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1890 IDENTIFICATION OF SUSPECTED FRAUD AND ABUSE.

Subpart 1. **Duties of SUR.** SUR shall be responsible for the detection and identification of suspected fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts by providers who have billed the programs for health care rendered to a recipient.

Subp. 2. **Authorization to use information.** For the purposes of parts 9505.1750 to 9505.2150, SUR shall be authorized to utilize information from sources which shall include, but not be limited to:

A. units of local, state, and federal government;

B. other third-party payers including health insurance carriers;

C. professional standards review organizations;

D. citizens, including recipients;

E. providers, professional associations, and health care professionals; and

F. computer reports generated by MMIS, using claim data to develop profiles on the provision and utilization of health care reimbursed by the programs. The profiles compare data on a peer group basis, and identify providers and recipients who appear exceptional when compared to group norms.

Subp. 3. **Assessment and consultation.** In assessing questions of abuse or medical necessity, SUR shall consult with a review organization as defined in Minnesota Statutes, section 145.61 or other provider advisory committees as appointed by the commissioner.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1900 INVESTIGATION OF SUSPECTED FRAUD OR ABUSE BY PROVIDERS.

Subpart 1. **Duties of SUR.** SUR shall be responsible for the investigation of suspected fraud and abuse identified pursuant to part 9505.1890. An investigation shall be conducted for the purposes of determining one or more of the following:

A. whether the suspected aberrant activity of a provider is the result of a legitimate condition of practice;

B. whether suspected fraud and abuse exists and can be documented;

C. whether sufficient evidence can be developed to support administrative, civil, or criminal action as to such fraud and abuse.

Subp. 2. **The investigation.** A SUR investigation may include, but is not limited to:

A. examination of records pursuant to parts 9505.1800 to 9505.1880;

B. interviews of providers, their associates, and employees;

C. interviews of program recipients;

D. verification of the professional credentials of providers, their associates, and employees;

E. examination of any equipment, stock, materials, or other items used in or for the treatment of program recipients;

F. examination of prescriptions written for program recipients; and

G. determination of whether the health care provided was medically necessary.

Subp. 3. **Postinvestigation action.** Following the completion of an investigation, SUR shall take one or more of the following actions:

A. determine that no further action is warranted and so notify the provider;

B. impose administrative sanctions against a provider in accordance with part 9505.1910;

C. seek monetary recovery from a provider as set forth in part 9505.1910; and

D. refer the case in writing to the attorney general for possible civil or criminal legal action.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1910 MONETARY RECOVERY AND SANCTIONS AGAINST PROVIDERS.

The commissioner shall be authorized to seek monetary recovery or impose administrative sanctions to protect the public welfare and the interests of the program. Monetary recovery and sanctions implemented by the commissioner shall be based upon documentation of fraud and abuse as set forth in parts 9505.1890 and 9505.1900.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1920 GROUNDS FOR MONETARY RECOVERY FROM PROVIDERS.

The commissioner may seek monetary recovery against providers for any of the following:

A. fraud, theft, or abuse in connection with health care services billed to the programs;

B. presentment of false or duplicate claims, or claims for services not medically necessary; and

C. false statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1930 GROUNDS FOR IMPOSITION OF ADMINISTRATIVE SANCTIONS AGAINST PROVIDERS.

The commissioner may impose administrative sanctions against providers for any of the following:

A. fraud, theft, or abuse in connection with health care services billed to the program;

B. a pattern of presentment of false or duplicate claims or claims for services not medically necessary;

C. a pattern of making false statement of material facts for the purpose of obtaining greater compensation than that to which the provider is legally entitled; and

D. refusal to grant the state agency access to records pursuant to part 9505.1830.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1940 EFFECT OF FRAUD OR ABUSE OF MEDICARE PROGRAM.

The commissioner shall suspend or terminate any provider who has been suspended or terminated from participation in the medicare program because of fraud or abuse in connection with the title XVIII of the Social Security Act.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1950 METHODS OF MONETARY RECOVERY FROM PROVIDERS.

The commissioner shall make monetary recovery from providers of moneys erroneously paid due to violations described in part 9505.1920 by the following means:

A. permitting voluntary repayment by the provider of moneys erroneously paid, either in lump sum payment or installment payments;

B. withholding of payments;

C. debiting from program payments, moneys determined to have been erroneously paid; and

D. using any legal process to collect such moneys.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1960 USE OF RANDOM SAMPLE EXTRAPOLATION.

Subpart 1. **Authorization.** For the purpose of part 9505.1950, the commissioner shall be authorized to make monetary recovery from providers of moneys erroneously paid, based upon extrapolation from systematic random samples of claims submitted by a provider and paid by the programs.

Subp. 2. **Decision to use samples.** The decision to use sampling and extrapolation in calculating a monetary recovery shall be at the discretion of the director of the SUR section. The following criteria shall apply in determining whether the sampling technique will be used:

A. the claims to be sampled represent services to 50 or more recipients; or

B. there are more than 1,000 claims to be sampled; or

C. the claims to be sampled constitute charges to the department of more than $2,000.

Subp. 3. **Sampling method.** The following factors shall apply in determining recovery by sampling and extrapolation:

A. Samples shall be selected such that every claim to be sampled has an equal and independent chance of being chosen for the sample.

B. Samples shall only be selected from claims within a time period which coincides with the duration of the violations for which recovery will be made.

C. The sampling method, to include sample size, sample selection, and extrapolation from the results of the sample, shall be in accordance with statistical procedures published in the following texts: L. Kish, Survey Sampling, John Wiley and Sons, New York (1965), or W. Cochran, Sampling Techniques, John Wiley and Sons, New York 3rd Ed. (1977).

D. Samples shall be selected at the 95 percent confidence level, such that, the overall monetary recovery amount determined by extrapolation from the sample recovery amount will be within five percent of the amount which would be recovered by a complete audit, 95 percent of the time. The department will recover the extrapolated amount less the five percent factor.

Subp. 4. **Notice of intent to use samples.** The department shall notify the provider of its intent to use sampling and extrapolation. The notice shall state the nature of claims to be sampled, the sample size, the sample selection method, and the formulas and calculators to be used in extrapolation.

Subp. 5. **Rebuttable sampling results.** The monetary recovery proposed by the department, based upon the use of sampling and extrapolation is rebuttable. The provider may present, at a conference with the SUR director, material to rebut the sample size and design, the facts and conclusions drawn from each sample used, and the calculations used to extrapolate the sample findings to all services furnished for the period of time reviewed. The costs of gathering and

presenting the information will be met by the provider. Alternatively, the provider, at his expense, may conduct a complete audit and use the results to rebut the department's findings.

Subp. 6. **Appeal procedure.** If the department does not accept the provider's rebuttal, the provider may appeal under procedures cited at part 9505.2150.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1970 SANCTIONS AGAINST PROVIDERS.

The commissioner may impose any of the following sanctions for the conduct described in part 9505.1930:

A. referral to the appropriate state regulatory agency;

B. referral to the appropriate peer review mechanism;

C. transfer to a provider agreement of limited duration not to exceed 12 months;

D. transfer to a provider agreement which stipulates specific conditions of participation; and

E. suspending or terminating participation.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1980 NOTICE TO PROVIDERS OF AGENCY ACTION.

Subpart 1. **Requirement.** The state agency shall notify providers in writing of any recovery of money or sanction it intends to impose.

Subp. 2. **Contents.** The notice shall state:

A. the factual basis for alleging discrepancies or violations;

B. the dollar value to such discrepancies or violations;

C. how such dollar value was computed;

D. what actions the state agency intends to take;

E. the provider's right to dispute the state agency's factual allegations and to provide evidence to support the provider's position; and

F. the provider's right to appeal the state agency's proposed action pursuant to part 9505.2150.

Subp. 3. **Effective date of recovery or sanction.** The effective date of the proposed monetary recovery or sanction shall be at least 20 calendar days following receipt of certified mail notifying the provider of the proposed action. If the provider appeals pursuant to part 9505.2150, the action shall not be implemented until the commissioner's order is issued following the hearing on appeal, provided that the suspending or withholding of payment shall be effective on the date the notice is received, if in the commissioner's opinion such action is necessary to protect the public welfare and interests of the program. However, the commissioner shall not order a prehearing suspension or withholding of payments to a nursing home or board and care home. Implementation of a proposed action following the hearing on appeal may be postponed if in the opinion of the commissioner the delayed action is necessary to protect the welfare or interests of program recipients.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.1990 COMMISSIONER TO DECIDE IMPOSITION OF SANCTION AGAINST PROVIDER.

The decision as to the sanction to be imposed against a provider, pursuant to part 9505.1930, shall be at the discretion of the commissioner. The following factors shall be considered in determining the sanctions to be imposed:

A. nature and extent of offenses or violations;

B. history of prior violations;

C. provider's willingness to obey program rules; and

D. actions taken or recommended by other state regulatory agencies.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2000 SUSPENSION OR TERMINATION OF PROVIDER PARTICIPATION.

Suspension or termination from participation shall preclude a provider from submitting any claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association for any health care provided under the programs, except for health care provided prior to the suspension or termination.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2010 PROHIBITED SUBMISSION OF PROVIDER'S CLAIMS.

No clinic, group, corporation, or other association which is a provider of services shall submit any claim for payment for any health care provided by an individual provider within such organization who has been suspended or terminated from participation in the programs, except for health care provided prior to the suspension or termination. The state agency shall seek monetary recovery of such claims. Knowing submission of such claims shall be a ground for administrative sanction.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2020 AGENCY NOTICE OF PROVIDER'S SANCTIONS.

When a provider has been sanctioned in accordance with part 9505.1960, after all appeals have been exhausted or the time in which to file an appeal has elapsed, the state agency shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made, sanctions imposed, appeals made, and the results of any subsequent appeal.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2030 MONEY RECOVERY AND SANCTIONS AGAINST PROVIDERS.

Nothing in parts 9505.1750 to 9505.2150 shall prevent the commissioner from simultaneously seeking monetary recovery and imposing sanction against a provider.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2040 ROUTINE AUDITS OF PROVIDERS.

Nothing in parts 9505.1750 to 9505.2150 shall prohibit SUR from conducting routine audits of providers in order to monitor compliance with program requirements.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2050 SUSPENSION OR WITHHOLDING OF PAYMENTS TO PROVIDERS PRIOR TO A HEARING.

The commissioner is authorized to suspend or withhold payments to a provider prior to a hearing, as provided in part 9505.1980, subpart 3, if:

A. there is a substantial likelihood of prevailing in an action pursuant to parts 9505.1910 to 9505.2040; or

B. there is a substantial likelihood that the provider's pattern of practice which prompted a SUR investigation, will continue in the future; or

C. there is reasonable cause to doubt a provider's financial ability to refund any amounts determined to be due the program.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2060 FEDERAL LAW PREVAILS.

To the extent that federal law or regulation mandates sanctions against providers or recipients which conflict with provisions of parts 9505.1750 to 9505.2150, such federal law or regulation shall prevail.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2070 IDENTIFICATION OF SUSPECTED FRAUD AND ABUSE BY RECIPIENTS.

Subpart 1. **Duties of SUR.** SUR shall be responsible for the detection and investigation of suspected fraud, theft, or abuse by recipients of the programs.

Subp. 2. **Information available.** For the purpose of parts 9505.1750 to 9505.2150, SUR shall be authorized to utilize at least the sources of information identified in part 9505.1890, subpart 2.

Subp. 3. **Assessment of medical necessity.** In assessing the question of medical necessity, SUR shall consult with a review organization as defined in Minnesota Statutes, section 145.61 or other provider advisory committees as appointed by the commissioner.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2080 INVESTIGATION OF SUSPECTED FRAUD AND ABUSE BY RECIPIENTS.

SUR shall be responsible for the investigation of suspected fraud and abuse identified pursuant to part 9505.2070. A SUR investigation shall be conducted for the purpose of determining:

A. whether suspected fraud, theft, or abuse exists and can be documented;

B. whether sufficient evidence can be developed to support restricting recipient participation in the programs in accordance with parts 9505.2090 to 9505.2140; and

C. whether sufficient evidence exists to support the imposition of other sanctions in accordance with parts 9505.2090 to 9505.2140.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2090 GROUNDS FOR SANCTIONS AGAINST RECIPIENTS.

SUR may impose administrative sanctions against program recipients for any of the following:

A. altering or duplicating the medical identification card in any manner;

B. permitting the use of his or her medical identification card by any unauthorized individual for the purpose of obtaining health care through the programs;

C. using a medical identification card that belongs to another person;

D. using the medical identification card to assist any unauthorized individual in obtaining health care for which the programs are billed;

E. duplicating or altering prescriptions;

F. knowingly misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, or drugs;

G. knowingly furnishing incorrect eligibility status or information to a provider;

H. knowingly furnishing false information to a provider in connection with health care previously rendered which the recipient has obtained and for which the programs have been billed;

I. knowingly obtaining health care in excess of established program limitations, or knowingly obtaining health care which is clearly not medically necessary;

J. knowingly obtaining duplicate services from a multiple number of providers for the same health care condition, excluding confirmation of diagnosis; or

K. otherwise obtaining health care by false pretenses.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2100 SANCTIONS AGAINST PROGRAM RECIPIENTS.

SUR may impose any of the following sanctions for the conduct described in part 9505.2090:

A. referring the recipient for appropriate health counseling in order to correct inappropriate or dangerous utilization of health care;

B. referring the recipient to the attorney general for possible criminal or civil legal action;

C. recovery from recipients, to the extent permitted by law all amounts incorrectly paid by the programs;

D. terminating participation for that period during which a potential recipient refuses to sign a consent for release of records; or

E. restricting the recipient's participation in a program to receiving health care from a provider whom the recipient has had the opportunity to select.

The restriction shall be for a specified period of time and all changes in the designation of a provider during the restriction period shall be approved by the state agency. Reimbursement for nonemergency health care shall be limited to the designated provider.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2110 NOTICE TO RECIPIENTS OF SANCTIONS.

The state agency shall cause the recipients to be notified in writing of any sanction it intends to impose.

The notice shall state:

A. the factual basis for alleging discrepancies or violations;

B. the dollar value to such discrepancies or violations;

C. how such dollar amount was computed;

D. what actions the state agency intends to take;

E. the recipient's right to dispute the state agency's factual allegations; and

F. the recipient's right to appeal the state agency's proposed action pursuant to part 9505.2150.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2120 REIMBURSEMENT FOR EMERGENCY HEALTH CARE OF A RESTRICTED RECIPIENT.

Emergency health care provided a restricted recipient by any provider shall be eligible for reimbursement by the programs if the claim for reimbursement is accompanied by a full explanation of the emergency circumstances.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2130 SPECIALIZED HEALTH CARE OF RESTRICTED RECIPIENT.

The programs shall pay for specialized health care provided a restricted recipient if a copy of the written referral by the recipient's chosen provider is sent to the SUR section.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2140 RESTRICTION TO BE INDICATED ON MEDICAL CARD.

The fact that a recipient is restricted shall be clearly indicated on the medical card.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

9505.2150 APPEAL OF AGENCY ACTIONS.

Subpart 1. **Provider's right to appeal.** A provider may appeal the state agency's proposed administrative sanction, proposed suspension or withholding of payment, or demand for monetary recovery against a provider pursuant to the provisions of Minnesota Statutes, sections 14.57, 14.58, and 14.59 pertaining to contested cases. An appeal shall be considered timely if written notice of appeal is received by the commissioner within 20 days of the date notice is received pursuant to part 9505.1980.

Subp. 2. **Recipient's right to appeal.** A recipient may appeal any sanction proposed by the state agency pursuant to the provisions of Minnesota Statutes, section 256.045.

Subp. 3. **Informal discussion of issues.** Nothing in parts 9505.1750 to 9505.2150 shall prevent a provider or recipient, upon receipt of a notice of intended sanction, from meeting with the commissioner to informally discuss the matter in dispute, so long as an appeal has not been commenced.

Statutory Authority: *MS s 62E.54 subd 1; 256B.04 subd 10; 256D.04 cl (2)*

PREADMISSION SCREENING PROGRAM

9505.2250 RESPONSIBILITY FOR THE PREADMISSION SCREENING PROGRAM.

The county agency responsible for administering the medical assistance program in each participating county shall be responsible for complying with requirements of the preadmission screening program.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2260 PROGRAM SCOPE.

In counties participating in the program, screening teams shall review and make recommendations for nursing home applicants who are eligible for medical assistance and those who will be eligible within 90 days of admission to a nursing home. If an applicant or recipient's county of financial responsibility is included in the screening program, such applicant or recipient must be screened by the county of financial responsibility for admission to any nursing home. The procedures and criteria used by the screening team shall be in accordance with parts 9505.2300 to 9505.2340. Participating counties shall be eligible for the alternative care grant program described in part 9505.2340.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2270 NOTICE TO ELIGIBLE PERSONS.

The county agency responsible for the screening program shall refer to a screening team all persons eligible for the screening as described in part 9505.2260. When possible, medical assistance recipients shall be notified of the screening requirement through a direct mailing by the local welfare agency. At the time of the referral, with the consent of the applicant, the local welfare agency shall notify a responsible party or appropriate relative that the person has been referred, and the preadmission screening is a condition of medical assistance coverage.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2280 PUBLIC NOTICE OF SCREENING REQUIREMENT.

The county agency responsible for the screening program shall provide public notification of the screening requirement. The methods of public notification shall include publication in available appropriate newsletters, display and dissemination of information leaflets in a readable form and in accessible locations, and promotion through other local media sources. The public notification shall include information on how to contact the screening team, implications of the screening team's recommendations, and the individuals' rights to appeal the screening team's recommendations.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2290 NOTICE TO OFFICIALS AND HEALTH CARE PROFESSIONALS.

The Department of Human Services shall provide formal notification about the screening program to county commissioners, local health and welfare agencies, state hospitals, nursing homes, and physicians. The department shall assist participating counties in providing information sessions and materials to further explain the program.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

History: *L 1984 c 654 art 5 s 58*

9505.2300 RESOURCE MATERIAL FOR SCREENING PROGRAMS.

Subpart 1. **Screening tool.** The department shall recommend a screening tool to be used as a guide in conducting the screening interview. The screening tool recommended by the department shall obtain consistent categories of information and ensure that persons are receiving uniform screening. The assessment tool used by the county screening teams shall require information related to the following criteria:

A. present medical conditions;

B. present unmet needs;

C. informal and formal service available or being provided to the person;

D. the recipient's preferences;

E. persons consulted in the screening process;

F. observations of the screening team during the onsite visit;

G. assessment of functional capacity; and

H. a preliminary service care plan.

The state agency shall allow counties flexibility in using the recommended tool or a comparable one which includes the information related to the criteria in items A to H and has been approved by the state agency.

Subp. 2. **Technical assistance.** Department staff shall be available to provide technical assistance in conducting the screenings, including special training sessions.

Subp. 3. **Directory of services.** The county agency shall develop a resource directory of available institutional and noninstitutional services to be used by the screening team in determining how well an applicant's needs can be met by existing community services.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2310 SCREENING REQUIREMENTS.

Subpart 1. **Screening team.** Minnesota Statutes, section 256B.091, subdivision 2, shall govern the composition of the screening team. The screening team must include a public health nurse from the local public health nursing service, a social worker from the local community welfare agency, a physician available for consultation when necessary, and the individual's

physician if the physician chooses to participate. The screening team shall utilize the individual's attending physicians' assessment forms if available.

Subp. 2. **Screening procedures.** The screening team shall notify the individual's attending physician that the screening is a condition of medical assistance and that the physician has the right to participate in the screening procedure. The screening team shall begin the screening process within five working days after receiving the request, and it shall issue a recommendation within ten working days after receiving the request. The screening team shall notify the applicant or appropriate relative or responsible party of the decision. The team shall also notify the referring physician, the referring local welfare department if the applicant is a medical assistance recipient, and the nursing home if placement is recommended.

Subp. 3. **Rescreening procedures.** Reconsideration of a previously denied application shall be given when there has been a change in circumstances. The application shall be resubmitted to the screening team with a written explanation of the change in circumstances. Time requirements for initial applications shall apply.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2320 CRITERIA FOR SCREENING TEAM RECOMMENDATIONS.

Subpart 1. **Nursing home admission.** The screening team shall recommend admission to a nursing home when it is determined that the individual requires care or services which are not available to the recipient outside of the nursing home and cannot be provided through the alternative care grants program. In assessing the individual's need for service, the screening team may use reliable information gathered by others.

Subp. 2. **Use of community services.** The screening team shall not recommend admission to a nursing home when it is determined that the individual can remain in the community and that care and services are available to the individual in his or her own community.

Subp. 3. **Choice of care.** The recipient or his or her representative shall be informed of all feasible alternatives and allowed to choose among them where the cost of home and community-based services are not expected to exceed the cost of the appropriate level of nursing home care. This choice shall be recorded and maintained in the individual's plan of care.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2330 PLAN OF CARE.

Subpart 1. **Requirement.** A recommendation for the applicant to remain in the community shall be accompanied by a plan of care including referral to service providers and assignment of responsibility for implementing the plan.

Subp. 2. **Development of the plan.** The plan of care shall be developed by the screening team in consultation with the individual, the treating physician, and appropriate family members or responsible parties. The resource directory described in part 9505.2300, subpart 3 shall be used in determining what services are available.

Subp. 3. **Services provided in the plan of care.** Where the plan of care includes services that are not available at that time through other public assistance sources, the services shall be provided through an alternative care grant described in part 9505.2340.

Subp. 4. **Responsibility for the plan of care.** The plan of care shall include the name of the person responsible for ensuring compliance, the method of monitoring the recipient's acceptance of and adjustment to the services provided under the plan, the date for reevaluation, and any temporary measures that

might be required immediately in order to ensure the safety of the person. When needed services become unavailable, the assigned person shall be responsible for recommending a reevaluation by the screening team.

Subp. 5. **Cost-effective alternatives.** The plan of care shall include documentation that the most cost-effective alternatives available have been offered to the individual.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2340 ALTERNATIVE CARE GRANT.

Subpart 1. **Use of grant.** The grant shall be used to provide services to medical assistance recipients who have been screened and found appropriate for home or community care. Services that may be provided through this grant are day care, case management, homemaker, home health aide, personal care, respite care, foster care, and others for which federal participation is provided under the Social Security Act, section 1915, as added by Public Law Number 97-35, as amended through December 31, 1981. The grant shall supplement but not supplant services available through other public assistance or service programs. The grant shall not be used to establish new programs for which public money is available through other sources.

Subp. 2. **Service provision.** The services shall be provided by a licensed health care provider; a home health service eligible for reimbursement under United States Code, title 42, subchapters XVIII or XIX, as amended through December 31, 1981, and Code of Federal Regulations, title 42, sections 405.1201 to 405.1230 (1981); or by persons employed by, or under contract to, the county board or the local welfare agency.

Subp. 3. **Reimbursement of services.** Services shall be reimbursed at a level no greater than that which is allowed under United States Code, title 42, subchapters XIX and XX, as amended through December 31, 1981, and Code of Federal Regulations, title 42, sections 405.201 to 405.252 (1981), unless lower rates are negotiated with providers at a level sufficient to insure the availability of such services in the community.

Subp. 4. **Assurances.** The county shall provide the commissioner of human services with assurances that the alternative care grant is used for purposes specified in Minnesota Statutes, section 256B.091, subdivision 8 and in Public Law Number 97-35, section 2176 relating to community-based services.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

History: *L 1984 c 654 art 5 s 58*

9505.2350 REIMBURSEMENT OF NURSING HOME COSTS.

Subpart 1. **Notification of admission of unscreened applicants.** When an individual covered by the mandatory screening requirement is admitted to a nursing home on an emergency or nonemergency basis and has not obtained the required preadmission screening, the nursing home shall notify the screening team within two working days. If the admitting facility fails to contact the screening team within the prescribed period, the facility shall not be reimbursed for any costs incurred until the decision is made and the recipient and the nursing home are notified. Patient days resulting from that stay must be counted in the facility's patient day statistics for the purposes of rate calculation under parts 9510.0010 to 9510.0480.

Subp. 2. **Screening team review.** When an unscreened applicant has been admitted to the nursing home, the screening team shall make a decision on the case within five working days of being contacted by the nursing home. If the person prefers to return to the community, medical assistance shall cover the costs only for the period through the date the screening team notified the nursing home of this decision and until a plan for alternative care can be implemented.

Subp. 3. **Persons not screened.** Nursing home applicants who have not been screened and are not medical assistance recipients shall be asked by the nursing home if they have sufficient funds to cover 90 days of nursing home care or whether they will be applying for medical assistance within that time period. If, based on the information given and recorded, the nursing home determines that the person is not subject to the screening requirement the applicant may be admitted without screening. The nursing home shall maintain documentation of the basis for this decision in the patient's file. If the patient's statement concerning proposed eligibility is inaccurate, the health care facility shall not be denied reimbursement because of the inaccuracy of this statement.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2360 REIMBURSEMENT FOR SCREENING COSTS.

Subpart 1. **Persons eligible for medical assistance.** The Department of Human Services shall reimburse the county agency for the preadmission screening required for persons who are eligible for medical assistance and those who will be eligible for medical assistance within 90 days of admission to a nursing home. Reimbursement shall be in a manner agreed upon by both parties.

Subp. 2. **Persons not receiving assistance.** The Department of Human Services shall reimburse the county agency for all or a portion of the cost of screening for a person whose costs are not reimbursed under subpart 1. The percentage rate of reimbursement by the department shall be determined according to the schedule in subpart 3, except that the maximum amount of reimbursement from the department for a screening shall not exceed the maximum reimbursement available to a county agency for the cost of a screening reimbursed under subpart 1. The county agency may assess the person who is screened for the part of the screening cost not reimbursed by the department.

Subp. 3. **Reimbursement schedule.**

Annual Gross Income per Individual	Screening Fee Reimbursement for Applicants Not Eligible for Medical Assistance
under - 13,000	100 %
13,001 - 13,500	90
13,501 - 14,000	80
14,001 - 14,500	70
14,501 - 15,000	60
15,001 - 15,500	50
15,501 - 16,000	40
16,001 - 16,500	30
16,501 - 17,000	20
17,001 - 17,500	10
17,501 - and over	0

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

History: *L 1984 c 654 art 5 s 58*

9505.2370 RIGHT TO APPEAL.

Subpart 1. **Appeal procedures.** Persons who are recipients of or applying for medical assistance have the right to a fair hearing pursuant to Minnesota Statutes, section 256.045 if they are not informed of and allowed to choose among alternatives available to them as set forth in part 9505.2320, subpart 3, or if the plan of care is not satisfactory. The hearing shall be conducted in accordance with appeal procedures set forth in Minnesota Statutes, section 256.045. If it appears at the hearing that circumstances are different than they

were at the time the plan of care was established, the referee may refer the case back to the screening team for reconsideration.

Subp. 2. **Appeal by the physician.** When the treating physician disagrees with the outcome of the screening, the physician shall notify the screening team in order to initiate an appeal on behalf of the individual. The appeal may be withdrawn with the consent of the individual and the treating physician.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

9505.2380 COUNTY REPORTS.

The county agency shall submit a report to the Department of Human Services according to a schedule agreed upon by the department and the county agency. The report shall be submitted on forms provided by the commissioner and include the number of persons screened, results of each screening, and the rationale for each screening recommendation. The county agency shall retain the plan of care for persons who are to remain in the community and shall make it available to the department on request. The county agency shall also provide information as requested by the commissioner for ongoing evaluation of the program.

Statutory Authority: *MS s 256B.04 subd 2; 256B.091 subds 1 to 9*

History: *L 1984 c 654 art 5 s 58*