CHAPTER 9505
DEPARTMENT OF HUMAN SERVICES
HEALTH CARE PROGRAMS

9505 0065 INCOME
MEDICAL ASSISTANCE PAYMENTS
9505 0170 APPLICABILITY
9505 0175 DEFINITIONS
9505 0180 SURVEILLANCE AND UTILIZATION CONTROL PROGRAM
9505 0185 PROFESSIONAL SERVICES ADVISORY COMMITTEE
9505 0190 RECIPIENT CHOICE OF PROVIDER
9505 0195 PROVIDER PARTICIPATION
9505 0200 COMPETITIVE BIDDING
9505 0205 PROVIDER RECORDS
9505 0210 COVERED SERVICES, GENERAL REQUIREMENTS
9505 0215 COVERED SERVICES, OUT-OF-STATE PROVIDERS
9505 0220 HEALTH SERVICES NOT COVERED BY MEDICAL ASSISTANCE
9505 0221 PAYMENT LIMITATION, PARTIES AFFILIATED WITH A PROVIDER
9505 0225 REQUEST TO RECIPIENT TO PAY
9505 0235 ABORTION SERVICES
9505 0240 AMBULATORY SURGICAL CENTERS
9505 0245 CHIROPRACTIC SERVICES
9505 0250 CLINIC SERVICES
9505 0255 COMMUNITY HEALTH CLINIC SERVICES
9505 0270 DENTAL SERVICES
9505 0275 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT
9505 0280 FAMILY PLANNING SERVICES
9505 0285 HEALTH CARE PREPAYMENT PLANS OR PREPAID HEALTH PLANS
9505 0290 HOME HEALTH AGENCY SERVICES
9505 0295 HOME HEALTH SERVICES
9505 0300 INPATIENT HOSPITAL SERVICES
9505 0305 LABORATORY AND X-RAY SERVICES
9505 0310 MEDICAL SUPPLIES AND EQUIPMENT
9505 0315 MEDICAL TRANSPORTATION
9505 0320 NURSE MIDWIFE SERVICES
9505 0325 NUTRITIONAL PRODUCTS
9505 0330 OUTPATIENT HOSPITAL SERVICES
9505 0335 PERSONAL CARE SERVICES
9505 0340 PHARMACY SERVICES
9505 0345 PHYSICIAN SERVICES
9505 0350 PODIATRY SERVICES
9505 0353 PRENATAL CARE SERVICES
9505 0355 PREVENTIVE HEALTH SERVICES
9505 0360 PRIVATE DUTY NURSING SERVICES
9505 0365 PROSTHETIC AND ORTHOTIC DEVICES
9505 0380 PUBLIC HEALTH CLINIC SERVICES
9505 0395 RURAL HEALTH CLINIC SERVICES
9505 0405 VISION CARE SERVICES
9505 0415 LONG-TERM CARE FACILITIES, LEAVE DAYS
9505 0420 LONG-TERM CARE FACILITY SERVICES
9505 0425 RESIDENT FUND ACCOUNTS
9505 0430 HEALTH CARE INSURANCE PREMIUMS
9505 0440 MEDICARE BILLING REQUIRED
9505 0445 PAYMENT RATES
9505 0450 BILLING PROCEDURES, GENERAL
9505 0455 BILLING PROCEDURE, BUSINESS AGENT
9505 0460 CONSEQUENCES OF A FALSE CLAIM
9505 0465 RECOVERY OF PAYMENT TO PROVIDER
9505 0470 PROVIDER RESPONSIBILITY FOR BILLING PROCEDURE
9505 0475 SUSPENSION OF PROVIDER CONVICTED OF CRIME RELATED TO MEDICARE OR MEDICAID
PREADMISSION SCREENING AND ALTERNATIVE CARE GRANT PROGRAM
9505 2390 SCOPE AND EFFECT
9505 2395 DEFINITIONS
9505 2396 COMPUTATION OF TIME INTERVALS TO MEET NOTICE REQUIREMENTS
9505 2400 PREADMISSION SCREENING REQUIREMENT
9505 2405 INFORMATION REGARDING AVAILABILITY OF PREADMISSION SCREENING
9505 2410 ESTABLISHMENT OF PREADMISSION SCREENING TEAM
9505 2413 CONTRACTS FOR PREADMISSION SCREENING TEAM MEMBERS FOR APPLICANTS DISCHARGED FROM HOSPITALS
9505 2415 HOSPITAL NOTICE REQUIREMENTS
9505 2420 TIME REQUIREMENTS FOR PREADMISSION SCREENING
9505 2425 SCREENING AND ASSESSMENT PROCEDURES REQUIRED DURING PREADMISSION SCREENING
9505 2426 APPLICANT'S AND NURSING HOME RESIDENT'S RIGHT TO CHOOSE COMMUNITY SERVICES
9505 2430 ESTABLISHMENT OF INDIVIDUAL SERVICE PLAN
9505 2435 RESCREENING
9505 2440 PREADMISSION SCREENING RATE
9505 2445 REIMBURSEMENT FOR PREADMISSION SCREENING
9505 2450 PENALTIES
9505 2455 ALTERNATIVE CARE GRANTS
9505 2458 CASE MANAGER ACTIONS TO ASSURE SAFETY AND HEALTH OF ACG CLIENT WHO IS A VULNERABLE ADULT
9505 2460 LOCAL AGENCY SELECTION OF ACG PROVIDERS
9505 2465 STANDARDS FOR PERSONAL CARE SERVICES
9505 2470 STANDARDS FOR HOME HEALTH AIDE SERVICES
9505 2473 STANDARDS FOR HOMEMAKER SERVICES
9505 2475 ESTABLISHMENT OF INDIVIDUAL TREATMENT PLAN
9505 2480 ALLOCATION OF STATE ACG MONEY
9505 2485 ALLOCATION OF NUMBER OF ACG CLIENTS TO BE SERVED UNDER THE WAIVER
9505 2486 LOCAL AGENCY ESTIMATION OF NUMBER OF PERSONS OTHER THAN RECIPIENTS TO BE SERVED AS ACG CLIENTS
9505 2490 RATES FOR ACG SERVICES
9505 2495 LOCAL AGENCY REPORTS AND RECORDS
9505 2496 CRITERION FOR DELAY IN SENDING REQUIRED NOTICES
9505 2500 APPEALS OF SCREENINGS, RESCREENINGS, AND REASSESSMENTS

9505.0065 INCOME.

[For text of subps 1 to 10, see M.R. 1987]

Subp. 11. **Eligibility based on income spend down.** A person determined eligible on the basis of a spend down is eligible for the periods specified in items A to G if the person incurs health service bills at least equal to the amount of the spend down during the eligibility period. Except as in items C and D, only bills for health services incurred during the eligibility period may be used to satisfy the spend down. Actual rates charged for the health service to the person less any portion of the bill covered by a liable third party payment shall be used in determining whether the person satisfies the spend down. Prior authorization requirements and medical assistance payment rates and service limitations under parts 9500.0900 to 9500.1080 shall not apply to health service bills used to satisfy a spend down. However, rates established by the department for long-term care in nursing homes and residential care facilities for mentally and physically handicapped persons must be used to calculate the continuing monthly spend down for a recipient who resides in a long-term care facility during the period between the date of application and the determination of eligibility.

[For text of subp 11, item A, see M.R. 1987]

B. The monthly spend down of a person residing in a long-term care facility shall be the net income remaining after deducting subitems (1) to (4). The spend down must be applied to monthly health service costs in the order incurred until the spend down is satisfied. For purposes of this item, deductions are:

[For text of subp 11, item B, subitem (1), see M.R. 1987]

(2) in the case of a person who has mental retardation or a related condition as defined in part 9525.0010, subpart 11 or is certified as disabled as defined in part 9505.0040, items E to H and is employed under a plan of rehabilitation, a special monthly personal allowance of the first $50 of gross monthly earned income;

[For text of subp 11, item B, subitems (3) to (5), see M.R. 1987]

[For text of subp 11, items C to G, see M.R. 1987]

[For text of subp 12, see M.R. 1987]

Statutory Authority: *MS s 252.28 subd 2; 256B.092 subd 6; 256B.503*

History: *12 SR 1148*

MEDICAL ASSISTANCE PAYMENTS

9505.0170 APPLICABILITY.

Parts 9505.0170 to 9505.0475 govern the administration of the medical assistance program, establish the services and providers that are eligible to receive medical assistance payments, and establish the conditions a provider must meet to receive payment.

Parts 9505.0170 to 9505.0475 must be read in conjunction with title XIX of the Social Security Act as amended through October 17, 1986; Code of Federal Regulations, title 42; and Minnesota Statutes, including chapters 256 and 256B; and parts 9505.5000 to 9505.5105. Unless otherwise specified, citations of Code of Federal Regulations, title 42, refer to the code amended as of October 1, 1985.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0175 DEFINITIONS.

Subpart 1. **Scope.** The terms used in parts 9505.0170 to 9505.0475 have the meanings given them in this part.

Subp. 2. **Attending physician.** "Attending physician" means the physician who is responsible for the recipient's plan of care.

Subp. 3. **Business agent.** "Business agent" means a person or entity who submits a claim for or receives a medical assistance payment on behalf of a provider.

Subp. 4. **Clinic.** "Clinic" means an entity enrolled in the medical assistance program to provide rural health clinic services, public health clinic services, community health clinic services, or the health services of two or more physicians or dentists.

Subp. 5. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's designee.

Subp. 6. **Covered service.** "Covered service" means a health service eligible for medical assistance payment under parts 9505.0170 to 9505.0475.

Subp. 7. **Dentist.** "Dentist" means a person who is licensed to provide health services under Minnesota Statutes, section 150A.06, subdivision 1.

Subp. 8. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 9. **Drug formulary.** "Drug formulary" means a list of drugs for which payment is made under medical assistance. The formulary is established under Minnesota Statutes, sections 256B.02, subdivision 8, and 256B.0625.

Subp. 10. **Durable medical equipment.** "Durable medical equipment" means a device or equipment that can withstand repeated use, is provided to correct or accommodate a physiological disorder or physical condition, and is suitable for use in the recipient's residence.

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

Subp. 12. **Employee.** "Employee" means a person:

A. employed by a provider who pays compensation to the employee and withholds or is required to withhold the federal and state taxes from the employee; or

B. who is a self-employed vendor and who has a contract with a provider to provide health services.

Subp. 13. **Health care prepayment plan or prepaid health plan.** "Health care prepayment plan" or "prepaid health plan" means a health insurer licensed and operating under Minnesota Statutes, chapters 60A, 62A, and 62C and a health maintenance organization licensed and operating under Minnesota Statutes, chapter 62D to provide health services to recipients.

Subp. 14. **Health services.** "Health services" means the goods and services eligible for medical assistance payment under Minnesota Statutes, sections 256B.02, subdivision 8, and 256B.0625.

Subp. 15. **Home health agency.** "Home health agency" means an organization certified by Medicare to provide home health services.

Subp. 16. **Hospital.** "Hospital" means an acute care institution defined in Minnesota Statutes, section 144.696, subdivision 3, licensed under Minnesota Statutes, sections 144.50 to 144.58, and maintained primarily to treat and care for persons with disorders other than tuberculosis or mental diseases.

Subp. 17. **Inpatient.** "Inpatient" means a person who has been admitted to an inpatient hospital and has not yet been formally discharged. Inpatient applies to a person absent from a hospital on a pass ordered by a physician. For purposes

of this definition, a person absent from the hospital against medical advice is not an inpatient during the absence.

Subp. 18. **Licensed consulting psychologist.** "Licensed consulting psychologist" means a person licensed to provide health services under Minnesota Statutes, section 148.91, subdivision 4.

Subp. 19. **Licensed practical nurse.** "Licensed practical nurse" means a person licensed to provide health services under Minnesota Statutes, sections 148.29 to 148.299.

Subp. 20. **Licensed psychologist.** "Licensed psychologist" means a person licensed to provide health services under Minnesota Statutes, section 148.91, subdivision 5.

Subp. 21. **Local agency.** "Local agency" means a county or multicounty agency that is authorized under Minnesota Statutes, sections 393.01, subdivision 7 and 393.07, subdivision 2, as the agency responsible for determining eligibility for the medical assistance program.

Subp. 22. **Local trade area.** "Local trade area" means the geographic area surrounding the person's residence, including portions of states other than Minnesota, which is commonly used by other persons in the same area to obtain similar necessary goods and services.

Subp. 23. **Long-term care facility.** "Long-term care facility" means a residential facility certified by the Minnesota Department of Health as a skilled nursing facility, an intermediate care facility, or an intermediate care facility for the mentally retarded.

Subp. 24. **Medical assistance.** "Medical assistance" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B.

Subp. 25. **Medically necessary or medical necessity.** "Medically necessary" or "medical necessity" means a health service that is consistent with the recipient's diagnosis or condition and:

A. is recognized as the prevailing standard or current practice by the provider's peer group; and

B. is rendered in response to a life threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or

C. is a preventive health service under part 9505.0355.

Subp. 26. **Medicare.** "Medicare" means the health insurance program for the aged and disabled under title XVIII of the Social Security Act.

Subp. 27. **Mental health practitioner.** "Mental health practitioner" means a staff person qualified under part 9520.0760, subpart 17 to provide clinical services in the treatment of mental illness.

Subp. 28. **Mental health professional.** "Mental health professional" means a person qualified under part 9520.0760, subpart 18 to provide clinical services in the treatment of mental illness.

Subp. 29. **Nondurable medical equipment.** "Nondurable medical equipment" means a supply or piece of equipment that is used to treat a health condition and that cannot be reused.

Subp. 30. **Nurse practitioner.** "Nurse practitioner" means a registered nurse who is currently certified as a primary care nurse or clinical nurse specialist by the American Nurses Association or by the National Board of Pediatric Nurse Practitioners and Associates.

Subp. 31. **On the premises.** "On the premises," when used to refer to a person supervising the provision of the health service, means that the person is physical-

ly located within the clinic, long-term care facility, or the department within the hospital where services are being provided at the time the health service is provided.

Subp. 32. **Performance agreement.** "Performance agreement" means a written agreement between the department and a provider that states the provider's contractual obligations for the sale and repair of medical equipment and medical supplies eligible for medical assistance payment. Examples of a performance agreement are an agreement between the department and a provider of nondurable medical supplies or durable medical equipment as specified in part 9505.0310, subpart 3, items A and B, and a hearing aid performance agreement between the department and a hearing aid dispenser as specified in part 9505.0365, subpart 1, item D.

Subp. 33. **Physician.** "Physician" means a person who is licensed to provide health services within the scope of his or her profession under Minnesota Statutes, chapter 147.

Subp. 34. **Physician assistant.** "Physician assistant" means a person who meets the requirements of part 5600.2600, subpart 11.

Subp. 35. **Plan of care.** "Plan of care" means a written plan that:

A. states with specificity the recipient's condition, functional level, treatment objectives, the physician's orders, plans for continuing care, modifications to the plan, and the plans for discharge from treatment; and

B. except in an emergency, is reviewed and approved, before implementation, by the recipient's attending physician in a hospital or long-term care facility or by the provider of a covered service as required in parts 9505.0170 to 9505.0475.

Subp. 36. **Podiatrist.** "Podiatrist" means a person who is licensed to provide health services under Minnesota Statutes, chapter 153.

Subp. 37. **Prior authorization.** "Prior authorization" means the procedures required in parts 9505.5010 to 9505.5030.

Subp. 38. **Provider.** "Provider" means a vendor as specified in Minnesota Statutes, section 256B.02, subdivision 7 that has signed an agreement approved by the department for the provision of health services to a recipient.

Subp. 39. **Provider agreement.** "Provider agreement" means a written contract between a provider and the department in which the provider agrees to comply with the provisions of the contract as a condition of participation in the medical assistance program.

Subp. 40. **Psychiatrist.** "Psychiatrist" means a physician who can give written documentation of having successfully completed a postgraduate psychiatry program of at least three years' duration that is accredited by the American Board of Psychiatry and Neurology.

Subp. 41. **Recipient.** "Recipient" means a person who has been determined by the local agency to be eligible for the medical assistance program.

Subp. 42. **Registered nurse.** "Registered nurse" means a nurse licensed under and within the scope of practice of Minnesota Statutes, sections 148.171 to 148.285.

Subp. 43. **Residence.** "Residence" means the place a person uses as his or her primary dwelling place, and intends to continue to use indefinitely for that purpose.

Subp. 44. **Screening team.** "Screening team" has the meaning given in Minnesota Statutes, section 256B.091.

Subp. 45. **Second surgical opinion.** "Second surgical opinion" means the requirement established in parts 9505.5035 to 9505.5105.

Subp. 46. **Supervision.** "Supervision" means the process of control and direction by which the provider accepts full professional responsibility for the

supervisee, instructs the supervisee in his or her work, and oversees or directs the work of the supervisee. The process must meet the following conditions.

A. The provider must be present and available on the premises more than 50 percent of the time when the supervisee is providing health services.

B. The diagnosis must be made by or reviewed, approved, and signed by the provider.

C. The plan of care for a condition other than an emergency may be developed by the supervisee, but must be reviewed, approved, and signed by the provider before the care is begun.

D. The supervisee may carry out the treatment but the provider must review and countersign the record of a treatment within five working days after the treatment.

Subp. 47. **Surgical assistant.** "Surgical assistant" means a person who assists a physician, dentist, or podiatrist in surgery but is not licensed as a physician, dentist, or podiatrist.

Subp. 48. **Third party.** "Third party" refers to a person, entity, agency, or government program as defined in part 9505.0015, subpart 46.

Subp. 49. **Usual and customary.** "Usual and customary," when used to refer to a fee billed by a provider, means the charge of the provider to the type of payer, other than recipients or persons eligible for payment on a sliding fee schedule, that constitutes the largest share of the provider's business. For purposes of this subpart, "payer" means a third party or persons who pay for health service by cash, check, or charge account.

Subp. 50. **Vendor.** "Vendor" means a vendor of medical care as defined in Minnesota Statutes, section 256B.02, subdivision 7. A vendor may or may not be a provider.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624; L 1988 c 689 art 2 s 268*

9505.0180 SURVEILLANCE AND UTILIZATION CONTROL PROGRAM.

Subpart 1. **Purpose.** For purposes of this part, "surveillance and utilization review" has the meaning given in part 9505.1750, subpart 15 and "utilization control" has the meaning given in part 9505.1750, subpart 19.

Subp. 2. **Duty to implement.** The department shall carry out a program of a surveillance and utilization review under parts 9505.1750 to 9505.2150 and Code of Federal Regulations, title 42, part 455, and a program of utilization control under Code of Federal Regulations, title 42, part 456. These programs together constitute the surveillance and utilization control program.

Subp. 3. **Surveillance and utilization review.** The surveillance and utilization review program must have a post payment review process to ensure compliance with the medical assistance program and to monitor both the use of health services by recipients and the delivery of health services by providers. The process must comply with parts 9505.1750 to 9505.2150.

Subp. 4. **Utilization control.** The department shall administer and monitor a program of utilization control to review the need for, and the quality and timeliness of, health services provided in a hospital, long-term care facility, or institution for the treatment of mental diseases. A facility certified for participation in the medical assistance program must comply with the requirements of Code of Federal Regulations, title 42, part 456 for utilization control.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0185 PROFESSIONAL SERVICES ADVISORY COMMITTEE.

Subpart 1. **Appointees.** The commissioner shall appoint a professional serv-

ices advisory committee comprised of persons who are licensed or certified in their professions under state law and who are familiar with the health service needs of low income population groups. The committee must have at least 15 members who are representative of the types of covered services. In appointing committee members, the commissioner shall:

A. publish a notice in the State Register to request applications from persons licensed or certified in a health service profession;

B. consider all individuals who respond to the notice in item A or are recommended by a provider or a professional organization of providers;

C. ensure that when the committee is reviewing a particular health service, at least one member of the committee is a provider or representative of the health service.

Subp. 2. **Condition of appointment.** As a condition of appointment, an individual named to serve on the committee shall sign a contract with the department. The contract shall conform to the requirements of Minnesota Statutes, section 16B.17, and shall provide for periods and hours of expected service by a committee member, the fee to be paid for service, and the grounds and notice required to cancel the contract.

Subp. 3. **Committee organization.** The chairperson of the committee shall be appointed by the commissioner. The committee may establish subcommittees of any of its members and may delegate to a member or a subcommittee any of its duties.

Subp. 4. **Committee meetings.** The committee shall meet at the call of the department. The chairperson of the committee may call additional meetings including telephone conferences as necessary to carry out the duties in subparts 5 and 6.

Subp. 5. **Duty to advise commissioner.** When requested by the commissioner, the committee shall review and advise the commissioner about the matters in items A to H:

A. payments of medical assistance funds for covered services;

B. requests for prior authorization;

C. billings for covered services that are not clearly within the service limits in parts 9505.0170 to 9505.0475;

D. purchase requests;

E. payments proposed for unlisted or unpriced procedures;

F. utilization procedures;

G. determinations of medical necessity; and

H. standards for determining the necessity of health services.

Subp. 6. **Other duties.** The committee may initiate discussions, and make recommendations to the commissioner, about policies related to health services eligible for medical assistance payments under parts 9505.0170 to 9505.0475 and about matters related to the surveillance and utilization review program under parts 9505.1750 to 9505.2150.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0190 RECIPIENT CHOICE OF PROVIDER.

Subject to the limitations in Minnesota Statutes, section 256B.69, and in parts 9505.1750 to 9505.2150, a recipient who requires a medically necessary health service may choose to use any provider located within Minnesota or within the recipient's local trade area. No provider other than a prepaid health plan shall require a recipient to use a health service that restricts a recipient's free choice of provider. A recipient who enrolls in a prepaid health plan that is a

provider must use the prepaid health plan for the health services provided under the contract between the prepaid health plan and the department.

A recipient who requires a medically necessary health service that is not available within Minnesota or the recipient's local trade area shall obtain prior authorization of the health service.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0195 PROVIDER PARTICIPATION.

Subpart 1. **Department administration of provider participation.** The department shall administer the participation of providers in the medical assistance program. The department shall:

A. determine the vendor's eligibility to enroll in the medical assistance program according to parts 9505.0170 to 9505.0475;

B. enroll an eligible vendor located in Minnesota retroactive to the first day of the month of application, or retroactive for up to 90 days to the effective date of Medicare certification of the provider, or retroactive to the date of the recipient's established retroactive eligibility;

C. enroll an out-of-state vendor as provided in subpart 9; and

D. monitor and enforce the vendor's compliance with parts 9505.1750 to 9505.2150 and with the terms of the provider agreement.

Subp. 2. **Application to participate.** A vendor that wants to participate in the medical assistance program shall apply to the department on forms provided by the department. The forms must contain an application and a statement of the terms for participation. The vendor shall complete, sign, and return the forms to the department. Upon approval of the application by the department under subpart 3, the signed statement of the terms for participation and the application constitute the provider agreement.

Subp. 3. **Department review of application.** The department shall review a vendor's application to determine whether the vendor is qualified to participate according to the criteria in parts 9505.0170 to 9505.0475.

Subp. 4. **Notice to vendor.** The department shall notify an applicant, in writing, of its determination within 30 days of receipt of the complete application to participate.

A. If the department approves the application, the notice must state that the application is approved and that the applicant has a provider agreement with the department.

B. If the department denies the application, the notice to the applicant must state the reasons for the denial and the applicant's right to submit additional information in support of the application.

C. If the department is unable to reach a decision within 30 days, the notice to the applicant must state the reasons for the delay and request any additional information necessary to make a decision.

Subp. 5. **Duration of provider agreement.** A provider agreement remains in effect until an event in items A to C occurs:

A. the ending date of the agreement specified in the agreement; or

B. the provider's failure to comply with the terms of participation; or

C. the provider's sale or transfer of ownership, assets, or control of an entity that has been enrolled to provide medical assistance services; or

D. 30 days following the date of the department's request to the provider to sign a new provider agreement that is required of all providers of a particular type of health service; or

E. the provider's request to end the agreement.

Subp. 6. **Consequences of failure to comply.** A provider who fails to comply with the terms of participation in the provider agreement or parts 9505.0170 to 9505.0475 or 9505.1750 to 9505.2150 is subject to monetary recovery, sanctions, or civil or criminal action as provided in parts 9505.1750 to 9505.2150. Unless otherwise provided by law, no provider of health services shall be declared ineligible without prior notice and an opportunity for a hearing under Minnesota Statutes, chapter 14, on the commissioner's proposed action.

Subp. 7. **Vendor who is not a provider.** A vendor of health services who does not have a provider agreement in effect, but who provides health services to recipients and who otherwise receives payments from the medical assistance program, is subject to parts 9505.0170 to 9505.0475 and 9505.1750 to 9505.2150.

Subp. 8. **Sale or transfer of entity providing health services.** A provider who sells an entity which has been enrolled to provide medical assistance services or who transfers ownership or control of an entity that has been enrolled to provide medical assistance services shall notify the department of the sale or transfer no later than 30 days before the effective date of the sale or transfer. The purchaser or transferee shall notify the department of transfer or sale no later than the effective date of the sale or transfer. Nothing in this subpart shall be construed to limit the right of the department to pursue monetary recovery or civil or criminal action against the seller or transferor as provided in parts 9505.1750 to 9505.2150.

Subp. 9. **Out-of-state vendor.** An out-of-state vendor may apply for retroactive enrollment as a provider effective on the date of service to a recipient. To be eligible for payment under the Minnesota medical assistance program, an out-of-state vendor must:

A. comply with the licensing and certification requirements of the state where the vendor is located;

B. complete and sign the forms required in subpart 2;

C. obtain department approval as in subpart 3; and

D. comply with the requirements of parts 9505.0170 to 9505.0475.

For purposes of this subpart, "out-of-state vendor" refers to a vendor who provides a health service to a Minnesota recipient at a site located in a state other than Minnesota.

Subp. 10. **Condition of participation.** A provider shall comply with title VI of the Civil Rights Act of 1964 and all regulations under the act, and with Minnesota Statutes, chapter 363. A provider shall not place restrictions or criteria on the services it will make available, the type of health conditions it will accept, or the persons it will accept for care or treatment, unless the provider applies those restrictions or criteria to all individuals seeking the provider's services. A provider shall render to recipients services of the same scope and quality as would be provided to the general public. Furthermore, a provider who has such restrictions or criteria shall disclose the restrictions or criteria to the department so the department can determine whether the provider complies with the requirements of this subpart.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0200 COMPETITIVE BIDDING.

Under certain conditions, the commissioner shall seek competitive bids for items designated in Minnesota Statutes, section 256B.04, subdivision 14, and for durable medical equipment. Competitive bids are required if the item of durable medical equipment is available from more than one manufacturer and at least one of the following conditions exists:

A. the projected fiscal year savings of medical assistance funds, resulting from purchase of the item through the bidding procedure, exceeds the cost of

administering the competitive bidding procedure. The projected savings in a fiscal year must be computed by determining the difference between actual expenditures for the item in the previous fiscal year and an estimated expenditure based on the actual number of units purchased times the predicted competitive bid prices; or

B. the item is a new item that was not available during the previous fiscal year but is estimated to be cost effective if purchased by competitive bidding. Competitive bidding for a new item is considered cost effective if the projected annual cost at predicted competitive bid prices is less than the projected annual payments at a reimbursement level which would be set by medical assistance in lieu of competitive bid.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0205 PROVIDER RECORDS.

A provider shall maintain medical, health care, and financial records, including appointment books and billing transmittal forms, for five years in the manner required under parts 9505.1800 to 9505.1880.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0210 COVERED SERVICES; GENERAL REQUIREMENTS.

The medical assistance program shall pay for a covered service provided to a recipient or to a person who is later found to be eligible at the time he or she received the service. To be eligible for payment, a health service must:

A. be determined by prevailing community standards or customary practice and usage to:

(1) be medically necessary;

(2) be appropriate and effective for the medical needs of the recipient;

(3) meet quality and timeliness standards;

(4) be the most cost effective health service available for the medical needs of the recipient;

B. represent an effective and appropriate use of medical assistance funds;

C. be within the service limits specified in parts 9505.0170 to 9505.0475;

D. be personally furnished by a provider except as specifically authorized in parts 9505.0170 to 9505.0475; and

E. if provided for a recipient residing in a long-term care facility, be part of the recipient's written plan of care, unless the service is for an emergency, included in the facility's per diem rate, or ordered in writing by the recipient's attending physician.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0215 COVERED SERVICES; OUT-OF-STATE PROVIDERS.

A health service provided to a Minnesota recipient by a provider located outside of Minnesota is eligible for medical assistance payment if the service meets one of the following requirements.

A. The health service is within the limitations of parts 9505.0170 to 9505.0475.

B. The service is medically necessary and is not available in Minnesota or the recipient's local trade area. Provision of the service, other than an emer-

gency service, outside of Minnesota or the recipient's local trade area requires prior authorization.

C. The service is provided to a person who is considered a Minnesota medical assistance recipient while residing out-of-state as specified in part 9505.0055, subparts 4 and 5.

D. The service is in response to an emergency.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0220 HEALTH SERVICES NOT COVERED BY MEDICAL ASSISTANCE.

The health services in items A to X are not eligible for payment under medical assistance:

A. health service paid for directly by a recipient or other source unless the recipient's eligibility is retroactive and the provider bills the medical assistance program for the purpose of repaying the recipient according to part 9505.0450, subpart 3;

B. drugs which are not in the drug formulary or which have not received prior authorization;

C. a health service for which the required prior authorization was not obtained, or, except in the case of an emergency, a health service provided before the date of approval of the prior authorization request;

D. autopsies;

E. missed or canceled appointments;

F. telephone calls or other communications that were not face to face between the provider and the recipient unless authorized by parts 9505.0170 to 9505.0475;

G. reports required solely for insurance or legal purposes unless requested by the local agency or department;

H. an aversive procedure, including cash penalties from recipients, unless otherwise provided by state rules;

I. a health service that does not comply with parts 9505.0170 to 9505.0475;

J. separate charges for the preparation of bills;

K. separate charges for mileage for purposes other than medical transportation of a recipient;

L. a health service that is not provided directly to the recipient, unless the service is a covered service;

M. concurrent care by more than one provider of the same type of provider or health service specialty, for the same diagnosis, without an appropriate medical referral detailing the medical necessity of the concurrent care, if the provider has reason to know concurrent care is being provided. In this event, the department shall pay the first submitted claim;

N. a health service, other than an emergency health service, provided to a recipient without the knowledge and consent of the recipient or the recipient's legal guardian, or a health service provided without a physician's order when the order is required by parts 9505.0170 to 9505.0475, or a health service that is not in the recipient's plan of care;

O. a health service that is not documented in the recipient's health care record or medical record as required in part 9505.1800, subpart 1;

P. a health service other than an emergency health service provided to a recipient in a long-term care facility and which is not in the recipient's plan of care or which has not been ordered, in writing, by a physician when an order is required;

Q. an abortion that does not comply with Code of Federal Regulations, title 42, sections 441.200 to 441.208 or Minnesota Statutes, sections 256B.02, subdivision 8, and 256B.0625;

R. a health service that is of a lower standard of quality than the prevailing community standard of the provider's professional peers. In this event, the provider of service of a lower standard of quality is responsible for bearing the cost of the service;

S. a health service that is only for a vocational purpose or an educational purpose that is not related to a health service;

T. except for an emergency, more than one consultation by a provider per recipient per day; for purposes of this item, "consultation" means a meeting of two or more physicians to evaluate the nature and progress of disease in a recipient and to establish the diagnosis, prognosis, and therapy;

U. except for an emergency, or as allowed in item V, more than one office, hospital, long-term care facility, or home visit by the same provider per recipient per day;

V. more than one home visit for a particular type of home health service by a home health agency per recipient per day except as specified in the recipient's plan of care;

W. record keeping, charting, or documenting a health service related to providing a covered service; and

X. services for detoxification which are not medically necessary to treat an emergency.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624; L 1988 c 689 art 2 s 268*

9505.0221 PAYMENT LIMITATION; PARTIES AFFILIATED WITH A PROVIDER.

Equipment, supplies, or services prescribed or ordered by a physician are not eligible for medical assistance payment if they are provided:

A. by a person or entity that provides direct or indirect payment to the physician for the order or prescription for the equipment, supplies, or services; or

B. upon or as a result of direct referral by the physician to an affiliate of the physician unless the affiliate is the only provider of the equipment, supplies, or services in the local trade area.

For purposes of this part, "affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with the referring physician.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0225 REQUEST TO RECIPIENT TO PAY.

Subpart 1. **Limitation on Participation.** Participation in the medical assistance program is limited to providers who accept payment for health services to a recipient as provided in subparts 2 and 3.

Subp. 2. **Payment for covered service.** If the health service to a recipient is a covered service, a provider must not request or receive payment or attempt to collect payment from the recipient for the covered service unless copayment by the recipient is authorized by Minnesota Statutes enacted according to Code of Federal Regulations, title 42, or unless the recipient has incurred a spend down obligation under part 9505.0065, subpart 11. This prohibition applies regardless of the amount of the medical assistance payment to the provider. The provider shall state on any statement sent to a recipient concerning a covered service that medical assistance payment is being requested.

Subp. 3. **Payment for noncovered service.** A provider who furnishes a recipient a noncovered service may request the recipient to pay for the noncovered service if the provider informs the recipient about the recipient's potential liability before providing the service.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0235 ABORTION SERVICES.

Subpart 1. **Definition.** For purposes of this part, "abortion related services" means services provided in connection with an elective abortion except those services which would otherwise be provided in the course of a pregnancy. Examples of abortion related services include hospitalization when the abortion is performed in an inpatient setting, the use of a facility when the abortion is performed in an outpatient setting, counseling about the abortion, general and local anesthesia provided in connection with the abortion, and antibiotics provided directly after the abortion.

Medically necessary services that are not considered to be abortion related include family planning services as defined in part 9505.0280, subpart 1, history and physical examination, tests for pregnancy and venereal disease, blood tests, rubella titer, ultrasound tests, rhoGAM(TM), pap smear, and laboratory examinations for the purpose of detecting fetal abnormalities.

Treatment for infection or other complications of the abortion are covered services.

Subp. 2. **Payment limitation.** Unless otherwise provided by law, an abortion related service provided to a recipient is eligible for medical assistance payment if the abortion meets the conditions in item A, B, or C.

A. The abortion must be necessary to prevent the death of a pregnant woman who has given her written consent to the abortion. If the pregnant woman is physically or legally incapable of giving her written consent to the procedure, authorization for the abortion must be obtained as specified in Minnesota Statutes, section 144.343. The necessity of the abortion to prevent the death of the pregnant woman must be certified in writing by two physicians before the abortion is performed.

B. The pregnancy is the result of criminal sexual conduct as defined in Minnesota Statutes, section 609.342, paragraphs (c) to (f). The conduct must be reported to a law enforcement agency within 48 hours after its occurrence. If the victim is physically unable to report the criminal sexual conduct within 48 hours after its occurrence, the report must be made within 48 hours after the victim becomes physically able to report the criminal sexual conduct.

C. The pregnancy is the result of incest. Before the abortion, the incest and the name of the relative allegedly committing the incest must be reported to a law enforcement agency.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0240 AMBULATORY SURGICAL CENTERS.

Subpart 1. **Definition; ambulatory surgical center.** "Ambulatory surgical center" means a facility licensed as an outpatient surgical center under parts 4675.0100 to 4675.2800 and certified under Code of Federal Regulations, title 42, part 416, to provide surgical procedures which do not require overnight inpatient hospital care.

Subp. 2. **Payment limitation; surgical procedures.** Medical assistance payment for surgical procedures performed in an ambulatory surgical center shall not exceed the payment for the same surgical procedure performed in another setting.

Subp. 3. **Payment limitation; items and services.** The items and services listed in items A to G are included in medical assistance payment when they are provided to a recipient by an ambulatory surgical center in connection with a surgical procedure that is a covered service.

A. Nursing services and other related services of employees who are involved in the recipient's health care.

B. Use by the recipient of the facilities of the ambulatory surgical center, including operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by those persons accompanying the recipient in connection with surgical procedures.

C. Drugs, medical supplies, and equipment commonly furnished by the ambulatory surgical center in connection with surgical procedures. Drugs are limited to those which cannot be self administered.

D. Diagnostic or therapeutic items and services that are directly related to the provision of a surgical procedure.

E. Administrative, record keeping, and housekeeping items and services necessary to run the ambulatory surgical center.

F. Blood, blood plasma, and platelets.

G. Anesthetics and any materials, whether disposable or reusable, necessary for the administration of the anesthetics.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0245 CHIROPRACTIC SERVICES.

Subpart 1. **Definitions.** The following terms used in this part have the meanings given them.

A. "Chiropractic service" means a medically necessary health service provided by a chiropractor.

B. "Chiropractor" means a person licensed under Minnesota Statutes, sections 148.01 to 148.101.

Subp. 2. **Payment limitations.** Medical assistance payment for chiropractic service is limited to medically necessary manual manipulation of the spine for treatment of incomplete or partial dislocations and the X-rays that are needed to support a diagnosis of subluxation.

A. Payment for manual manipulations of the spine of a recipient is limited to six manipulations per month and 24 manipulations per year unless prior authorization of a greater number of manipulations is obtained.

B. Payment for X-rays is limited to radiological examinations of the full spine; the cervical, thoracic, lumbar, and lumbosacral areas of the spine; the pelvis; and the sacroiliac joints.

Subp. 3. **Excluded services.** The following chiropractic services are not eligible for payment under the medical assistance program:

A. laboratory service;

B. diathermy;

C. vitamins;

D. ultrasound treatment;

E. treatment for a neurogenic or congenital condition that is not related to a diagnosis of subluxation;

F. medical supplies or equipment supplied or prescribed by a chiropractor; and

G. X-rays not listed in subpart 2.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0250 CLINIC SERVICES.

Subpart 1. **Definition.** "Clinic service" means a preventive, diagnostic, therapeutic, rehabilitative, or palliative service provided by a facility that is not part of a hospital but provides medical or dental care to outpatients.

Subp. 2. **Eligible provider.** To be eligible for medical assistance payment for a clinic service, a clinic must comply with items A to C.

A. The clinic must have a federal employer's identification number and must report the number to the department.

B. A clinic that provides physician services as defined in part 9505.0345, subpart 1 must have at least two physicians on the staff. The physician service must be provided by or under the supervision of a physician who is a provider and is on the premises.

C. A clinic that provides dental services as defined in part 9505.0270, subpart 1 must have at least two dentists on the staff. The dental service must be provided by or under the supervision of a dentist who is a provider and is on the premises.

Subp. 3. **Exemption from requirements.** The requirements of subpart 2 do not apply to a rural health clinic as in part 9505.0395, a community health clinic as in part 9505.0255, and a public health clinic as in part 9505.0380.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0255 COMMUNITY HEALTH CLINIC SERVICES.

Subpart 1. **Definition.** "Community health clinic service" means a health service provided by or under the supervision of a physician in a clinic that meets the criteria listed in items A to D. The clinic:

A. has nonprofit status as specified in Minnesota Statutes, chapter 317; and

B. has tax exempt status as provided in Internal Revenue Code, section 501(c)(3) as amended through October 4, 1976; and

C. is established to provide health services to low income population groups; and

D. has written clinic policies as provided in subpart 4.

Subp. 2. **Eligible health services.** The services listed in items A to F are eligible for payment as a community health clinic service:

A. physician services under part 9505.0345;

B. preventive health services under part 9505.0355;

C. family planning services under part 9505.0280;

D. early periodic screening, diagnosis, and treatment services under part 9505.0275;

E. dental services under part 9505.0270; and

F. prenatal care services under part 9505.0353.

Subp. 3. **Eligible vendors of community health clinic services.** Under the supervision of a physician, a health service provided by a physician assistant or nurse practitioner who contracts with, is a volunteer, or an employee of a community health clinic, is a covered service.

Subp. 4. **Written patient care policies.** To be eligible to participate as a community health clinic, as in subpart 1, a provider must establish, in writing:

A. a description of health services provided by the community health clinic;

B. policies concerning the medical management of health problems including health conditions which require referral to physicians and provision of emergency health services; and

C. policies concerning the maintenance and review of health records by the physician.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0270 DENTAL SERVICES.

Subpart 1. **Definition.** For the purposes of this part, the following terms have the meanings given them.

A. "Dental service" means a diagnostic, preventive, or corrective procedure furnished by or under the supervision of a dentist.

B. "Oral hygiene instruction" means an organized education program carried out by or under the supervision of a dentist to instruct a recipient about the care of the recipient's teeth.

C. "Rebase" refers to totally replacing the denture base material that rests on the recipient's denture foundation area.

D. "Reline" refers to resurfacing the portion of the denture base that rests on the recipient's denture foundation area.

E. "Removable prosthesis" means a removable structure that is prescribed by a dentist to replace a complete or partial set of teeth and made according to the dentist's direction.

Subp. 2. **Eligible dental services.** The medical assistance program shall pay for a recipient's dental service that is medically necessary.

Subp. 3. **Payment limitations; general.** Payment for dental services is limited to services listed in items A to I.

A. One oral hygiene instruction per recipient.

B. One reline or rebase every three years.

C. One topical fluoride treatment every six months for a recipient 16 years of age or under unless prior authorization is obtained.

D. One full mouth or panoramic X-ray survey every three years unless an additional survey is medically necessary and prior authorization is obtained.

E. One dental examination every six months unless an emergency requires medically necessary dental service.

F. One prophylaxis every six months.

G. One bitewing series of no more than four X-rays and no more than six periapical X-rays every 12 months unless a bitewing or periapical X-ray is medically necessary because of an emergency.

H. Palliative treatment for an emergent root canal problem.

I. One application of sealants to permanent first and second molars only and one reapplication of sealants to permanent first and second molars five years after the first application. Only a recipient 16 years of age or under is eligible for the application or reapplication of a sealant.

Subp. 4. **Criteria for prior authorization of removable prostheses.** All removable prostheses require prior authorization to be eligible for medical assistance payments. The criteria for prior authorization of a removable prosthesis are as specified in items A to C. A request for prior authorization of a removable prosthesis must be approved or denied no later than 30 days after the department has received information necessary to determine whether the request meets a criterion in one of the items A to C.

A. Purchase or replacement of a removable prosthesis is limited to one time every five years for a recipient, except as in items B and C.

B. Replacement of a removable prosthesis in excess of the limit in item A is eligible for payment if the replacement is necessary because the removable prosthesis was misplaced, stolen, or damaged due to circumstances beyond the

recipient's control. The recipient's degree of physical and mental impairment shall be considered in determining whether the circumstances were beyond the recipient's control.

C. Replacement of a partial prosthesis, in excess of the limits in item A, is eligible for payment if the existing prosthesis cannot be modified and one of the following subitems applies.

(1) The recipient is missing one or more of the upper or lower six front teeth which are in addition to those for which the prosthesis was designed.

(2) The recipient has less than four upper and four lower back teeth that meet and are in biting function unless the missing teeth are the permanent teeth and the recipient has only bicuspid occlusion.

(3) The recipient has lost one of the teeth used to anchor the partial prosthesis. In this event, prior authorization for replacement of the partial prosthesis will not be approved if the anchoring teeth are not expected to support the prosthesis for at least one year and if the X-rays of the area show sufficient bone loss so that the anchoring teeth will not sustain the denture.

Subp. 5. **Criteria for prior authorization of root canal treatment.** Root canal treatment after palliative treatment in subpart 3, item H, requires prior authorization to be eligible for medical assistance payment. Prior authorization of a root canal treatment shall be determined by:

A. the adequacy of bone support for the tooth to be treated;

B. the functional and aesthetic importance of the tooth;

C. the condition and restorability of the coronal portion of the tooth; and

D. the positional relationship of any teeth missing within the same dental arch.

Subp. 6. **Other services requiring prior authorization.** The dental services in items A to G are eligible for payment under the medical assistance program only if they have received prior authorization:

A. hospitalization for dental services;

B. periodontics;

C. root canal treatment subsequent to palliative treatment in subpart 3, item H;

D. orthodontics, except for space maintamers for second deciduous molars;

E. surgical services except emergencies and alveolectomies;

F. services in excess of the limits in subpart 3; and

G. removal of impacted teeth.

A request for prior authorization of one of the services listed in items A to G must be approved or denied no later than 30 days after the department has received the information necessary to document the request.

Subp. 7. **Criteria for prior authorization of orthodontic treatment.** An orthodontic treatment is eligible for medical assistance payment only if it has received prior authorization. The criteria for prior authorization of orthodontic treatment are as specified in items A to E:

A. disfigurement of the recipient's facial appearance including protrusion of upper or lower jaws or teeth;

B. spacing between adjacent teeth that may interfere with biting function;

C. overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when the person bites;

D. positioning of jaws or teeth to the extent that the chewing or biting function is impaired; or

E. overall orthodontic problem which is based on a comparable assessment of items A to D.

Subp. 8. **Payment limitation; removable prosthesis.** The payment rate for a removable prosthesis that received prior authorization under subpart 4 shall include payment for instruction in the use and care of the prosthesis and any adjustment necessary during the six months immediately following the provision of the prosthesis to achieve a proper fit. The dentist shall document the instruction and the necessary adjustments, if any, in the recipient's dental record.

Subp. 9. **Payment limitation; more than one recipient on same day in same long-term care facility.** When a dental service is provided by the same provider on the same day to two or more recipients who reside in the same long-term care facility, payment for the provider's visit to the first recipient shall be according to part 9505.0445, item E, for the procedure code for the visit. The provider's visit on the same day to other recipients within the same long-term care facility must be billed with the multiple visit code established by the department. This subpart shall not apply to a provider's visit to provide an emergency service on the same day within the same long-term care facility if the emergency service could not have been scheduled consecutively with another recipient visit. If the provider visits other recipients in the same facility on the same day after providing an emergency service, the provider's visits must be billed with the multiple visit code.

Subp. 10. **Excluded dental services.** The dental services in items A to M are not eligible for payment under the medical assistance program:

A. full mouth or panoramic X-rays for a recipient under eight years of age unless prior authorization is given, or in the case of an emergency;

B. bases or pulp caps;

C. a local anesthetic that is billed as a separate procedure;

D. hygiene aids, including toothbrushes;

E. medication dispensed by a dentist that a recipient is able to obtain from a pharmacy;

F. acid etch for a restoration that is billed as a separate procedure;

G. periapical X-rays, if done at the same time as a panoramic or full mouth X-ray survey unless prior authorization is given;

H. prosthesis cleaning;

I. unilateral partial prosthesis involving posterior teeth;

J. individual crown made of a substance other than stainless steel and prefabricated acrylic;

K. fixed prosthodontics;

L. replacement of a denture when a reline or rebase would correct the problem; and

M. gold restoration or inlay, including cast nonprecious and semiprecious metals.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0275 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT.

Subpart 1. **Definition.** "Early and periodic screening, diagnosis, and treatment service" means a service provided to a recipient under age 21 to identify a potentially handicapping condition and to provide diagnosis and treatment for a condition identified according to the requirements of the Code of Federal Regulations, title 42, section 441.55 and parts 9505.1500 to 9505.1690.

Subp. 2. **Duties of provider.** The provider shall sign a provider agreement

stating that the provider will provide screening services according to standards in parts 9505.1500 to 9505.1690 and Code of Federal Regulations, title 42, sections 441.50 to 441.62.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0280 FAMILY PLANNING SERVICES.

Subpart 1. **Definitions.** For purposes of this part, the terms in items A and B have the meanings given them.

A. "Family planning service" means a health service or family planning supply concerned with the voluntary planning of the conception and bearing of children and related to a recipient's condition of fertility, or to the treatment of a sexually transmitted disease or other genital infection.

B. "Family planning supply" means a prescribed drug or contraceptive device ordered by a physician for treatment of a condition related to a family planning service.

Subp. 2. **Conditions for payment.** A family planning service is eligible for medical assistance payment if:

A. the recipient requested the service;

B. the service is provided with the recipient's full knowledge and consent; and

C. the provider complies with Code of Federal Regulations, title 42, sections 441.250 to 441.259 concerning informed consent for voluntary sterilization procedures.

Subp. 3. **Eligible provider.** The following providers are eligible for medical assistance payment for a family planning service or family planning supply: physicians, physician directed clinics, community health clinics, rural health clinics, outpatient hospital departments, pharmacies, public health clinics, and family planning agencies.

For purposes of this subpart, "family planning agency" means an entity having a medical director that provides family planning services under the direction of a physician who is a provider as defined in part 9505.0345, subpart 3, item C.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0285 HEALTH CARE PREPAYMENT PLANS OR PREPAID HEALTH PLANS.

Subpart 1. **Eligible provider.** To be eligible for medical assistance payments, a prepaid health plan must:

A. have a contract with the department; and

B. provide a recipient, either directly or through arrangements with other providers, the health services specified in the contract between the prepaid health plan and the department.

Subp. 2. **Limitations on services and prior authorization requirements.** Health services provided by a prepaid health plan according to the contract in subpart 1, item A, must be comparable in scope, quantity, and duration to the requirements of parts 9505.0170 to 9505.0475. However, prior authorization, admission certification, and second surgical opinion requirements do not apply except that a prepaid health plan may impose similar requirements.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0290 HOME HEALTH AGENCY SERVICES.

Subpart 1. **Definition.** For the purposes of this part, "home health agency services" means a medically necessary health service provided by an agency qualified under subpart 2, prescribed by a physician as part of a written plan of care, and provided under the direction of a registered nurse to a recipient at his or her residence. For the purposes of this part, "residence" is a place other than a hospital or long-term care facility.

Subp. 2. **Eligible providers.** To be eligible for participation in the medical assistance program as a home health agency, the provider must be certified to participate under title XVIII of the Social Security Act under Code of Federal Regulations, title 42, sections 405.1201 to 405.1230.

Subp. 3. **Eligible home health agency services.** The following home health agency services are eligible for medical assistance payment.

A. Nursing service as defined by Minnesota Statutes, section 148.171, clause (3).

B. Home health aide services provided under the direction of a registered nurse on the order of a physician. For the purposes of this part, "home health aide" means an employee of a home health agency who is not licensed to provide nursing services, but who has been approved by the directing nurse to perform medically oriented tasks written in the plan of care.

C. Medical supplies and equipment ordered in writing by a physician or doctor of podiatry.

D. Rehabilitative and therapeutic services under part 9500.1070, subparts 12 and 13, and including respiratory therapy under part 9505.0295, subpart 2, item E.

Subp. 4. **Payment limitation.** To be eligible for medical assistance payment, a home health agency service must be documented in the recipient's health care record. The documentation shall include the date and nature of the service provided and the names of each home health aide, if any, and the registered nurse. In addition, continuation of the service must be reviewed and approved by the physician at least every 60 days.

Subp. 5. **Excluded home health agency services.** Homemaker services, social services such as reading and recreational activities, and educational services are not eligible for payment under the medical assistance program.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0295 HOME HEALTH SERVICES.

Subpart 1. **Definition.** For the purposes of this part, "home health service" means a medically necessary health service that is:

A. ordered by a physician; and

B. documented in a plan of care that is reviewed and revised as medically necessary by the physician at least once every 60 days; and

C. provided to the recipient at his or her residence that is a place other than a hospital or long-term care facility except as in part 9505.0360, or unless the home health service in an intermediate care facility is for an episode of acute illness and is not a required standard for care, safety, and sanitation in an intermediate care facility under Code of Federal Regulations, title 42, part 442, subpart F or G.

Subp. 2. **Covered services.** Home health services in items A to H are eligible for medical assistance payment:

A. nursing services under part 9505.0290;

B. private duty nursing services under part 9505.0360;

C. services of a home health aide under part 9505.0290;

D. personal care services under part 9505.0335;

E. respiratory therapy services ordered by a physician and provided by an employee of a home health agency who is a registered respiratory therapist or a certified respiratory therapist working under the direction of a registered respiratory therapist or a registered nurse. For purposes of this item, "registered respiratory therapist" means an individual who is registered as a respiratory therapist with the National Board for Respiratory Care; "certified respiratory therapist" means an individual who is certified as a respiratory therapist by the National Board for Respiratory Care; and "respiratory therapy services" means services defined by the National Board for Respiratory Care as within the scope of services of a respiratory therapist;

F. rehabilitative and therapeutic services that are defined under part 9500.1070, subparts 12 and 13;

G. medical supplies and equipment ordered in writing by a physician or doctor of podiatry; and

H. oxygen ordered in writing by a physician.

Subp. 3. **Payment limitation; general.** Medical assistance payments for home health services shall be limited according to items A to C.

A. Home health services to a recipient that began before and are continued without increase on or after October 12, 1987, shall be exempt from the payment limitations of this subpart.

B. Home health services to a recipient that begin or are increased in type, number, or frequency on or after October 12, 1987, are eligible for medical assistance payment without a screening team's determination of the recipient's eligibility if the total payment for each of two consecutive months of home health services does not exceed $1,200. The limitation of $1,200 shall be adjusted annually on July 1 to reflect the annual percentage increase reported in the most recent Consumer Price Index (Urban) for the Minneapolis-Saint Paul area new series index (1967=100) as published by the Bureau of Labor Statistics, United States Department of Labor. The Consumer Price Index (Urban) is incorporated by reference and is available from the Minitex interlibrary loan system. It is subject to frequent change.

C. If the total payment for each of two consecutive months of home health services exceeds $1200, a screening team shall determine the recipient's eligibility for home health services based on the case mix classification established under Minnesota Statutes, section 256B.431, subdivision 1, that is most appropriate to the recipient's diagnosis, condition, and plan of care.

(1) Home health services may be provided for a recipient determined by the screening team to be eligible for placement in a residential facility for the physically handicapped operated under parts 9570.2000 to 9570.3600, if the total payment for a month of home health services is less than the total monthly statewide average rate of the case mix classification most appropriate to the recipient if the recipient were placed in a residential facility for the physically handicapped.

(2) Home health services may be provided for a recipient determined by the screening team to be eligible for placement in a long-term care facility other than a residential facility for the physically handicapped operated under parts 9570.2000 to 9570.3600, if the total payment for a month of home health services is less than the total monthly statewide average rate for the case mix classification most appropriate to the recipient.

(3) Home health services may be provided for a ventilator dependent recipient if the screening team determines the recipient's health care needs can be provided in the recipient's residence and the cost of home health services is less than the projected monthly cost of services provided by the least expensive

hospital in the recipient's local trade area that is staffed and equipped to provide the recipient's necessary care. The recipient's physician in consultation with the staff of the hospital shall determine whether the hospital is staffed and equipped to provide the recipient's necessary care. The hospital's projected monthly cost must be computed by multiplying the projected monthly charges that the hospital would bill to medical assistance for services to the recipient by the hospital's cost to charge ratio as determined by a medical assistance settlement made under title XIX of the Social Security Act.

Subp. 4. **Review of screening team determinations of eligibility.** The commissioner shall appoint a grievance committee comprised of persons familiar with the receipt or delivery of home health services. The committee shall have at least seven members, of whom a majority must be qualified recipients. At the request of the commissioner or a recipient, the committee shall review and advise the commissioner regarding the determination of the screening team under subpart 3.

Subp. 5. **Payment limitation; screening team.** Medical assistance payment for screening team services provided in subpart 3 is prohibited for a screening team that has a common financial interest, with the provider of home health services or for a provider of a personal care service listed in part 9505.0335, subparts 8 and 9, unless:

A. approval by the department is obtained before screening is done; or

B. the screening team and provider of personal care services are parts of a governmental personnel administration system.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0300 INPATIENT HOSPITAL SERVICES.

Subpart 1. **Definition.** "Inpatient hospital service" means a health service provided to a recipient who is an inpatient.

Subp. 2. **Eligibility for participation in medical assistance program; general.** To be eligible for participation in the medical assistance program, a hospital must meet the conditions of items A to C.

A. Be qualified to participate in Medicare, except as in subpart 4.

B. Have in effect a utilization review plan applicable to all recipients. The plan must meet the requirements of the Code of Federal Regulations, title 42, section 405.1035 and part 456, unless a waiver has been granted by the secretary of the United States Department of Health and Human Services. The hospital's utilization review plans must ensure a timely review of the medical necessity of admissions, extended duration stay, and health services rendered.

C. Comply with the requirements of the Code of Federal Regulations, title 42, concerning informed consent for a voluntary sterilization procedure under section 441.257 and for a hysterectomy, under section 441.255, and for the documentation for abortion, under sections 441.205 and 441.206.

Subp. 3. **Payment limitation.** Payment for inpatient hospital services to a recipient shall be made according to parts 9500.1090 to 9500.1155. Inpatient hospital services that are medically necessary for treatment of the recipient's condition are not eligible for a separate payment but are included within the payment rate established under parts 9500.1090 to 9500.1155. An example of a medically necessary service is a private room that the recipient's physician certifies as medically necessary.

Subp. 4. **Eligibility for participation in medical assistance; emergency.** A hospital service provided to a recipient in an emergency is eligible for medical assistance payment regardless of whether the hospital providing the service is qualified to participate in Medicare. Urgent care services do not qualify for medical assistance payment under this subpart. For the purposes of this subpart,

"urgent care" means acute, episodic care similar to services provided in a physician directed clinic.

Subp. 5. **Excluded services.** Inpatient hospital admission and services are not eligible for payment under the medical assistance program if they are not medically necessary under parts 9505.0500 to 9505.0540; if they are for alcohol detoxification that is not medically necessary to treat an emergency; if they are denied a required prior authorization; or if they are surgical procedures requiring a second surgical opinion that has failed to be approved by a second or third surgical opinion.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0305 LABORATORY AND X-RAY SERVICES.

Subpart 1. **Definition.** "Laboratory and X-ray service" means a professional or technical health related laboratory or radiological service directly related to the diagnosis and treatment of a recipient's health status.

Subp. 2. **Covered service.** To be eligible for medical assistance payment, an independent laboratory or X-ray service must be ordered by a provider and must be provided in an office or facility other than a clinic, hospital, or hospital outpatient facility as defined in part 9505.0330, subpart 1. Only laboratory services certified by Medicare are eligible for medical assistance payment.

Subp. 3. **Eligible provider.** To be eligible for participation as a provider of independent laboratory service, a vendor must be certified according to Code of Federal Regulations, title 42, sections 405.1310 to 405.1317. To be eligible for participation as a provider of X-ray service, a vendor must be in compliance with Code of Federal Regulations, title 42, sections 405.1411 to 405.1416.

Subp. 4. **Payment limitation.** A claim for medical assistance payment of an independent laboratory or X-ray service must be submitted to the department by the provider who performs the service. The payment must be made to the provider who performed the service. The payment must not exceed the amount established by Medicare for the service.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0310 MEDICAL SUPPLIES AND EQUIPMENT.

Subpart 1. **Conditions for payment.** To be eligible for payment under the medical assistance program, medical supplies and equipment must meet the conditions in items A to C.

A. A purchase of nondurable medical supplies not requiring prior authorization must not exceed an amount necessary to provide a one month supply.

B. The cost of a repair to durable medical equipment that is rented or purchased by the medical assistance program under a warranty is not eligible for medical assistance payment if the repair is covered by the warranty.

C. In the case of rental equipment, the sum of rental payments during the projected period of the recipient's use must not exceed the purchase price allowed by medical assistance unless the sum of the projected rental payments in excess of the purchase price receives prior authorization. All rental payments must apply to purchase of the equipment.

Subp. 2. **Payment limitation on durable medical equipment in hospitals and long-term care facilities.** Durable medical equipment is subject to the payment limitations in items A and C.

A. A provider who furnishes durable medical equipment for a recipient who is a resident of a hospital or long-term care facility may submit a separate claim for medical assistance payment if the equipment has been modified for the

recipient or the item is necessary for the continuous care and exclusive use of the recipient to meet the recipient's unusual medical need according to the written order of a physician.

For purposes of this item, "modified" refers to the addition of an item to a piece of durable medical equipment that cannot be removed without damaging the equipment or refers to the addition of an item to a piece of durable medical equipment that permanently alters the equipment. Equipment purchased through medical assistance on a separate claim for payment becomes the property of the recipient.

Payment for durable medical equipment that is not for the continuous care and exclusive use of the recipient is included within the payment rate made to the hospital under parts 9500.1090 to 9500.1155 and to the long-term care facility under part 9549.0060.

B. In addition to the types of equipment and supplies specified in part 9549.0040, subpart 5, item U, the following durable medical equipment, prosthetics, and medical supplies are considered to be included in the payment to a hospital or long-term care facility and are not eligible for medical assistance payment on a separate claim for payment.

(1) Equipment of the type required under parts 4655.0090 to 4655.9900.

(2) Equipment used by individual recipients that is reusable and expected to be necessary for the health care needs of persons expected to receive health services in the hospital or long-term care facility. Examples include heat, light, and cold application devices; straight catheters; walkers, wheelchairs not specified under item A, and other ambulatory aids; patient lifts; transfer devices; weighing scales; monitoring equipment, including glucose monitors; trapezes.

(3) Equipment customarily used for treatment and prevention of skin pressure areas and decubiti. Examples are alternating pressure mattresses, and foam or gel cushions and pads.

(4) Emergency oxygen.

(5) Beds suitable for recipients having medically necessary positioning requirements.

C. Any medical equipment encompassed within the definition of depreciable equipment as defined in part 9549.0020, subpart 17, is not eligible for medical assistance payment on a separate claim for payment under parts 9505.0170 to 9505.0475.

Subp. 3. **Payment limitation; prior authorization.** Prior authorization is a condition of medical assistance payment for the medical supplies and equipment in items A to C:

A. a nondurable medical supply that costs more than the performance agreement limit;

B. durable medical equipment, prostheses, and orthoses if the cost of their purchase, projected cumulative rental for the period of the recipient's expected use, or repairs exceeds the performance agreement limit; and

C. maintenance of durable medical equipment.

For purposes of this subpart, "maintenance" means a service made at routine intervals based on hours of use or calendar days to ensure that equipment is in proper working order. "Repair" means service to restore equipment to proper working order after the equipment's damage, malfunction, or cessation of function.

Subp. 4. **Excluded medical supplies and equipment.** The medical supplies and equipment in items A to F are not eligible for medical assistance payments:

A. medical supplies and equipment that are not covered under Medicare except for raised toilet seats; bathtub chairs and seats; bath lifts; prosthetic communication devices; and any item that meets the criteria in part 9505.0210;

B. routine, periodic maintenance on medical equipment owned by a long-term care facility or hospital when the cost of maintenance is billed to medical assistance on a separate claim for payment;

C. durable medical equipment that will serve the same purpose as equipment already in use by the recipient;

D. medical supplies or equipment requiring prior authorization when the prior authorization is not obtained;

E. dental hygiene supplies and equipment; and

F. stock orthopedic shoes as defined in part 9505.0350, subpart 6, item A.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0315 MEDICAL TRANSPORTATION.

Subpart 1. **Definitions.** For purposes of this part, the following terms have the meanings given them.

A. "Ancillary services" means health services, incident to ambulance services, that may be medically necessary on an individual basis, but are not routinely used, and are not included in the base rate for ambulance service.

B. "Common carrier transportation" means the transport of a recipient by a bus, taxicab, or other commercial carrier or by private automobile.

C. "Ambulance service" means the transport of a recipient whose medical condition or diagnosis requires medically necessary services before and during transport.

D. "Medical transportation" means the transport of a recipient for the purpose of obtaining a covered service or transporting the recipient after the service is provided. The types of medical transportation are common carrier, life support, and special transportation.

E. "No load transportation" refers to medical transportation that does not involve transporting a recipient.

F. "Special transportation" means the transport of a recipient who, because of a physical or mental impairment, is unable to use a common carrier and does not require ambulance service.

For the purposes of item F, "physical or mental impairment" means a physiological disorder, physical condition, or mental disorder that prohibits access to or safe use of common carrier transportation.

Subp. 2. **Payment limitations; general.** To be eligible for medical assistance payment, medical transportation must be to or from the site of a covered service to a recipient. Examples of covered services are the services specified in parts 9505.0170 to 9505.0475 and services provided by a rehabilitation facility or a training and habilitation center.

Subp. 3. **Payment limitations; transportation between providers of covered services.** Medical transportation of a recipient between providers of covered services is eligible for medical assistance payment as specified in items A to C.

A. Except for an emergency, transportation between two long-term care facilities must be medically necessary because the health service required by the recipient's plan of care is not available at the long-term care facility where the recipient resides.

B. Transportation between two hospitals must be to obtain a medically necessary service that is not available at the hospital where the recipient was when the medical necessity was diagnosed.

C. Claims for payment for transportation between two long-term care facilities or between two hospitals must be documented by a statement signed by

a member of the nursing staff at the originating facility that the medically necessary health service is part of the recipient's plan of care and is not available at the originating facility.

Subp. 4. **Payment limitation; transportation of deceased person.** Payment for transportation of a deceased person is limited to the circumstances in items A to C.

A. If a recipient is pronounced dead by a legally authorized person after medical transportation is called but before it arrives, service to the point of pickup is eligible for payment.

B. If medical transportation is provided to a recipient who is pronounced dead en route or dead on arrival by a legally authorized person, the medical transportation is eligible for payment.

C. If a recipient is pronounced dead by a legally authorized person before medical transportation is called, medical transportation is not eligible for payment.

Subp. 5. **Excluded costs related to transportation; general.** The costs of items A to F are not eligible for payment as medical transportation:

A. transportation of a recipient to a hospital or other site of health services for detention that is ordered by a court or law enforcement agency except when ambulance service is a medical necessity;

B. transportation of a recipient to a facility for alcohol detoxification that is not a medical necessity;

C. no load transportation except as in subpart 6, item E;

D. additional charges for luggage, stair carry of the recipient, and other airport, bus, or railroad terminal services;

E. airport surcharge; and

F. federal or state excise or sales taxes on air ambulance service.

Subp. 6. **Payment limitations; ambulance service.** To be eligible for the medical assistance payment rate as an ambulance service, the transportation must comply with the conditions in items A to E.

A. The provider must be licensed under Minnesota Statutes, sections 144.802 and 144.804 as an advanced life support, basic life support, or scheduled ambulance service.

B. The provider must identify the level of medically necessary services provided to the recipient in the claim for payment.

C. The medical necessity of the ambulance service for a recipient must be documented by the state report required under Minnesota Statutes, section 144.807.

D. The recipient's transportation must be in response to a 911 emergency call, a police or fire department call, or an emergency call received by the provider. Except as in item E, an ambulance service that responds to an emergency call but does not transport a recipient as a result of the call is not eligible for medical assistance payment.

E. Ambulance service that responds to a medical emergency is eligible for payment for no load transportation only if the ambulance service provided medically necessary treatment to the recipient at the pickup point of the recipient. The payment is limited to charges for transportation to the point of pickup and for ancillary services.

Subp. 7. **Payment limitation; special transportation.** To be eligible for medical assistance payment, a provider of special transportation, except as specified in Minnesota Statutes, section 174.30, must be certified by the Department of Transportation under Minnesota Statutes, sections 174.29 to 174.30. Payment eligibility of special transportation is subject to the limitations in items A to D.

A. The special transportation is provided to a recipient who has been determined eligible for special transportation by the local agency on the basis of a certification of need by the recipient's attending physician.

B. Special transportation to reach a health service destination outside of the recipient's local trade area is ordered by the recipient's attending physician and the local agency has approved the service.

C. The cost of special transportation of a recipient who participates in a training and habilitation program is not eligible for reimbursement on a separate claim for payment if transportation expenses are included in the per diem payment to the intermediate care facility for the mentally retarded or if the transportation rate has been established under parts 9525.1200 to 9525.1330.

D. One-way mileage for special transportation within the recipient's local trade area must not exceed 20 miles for a trip originating in the seven county metropolitan area or 40 miles for a trip originating outside of the seven county metropolitan area if a similar health service is available within the mileage limitation. The seven county metropolitan area consists of the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington.

Subp. 8. **Payment limitation; common carrier transportation.** To be eligible for medical assistance payment, the claim for payment of common carrier transportation must state the date of service, the origin and destination of the transportation, and the charge. Claims for payment must be submitted to the local agency.

Subp. 9. **Payment limitation; air ambulance.** Transportation by air ambulance shall be eligible for medical assistance payment if the recipient has a life threatening condition that does not permit the recipient to use another form of transportation.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624; L 1987 c 209 s 39; L 1988 c 689 art 2 s 268*

9505.0320 NURSE MIDWIFE SERVICES.

Subpart 1. **Definitions.** For the purposes of this part, the following terms have the meanings given them.

A. "Maternity period" means the interval comprised of a woman's pregnancy, labor, and delivery and up to 60 days after delivery.

B. "Nurse midwife" means a registered nurse who is certified as a nurse midwife by the American College of Nurse Midwives.

C. "Nurse midwife service" means a health service provided by a nurse midwife for the care of the mother and newborn throughout the maternity period.

Subp. 2. **Payment limitation.** Medical assistance payment for nurse midwife service is limited to services necessary to provide the care of the mother and newborn throughout the maternity period and provided within the scope of practice of the nurse midwife.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0325 NUTRITIONAL PRODUCTS.

Subpart 1. **Definition.** "Nutritional product" means a commercially formulated substance that provides nourishment and affects the nutritive and metabolic processes of the body.

Subp. 2. **Eligible provider.** To be eligible for medical assistance payment, a parenteral nutritional product must be prescribed by a physician and must be dispensed as a pharmacy service under part 9505.0340. To be eligible for medical assistance payment, an enteral nutritional product must be prescribed by a physician and supplied by a pharmacy or a medical supplier who has signed a medical supplies agreement with the department.

Subp. 3. **Payment limitation; enteral nutritional products.** Except as provided in subparts 4 and 5, an enteral nutritional product must receive prior authorization to be eligible for medical assistance payment.

Subp. 4. **Covered services; enteral nutritional products for designated health condition.** An enteral nutritional product is a covered service and does not require prior authorization if it is necessary to treat a condition listed in items A to D:

A. phenylketonuria;

B. hyperlysinemia;

C. maple syrup urine disease; or

D. a combined allergy to human milk, cow milk, and soy formula.

Subp. 5. **Covered services; enteral nutritional product for recipient discharged from a hospital.** An enteral nutritional product provided for a recipient being discharged from a hospital to a residence other than a long-term care facility does not require prior authorization of an initial supply adequate for 30 days or less.

Subp. 6. **Payment limitations; long-term care facilities and hospitals.** An enteral nutritional product for a recipient in a long-term care facility or hospital is not eligible for payment on a separate claim for payment. Payment must be made according to parts 9500.1090 to 9500.1155, 9549.0010 to 9549.0080, 9549.0050 to 9549.0059 as published in the State Register, December 1, 1986, volume 11, number 22, pages 991 to 1004, and 9553.0010 to 9553.0080.

Subp. 7. **Payment limitation; parenteral nutritional products.** Parenteral nutritional products are subject to the payment limitations applicable to pharmacy services as provided in part 9505.0340.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0330 OUTPATIENT HOSPITAL SERVICES.

Subpart 1. **Definition.** "Outpatient hospital service" means a health service that is medically necessary and is provided to a recipient by or under the supervision of a physician, dentist, or other provider having medical staff privileges in an outpatient hospital facility licensed under Minnesota Statutes, section 144.50.

Subp. 2. **Eligibility for participation in medical assistance program.** To be eligible for participation in the medical assistance program, an outpatient hospital facility must meet the requirements of part 9505.0300, subparts 2 and 4.

Subp. 3. **Payment limitations; general.** Payment for an outpatient hospital service, other than an emergency outpatient hospital service, is subject to the same service and payment limitations that apply to covered services in parts 9505.0170 to 9505.0475. Further, the payment for an outpatient hospital service is subject to the same prior authorization requirement and payment rate that apply to a similar health service when that service is furnished by a provider other than an outpatient hospital facility.

Subp. 4. **Payment limitations; emergency outpatient hospital service.** Medical assistance payments are allowed for the following service components of an emergency outpatient hospital service:

A. a facility usage charge based on the outpatient hospital facility's usual and customary charge for emergency services;

B. a separate charge for medical supplies not included in the usual and customary charge for emergency services;

C. a separate charge for a physician service not included in the usual and customary charge.

Separate charges for items B and C must be billed in the manner prescribed by the department.

For purposes of this subpart, "emergency outpatient hospital service" means a health service provided by an outpatient hospital facility in an area that is designated, equipped, and staffed for emergency services.

Subp. 5. **Payment limitations; nonemergency outpatient hospital services.** An outpatient hospital service that is not an emergency but is provided in an area that is designated, equipped, and staffed for emergency services is not eligible for payment of a facility usage charge as specified in subpart 4, item A. An outpatient hospital service provided in an area of an outpatient hospital which is advertised, represented, or held out to the public as providing acute, episodic care similar to services provided in a physician directed clinic is not eligible for payment as an emergency outpatient hospital service.

Subp. 6. **Payment limitation; laboratory and X-ray services.** Laboratory and X-ray services provided by an outpatient hospital as a result of a recipient's scheduled visit that immediately precedes hospital admission as an inpatient are not covered services.

Subp. 7. **Excluded services.** The outpatient hospital services in items A to C are not eligible for payment under the medical assistance program:

A. diapers;

B. an outpatient hospital service provided by an employee of the hospital such as an intern or a resident when billed on a separate claim for payment; and

C. outpatient hospital service for alcohol detoxification that is not medically necessary to treat an emergency.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0335 PERSONAL CARE SERVICES.

Subpart 1. **Definitions.** For purposes of this part, the following terms have the meanings given them.

A. "Capable of directing his or her own care" refers to a recipient's functional impairment status as determined by the recipient's ability to communicate:

(1) orientation to person, place, and time;

(2) an understanding of the recipient's plan of care, including medications and medication schedule;

(3) needs; and

(4) an understanding of safety issues, including how to access emergency assistance.

B. "Independent living" or "live independently" refers to the situation of a recipient living in his or her own residence and having the opportunity to control basic decisions about the person's own life to the fullest extent possible. For purposes of this definition and this part, "residence" does not include a long-term care facility or an inpatient hospital.

C. "Personal care assistant" means a person who meets, through training or experience, one of the training requirements in subpart 3, is an employee of or is under contract to a personal care provider, and provides a personal care service.

D. "Personal care provider" means an agency that has a contract with the department to provide personal care services.

E. "Personal care service" means a health service as listed in subparts 8 and 9 ordered by a physician and provided by a personal care assistant to a recipient to maintain the recipient in his or her residence. The two types of personal care service are private personal care service and shared personal care service.

F. "Plan of personal care services" means a written plan of care specific to personal care services.

G. "Private personal care service" means personal care service that is not a shared personal care service.

H. "Qualified recipient" means a recipient who needs personal care services to live independently in the community, is in a stable medical condition, and does not have acute care needs that require inpatient hospitalization or cannot be met in the recipient's residence by a nursing service as defined by Minnesota Statutes, section 148.171, clause (3).

I. "Responsible party" means an individual residing with a qualified recipient who is capable of providing the support care necessary to assist a qualified recipient to live independently, is at least 18 years old, and is not a personal care assistant.

J. "Shared personal care service" means personal care services provided by a personal care assistant to more than one qualified recipient residing in the same residential complex. The services of the assistant are shared by the qualified recipients and are provided on a 24 hour basis.

Subp. 2. **Covered services.** To be eligible for medical assistance payment, a personal care service that begins or is increased on or after January 1, 1988, must be given to a recipient who meets the criteria in items A to D. The service must be under the supervision of a registered nurse as in subpart 4, according to a plan of personal care services. The criteria are as follows.

A. The recipient meets the criteria specified in part 9505.0295, subpart 3.

B. The recipient is a qualified recipient.

C. The recipient is capable of directing his or her own care, or a responsible party lives in the residence of the qualified recipient.

D. The recipient has a plan of personal care services developed by the supervising registered nurse together with the recipient that specifies the personal care services required.

Subp. 3. **Training requirements.** A personal care assistant must show successful completion of a training requirement in items A to E:

A. a nursing assistant training program or its equivalent for which competency as a nursing assistant is determined according to a test administered by the State Board of Vocational Technical Education;

B. a homemaker home health aide preservice training program using a curriculum recommended by the Minnesota Department of Health;

C. an accredited educational program for registered nurses or licensed practical nurses;

D. a training program that provides the assistant with skills required to perform personal care assistant services specified in subpart 8, items A to N; or

E. determination by the personal care provider that the assistant has, through training or experience, the skills required to perform the personal care services specified in subpart 8, items A to N.

Subp. 4. **Supervision of personal care services.** A personal care service to a qualified recipient must be under the supervision of a registered nurse who shall have the duties described in items A to I.

A. Ensure that the personal care assistant is capable of providing the required personal care services through direct observation of the assistant's work or through consultation with the qualified recipient.

B. Ensure that the personal care assistant is knowledgeable about the plan of personal care services before the personal care assistant performs personal care services.

C. Ensure that the personal care assistant is knowledgeable about essential observations of the recipient's health, and about any conditions that should be immediately brought to the attention of either the nurse or the attending physician.

D. Evaluate the personal care services of a recipient through direct observation of the personal care assistant's work or through consultation with the qualified recipient. Evaluation shall be made:

(1) within 14 days after the placement of a personal care assistant with the qualified recipient;

(2) at least once every 30 days during the first 90 days after the qualified recipient first receives personal care services according to the plan of personal care service; and

(3) at least once every 120 days following the period of evaluations in subitem (2). The nurse shall record in writing the results of the evaluation and actions taken to correct any deficiencies in the work of the personal care assistant.

E. Review, together with the recipient, and revise, as necessary, the plan of personal care services at least once every 120 days after a plan of personal care services is developed.

F. Ensure that the personal care assistant and recipient are knowledgeable about a change in the plan of personal care services.

G. Ensure that records are kept, showing the services provided to the recipient by the personal care assistant and the time spent providing the services.

H. Determine that a qualified recipient is capable of directing his or her own care or resides with a responsible party.

I. Determine with a physician that a recipient is a qualified recipient.

Subp. 5. **Personal care provider; eligibility.** The department may contract with an agency to provide personal care services to qualified recipients. To be eligible to contract with the department as a personal care provider, an agency must meet the criteria in items A to L:

A. possess the capacity to enter into a legally binding contract;

B. possess demonstrated ability to fulfill the responsibilities in this subpart and subpart 6;

C. demonstrate the cost effectiveness of its proposal for the provision of personal care services;

D. comply with part 9505.0210;

E. demonstrate a knowledge of, sensitivity to, and experience with the special needs, including communication needs and independent living needs, of the condition of the recipient;

F. ensure that personal care services are provided in a manner consistent with the recipient's ability to live independently;

G. provide a quality assurance mechanism;

H. demonstrate the financial ability to produce a cash flow sufficient to cover operating expenses for 30 days;

I. disclose fully the names of persons with an ownership or control interest of five percent or more in the contracting agency;

J. demonstrate an accounting or financial system that complies with generally accepted accounting principles;

K. demonstrate a system of personnel management; and

L. if offering personal care services to a ventilator dependent recipient, demonstrate the ability to train and to supervise the personal care assistant and the recipient in ventilator operation and maintenance.

Subp. 6. **Personal care provider responsibilities.** The personal care provider shall:

A. employ or contract with services staff to provide personal care services and to train services staff as necessary;

B. supervise the personal care services as in subpart 4;

C. employ or contract with a personal care assistant that a qualified recipient brings to the personal care provider as the recipient's choice of assistant and who meets the employment qualifications of the provider. However, a personal care provider who must comply with the requirements of a governmental personnel administration system is exempt from this item;

D. bill the medical assistance program for a personal care service by the personal care assistant and a visit by the registered nurse supervising the personal care assistant;

E. establish a grievance mechanism to resolve consumer complaints about personal care services, including the personal care provider's decision whether to employ or subcontract the qualified recipient's choice of a personal care assistant;

F. keep records as required in parts 9505.1750 to 9505.1880;

G. perform functions and provide services specified in the personal care provider's contract under subpart 5;

H. comply with applicable rules and statutes; and

I. perform other functions as necessary to carry out the responsibilities in items A to I.

Subp. 7. **Personal care provider; employment prohibition.** A personal care provider shall not employ or subcontract with a person to provide personal care service for a qualified recipient if the person:

A. refuses to provide full disclosure of criminal history records as specified in subpart 12;

B. has been convicted of a crime that directly relates to the occupation of providing personal care services to a qualified recipient;

C. has jeopardized the health or welfare of a vulnerable adult through physical abuse, sexual abuse, or neglect as defined in Minnesota Statutes, section 626.557; or

D. is misusing or is dependent on mood altering chemicals including alcohol to the extent that the personal care provider knows or has reason to believe that the use of chemicals has a negative effect on the person's ability to provide personal care services or the use of chemicals is apparent during the hours the person is providing personal care services.

Subp. 8. **Payment limitation; general.** Except as in subpart 9, personal care services eligible for medical assistance payment are limited to items A to N:

A. bowel and bladder care;

B. skin care, including prophylactic routine and palliative measures documented in the plan of care that are done to maintain the health of the skin. Examples are exposure to air, use of nondurable medical equipment, application of lotions, powders, ointments, and treatments such as heat lamp and foot soaks;

C. range of motion exercises;

D. respiratory assistance;

E. transfers;

F. bathing, grooming, and hairwashing necessary for personal hygiene;

G. turning and positioning;

H. assistance with furnishing medication that is ordinarily self administered;

I. application and maintenance of prosthetics and orthotics;

J. cleaning equipment;

K. dressing or undressing;

L. assistance with food, nutrition, and diet activities;

M. accompanying a recipient to obtain medical diagnosis or treatment and to attend other activities such as church and school if the personal care assistant is needed to provide personal care services while the recipient is absent from his or her residence; and

N. performing other services essential to the effective performance of the duties in items A to M.

Subp. 9. **Shared personal care services.** The shared personal care services in items A to D are eligible for medical assistance payment:

A. personal care services in subpart 8;

B. services provided for the recipient's personal health and safety;

C. monitoring and control of a recipient's personal funds as required in the plan of care; and

D. helping the recipient to complete daily living skills such as personal and oral hygiene and medication schedules.

Subp. 10. **Excluded services.** The services in items A to G are not covered under medical assistance as personal care services:

A. a health service provided by and billed by a provider who is not a personal care provider;

B. a homemaking and social service except as provided in subpart 8, item N, or subpart 9;

C. personal care service that is not in the plan of personal care services;

D. personal care service that is not supervised by a registered nurse;

E. personal care service that is provided by a person who is the recipient's legal guardian or related to the recipient as spouse, parent, or child whether by blood, marriage, or adoption;

F. sterile procedures except for routine, intermittent catheterization; and

G. giving of injections of fluids into veins, muscles, or skin.

Subp. 11. **Maximum payment.** The maximum medical assistance payment for personal care services to a recipient shall be subject to the payment limitations established for home health services in part 9505.0295, subpart 3.

Subp. 12. **Preemployment check of criminal history.** Before employing a person as a personal care assistant of a qualified recipient, the personal care provider shall require from the applicant full disclosure of conviction and criminal history records pertaining to any crime related to the provision of health services or to the occupation of a personal care assistant.

Subp. 13. **Overutilization of personal care services.** A personal care provider who is found to be providing personal care services that are not medically necessary shall be prohibited from participating in the medical assistance program. The determination of whether excess services are provided shall be made by a screening team or according to parts 9505.1750 to 9505.2150. The termination of the personal care provider shall be consistent with the contract between the provider and the department.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0340 PHARMACY SERVICES.

Subpart 1. **Definitions.** The following terms used in this part have the meanings given to them.

A. "Actual acquisition cost" means the cost to the provider including quantity and other special discounts except time and cash discounts.

B. "Compounded prescription" means a prescription prepared under part 6800.3100.

C. "Dispensing fee" means the amount allowed under the medical assistance program as payment for the pharmacy service in dispensing the prescribed drug.

D. "Maintenance drug" means a prescribed drug that is used by a particular recipient for a period greater than two consecutive months.

E. "Pharmacist" means a person licensed under Minnesota Statutes, chapter 151, to provide services within the scope of pharmacy practice.

F. "Pharmacy" means an entity registered by the Minnesota Board of Pharmacy under Minnesota Statutes, chapter 151.

G. "Pharmacy service" means the dispensing of drugs under Minnesota Statutes, chapter 151 or by a physician under subpart 2, item B.

H. "Prescribed drug" means a drug as defined in Minnesota Statutes, section 151.01, subdivision 5, and ordered by a practitioner.

I. "Practitioner" means a physician, osteopath, dentist, or podiatrist licensed under Minnesota Statutes or the laws of another state or Canadian province to prescribe drugs within the scope of his or her profession.

J. "Usual and customary charge" refers to the meaning in part 9505.0175, subpart 49, whether the drug is purchased by prescription or over the counter, in bulk, or unit dose packaging. However, if a provider's pharmacy is not accessible to, or frequented by, the general public, or if the over the counter drug is not on display for sale to the general public, then the usual and customary charge for the over the counter drug shall be the actual acquisition cost of the product plus a 50 percent markup based on the actual acquisition cost. In this event, this calculated amount must be used in billing the department for an over the counter drug.

Amounts paid in full or in part by third-party payers shall be included in the calculation of the usual and customary charge only if a third party payer constitutes 51 percent or more of the pharmacy's business based on the number of prescriptions filled by the pharmacy on a quarterly basis.

Subp. 2. **Eligible providers.** The following providers are eligible for payment under the medical assistance program for dispensing prescribed drugs:

A. a pharmacy that is licensed by the Minnesota Board of Pharmacy;

B. an out-of-state vendor under part 9505.0195, subpart 9; and

C. a physician located in a local trade area where there is no enrolled pharmacy. The physician to be eligible for payment shall personally dispense the prescribed drug according to Minnesota Statutes, section 151.37, and shall adhere to the labeling requirements of the Minnesota Board of Pharmacy.

Subp. 3. **Payment limitations.** Payments for pharmacy services under the medical assistance program are limited as follows.

A. The prescribed drug must be a drug or compounded prescription that is approved by the commissioner for inclusion in the department's drug formulary. The drug formulary committee established under Minnesota Statutes, sections 256B.02, subdivision 8, and 256B.0625 shall recommend to the commissioner the inclusion of a drug or compounded prescription in the drug formulary. The commissioner may add or delete a drug or compounded prescription from the drug formulary. A provider, recipient, or seller of prescription drugs or compounded prescriptions may apply to the department on the form specified in the drug formulary to add or delete a drug from the drug formulary.

B. A prescribed drug must be dispensed in the quantity specified on the prescription unless the pharmacy is using unit dose dispensing or the specified quantity is not available in the pharmacy when the prescription is dispensed. Only one dispensing fee is allowed for dispensing the quantity specified on the prescription.

C. The dispensed quantity of a prescribed drug must not exceed a three month supply unless prior authorization is obtained by the pharmacist or dispensing physician.

D. An initial or refill prescription for a maintenance drug shall be dispensed in not less than a 30 day supply unless the pharmacy is using unit dose dispensing. No additional dispensing fee shall be paid until that quantity is used by the recipient.

E. Except as in item F, the dispensing fee billed by or paid to a particular pharmacy or dispensing physician for a maintenance drug for a recipient is limited to one fee per 30 day supply.

F. More than one dispensing fee per calendar month for a maintenance drug for a recipient is allowed if the record kept by the pharmacist or dispensing physician documents that there is a significant chance of overdosage by the recipient if a larger quantity of drug is dispensed, and if the pharmacist or dispensing physician writes a statement of this reason on the prescription.

G. A refill of a prescription must be authorized by the practitioner. Refilled prescriptions must be documented in the prescription file, initialed by the pharmacist who refills the prescription, and approved by the practitioner as consistent with accepted pharmacy practice under Minnesota Statutes, chapters 151 and 152.

H. A generically equivalent drug as defined in Minnesota Statutes, section 151.21, subdivision 2, must be dispensed in place of the prescribed drug if:

(1) the generically equivalent drug is approved by the United States Food and Drug Administration and is also determined as therapeutically equivalent by the United States Food and Drug Administration; and

(2) in the professional judgment of the pharmacist, the substituted drug is therapeutically equivalent to the prescribed drug; and

(3) the charge for the substituted generically equivalent drug does not exceed the charge for the drug originally prescribed.

However, a substitution must not be made if the practitioner has written in his or her own handwriting "Dispense as Written" or "DAW" on the prescription, as provided in the Minnesota Drug Selection Act, Minnesota Statutes, section 151.21. The pharmacy must notify the recipient and the department when a generically equivalent drug is dispensed. The notice to the recipient may be given orally or by appropriate labeling on the prescription's container. The notice to the department must be by appropriate billing codes.

I. Unless otherwise established by the legislature, the amount of the dispensing fee shall be set by the commissioner. The fee shall be the lower of the average dispensing fee set by third party payers in the state or the average fee determined by a cost of operation survey of pharmacy providers reduced by the yearly consumer price index (urban) for the Minneapolis-Saint Paul area to the base year set by the legislature for other provider fees.

J. The cost of delivering a drug is not a covered service.

Subp. 4. **Payment limitations; unit dose dispensing.** Drugs dispensed under unit dose dispensing in accordance with part 6800.3750 shall be subject to the medical assistance payment limitations in items A to C.

A. Dispensing fees for drugs dispensed in unit dose packaging as specified in part 6800.3750 shall not be billed or paid more often than once per calendar month or when a minimum of 30 dosage units have been dispensed, whichever results in the lesser number of dispensing fees, regardless of the type of unit dose system used by the pharmacy or the number of times during the month that the pharmacist dispenses the drug. If the recipient's drug supply is dispensed in small increments during the calendar month, the pharmacy must keep a written record of each dispensing act that shows the date, National Drug Code, and the quantity of the drug dispensed.

B. Only one dispensing fee per calendar month shall be billed or paid for each maintenance drug regardless of the type of unit dose system used by the pharmacy or the number of times during the month that the pharmacist dispenses the drug. If the recipient's drug supply is dispensed in small increments during the month, the pharmacy must keep a written record of each dispensing act that shows the date, National Drug Code, and the quantity of drug dispensed.

C. The date of dispensing must be reported as the date of service on the claim to the department except when the recipient's drug supply is dispensed in small increments during the month. For this exception, the last dispensing date of the calendar month must be reported on the claim to the department as the date of service. In the case of an exception, the quantity of drug dispensed must be reported as the cumulative total dispensed during the month or a minimum amount as required in item A, whichever results in the lesser number of dispensing fees.

Subp. 5. **Return of drugs.** Drugs dispensed in unit dose packaging under part 6800.3750, subpart 2, shall be returned to a pharmacy as specified in items A to C when the recipient no longer uses the drug.

A. A provider of pharmacy services using a unit dose system must comply with part 6800.2700.

B. A long-term care facility must return unused drugs dispensed in unit dose packaging to the provider that dispensed the drugs.

C. The provider that receives the returned drugs must repay medical assistance the amount billed to the department as the cost of the drug.

Subp. 6. **Billing procedure.** Providers of pharmacy services shall bill the department their usual and customary charge for the dispensed drug. All pharmacy claims submitted to the department must identify the National Drug Code printed on the container from which the prescription is actually filled. If a National Drug Code is not printed on the manufacturer's container from which the prescription is filled, the claim must name the code required by the department under the drug formulary, or identify either the generic or brand name of the drug. Except as provided in subpart 4, item C, the date reported as the date dispensed must be the date on which the quantity reported on the billing claim was dispensed.

Subp. 7. **Maximum payment for prescribed drugs.** The maximum payment for a prescribed drug or compounded prescription under the medical assistance program must be the lowest of the following rates:

A. The maximum allowable cost for a drug established by the department or the Health Care Financing Administration of the United States Department of Health and Human Services plus a dispensing fee.

B. The actual acquisition cost for a drug plus a dispensing fee.

C. The pharmacy's usual and customary charge.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624; L 1988 c 689 art 2 s 268*

9505.0345 PHYSICIAN SERVICES.

Subpart 1. **Definitions.** For purposes of this part, the following terms have the meanings given them.

A. "Physician directed clinic" means an entity with at least two physicians on staff which is enrolled in the medical assistance program to provide physician services.

B. "Physician's employee" means a nurse practitioner or physician assistant, mental health practitioner, or mental health professional.

C. "Physician service" means a medically necessary health service provided by or under the supervision of a physician.

Subp. 2. **Supervision of nonenrolled vendor.** Except for a physician service provided in a physician directed clinic or a long-term care facility, a physician service by a physician's employee must be under the supervision of the provider in order to be eligible for payment under the medical assistance program.

Physician service in a physician directed clinic must be provided under the supervision of a physician who is on the premises and who is a provider.

Subp. 3. **Physician service in long-term care facility.** A physician service provided by a physician's employee in a long-term care facility is a covered service if provided under the direction of a physician who is a provider except as in items A to C.

A. The service is a certification made at the recipient's admission.

B. The service is to write a plan of care required by Code of Federal Regulations, title 42, part 456.

C. The service is a physician visit in a skilled nursing facility required by Code of Federal Regulations, title 42, section 405.1123 or a physician visit in an intermediate care facility required by Code of Federal Regulations, title 42, section 442.346. For purposes of this subpart, "physician visit" means the term specified in Code of Federal Regulations, title 42, sections 405.1123 and 442.346.

For purposes of this subpart, "under the direction of a physician who is a provider" means that the physician has authorized and is professionally responsible for the physician services performed by the physician's employee and has reviewed and signed the record of the service no more than five days after the service was performed.

Subp. 4. **Payment limitation on medically directed weight reduction program.** A weight reduction program requires prior authorization. It is a covered service only if the excess weight complicates a diagnosed medical condition or is life threatening. The weight reduction program must be prescribed and administered under the supervision of a physician.

Subp. 5. **Payment limitation on service to evaluate prescribed drugs.** Payment for a physician service to a recipient to evaluate the effectiveness of a drug prescribed in the recipient's plan of care is limited for each recipient to one service per week. The payment shall be made only for the evaluation of the effect of antipsychotic or antidepressant drugs.

Subp. 6. **Payment limitation on podiatry service furnished by a physician.** The limitations and exclusions applicable to podiatry services under part 9505.0350, subparts 2 and 3, apply to comparable services furnished by a physician.

Subp. 7. **Payment limitations on visits to long-term care facilities.** Payment for a physician visit to a long-term care facility is limited to once every 30 days per resident of the facility unless the medical necessity of additional visits is documented.

Subp. 8. **Payment limitation on laboratory service.** A laboratory service ordered by a physician is subject to the payment limitation of part 9505.0305, subpart 4. Furthermore, payment for a laboratory service performed in a physician's laboratory shall not exceed the amount paid for a similar service performed in an independent laboratory under part 9505.0305.

Subp. 9. **Payment limitation; more than one recipient on same day in same long-term care facility.** When a physician service is provided to more than one recipient who resides in the same long-term care facility by the same provider on the same day, payment for the provider's visit to the first recipient shall be according to part 9505.0445, item E, for the procedure code for the visit. The provider's visit on the same day to other recipients within the same long-term care facility must be billed with the multiple visit code established by the department. This subpart shall not apply to a provider's visit to provide an emergency service on the same day within the same long-term care facility if the emergency service could not have been scheduled consecutively with another

recipient visit. If the provider visits other recipients in the same facility on the same day after providing an emergency service, the provider's visits must be billed with the multiple visit code.

Subp. 10. **Excluded physician services.** The physician services in items A to E are not eligible for payment under the medical assistance program:

A. artificial insemination;

B. procedure to reverse voluntary sterilization;

C. surgery primarily for cosmetic purposes;

D. services of a surgical assistant; and

E. inpatient hospital visits when the physician has not had face to face contact with the recipient.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0350 PODIATRY SERVICES.

Subpart 1. **Definitions.** The following terms used in this part shall have the meanings given them.

A. "Foot hygiene" means the care of the foot to maintain a clean condition.

B. "Podiatry service" means a service provided by a podiatrist within the scope of practice defined in Minnesota Statutes, chapter 153.

Subp. 2. **Payment for debridement or reduction of nails, corns, and calluses.** Debridement or reduction of pathological toenails and of infected or eczematized corns or calluses shall be a covered service. The service shall be eligible for payment once every 60 days.

Subp. 3. **Limitation on payment for debridement or reduction of nails, corns, and calluses.** Payment for debridement or reduction of nonpathological toenails and of noninfected or noneczematized corns or calluses is limited to the conditions in items A to C.

A. The recipient has a diagnosis of diabetes mellitus, arteriosclerosis obliterans, Buerger's disease (thromboangitis obliterans), chronic thrombophlebitis, or peripheral neuropathies involving the feet. The service is eligible for payment only once every 60 days unless the service is required more often to treat ulcerations or abscesses complicated by diabetes or vascular insufficiency. Payment for treatment of ulcerations or abscesses complicated by diabetes or vascular insufficiency is limited to services that are medically necessary.

B. The recipient who is not a resident of a long-term care facility has a medical condition that physically prevents him or her from reducing the nail, corn, or callus. Examples of such a medical condition are blindness, arthritis, and malformed feet.

C. A podiatry visit charge must not be billed on the same date as the date of the service provided under item A or B.

Subp. 4. **Limitation on payment for podiatry service provided to a resident of a long-term care facility.** To be eligible for medical assistance payment, a podiatry service provided to a recipient who resides in a long-term care facility must result from a self referral or a referral by a registered nurse or a licensed practical nurse who is employed by the facility or the recipient's family, guardian, or attending physician.

Subp. 5. **Payment limitation; more than one recipient on same day in same long-term care facility.** When a podiatry service is provided to more than one recipient who resides in the same long-term care facility by the same provider on the same day, payment for the provider's visit to the first recipient shall be according to part 9505.0445, item E, for the procedure code for the visit. The provider's visit on the same day to other recipients within the same long-term

care facility must be billed with the multiple visit code established by the department. This subpart shall not apply to a provider's visit to provide an emergency service on the same day within the same long-term care facility if the emergency service could not have been scheduled consecutively with another recipient visit. If the provider visits other recipients in the same facility on the same day after providing an emergency service, the provider's visits must be billed with the multiple visit code.

Subp. 6. **Excluded services.** The podiatry services in items A to I are not eligible for payment under the medical assistance program:

A. stock orthopedic shoes; "stock orthopedic shoes" means orthopedic shoes other than those built to a person's specifications as prescribed by a podiatrist;

B. surgical assistants;

C. local anesthetics that are billed as a separate procedure;

D. operating room facility charges;

E. foot hygiene;

F. use of skin creams to maintain skin tone;

G. service not covered under Medicare, or service denied by Medicare because it is not medically necessary;

H. debridement or reduction of the nails, corns, or calluses except as in subparts 2 to 4; and

I. if the recipient is a resident of a long-term care facility, general foot care that can be reasonably performed by nursing staff of long-term care facilities. An example of general foot care is the reduction of toenails, corns, or calluses of a recipient who is not diagnosed as having a medical condition listed in subpart 3.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0353 PRENATAL CARE SERVICES.

Subpart 1. **Definitions.** For purposes of this part, the terms in items A to F have the meaning given them.

A. "At risk" refers to the recipient who requires additional prenatal care services because of a health condition that increases the probability of a problem birth or the delivery of a low birth weight infant. The term includes "at risk of poor pregnancy outcome" and "at high risk of poor pregnancy outcome."

B. "Prenatal care management" means the development, coordination, and ongoing evaluation of a plan of care for an at risk recipient by a physician or registered nurse on a one to one basis.

C. "Prenatal care services" refers to the total array of medically necessary health services provided to an at risk recipient during pregnancy. The services include those necessary for pregnancy and those additional services that are authorized in this part.

D. "Nutrition counseling" means services provided by a health care professional with specialized training in prenatal nutrition education to assess and to minimize the problems hindering normal nutrition in order to improve the recipient's nutritional status during pregnancy.

E. "Prenatal education" means services provided to recipients at risk of poor pregnancy outcomes by a health care professional with specialized training in instructing at risk recipients how to change their lifestyles, develop self care and parenting skills, and recognize warning signs of preterm labor and childbirth.

F. "Risk assessment" means identification of the medical, genetic, lifestyle, and psychosocial factors which identify recipients at risk of poor pregnancy outcomes.

Subp. 2. **Risk assessment.** To be eligible for medical assistance payment, a provider of prenatal care services shall complete a risk assessment for a recipient for whom the services are provided. The risk assessment must be completed at the recipient's first prenatal visit and on a form supplied by the department. The provider shall submit the completed form to the department when the provider submits the first claim for payment of services to the recipient.

Subp. 3. **Additional service for at risk recipients.** The services in items A to C shall be provided to a recipient if the recipient's risk assessment identifies the services as medically necessary because of her at risk status and if prior authorization is obtained.

A. Prenatal care management must include:

(1) development of an individual plan of care that addresses the recipient's specific needs related to the pregnancy;

(2) ongoing evaluation and, if appropriate, revision of the plan of care according to the recipient's needs related to pregnancy;

(3) assistance to the recipient in identifying, obtaining, and using services specified in the recipient's plan of care;

(4) monitoring, coordinating, and managing nutrition counseling and prenatal education services to assure that these are provided in the most economical, efficient, and effective manner.

B. Nutrition counseling includes:

(1) assessing the recipient's knowledge of nutritional needs in pregnancy;

(2) determining the areas of the recipient's dietary insufficiency;

(3) instructing the recipient about her nutritional needs during pregnancy;

(4) developing an individual nutrition plan, if indicated, including referral to community resources which assist in providing adequate nutrition.

C. Prenatal education includes:

(1) information and techniques for a healthy lifestyle during pregnancy, including stress management, exercise, and reduction or cessation of drug, alcohol, and cigarette use;

(2) instruction about preterm labor, warning signs of preterm labor, and appropriate methods to delay labor; and

(3) information about the childbirth process, parenting, and additional community resources as appropriate to the individual recipient.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0355 PREVENTIVE HEALTH SERVICES.

Subpart 1. **Definition; preventive health service.** For the purposes of this part, "preventive health service" means a health service provided to a recipient to avoid or minimize the occurrence of illness, infection, disability, or other health condition. Examples are diabetes education, cardiac rehabilitation, weight loss programs, and nutrition counseling that meet the criteria established in part 9505.0210.

Subp. 2. **Covered preventive health services.** To be eligible for medical assistance payment, a preventive health service must:

A. be provided to the recipient in person;

B. affect the recipient's health condition rather than the recipient's physical environment;

C. not be otherwise available to the recipient without cost as part of another program funded by a government or private agency;

D. not be part of another covered service;

E. be to minimize an illness, infection, or disability which will respond to treatment;

F. be generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize the illness; and

G. be ordered in writing by a physician and contained in the plan of care approved by the physician.

Subp. 3. **Payment limitations.** The services in items A and B are not eligible for medical assistance payment:

A. service that is only for a vocational purpose or an educational purpose that is not health related; and

B. service dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0360 PRIVATE DUTY NURSING SERVICES.

Subpart 1. **Definition; private duty nursing service.** For purposes of this part, "private duty nursing service" means a nursing service ordered by a physician to provide individual and continual care to a recipient by a registered nurse or by a licensed practical nurse.

Subp. 2. **Prior authorization requirement.** Medical assistance payment for private duty nursing service provided to a recipient without prior authorization is limited to no more than 50 hours per month. Prior authorization is a condition of medical assistance payment for private duty nursing services to a recipient in excess of 50 hours per month and for private duty nursing services provided in a hospital or long-term care facility.

Subp. 3. **Covered service.** A private duty nursing service in items A to C is eligible for medical assistance payment:

A. service given to the recipient in his or her home, a hospital, or a skilled nursing facility if the recipient requires individual and continual care beyond the care available from a Medicare certified home health agency or personal care assistant or beyond the level of nursing care for which a long-term care facility or hospital is licensed and certified;

B. service given during medically necessary ambulance service; and

C. service that is required for the instruction or supervision of a personal care assistant under part 9505.0335. The service must be provided by a registered nurse.

Subp. 4. **Payment limitations.** To be eligible for medical assistance payment, a private duty nursing service must meet the conditions in items A to D.

A. The service must be ordered in writing by the recipient's physician.

B. The service must comply with the written plan of care approved by the recipient's physician.

C. The service may be provided only if:

(1) a home health agency, a skilled nursing facility, or a hospital is not able to provide the level of care specified in the recipient's plan of care; or

(2) a personal care assistant is not able to perform the level of care specified in the recipient's plan of care.

D. The service must be given by a registered nurse or licensed practical nurse who is not the recipient's legal guardian or related to the recipient as spouse, parent, or child whether by blood, marriage, or adoption.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624; L 1987 c 209 s 39*

9505.0365 PROSTHETIC AND ORTHOTIC DEVICES.

Subpart 1. **Definitions.** The following terms used in this part have the meanings given them.

A. "Ambulatory aid" means a prosthetic or orthotic device that assists a person to move from place to place.

B. "Audiologist" means a person who has a current certificate of clinical competence from the American Speech, Language, and Hearing Association.

C. "Hearing aid" means a prosthetic or orthotic device that aids or improves a person's auditory function.

D. "Hearing aid dispenser" means a person or entity who specializes in the sale and repair of hearing aids and has signed a performance agreement with the department.

E. "Prosthetic or orthotic device" means an artificial device as defined by Medicare to replace a missing or nonfunctional body part, to prevent or correct a physical deformity or malfunction, or to support a deformed or weak body part.

F. "Physiatrist" means a physician who specializes in physical medicine or physical therapy and who is board certified by the American Board of Physical Medicine and Rehabilitation.

Subp. 2. **Eligible providers; medical supply agreement.** To be eligible for medical assistance payment, a supplier of a prosthetic or orthotic device must sign a performance agreement as defined in part 9505.0175, subpart 32.

Subp. 3. **Payment limitation; ambulatory aid.** To be eligible for medical assistance payment, an ambulatory aid must be prescribed by a physician who is knowledgeable in orthopedics or physiatrics or by a physician in consultation with an orthopedist, physiatrist, physical therapist, or occupational therapist, or by a podiatrist.

Prior authorization of an ambulatory aid is required for an aid that costs in excess of the limits specified in the provider's performance agreement.

Subp. 4. **Payment limitation; hearing aid.** To be eligible for medical assistance payment, a hearing aid must be ordered by a physician in consultation with an audiologist. Payment for hearing aids and their maintenance and repair is limited as in items A to E. A request for prior authorization as required in items A and B must be approved or denied no later than one month after the department has received information necessary to determine whether the service is medically necessary.

A. One monaural aid or one set of binaural aids in a five year period unless prior authorization is obtained.

B. One repair per calendar year unless prior authorization is obtained. The vendor of the repair must itemize the charges.

C. One visit per calendar year to the recipient's residence by a hearing aid dispenser unless prior authorization is obtained. The visit to the residence must be medically necessary.

D. Replacement batteries as necessary to maintain the hearing aid's effectiveness.

E. Service to test, prescribe, or fit a hearing aid for a resident of a long-term care facility when need for the hearing aid is established in the resident's plan of care.

Subp. 5. **Payment limitation; general.** The cost of repair to a prosthetic or orthotic device that is rented or purchased by the medical assistance program under a warranty is not eligible for medical assistance payment if the repair is covered by warranty.

Subp. 6. **Excluded prosthetic and orthotic devices.** The prosthetic and orthotic devices in items A to K are not eligible for medical assistance payment:

A. a device for which Medicare has denied the claim as not medically necessary;

B. a device that is not medically necessary for the recipient;

C. a device, other than a hearing aid, that is provided to a recipient who is an inpatient or resident of a long-term care facility and that is billed directly to medical assistance except as in part 9505.0310, subpart 2;

D. repair of a rented device;

E. routine, periodic service of a recipient's device owned by a long-term care facility;

F. a device whose primary purpose is to serve as a convenience to a person caring for the recipient;

G. a device that is not received by the recipient;

H. a device that serves to address social and environment factors and that does not directly address the recipient's physical or mental health;

I. a device that is supplied to the recipient by the physician who prescribed the device or by the consultant to the physician in subpart 3 or 4;

J. a device that is supplied to the recipient by a provider who is an affiliate of the physician who prescribes the device for the recipient or of the consultant to the physician as in subpart 3 or 4. For purposes of this item, "affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with the referring physician; and

K. replacement batteries provided on a schedule under contract.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0380 PUBLIC HEALTH CLINIC SERVICES.

Subpart 1. **Definition.** "Public health clinic services" means a health service provided by or under the supervision of a physician in a clinic that is a department of, or operates under the direct authority of a unit of government.

Subp. 2. **Eligible health services.** The services in items A to F are eligible for payment as public health clinic services:

A. physician services as in part 9505.0345;

B. preventive health services as in part 9505.0355;

C. family planning services as in part 9505.0280;

D. prenatal care services as in part 9505.0353;

E. dental services as in part 9505.0270; and

F. early and periodic screening diagnosis and treatment as in part 9505.0275.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0395 RURAL HEALTH CLINIC SERVICES.

Subpart 1. **Definition.** "Rural health clinic service" means a health service provided in a clinic certified under Code of Federal Regulations, title 42, part 491.

Subp. 2. **Covered services.** All health services provided by a rural health clinic are covered services within the limitations applicable to the same services under parts 9505.0170 to 9505.0475 if the rural health clinic's staffing requirements and written policies governing health services provided by personnel other than a physician are in compliance with Code of Federal Regulations, title 42, part 491.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0405 VISION CARE SERVICES.

Subpart 1. **Definitions.** The following terms used in this part have the meanings given them.

A. "Complete vision examination" means diagnostic procedures to determine the health of the eye and the refractive status of the eye, and the need for eyeglasses or a change in eyeglasses.

B. "Dispensing services" means the technical services necessary for the design, fitting, and maintenance of eyeglasses as prescribed by an optometrist or physician skilled in diseases of the eye.

C. "Eyeglasses" means lenses, frames for the lenses if necessary, and other aids to vision prescribed by an optometrist or physician skilled in diagnosing and treating diseases of the eye.

D. "Optician" means a supplier of eyeglasses to a recipient as prescribed by the optometrist or medical doctor.

E. "Optometrist" means a person licensed under Minnesota Statutes, sections 148.52 to 148.62.

F. "Physician skilled in diseases of the eye" means a physician who has academic training beyond the requirements for licensure under Minnesota Statutes, chapter 147, and experience in the treatment and diagnosis of diseases of the eye.

G. "Vision care services" means a prescriptive, diagnostic, or therapeutic service provided by and within the scope of practice of an optometrist or physician skilled in diseases of the eye and the dispensing services provided by an optician, optometrist, or physician in fabricating or dispensing eyeglasses or other aids to vision that an optometrist or physician skilled in diseases of the eye prescribes for a recipient.

Subp. 2. **Payment limitations.** Payment for a recipient's vision care services provided under the medical assistance program is limited as in items A to D.

A. One complete vision examination in a 24 month period unless a request for prior authorization is approved for an additional complete vision examination.

B. One pair of eyeglasses or one replacement of each lens in the eyeglasses in a 24 month period unless a pair of eyeglasses or a replacement of a lens in the eyeglasses that is in excess of this limit obtains prior authorization. Eyeglasses or a change of eyeglasses must be shown to be medically necessary by a complete vision examination.

C. Replacement of a pair of eyeglasses or replacement of a lens in the eyeglasses in excess of the limit in item B if the replacement is necessary because the eyeglasses were misplaced or stolen or a lens or pair of eyeglasses was damaged due to circumstances beyond the recipient's control and prior authorization is obtained. The recipient's degree of physical and mental impairment shall be considered in determining whether the circumstances were beyond the recipient's control.

D. A request for prior authorization of eyeglasses required under item A or B must be approved or denied no later than one month after the department has received the information necessary to document the request.

Subp. 3. **Payment limitation; more than one recipient on same day in same long-term care facility.** When a vision care service is provided by the same provider to more than one recipient who resides in the same long-term care facility on the same day, payment for the provider's visit to the first recipient shall be according to part 9505.0445, item E, for the procedure code for the visit. The provider's visit on the same day to other recipients within the same long-term care facility must be billed with the multiple visit code established by the department. This subpart shall not apply to a provider's visit to provide an

emergency service on the same day within the same long-term care facility if the emergency service could not have been scheduled consecutively with another recipient visit. If the provider visits other recipients in the same facility on the same day after providing an emergency service, the provider's visits must be billed with the multiple visit code.

Subp. 4. **Excluded services.** The following vision care services are not eligible for payment under the medical assistance program.

A. Services provided for cosmetic reasons. Examples are:

(1) contact lenses prescribed for reasons other than aphakia, keratoconus, aniseikonia, marked acuity improvement over correction with eyeglasses, or therapeutic application; and

(2) replacement of lenses or frames due to the recipient's personal preference for a change of style or color.

B. Dispensing services related to noncovered services.

C. Fashion tints that do not absorb ultraviolet or infrared wave lengths.

D. Protective coating for plastic lenses.

E. Edge and antireflective coating of lenses.

F. Industrial or sport eyeglasses unless they are the recipient's only pair and are necessary for vision correction.

G. Replacement of lenses or frames, if the replacement is not medically necessary.

H. Oversize lenses which exceed the lens size specified in the competitive bidding contract established under Minnesota Statutes, chapter 16B.

I. Invisible bifocals or progressive bifocals.

J. A vision care service for which a required prior authorization was not obtained.

K. Replacement of lenses or frames due to the provider's error in prescribing, frame selection, or measurement. The provider making the error is responsible for bearing the cost of correcting the error.

L. Services or materials that are determined to be experimental or nonclinically proven by prevailing community standards or customary practice.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0415 LONG-TERM CARE FACILITIES; LEAVE DAYS.

Subpart 1. **Definitions.** For the purpose of this part, the following terms have the meanings given them.

A. "Certified bed" means a bed certified under title XIX of the Social Security Act.

B. "Discharge" or "discharged" refers to the status of a recipient as defined in part 9549.0051, subpart 7, as published in the State Register, December 1, 1986, volume 11, number 22.

C. "Hospital leave" means the status of a recipient who has been transferred from the long-term care facility to an inpatient hospital for medically necessary health care, with the expectation the recipient will return to the long-term care facility.

D. "Leave day" means any calendar day during which the recipient leaves the facility and is absent overnight, and all subsequent, consecutive calendar days. An overnight absence from the facility of less than 23 hours does not constitute a leave day. Nevertheless, if the recipient is absent from the facility to participate in active programming of the facility under the personal direction and observation of facility staff, the day shall not be considered a leave day regardless of the number of hours of the recipient's absence. For purposes of this item, "calendar day" means the 24 hour period ending at midnight.

E. "Reserved bed" means the same bed that a recipient occupied before leaving the facility for hospital leave or therapeutic leave or an appropriately certified bed if the recipient's physical condition upon returning to the facility prohibits access to the bed he or she occupied before the leave.

F. "Therapeutic leave" means the absence of a recipient from a long-term care facility, with the expectation of the recipient's return to the facility, to a camp meeting applicable licensure requirements of the Minnesota Department of Health, a residential setting other than a long-term care facility, a hospital, or other entity eligible to receive federal, state, or county funds to maintain a recipient. Leave for a home visit or a vacation is a therapeutic leave.

Subp. 2. **Payment for leave days.** A leave day is eligible for payment under medical assistance, subject to the limitations of this part. The leave day must be for hospital leave or therapeutic leave of a recipient who has not been discharged from the long-term care facility. A reserved bed must be held for a recipient on hospital leave or therapeutic leave.

Subp. 3. **Hospital leave.** A hospital leave for which a leave day is claimed must comply with the conditions in items A to C if the leave day is to be eligible for medical assistance payment.

A. The recipient must have been transferred from the long-term care facility to a hospital.

B. The recipient's health record must document the date the recipient was transferred to the hospital and the date the recipient returned to the long-term care facility.

C. The leave days must be reported on the invoice submitted by the long-term care facility.

Subp. 4. **Therapeutic leave.** A therapeutic leave for which a leave day is claimed must comply with the conditions in items A and B if the leave day is to be eligible for payment under medical assistance.

A. The recipient's health care record must document the date and the time the recipient leaves the long-term care facility and the date and the time of return.

B. The leave days must be reported on the invoice submitted by the long-term care facility.

Subp. 5. **Payment limitations on number of leave days for hospital leave.** Payment for leave days for hospital leave is limited to 18 consecutive days for each separate and distinct episode of medically necessary hospitalization. For the purpose of this part "separate and distinct episode" means:

A. the occurrence of a health condition that is an emergency;

B. the occurrence of a health condition which requires inpatient hospital services but is not related to a condition which required previous hospitalization and was not evident at the time of discharge; or

C. the repeat occurrence of a health condition that is not an emergency but requires inpatient hospitalization at least two calendar days after the recipient's most recent discharge from a hospital.

Subp. 6. **Payment limitations on number of leave days for therapeutic leave.** Payment for leave days for therapeutic leave is limited to the number of days as in items A to D:

A. recipients receiving skilled nursing facility services as provided in part 9505.0420, subpart 2, 36 leave days per calendar year;

B. recipients receiving intermediate care facility services as provided in part 9505.0420, subpart 3, 36 leave days per calendar year;

C. recipients receiving intermediate care facility, mentally retarded services as provided in part 9505.0420, subpart 4, 72 leave days per calendar year;

D. recipients residing in a long-term care facility that has a license to provide services for the physically handicapped as provided in parts 9570.2000 to 9570.3600, 72 leave days per calendar year.

Subp. 7. **Payment limitation on billing for leave days.** Payment for leave days for hospital leave and therapeutic leave shall be subject to the limitation as in items A to C. For purposes of this subpart, a reserved bed is not a vacant bed when determining occupancy rates and eligibility for payment of a leave day.

A. Long-term care facilities with 25 or more licensed beds shall not receive payment for leave days in a month for which the average occupancy rate of licensed beds is 93 percent or less.

B. Long-term care facilities with 24 or fewer licensed beds shall not receive payment for leave days if a licensed bed has been vacant for 60 consecutive days prior to the first leave day of a hospital leave or therapeutic leave.

C. The long-term care facility charge for a leave day for a recipient must not exceed the charge for a leave day for a private paying resident. "Private paying resident" has the meaning given in part 9549.0020, subpart 35.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0420 LONG-TERM CARE FACILITY SERVICES.

Subpart 1. **Covered service.** Services provided to a recipient in a long-term care facility are eligible for medical assistance payment subject to the provisions in subparts 2, 3, and 4, and in parts 9505.2250 to 9505.2380, 9549.0010 to 9549.0080, and 9553.0010 to 9553.0080.

Subp. 2. **Payment limitation; skilled nursing care facility.** The medical assistance program shall pay the cost of care of a recipient who resides in a skilled nursing facility when the recipient requires:

A. daily care ordered by the recipient's attending physician on a 24 hour basis; and one of the following:

B. nursing care as defined in Minnesota Statutes, section 144A.01, subdivision 6, that can be safely performed only by or under the direction of a registered nurse in compliance with parts 4655.0090 to 4655.9900; or

C. rehabilitative and therapeutic services as in part 9500.1070, subpart 13.

Subp. 3. **Payment limitation; intermediate care facility, levels I and II.** The medical assistance program shall pay the cost of care of a recipient who resides in a facility certified as an intermediate care facility, level I or II by the Department of Health when the recipient requires:

A. daily care ordered by the recipient's attending physician to be provided in compliance with parts 4655.0090 to 4655.9900;

B. ongoing care and services because of physical or mental limitations that can be appropriately cared for only in an intermediate care facility.

Subp. 4. **Payment limitation; intermediate care facility, mentally retarded.** The medical assistance program shall pay the cost of care of a recipient who resides in a facility certified as an intermediate care facility for mentally retarded persons licensed under Minnesota Statutes, sections 144.50 to 144.56, or chapter 144A and licensed for program services under parts 9525.0210 to 9525.0430 when the recipient:

A. meets the admission criteria specified in Code of Federal Regulations, title 42, section 442.418;

B. requires care under the management of a qualified mental retardation professional as defined by Code of Federal Regulations, title 42, section 442.401; and

C. requires active treatment as defined in Code of Federal Regulations, title 42, section 435.1009.

Subp. 5. **Exemptions from the federal utilization control requirements.** A skilled nursing facility, an intermediate care facility, or intermediate care facility for mentally retarded persons that is operated, listed, and certified as a Christian Science sanatorium by the First Church of Christ, Scientist, of Boston, Massachusetts, is not subject to the federal regulations for utilization control in order to receive medical assistance payments for the cost of recipient care.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0425 RESIDENT FUND ACCOUNTS.

Subpart 1. **Use of resident fund accounts.** A resident who resides in a long-term care facility may choose to deposit his or her funds including the personal needs allowance established under Minnesota Statutes, section 256B.35, subdivision 1, in a resident fund account administered by the facility.

Subp. 2. **Administration of resident fund accounts.** A long-term care facility must administer a resident fund account as in items A to I and parts 4655.4100 to 4655.4170.

A. The facility must credit to the account all funds attributable to the account including interest and other forms of income.

B. The facility must not commingle resident funds with the funds of the facility.

C. The facility must keep a written record of the recipient's resident fund account. The written record must show the date, amount, and source of a deposit in the account, and the date and amount of a withdrawal from the account. The facility must record contemporaneously a deposit or withdrawal and within five working days after the deposit or withdrawal must update the recipient's individual written record to reflect the transaction.

D. The facility shall require a recipient who withdraws $10 or more at one time to sign a receipt for the withdrawal. The facility shall retain the receipt and written records of the account until the account is subjected to the field audit required under Minnesota Statutes, section 256B.35, subdivision 4. A withdrawal of $10 or more that is not documented by a receipt must be credited to the recipient's account. Receipts for the actual item purchased for the recipient's use may substitute for a receipt signed by the recipient.

E. The facility must not charge the recipient a fee for administering the recipient's account.

F. The facility must not solicit donations or borrow from a resident fund account.

G. The facility shall report and document to the local agency a recipient's donation of money to the facility when the donation equals or exceeds the statewide average monthly per person rate for skilled nursing facilities determined under parts 9549.0010 to 9549.0080. This documentation may be audited by the commissioner.

H. The facility must not use resident funds as collateral for or payment of any obligations of the facility.

I. Payment of any funds remaining in a recipient's account when the recipient dies or is discharged shall be treated under part 4655.4170.

Subp. 3. **Limitations on purpose for which resident fund account funds may be used.** Except as otherwise provided in this part, funds in a recipient's resident fund account may not be used to purchase the materials, supplies, or services specified in items A to F. Nevertheless, the limitations in this subpart do not prohibit the recipient from using his or her funds to purchase a brand name supply or other furnishing or item not routinely supplied by the long-term care facility.

A. Medical transportation as provided in part 9505.0315.

B. The initial purchase or the replacement purchase of furnishings or equipment required as a condition of certification as a long-term care facility.

C. Laundering of the recipient's clothing as provided in part 9549.0040, subpart 2.

D. Furnishings or equipment which are not requested by the recipient for his or her personal convenience.

E. Personal hygiene items necessary for daily personal care. Examples are bath soap, shampoo, toothpaste, toothbrushes, dental floss, shaving cream, nonelectric shaving razor, and facial tissues.

F. Over the counter drugs or supplies used by the recipient on an occasional, as needed basis that have not been prescribed for long-term therapy of a medical condition. Examples of over the counter drugs or supplies are aspirin, aspirin compounds, acetaminophen, antacids, antidiarrheals, cough syrups, rubbing alcohol, talcum powder, body lotion, petrolatum jelly, lubricating jelly, and mild antiseptic solutions.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0430 HEALTH CARE INSURANCE PREMIUMS.

The medical assistance program shall pay the cost of a premium to purchase health insurance coverage for a recipient when the premium purchases coverage limited to health services and the department approves the health insurance coverage as cost effective.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0440 MEDICARE BILLING REQUIRED.

A provider shall comply with the Medicare billing requirements in items A and B.

A. A provider who is authorized to participate in Medicare shall bill Medicare before billing medical assistance for services covered by Medicare unless the provider has reason to believe that a service covered by Medicare will not be eligible for payment. A provider shall not be required to take an action that may jeopardize the limitation on liability under Medicare as specified in Code of Federal Regulations, title 42, section 405.195. However, the provider must document that, because of recent claim experiences with Medicare or because of written communication from Medicare, coverage is not available.

B. A provider specified in item A shall accept Medicare assignment if the medical assistance payment rate for the service to the recipient is at the same rate or less than the Medicare payment.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0445 PAYMENT RATES.

The maximum payment rates for health services established as covered services by parts 9505.0170 to 9505.0475 shall be as in items A to N.

A. For skilled nursing care facility services, the rates shall be as established in parts 9549.0010 to 9549.0080 and 9549.0050 to 9549.0059 as published in the State Register, December 1, 1986, volume 11, number 22, pages 991 to 1004.

B. For intermediate care facility services, the rates shall be as established in parts 9549.0010 to 9549.0080 and 9549.0050 to 9549.0059 as published in the State Register, December 1, 1986, volume 11, number 22, pages 991 to 1004.

C. For services of an intermediate care facility for persons with mental retardation or related conditions, the rates shall be as established in parts 9553.0010 to 9553.0080.

D. For hospital services, the rates shall be as established in parts 9500.1090 to 9500.1155.

E. For audiology services, chiropractic services, dental services, mental health center services, physical therapy, physician services, podiatry services, psychological services, speech pathology services, and vision care, the rate shall be the lowest of the provider's submitted charge, the provider's individual customary charge submitted during the calendar year specified in the legislation governing maximum payment rates, or the 50th percentile of the usual and customary fees based upon billings submitted by all providers of the service in the calendar year specified in legislation governing maximum payment rates.

F. For clinic services other than rural health clinic services, the rate shall be the lowest of the provider's submitted charge, the provider's individual customary charge submitted during the calendar year specified in the legislation governing maximum payment rates, the 50th percentile of the usual and customary fees based upon billings submitted by all providers of the service in the calendar year specified in legislation governing maximum payment rates, or Medicare payment amounts for comparable services under comparable circumstances.

G. For outpatient hospital services excluding emergency services and excluding facility fees for surgical services, the rate shall be the lowest of the provider's submitted charge, the provider's individual customary charge submitted in the calendar year specified in legislation governing maximum payment rates, the 50th percentile of the usual and customary fees based upon billings submitted by all providers of the service in the calendar year specified in legislation governing maximum payment rates, or Medicare payment amounts for comparable services under comparable circumstances.

H. For facility services which are performed in an outpatient hospital or an ambulatory surgical center, the rate shall be the lower of the provider's submitted charge or the standard flat rate under Medicare reimbursement methods for facility services provided by ambulatory surgical centers. The standard flat rate shall be the rate based on Medicare costs reported by ambulatory surgical centers for the calendar year in legislation governing maximum payment rates.

I. For facility fees for emergency outpatient hospital services, the rate shall be the provider's individual usual and customary charge for facility services based on the provider's costs in calendar year 1983. The calendar year in this item shall be revised as necessary to be consistent with calendar year revisions enacted after October 12, 1987, in legislation governing maximum payments for providers named in item D.

J. For home health agency services, the rate shall be the lower of the provider's submitted charge or the Medicare cost per visit limits based on Medicare cost reports submitted by free standing home health agencies in the Minneapolis and Saint Paul area in the calendar year specified in legislation governing maximum payment rates for services in item E.

K. For private duty nursing services, the rate shall be the lower of the provider's submitted charge or the maximum rate established by the legislature. The maximum rate shall be adjusted annually on July 1 to reflect the annual percentage increase reported in the most recent Consumer Price Index (Urban) for the Minneapolis-Saint Paul area new series index (1967=100) as published by the Bureau of Labor Statistics, United States Department of Labor. The Consumer Price Index (Urban) is incorporated by reference and is available from the Minitex interlibrary loan system. It is subject to frequent change.

L. For personal care assistant services, the rate shall be the lower of the

provider's submitted charge or the maximum rate established by the department. The maximum rates shall be adjusted annually on July 1 to reflect the annual percentage increase reported in the most recent Consumer Price Index (Urban) for the Minneapolis-Saint Paul area as specified in item K.

M. For EPSDT services provided in a physician supervised clinic, the rate shall be the lower of the provider's submitted charge or the 75th percentile of all screening charges submitted by physician supervised clinics during the previous six month period of November to April. For EPSDT services provided in a nurse supervised clinic, the rate shall be the lower of the provider's submitted charge or the 75th percentile of all screening charges submitted by nurse supervised clinics during the previous six month period of November to April. The adjustment necessary to reflect the 75th percentile shall be effective annually on August 1.

N. For pharmacy services, the rates shall be as established in part 9505.0340, subpart 7.

O. For rehabilitation agency services, the rate shall be the lowest of the provider's submitted charges, the provider's individual and customary charge submitted during the calendar year specified in the legislation governing maximum payment rates for providers in item D, or the 50th percentile of the usual and customary fees based upon billings submitted by all providers of the service in the calendar year specified in legislation governing maximum payment rates for providers in item D.

P. For rural health clinic services, reimbursement shall be according to the methodology in Code of Federal Regulations, title 42, section 447.371. If a rural health clinic other than a provider clinic offers ambulatory services other than rural health clinic services, maximum reimbursement for these ambulatory services shall be at the levels specified in this part for similar services. For purposes of this item, "provider clinic" means a clinic as defined in Code of Federal Regulations, title 42, section 447.371(a); "rural health clinic services" means those services listed in Code of Federal Regulations, title 42, section 440.20(b); "ambulatory services furnished by a rural health clinic" means those services listed in Code of Federal Regulations, title 42, section 440.20(c).

Q. For laboratory and x-ray services performed by a physician, independent laboratory, or outpatient hospital, the payment rate shall be the lowest of the provider's submitted charge, the provider's individual customary charge submitted during the calendar year specified in the legislation governing maximum payment rates, the 50th percentile of the usual and customary fees based on billings submitted by all providers of the service in the calendar year specified in legislation, or maximum Medicare fee schedules for outpatient clinical diagnostic laboratory services.

R. For medical transportation services, the rates shall be as specified in subitems (1) to (4).

(1) Payment for ambulance service must be the lowest of the medical assistance maximum allowable charge, the provider's usual and customary charge, the charge submitted by the provider, or the payment allowed by Medicare for a similar service. If a provider transports two or more persons simultaneously in one vehicle, the payment must be prorated according to the schedule in subitem (2). Payment for ancillary service to a recipient during ambulance service must be based on the type of ancillary service and is not subject to proration.

(2) Payment for special transportation must be the lowest of the actual charge for the service, the provider's usual and customary rate, or the medical assistance maximum allowable charge. If a provider transports two or more persons simultaneously in one vehicle from the same point of origin, the payment must be prorated according to the following schedule:

Number of Riders	Percent of Allowed Base Rate Per Person in Vehicle	Percent of Allowed Mileage Rate
1	100	100
2	80	50
3	70	34
4	60	25
5-9	50	20
10 or more	40	10

(3) The payment rate for bus, taxicab, and other commercial carriers must be the carrier's usual and customary fee for the service but must not exceed the department's maximum allowable payment for special transportation services.

(4) The payment rate for private automobile transportation must be the amount per mile allowed on the most recent federal income tax return for actual miles driven for business purposes.

(5) The payment rate for air ambulance transportation must be consistent with the level of medically necessary services provided during the recipient's transportation and must be the lowest of the medical assistance maximum allowable charge, the provider's usual and customary charge, the charge submitted by the provider, or the payment allowed by Medicare for a similar service. Payment for air ambulance transportation of a recipient not having a life threatening condition requiring air ambulance transportation shall be at the level of medically necessary services which would have been otherwise provided to the recipient at rates specified in subitems (1) to (4).

S. For medical supplies and equipment, the rates shall be the lowest of the provider's submitted charge, the Medicare fee schedule amount for medical supplies and equipment, or the amount determined as appropriate by use of the methodology set forth in this item. If Medicare has not established a reimbursement amount for an item of medical equipment or a medical supply, then the medical assistance payment shall be based upon the 50th percentile of the usual and customary charges submitted to the department for the item or medical supply for the previous calendar year minus 20 percent. For an item of medical equipment or a medical supply for which no information about usual and customary charges exists for a previous calendar year payments shall be based upon the manufacturer's suggested retail price minus 20 percent.

T. For prosthetics and orthotics, the rate shall be the lower of the Medicare fee schedule amount or the provider's submitted charge.

U. For health services for which items A to T do not provide a payment rate, the department may use competitive bidding, negotiate a rate, or establish a payment rate by other means consistent with statutes, federal regulations, and state rules.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624; L 1987 c 209 s 39*

9505.0450 BILLING PROCEDURES; GENERAL.

Subpart 1. **Billing for usual and customary fee.** A provider shall bill the department for the provider's usual and customary fee only after the provider has provided the health service to the recipient.

Subp. 2. **Time requirements for claim submission.** Except as in subpart 4, a provider shall submit a claim for payment no later than 12 months after the date of service to the recipient and shall submit a request for an adjustment to a payment no later than six months after the payment date. The department has no obligation to pay a claim or make an adjustment to a payment if the provider does not submit the claim within the required time.

Subp. 3. **Retroactive billing.** If the recipient is retroactively eligible for medical assistance and notifies the provider of the retroactive eligibility, the provider may bill the department the provider's usual and customary charge. If the recipient paid any portion of the provider's usual and customary charge during this period, the provider must reimburse the recipient the actual amount paid by the recipient but not more than the amount paid to the provider by medical assistance. Failure of the provider to comply with this part shall not be appealable by the recipient under Minnesota Statutes, section 256.045.

Subp. 4. **Exceptions to time requirements.** A provider may submit a claim for payment more than 12 months after the date of service to the recipient if one of the circumstances in items A to D exists. The department shall pay the claim if it satisfies the other requirements of a claim for a covered service.

A. The medical assistance claim was preceded by a claim for payment under Medicare which was filed according to Medicare time limits. To be eligible for payment, the claim must be presented to the department within six months of the Medicare determination.

B. Medical assistance payment of the claim is ordered by the court and a copy of the court order accompanies the claim or an appeal under Minnesota Statutes, section 256.045, is upheld. To be eligible for payment, the claim must be presented within six months of the court order.

C. The provider's claim for payment was rejected because the department received erroneous or incomplete information about the recipient's eligibility. To be eligible for payment, the provider must resubmit the claim to the department within six months of the erroneous determination, together with a copy of the original claim, a copy of the corresponding remittance advice, and any written communication the provider has received from the local agency about the claim. The local agency must verify to the department the recipient's eligibility at the time the recipient received the service.

D. The provider's claim for payment was erroneously rejected by the department. To be eligible for payment, the provider must resubmit the claim within six months of receipt of the notice of the erroneous determination by sending the department a copy of the original claim, a copy of the remittance advice, any written communication about the claim sent to the provider by the local agency or department, and documentation that the original claim was submitted within the 12-month limit in subpart 2.

Subp. 5. **Format of claims.** To be eligible for payment, a provider must enter on the claim the diagnosis and procedure codes required by the department and submit the claim on forms or in the format specified by the department. The provider must include with the claim information about a required prior authorization or second surgical opinion. Further, the provider shall submit with the claim additional records or reports requested by the department as necessary to determine compliance with parts 9505.0170 to 9505.0475.

Subp. 6. **Repeated submission of nonprocessible claims.** A provider's repeated submission of claims that cannot be processed without obtaining additional information shall constitute abuse and shall be subject to the sanctions available under parts 9505.1750 to 9505.2150.

Subp. 7. **Direct billing by provider.** Except as in parts 9505.0070 and 9505.0440, a provider or the provider's business agent as in part 9505.0455 shall directly bill the department for a health service to a recipient.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0455 BILLING PROCEDURE; BUSINESS AGENT.

A health service rendered by a provider may be billed by the provider's business agent, if the business agent's compensation is related to the actual cost

of processing the billing; is not related on a percentage or other basis to the amount that is billed; and is not dependent upon collection of the payment.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0460 CONSEQUENCES OF A FALSE CLAIM.

A provider who wrongfully obtains a medical assistance payment is subject to Minnesota Statutes, sections 256B.064, 256B.121, 609.466, and 609.52; section 1909 of the Social Security Act; and parts 9505.1750 to 9505.2150.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0465 RECOVERY OF PAYMENT TO PROVIDER.

Subpart 1. **Department obligations to recover payment.** The department shall recover medical assistance funds paid to a provider if the department determines that the payment was obtained fraudulently or erroneously. Monetary recovery under the medical assistance program is permitted for the following:

A. intentional and unintentional error on the part of the provider or state or local welfare agency;

B. failure of the provider to comply fully with all authorization control requirements, prior authorization procedures, or billing procedures;

C. failure to properly report third-party payments; and

D. fraudulent or abusive actions on the part of the provider.

Subp. 2. **Methods of monetary recovery.** The monetary recovery may be made by withholding current payments due the provider, by demanding that the provider refund amounts so received as provided in part 9505.1950, or by any other legally authorized means.

Subp. 3. **Interest charges on monetary recovery.** If the department allows the provider to repay medical assistance funds by installment payments, the provider must pay interest on the funds to be recovered. The interest rate shall be the rate established by the Department of Revenue under Minnesota Statutes, section 270.75.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0470 PROVIDER RESPONSIBILITY FOR BILLING PROCEDURE.

For the purposes of parts 9505.0170 to 9505.0475 and 9505.1760 to 9505.2150, a provider is responsible for all medical assistance payment claims submitted to the department for health services furnished by the provider or the provider's designee to a recipient regardless of whether the claim is submitted by the provider or the provider's employee, vendor, or business agent, or an entity who has a contract with the provider.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.0475 SUSPENSION OF PROVIDER CONVICTED OF CRIME RELATED TO MEDICARE OR MEDICAID.

Subpart 1. **Crime related to Medicare.** A provider convicted of a crime related to the provision, management, or administration of health services under Medicare is suspended from participation under the medical assistance program. The effective date of the suspension is the date established by the Department of Health and Human Services; the period of suspension is the period established by the Department of Health and Human Services.

Subp. 2. **Crime related to medical assistance.** A provider convicted of a crime

related to the provision, management, or administration of health services under medical assistance is suspended from participation under the medical assistance program. The effective date of suspension is the date of conviction. The period of suspension is the period of any sentence imposed by the sentencing court, even if the sentence is suspended or the provider is placed on probation. A provider is provisionally suspended upon conviction and pending sentencing.

Subp. 3. **Definition of "convicted."** "Convicted" for purposes of this part means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from the judgment is pending, and includes a plea of guilty or nolo contendere.

Subp. 4. **Suspension after conviction of person with ownership interest.** This part also applies to and results in the suspension of any provider when a person who has an ownership or control interest in the provider, as defined and determined by Code of Federal Regulations, title 42, sections 455.101 and 455.102, is convicted of a crime related to medical assistance. A provider suspended under this subpart may seek reinstatement at the time the convicted person ceases to have any ownership or control interest in the provider.

Subp. 5. **Notice of suspension.** The commissioner shall notify a provider in writing of suspension under this part. The notice shall state the reasons for the suspension, the effective date and duration of the suspension, and the provider's right to appeal the suspension.

Subp. 6. **Right to appeal.** A provider suspended under this part may file an appeal pursuant to Minnesota Statutes, section 256B.064, and part 9505.2150. The appeal shall be heard by an administrative law judge according to Minnesota Statutes, sections 14.48 to 14.56. Unless otherwise decided by the commissioner, the suspension remains in effect pending the appeal.

Statutory Authority: *MS s 256B.04 subds 4,12*

History: *12 SR 624*

9505.2250 [Repealed, 13 SR 258]

9505.2260 [Repealed, 13 SR 258]

9505.2270 [Repealed, 13 SR 258]

9505.2280 [Repealed, 13 SR 258]

9505.2290 [Repealed, 13 SR 258]

9505.2300 [Repealed, 13 SR 258]

9505.2310 [Repealed, 13 SR 258]

9505.2320 [Repealed, 13 SR 258]

9505.2330 [Repealed, 13 SR 258]

9505.2340 [Repealed, 13 SR 258]

9505.2350 [Repealed, 13 SR 258]

9505.2360 [Repealed, 13 SR 258]

9505.2370 [Repealed, 13 SR 258]

9505.2380 [Repealed, 13 SR 258]

PREADMISSION SCREENING AND ALTERNATIVE CARE GRANT PROGRAM

9505.2390 SCOPE AND EFFECT.

Subpart 1. **Scope.** Parts 9505.2390 to 9505.2500 establish the standards and

procedures applicable to the preadmission screening and alternative care grant program. The preadmission screening program screens persons who are applicants for admission to a nursing home or nursing home residents who request a screening as required under part 9505.2435, subpart 2. An alternative care grant pays for some community services in lieu of nursing home admission or continued nursing home resident status for persons who meet the requirements of parts 9505.2390 to 9505.2500.

Parts 9505.2390 to 9505.2500 must be read in conjunction with Minnesota Statutes, sections 256B.04, subdivision 2, 256B.05, 256B.091, subdivisions 1 to 9, and Code of Federal Regulations, title 42, sections 440.180 and 441.300 to 441.310. Unless otherwise specified, citations of Code of Federal Regulations, title 42, refer to the code amended as of October 1, 1986.

Parts 9505.2390 to 9505.2500 also must be read in conjunction with the requirements of the waiver obtained by the state from the United States Department of Health and Human Services.

Subp. 2. **Effect.** References to the waiver and waiver provisions that occur in parts 9505.2390 to 9505.2500 shall continue in effect only as long as the waiver from the United States Department of Health and Human Services remains in effect in Minnesota.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2395 DEFINITIONS.

Subpart 1. **Applicability.** The definitions in this part apply to parts 9505.2390 to 9505.2500.

Subp. 2. **Adult day care services.** "Adult day care services" means services provided to alternative care grant clients by adult day care programs established under Minnesota Statutes, sections 245A.01 to 245A.17, including adult day care centers licensed under parts 9555.9600 to 9555.9730.

Subp. 3. **Adult foster care services.** "Adult foster care services" means supervised living arrangements for adults in an adult foster care home licensed under parts 9555.5105 to 9555.6265.

Subp. 4. **Alternative care grant or ACG.** "Alternative care grant" or "ACG" means funds allocated to a local agency by the commissioner under Minnesota Statutes, section 256B.091 to pay for alternative care services.

Subp. 5. **Alternative care grant client or ACG client.** "Alternative care grant client" or "ACG client" means a person who has been determined eligible to receive or is receiving services funded by an alternative care grant.

Subp. 6. **Alternative care grant services.** "Alternative care grant services" means the services listed in items A to G provided to ACG clients:

A. case management services;

B. respite care services;

C. homemaker services;

D. home health aide services;

E. adult foster care services;

F. adult day care services; and

G. personal care services.

Subp. 7. **Applicant.** "Applicant" means a person who is seeking admission to a nursing home or who has been admitted to a nursing home but has not yet been screened by the preadmission screening team as required in part 9505.2420.

Subp. 8. **Assessment form.** "Assessment form" means the form supplied by the commissioner that is used to record the information required under parts 9505.2425, subpart 1 and 9505.2455, subpart 12.

Subp. 9. **Case management services.** "Case management services" means services that identify, acquire, authorize, and coordinate services for an ACG client; monitor the delivery of services to the ACG client; and adjust services to the needs of the ACG client.

Subp. 10. **Case manager.** "Case manager" means a social worker employed by or under contract with the local agency or a registered nurse who is employed by the local public health department and under contract with the local agency to provide case management services. "Local agency" in this subpart refers to the county of service.

Subp. 11. **Commissioner.** "Commissioner" means the commissioner of the Minnesota Department of Human Services or the commissioner's authorized representative.

Subp. 12. **Community services.** "Community services" means home and community based services including services provided under the ACG as specified in part 9505.2430, subpart 4, item B, subitem (3), that can be used to meet the health or social needs of an ACG client.

Subp. 13. **County of financial responsibility.** "County of financial responsibility" means the county responsible for paying for preadmission screening of a recipient or the county responsible for paying for ACG services under part 9505.2455, subpart 3.

Subp. 14. **County of service.** "County of service" means the county whose local agency performs preadmission screening of an applicant or nursing home resident or arranges case management services for an ACG client. The county of service may be the same as or different from the county of financial responsibility.

Subp. 15. **Delay of screening.** "Delay of screening" means that preadmission screening has not been completed for an applicant but will be completed according to the time requirements established for:

A. emergency admission under part 9505.2420, subpart 3;

B. preadmission screening of hospital patients under part 9505.2420, subpart 2;

C. 30 day exemption from screening under part 9505.2420, subpart 4; or

D. admission of an applicant from another state under part 9505.2420, subpart 6.

Subp. 16. **Department.** "Department" means the Minnesota Department of Human Services.

Subp. 17. **Directory of services.** "Directory of services" means the list of all community services available in a geographic area that is developed under part 9505.2425, subpart 7.

Subp. 18. **Discharge planner.** "Discharge planner" means a person qualified as a public health nurse or a social worker who is employed by a hospital to coordinate the development of an individual service plan of a person who no longer needs the services of the hospital.

Subp. 19. **Emergency admission.** "Emergency admission" means the admission of an applicant from the community to a nursing home before completion of preadmission screening when a physician has determined that the delay in admission needed for preadmission screening would adversely affect the applicant's health and safety. For purposes of this definition, "community" does not include a hospital.

Subp. 20. **Formal caregivers.** "Formal caregivers" means persons or entities providing ACG services who are employed or who are under contract with a local agency, or other agency or organization, public or private.

Subp. 21. **Home health aide.** "Home health aide" means a person who meets the requirements of part 9505.2470 and provides home health aide services to an ACG client.

Subp. 22. **Home health aide services.** "Home health aide services" means services provided under part 9505.2470 that are written in the individual treatment plan. Home health aide services include the performance of procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self administered, reporting changes in the ACG client's condition and needs, and completing necessary records.

Subp. 23. **Homemaker services.** "Homemaker services" means services that assist an ACG client as set forth in items A to G:

A. performing house cleaning activities;

B. laundering, ironing, and mending;

C. meal planning, preparation, and cleanup;

D. assisting with money management;

E. providing companionship, emotional support, and social stimulation;

F. observing and evaluating home safety practices and seeking to improve these practices where appropriate; and

G. performing essential errands and shopping.

Subp. 24. **Hospital.** "Hospital" has the definition given in Minnesota Statutes, section 144.696, subdivision 3.

Subp. 25. **Individual service plan.** "Individual service plan" means the written plan of a community service or a combination of community services designed to meet the health and social needs of an applicant or nursing home resident screened according to part 9505.2430. The individual service plan is the plan of care referred to in Minnesota Statutes, section 256B.091.

Subp. 26. **Individual treatment plan.** "Individual treatment plan" means the written treatment plan of care for providing personal care and home health aide services under part 9505.2475 to an ACG client.

Subp. 27. **Informal caregivers.** "Informal caregivers" means family, friends, neighbors, or others who provide services and assistance to the elderly without the sponsorship of an agency or organization.

Subp. 28. **Local agency.** "Local agency" means the county or multicounty agency that is required under Minnesota Statutes, section 256B.05, to administer the medical assistance program.

Subp. 29. **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. 30. **Mental illness.** "Mental illness" means an illness as defined in Minnesota Statutes, section 245.462, subdivision 20, clause (2).

Subp. 31. **Nursing home.** "Nursing home" means a facility licensed under Minnesota Statutes, chapter 144A or sections 144.50 to 144.56, that is certified to participate in the medical assistance program as a skilled nursing facility or an intermediate care facility. This definition includes boarding care homes.

Subp. 32. **Nursing home resident.** "Nursing home resident" means a person who resides, and expects to continue to reside, in a nursing home for more than 30 days. For purposes of parts 9505.2390 to 9505.2500, "nursing home resident" does not include a person who is in a nursing home for respite care.

Subp. 33. **Personal care services.** "Personal care services" means services meeting the requirements of part 9505.2465.

Subp. 34. **Personal care assistant.** "Personal care assistant" means a person who provides personal care services under part 9505.2465 and meets the training requirements of part 9505.2465, subpart 2.

Subp. 35. **Person with mental retardation or related conditions.** "Person with mental retardation or related conditions" means a person as defined in part 9525.0015, subpart 20.

Subp. 36. **Physician.** "Physician" means a person who is authorized to practice medicine under Minnesota Statutes, chapter 147.

Subp. 37. **Preadmission screening.** "Preadmission screening" means the activities performed by a preadmission screening team under Minnesota Statutes, section 256B.091, and parts 9505.2390 to 9505.2500. This definition does not include the activities of teams authorized under Minnesota Statutes, section 256B.092, and established in parts 9525.0015 to 9525.0165 and under the Minnesota Comprehensive Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486.

Subp. 38. **Preadmission screening document.** "Preadmission screening document" means the document required in part 9505.2495, subpart 1, and supplied by the commissioner.

Subp. 39. **Preadmission screening team.** "Preadmission screening team" means the team authorized in Minnesota Statutes, section 256B.091, and required by part 9505.2410, to assess the financial, health, and social needs of an applicant or a nursing home resident.

Subp. 40. **Primary caregiver.** "Primary caregiver" means the informal caregiver who customarily provides care to the ACG client and cooperates with the case manager in assuring the provision of services by the formal caregivers.

Subp. 41. **Public health nurse.** "Public health nurse" means a registered nurse certified by the Minnesota Department of Health as a public health nurse under Minnesota Statutes, section 145A.02, subdivision 18, and employed by a local board of health under Minnesota Statutes, section 145A.10, subdivision 1.

Subp. 42. **Public health nursing services.** "Public health nursing services" means the nursing program provided by a board of health under Minnesota Statutes, section 145A.10, subdivision 1.

Subp. 43. **Reassessment.** "Reassessment" means the reevaluation of an ACG client's financial, health, and social needs under part 9505.2455, subparts 11 and 12.

Subp. 44. **Recipient.** "Recipient" means a person who has been determined by the local agency to be eligible for medical assistance under parts 9505.0010 to 9505.0150.

Subp. 45. **Registered nurse.** "Registered nurse" means a person licensed under Minnesota Statutes, section 148.211.

Subp. 46. **Representative.** "Representative" means a person appointed by the court as a guardian or conservator under Minnesota Statutes, sections 252A.01 to 252A.21 or 525.539 to 525.6198 or a parent of a child under age 18 unless the parent's parental rights have been terminated.

Subp. 47. **Rescreening.** "Rescreening" means the completion of the activities in part 9505.2435, subpart 3, after an initial preadmission screening.

Subp. 48. **Resident class.** "Resident class" refers to the case mix classification required under Minnesota Statutes, section 256B.091, subdivision 2, and assigned to a person as required under parts 9549.0058, subpart 2, and 9549.0059.

Subp. 49. **Resident day.** "Resident day" means a day for which nursing services in a nursing home are rendered or a day for which a nursing home bed is held.

Subp. 50. **Respite care services.** "Respite care services" means short term supervision, assistance, and care provided to an ACG client due to the temporary absence or need for relief of the ACG client's primary caregiver. Respite care services may be provided in the client's home or in a facility approved by the state such as a hospital, nursing home, foster home, or community residential facility.

Subp. 51. **Room and board costs.** "Room and board costs" means costs associated with providing food and shelter to a person, including the directly identifiable costs of:

A. private and common living space;

B. normal and special diet food preparation and service;

C. linen, bedding, laundering, and laundry supplies;

D. housekeeping, including cleaning and lavatory supplies;

E. maintenance and operation of the building and grounds, including fuel, electricity, water, supplies, and parts and tools to repair and maintain equipment and facilities; and

F. allocation of salaries and other costs related to items A to E.

Subp. 52. **Skilled nursing service.** "Skilled nursing service" refers to the term described in Code of Federal Regulations, title 42, section 405.1224.

Subp. 53. **Social worker.** "Social worker" means a person who has met the minimum qualifications of a social worker under the Minnesota Merit System or a county civil service system in Minnesota.

Subp. 54. **Unscreened applicant.** "Unscreened applicant" means an applicant for whom preadmission screening has not been completed under parts 9505.2390 to 9505.2500.

Subp. 55. **Waiver.** "Waiver" means the approval given by the United States Department of Health and Human Services which allows the state to pay for home and community based services authorized under Code of Federal Regulations, title 42, section 441, subpart G. The term includes all amendments to the waiver including any amendments made after the effective date of parts 9505.2395 to 9505.2500, as approved by the United States Department of Health and Human Services.

Subp. 56. **Working day.** "Working day" means the hours of a day, excluding Saturdays, Sundays, and holidays, when a local agency is open for business.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2396 COMPUTATION OF TIME INTERVALS TO MEET NOTICE REQUIREMENTS.

For purposes of parts 9505.2390 to 9505.2500, a required time interval to meet notice requirements must be computed to exclude the first and include the last day of the prescribed interval of time. The term "day" includes Saturday, Sunday, and holidays unless it is modified as "working day."

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2400 PREADMISSION SCREENING REQUIREMENT.

Subpart 1. **Coverage.** The preadmission screening team established by the local agency must complete the preadmission screening of all applicants except individuals who are exempt under subpart 2 and the preadmission screening of current nursing home residents who request a screening. The preadmission screening team shall complete the screening as specified in part 9505.2425, except in the cases of persons with mental retardation or related conditions. Persons with mental retardation or related conditions must be provided services according to parts 9525.0015 to 9525.0165. Persons with mental illness must be provided services according to the Minnesota Comprehensive Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486.

Subp. 2. **Exemptions.** The following individuals are exempt from the requirement of subpart 1:

A. a nursing home resident who transfers from one nursing home located within Minnesota directly to another nursing home located within Minnesota, regardless of the location of either nursing home;

B. a nursing home resident who is admitted to a hospital from a nursing home and who returns to a nursing home;

C. a nursing home resident who changes certified levels of care within the same nursing home;

D. an applicant for whom preadmission screening was completed within the previous three months;

E. an applicant who has been screened and who is currently receiving ACG services;

F. an applicant who has been screened and who is currently receiving services from a certified home health agency;

G. an applicant who is not eligible for medical assistance and whose length of residency in a nursing home is expected to be 30 days or less as determined under part 9505.2420, subpart 4;

H. an applicant whose nursing home care is paid for indefinitely by the United States Veterans Administration;

I. an applicant who enters a nursing home administered by and for the adherents of a recognized church or religious denomination described in Minnesota Statutes, section 256B.091, subdivision 4; and

J. an applicant to a nursing home described in Minnesota Statutes, section 256B.431, subdivision 4, paragraph (c).

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2405 INFORMATION REGARDING AVAILABILITY OF PREADMISSION SCREENING.

The local agency must annually publish a notice that preadmission screening is available to persons in the area served by the local agency. At a minimum, the notice must appear in the newspaper that has the largest circulation within the geographic area served by the local agency. The notice must:

A. explain the purpose of preadmission screening as stated in Minnesota Statutes, section 256B.091, subdivision 1;

B. instruct the public how to contact the preadmission screening team; and

C. state who is subject to and who may request preadmission screening under Minnesota Statutes, section 256B.091, subdivisions 2 and 4, and part 9505.2400.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2410 ESTABLISHMENT OF PREADMISSION SCREENING TEAM.

Subpart 1. **Establishment.** A local agency must establish at least one preadmission screening team to complete preadmission screening of applicants and nursing home residents. In addition, a local agency may contract with a nonprofit hospital to perform the functions of a preadmission screening team under part 9505.2413 for applicants being discharged from the hospital. If a nonprofit hospital performs the functions of a preadmission screening team under contract with a local agency, the hospital's discharge planner shall not be a member of the team unless the applicant is a person being discharged from the hospital. If a nonprofit hospital does not have a contract with the local agency to perform the functions of a screening team, the hospital's discharge planner may be present at the preadmission screenings and may participate in the discussions but not in making the screening team's recommendations.

Subp. 2. **Composition of preadmission screening team.** A preadmission screening team must be composed as specified in items A to C.

A. The preadmission screening team must include a social worker and a public health nurse. The team must also include the applicant's or nursing home resident's physician if the physician chooses to participate.

B. The social worker of the local agency's preadmission screening team must be employed by or under contract with the local agency and must be designated by name as a member of the preadmission screening team.

C. If a local agency has a human services board organized under Minnesota Statutes, sections 402.01 to 402.10, the local agency must designate by name the public health nurse member of the preadmission screening team. If a local agency does not have a human services board organized under Minnesota Statutes, sections 402.01 to 402.10, the local agency must contract with the board of health organized under Minnesota Statutes, section 145.913, or a public or nonprofit agency under contract with the local agency to provide public health nursing services to provide the public health nurse member of the preadmission screening team. The local board of health or a public or nonprofit agency under contract with the local agency to provide public health nursing services must designate by name the public health nurse member of a preadmission screening team.

Subp. 3. **Number of preadmission screening team members present at screening.** Except as provided in subpart 5, the social worker and the public health nurse designated as members of the preadmission screening team must be present at a preadmission screening. The applicant's or nursing home resident's physician may be present if the physician chooses to participate in the preadmission screening.

Subp. 4. **Physician notification of preadmission screening.** The local agency must notify the physician of the applicant or nursing home resident being screened, by telephone, of the date, time, and place the person's preadmission screening is to take place. The telephone notice must be made on the day that the preadmission screening team schedules the screening. The notice must state the physician's right to participate as a member of the preadmission screening team. No later than ten working days after the telephone notice, the local agency must send the physician a written notice that contains the information given in the telephone notice.

Subp. 5. **Preadmission screening by public health nurse.** Preadmission screening may be completed by the public health nurse member of the team, in consultation with the social worker, for applicants who are being admitted to a nursing home from a hospital and who are not eligible for medical assistance under parts 9505.0010 to 9505.0150. For the purpose of this subpart, "consultation" means a meeting or telephone conversation between the public health nurse and the social worker that takes place after the public health nurse has completed the preadmission screening. The purpose of the consultation is to discuss the assessment, the recommendation, and, as appropriate, the applicant's individual service plan or the applicant's plans for discharge from the nursing home.

Subp. 6. **Physician consultant to preadmission screening team.** A local agency must designate a physician who practices within the local agency's service area to serve as a consultant to the preadmission screening teams designated under subpart 2.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2413 CONTRACTS FOR PREADMISSION SCREENING TEAM MEMBERS FOR APPLICANTS DISCHARGED FROM HOSPITALS.

The local agency may contract with a nonprofit hospital to provide one or both members of a preadmission screening team to screen applicants being discharged from the nonprofit hospital and to make recommendations for the

screened applicants about nursing home admission and community services necessary for the applicant's individual service plan. The contract between the local agency and the nonprofit hospital must:

A. set beginning and ending dates of the contract;

B. specify the duties and responsibilities of the local agency and the nonprofit hospital;

C. specify that a member of the preadmission screening team to be provided by the hospital must be a discharge planner;

D. designate by name the person or persons to be provided by the hospital;

E. require the designated preadmission screening team member or members to comply with parts 9505.2390 to 9505.2500;

F. specify that the member or members of the preadmission screening team under contract will screen only applicants being discharged from that nonprofit hospital;

G. designate the person employed by the hospital and the person employed by the local agency who are responsible for proper performance under the contract;

H. state that the nonprofit hospital must complete a preadmission screening for an applicant before the applicant's discharge from the nonprofit hospital;

I. require that a member of the nonprofit hospital's screening team have no direct or indirect financial or self-serving interest in a nursing home or other referral such that it would not be possible for the member to consider each case objectively;

J. specify the amount the local agency must pay the nonprofit hospital for carrying out the terms of the contract;

K. specify the person employed by the hospital who is responsible for implementing appropriate data practices; and

L. specify reports and records to be kept by the nonprofit hospital.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2415 HOSPITAL NOTICE REQUIREMENTS.

Subpart 1. **Notification of preadmission screening team.** Except as indicated under subpart 2, the discharge planner of a hospital must notify the preadmission screening team about a hospital patient who is an applicant. Oral and written notices must be given. The oral notice must be given to the preadmission screening team at least three working days before discharge of the applicant. The hospital must document the oral notice by sending the preadmission screening team a written notice within ten working days after the oral notice. The notice must:

A. provide the name of the applicant;

B. provide the name of the nursing home that the applicant is considering;

C. provide the applicant's primary diagnosis;

D. indicate the interval in which the applicant is expected to be discharged from the nursing home. The intervals are: less than 30 consecutive days; 30 days but less than three months; three months but less than six months; or six months or more;

E. indicate that the discharge planner gave information to the applicant about the purpose of preadmission screening and community services; and

F. indicate if the discharge planner wants to participate in the preadmission screening.

Subp. 2. **Exception to notice required of hospital.** If the applicant is in the hospital for less than three working days and preadmission screening is not completed, the hospital may discharge the applicant to a nursing home, but the hospital discharge planner must contact the preadmission screening team by telephone or in person before the applicant's discharge and complete the notice required under subpart 1.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2420 TIME REQUIREMENTS FOR PREADMISSION SCREENING.

Subpart 1. **General time requirements.** Except as provided in subparts 2 to 6, the local agency must schedule a preadmission screening within five working days of receiving a request for the preadmission screening from an applicant or an applicant's representative. Except as provided in subparts 2 to 6, the preadmission screening must be completed within the period of ten working days following the applicant's request for preadmission screening.

Subp. 2. **Preadmission screening of hospital patients.** Notwithstanding subpart 1, the local agency must complete the preadmission screening of an applicant who is a hospital patient within three working days of receiving oral notice from the discharge planner under part 9505.2415, subpart 1. However, the local agency may delay the preadmission screening of an applicant who is a hospital patient when, based on information given in the oral notice, the preadmission screening cannot be completed before discharge from the hospital and the applicant's discharge plan indicates that the applicant must be admitted to a nursing home. If preadmission screening is delayed and the local agency and the nursing home are located in the same county, the local agency must notify the nursing home orally and in writing of the scheduled date for the preadmission screening and perform the preadmission screening within ten working days after the applicant's admission to the nursing home.

If preadmission screening is delayed and the nursing home and the local agency are located in different counties, the local agency of the county in which the nursing home is located must be responsible for the preadmission screening. The local agency of the county in which the hospital is located must send an oral and a written notice of the applicant's discharge plan to the local agency in the county where the nursing home is located. Oral notice must be given on the day that the local agency of the county in which the hospital is located delays preadmission screening. The written notice must be sent within ten working days after the oral notice. The written notice must include a copy of the delay of screening form completed by the local agency of the county in which the hospital is located and a copy of the hospital's discharge notice. The preadmission screening team from the local agency in the county where the nursing home is located must then notify the nursing home orally and in writing of the scheduled date for the preadmission screening and perform the preadmission screening within ten working days after the applicant's admission to the nursing home.

Subp. 3. **Emergency admission.** When preadmission screening is not completed due to an emergency admission, the procedures in items A to C must be followed.

A. The attending physician must certify the reason for the emergency in the applicant's medical record.

B. The nursing home must orally notify the preadmission screening team within two working days after the date of the emergency admission.

C. The preadmission screening team must complete the preadmission screening of the applicant within ten working days of the date of the applicant's admission to the nursing home or within ten working days after receiving the oral referral for preadmission screening, whichever is earlier.

Subp. 4. **Thirty day exemption from preadmission screening.** A local agency must grant a 30 day exemption from preadmission screening to applicants who are not eligible for medical assistance if the requirements in items A and B are met.

A. The nursing home must notify the local agency of the applicant's admission no later than the day of the applicant's admission to the nursing home. The notice must include information stating that the requirements of item B have been met.

B. The attending physician must certify in the applicant's medical record in the nursing home that the applicant's expected length of stay in the nursing home will be 30 consecutive days or less.

The preadmission screening team of the local agency that has determined that the applicant's request for a 30 day exemption from preadmission screening meets the requirements in items A and B must complete and send the nursing home a form supplied by the commissioner authorizing the 30 day exemption and at the same time must send a copy of the form to the applicant.

The nursing home must provide an update to the preadmission screening team before or on the 30th day of the applicant's stay if the applicant will continue to live in the nursing home for more than 30 consecutive days. The local agency must complete preadmission screening within ten working days after the 30th day unless the applicant is discharged within these ten working days, does not return to the nursing home, and does not become an applicant to a different nursing home.

Subp. 5. **Nursing home applicant admitted to a hospital from a nursing home before completion of preadmission screening.** The local agency must complete preadmission screening of a nursing home applicant who has been admitted to a nursing home within the periods required under subparts 1 to 4 unless the nursing home applicant is admitted to a hospital during these periods. If a nursing home applicant is admitted to a hospital during the periods under subparts 1 to 4, the preadmission screening time requirements begin again on the date of readmission to the nursing home.

Subp. 6. **Applicant from another state.** When an applicant from another state is admitted to a nursing home in Minnesota, the nursing home must notify the preadmission screening team within two working days after the date of the admission. The notice may be oral or written. The preadmission screening team must then complete the preadmission screening of the applicant within ten working days after the date of admission to the nursing home.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2425 SCREENING AND ASSESSMENT PROCEDURES REQUIRED DURING PREADMISSION SCREENING.

Subpart 1. **General requirements.** The preadmission screening team must assess the health and social needs of the applicant or nursing home resident being screened using the assessment form provided by the commissioner. The preadmission screening team must carry out the responsibilities specified in subparts 2 to 14 and the duties listed in part 9505.0295, subpart 3, item C. The preadmission screening team must ask whether the person being screened has been determined eligible for or is receiving medical assistance and must give a person whose eligibility for medical assistance has not been determined information about making a medical assistance application.

Subp. 2. **Assessment interview.** The preadmission screening team must conduct the assessment in a face to face interview with the person being screened and the person's representative, if any.

Subp. 3. **Information given to person being screened by screening team during**

preadmission screening. The preadmission screening team must give the person being screened or the person's representative the form or forms supplied by the commissioner containing the information specified in items A to E:

A. the purpose of the preadmission screening and alternative care grant program under Minnesota Statutes, section 256B.091;

B. the person's freedom to accept or reject the recommendation of the preadmission screening team;

C. the person's right to confidentiality under the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13;

D. the person's right to appeal the preadmission screening team's recommendation under part 9505.2500 and Minnesota Statutes, sections 256.045, subdivisions 2 and 3 and 256B.091, subdivision 5; and

E. if the person is not a recipient, the right of the person and the person's spouse to retain liquid assets up to the amount specified in Minnesota Statutes, sections 256B.14, subdivision 2; 256B.17; and 256B.48.

The preadmission screening team must document compliance with this subpart by signing and placing in the local agency's records of the person being screened the forms supplied by the commissioner that state the required information was given to the person being screened.

Subp. 4. **Access to medical records.** The preadmission screening team must ask the person being screened or the person's representative to sign forms necessary to authorize the team's access to the person's medical records. Furthermore, a nursing home or a hospital's discharge planner that conducts a preadmission screening must ask the person being screened or the person's representative to sign forms necessary to authorize the team's access to information that is needed to complete preadmission screening for the person. If the person or the person's representative agrees to sign the forms, the authorization must be completed as prescribed in subpart 14.

Subp. 5. **Preadmission screening team recommendations.** After completing the assessment form required in subpart 1, the preadmission screening team must offer the person being screened or the person's representative the most cost effective alternatives available to meet the person's needs and must recommend one of the choices specified in items A to E.

A. The preadmission screening team must recommend admission to a nursing home for an applicant or continued stay for a nursing home resident when the assessment indicates that the applicant or nursing home resident requires community services that are not available or that the anticipated cost of providing the required community services would exceed the annual monthly statewide average payment of the resident class under parts 9549.0050 to 9549.0059 that would be applicable to the person being screened if the person were placed in a nursing home, calculated from the payments made for that resident class in the previous fiscal year.

B. The preadmission screening team must recommend use of community services when the assessment indicates that the community services needed by the person are available and the anticipated cost of providing the community services is less than the total annual statewide monthly average payment of the resident class under parts 9549.0050 to 9549.0059 that would be applicable to the person if the person were placed in a nursing home, calculated from the payments made for that resident class in the previous fiscal year.

C. The preadmission screening team must recommend that the person live in the community without community services if the assessment indicates that the person does not need either admission to a nursing home or community services.

D. A preadmission screening team that has reason to believe that a person being screened has or may have a diagnosis of mental retardation or

related conditions must refer the person for services including screening, development of the individual service plan, and case management services according to parts 9525.0015 to 9525.0165.

E. A preadmission screening team that has reason to believe that a person being screened has been diagnosed or may be diagnosed as mentally ill must refer the person for a diagnostic assessment as defined in Minnesota Statutes, section 245.462, subdivision 9. If the person is determined by the diagnostic assessment to have serious and persistent mental illness as defined in Minnesota Statutes, section 245.462, subdivision 20, and the person chooses community services under an ACG, the preadmission screening team must establish the individual service plan as required in part 9505.2430, subpart 4, and assure the assignment of a case manager as specified in part 9505.2430, subpart 6. The case manager shall incorporate the person's individual community support plan as defined in Minnesota Statutes, section 245.462, subdivision 12, into the person's individual service plan and shall coordinate the person's services that are specified in the Comprehensive Mental Health Act, Minnesota Statutes, sections 245.461 to 245.486.

Subp. 6. **Required application for ACG services.** If the person being screened chooses to remain in the community with community services the preadmission screening team must request the person or the person's representative to sign an application for the community services under the ACG. To be eligible to receive the community services under the ACG, the person being screened or the person's representative must sign the application. The application shall be on a form prescribed by the commissioner.

Subp. 7. **Use of directory of services during preadmission screening.** The preadmission screening team must use a directory of services provided by the local agency during the preadmission screening in determining the individual service plan of a person being screened. The local agency must make a directory of services available to the preadmission screening team, the person being screened, and other persons present at a screening. The local agency may compile its own directory of services or use a directory prepared by a community resource. In either event, the directory must be one that is updated annually.

Subp. 8. **Notification of preadmission screening team recommendation.** The preadmission screening team must give or send a written notice stating the team's recommendation to the person being screened, the person's representative, if any, and the person's physician. The preadmission screening team must also send the written notice to the county of financial responsibility. Both types of notice must be given or sent within ten working days after the date of the request for the preadmission screening.

Subp. 9. **Individual service plan.** The preadmission screening team must develop an individual service plan according to part 9505.2430 when the person or the person's representative chooses to use community services.

Subp. 10. **Submittal of ACG client information to county of financial responsibility.** If the county of service is different from the county of financial responsibility for an ACG client, the county of service must submit client information to the county of financial responsibility for approval of the individual service plan. The information must include items A to D:

A. the original individual service plan;

B. the original signed application if required under subpart 6;

C. the original preadmission screening document; and

D. a copy of the completed financial information form required in part 9505.2455, subpart 1, item C.

Subp. 11. **County of financial responsibility review of individual service plan.** The county of financial responsibility for an ACG client under part 9505.2455, subpart 3, must approve or reject the proposed individual service plan under items A to E and part 9505.2455, subpart 2.

A. If the costs of ACG services, together with the costs of skilled nursing services provided by public health nursing services that are reimbursable under medical assistance, if applicable, do not exceed the cost limitations in subpart 5, item B, the county of financial responsibility must approve the proposed individual service plan. If the cost of ACG services together with the costs of skilled nursing services provided by public health nursing services that are reimbursable under medical assistance exceeds the cost limitations in subpart 5, item B, the county of financial responsibility must reject the individual service plan. Rejection of an individual service plan by the county of financial responsibility shall occur only if cost limitations of subpart 5, item B, are not met. If the county of financial responsibility and the county of service are the same, the county shall not reject the individual service plan prepared by the county's preadmission screening team if the individual service plan falls within the cost limitations of subpart 5, item B.

B. The county of financial responsibility must orally notify the preadmission screening team of the approval or rejection of the individual service plan within three working days after receiving the plan from the county of service. The county of financial responsibility must mail a written notice to the preadmission screening team within ten working days after receiving the individual service plan.

C. If the individual service plan is approved by the county of financial responsibility, the county of service must implement the plan upon oral notice of approval from the county of financial responsibility.

D. If the individual service plan is rejected by the county of financial responsibility because it exceeds the cost limitations in subpart 5, item B, the oral and written notice of rejection sent to the preadmission screening team must explain the reasons for the rejection and define the corrections needed to obtain approval. The preadmission screening team must develop a revised individual service plan for an ACG client whose initial individual service plan was rejected by the county of financial responsibility. The preadmission screening team must send the revised individual service plan to the county of financial responsibility within ten days after receiving the oral rejection.

E. If the revised individual service plan includes ACG services that meet the cost limitations in subpart 5, item B, the county of financial responsibility must approve the individual service plan and orally notify the preadmission screening team of the approval within three working days after receiving the revised plan. The county of financial responsibility must send a written notice of approval to the preadmission screening team within ten working days after receiving the revised plan.

Subp. 12. **Sending individual service plan to county of service.** If the county of financial responsibility approves an individual service plan, the preadmission screening team must send the written individual service plan to the county of service within ten working days after the approval.

Subp. 13. **Resident class assessment.** The preadmission screening team must complete the resident class assessment of the applicant required under parts 9549.0058 and 9549.0059 for an applicant who is not exempt from preadmission screening under part 9505.2400, subpart 5, or 9549.0059, subpart 1, item A, subitem (2). The resident class assessment shall be completed concurrently with preadmission screening performed within the time requirements of part 9505.2420.

Subp. 14. **Authorization to release information.** When a preadmission screening team, nursing home, or hospital's discharge planner asks a person being screened or the person's representative to sign forms needed to have access to information necessary to complete the preadmission screening, the following information must be on the form above the person's signature:

A. the person's name;

B. the date;

C. the information authorized;

D. who is authorized to give the information;

E. to whom the information is to be given;

F. the information's use during the screening to determine the appropriateness of nursing home admission or continued nursing home placement or use of community services for the person; and

G. the date of expiration of the authorization.

A separate form must be completed and signed for each authorization of access to a medical record. The period of the authorization must not exceed one year.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2426 APPLICANT'S AND NURSING HOME RESIDENT'S RIGHT TO CHOOSE COMMUNITY SERVICES.

After completion of the preadmission screening required under part 9505.2425, subpart 5, or the rescreening required under part 9505.2435, the applicant, nursing home resident, or the representative of the applicant or nursing home resident shall decide whether to accept or reject the recommendations of the preadmission screening team. If the applicant, nursing home resident, or the representative of the applicant or nursing home resident who is eligible for ACG services decides to receive the ACG services identified in his or her individual service plan, the applicant, nursing home resident, or the representative of the applicant or nursing home resident shall have the freedom to choose among the ACG providers under contract with the local agency to provide the identified ACG services.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2430 ESTABLISHMENT OF INDIVIDUAL SERVICE PLAN.

Subpart 1. **Individual service plan required.** The preadmission screening team must establish an individual service plan for each applicant or nursing home resident who requests preadmission screening and who has been assessed under part 9505.2425, and who has chosen community services except persons referred under part 9505.2425, subpart 5, items D and E. The preadmission screening team must consult the applicant or nursing home resident or the person's representative in establishing the plan. Additionally, the preadmission screening team must ask the applicant or the nursing home resident or the representative of the applicant or nursing home resident whether he or she chooses to have other persons consulted about the plan. The preadmission screening team must consult the persons that the applicant, nursing home resident, or the representative of the applicant or nursing home resident has designated by name to be consulted about the plan.

Subp. 2. **Request for information about eligibility for medical assistance or 180 day eligibility determination.** The preadmission screening team must ask the applicant, nursing home resident, or the representative of the applicant or nursing home resident whether the applicant or nursing home resident receives medical assistance, is a recipient, or would be eligible to receive medical assistance within 180 days after admission to a nursing home. If the preadmission screening team has reason to believe the person being screened would be eligible to receive medical assistance within 180 days after admission to a nursing home, the preadmission screening team must estimate what the person's financial eligibility would be 180 days after admission using a form prescribed by the commissioner.

Subp. 3. **Individual service plan for a person not eligible for an ACG.** The individual service plan prepared by the preadmission screening team for a person being screened who is not eligible for an ACG must document compliance with items A to D:

A. the preadmission screening team determined that the person is not eligible for community services funded by an ACG under part 9505.2455, subpart 2;

B. the preadmission screening team discussed with the person the community services identified as needed in the assessment under part 9505.2425;

C. the preadmission screening team told the person what information is available in the directory of services; and

D. the preadmission screening team gave a copy of the individual service plan to the person.

Subp. 4. **Individual service plan for a person who is eligible for an ACG.** The individual service plan prepared by the preadmission screening team for a person being screened who is eligible for an ACG must document compliance with items A to D. The person or the person's representative and a member of the preadmission screening team must sign the individual service plan. The preadmission screening team must give the person or the person's representative a copy of the individual service plan.

A. The preadmission screening team has determined that the person being screened is eligible for community services funded by an ACG under part 9505.2455, subpart 2.

B. Recommendation of an individual service plan that identifies:

(1) any treatment prescribed by the individual's attending physician as necessary and any follow-up treatment as necessary;

(2) the community services needed by the person;

(3) the available providers of the identified community services including ACG service providers under contract with or employed by the local agency and informal support networks such as family, friends, volunteers, and church groups;

(4) the needed frequency of the services;

(5) the initial date on which each service must begin;

(6) the funding sources for the community services;

(7) the estimated cost of skilled nursing services provided by public health nursing services;

(8) the total cost of the ACG services;

(9) an estimate of the total cost of the community services; and

(10) the name of the case manager assigned by the county of service.

C. The preadmission screening team allowed the person or the person's representative to choose among the available providers listed in the directory of services who are under contract with or employed by the county of service.

D. The preadmission screening team reviewed the individual service plan with the person or the person's representative at the time of the completion of the preadmission screening.

Subp. 5. **Sliding fee information.** The preadmission screening team must tell the person being screened who would be eligible to receive medical assistance within 180 days after admission to the nursing home about the amount of the sliding fee that the person is required to pay for alternative care grant services according to the sliding fee schedule established by the commissioner under Minnesota Statutes, section 256B.091, subdivision 8, if the person will be receiving ACG services under an individual service plan developed under subpart 4.

Subp. 6. **Assignment of case manager.** Upon completion of the individual

service plan, the local agency of the county of service shall assign a case manager to implement the individual service plan prepared for an ACG client under subpart 4.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2435 RESCREENING.

Subpart 1. **Applicability.** The preadmission screening team must conduct a rescreening when the local agency receives either a written or oral request under subpart 2 suggesting that a recommendation resulting from a rescreening would differ from the recommendation given by the preadmission screening team at the last preadmission screening. Rescreenings must be conducted for all persons who meet the above criteria except ACG clients.

Subp. 2. **Request for rescreening.** The applicant, nursing home resident, or person's representative must submit a request to the local agency to be rescreened when the applicant or nursing home resident meets the criteria in subpart 1. The request may be oral or written and must state the date and location of the person's last preadmission screening and any changes in the person's health and social needs that have occurred since the last screening.

Subp. 3. **Rescreening procedure.** The rescreening must be conducted according to the procedures for preadmission screening in parts 9505.2390 to 9505.2450.

Subp. 4. **Reimbursement for rescreening.** Reimbursement to the local agency for rescreening must be the same as reimbursement of a preadmission screening under parts 9505.2440 and 9505.2445.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2440 PREADMISSION SCREENING RATE.

For rate years beginning on January 1 following the effective date of parts 9505.2390 to 9505.2500, the commissioner shall annually establish the maximum statewide rate allowed for reimbursement of preadmission screening and the maximum reimbursement rate of a local agency for preadmission screening. The maximum statewide rate and the maximum reimbursement rate of a local agency shall not exceed the prior year's rate by more than the percentage change between the two previous Junes in the all urban consumer price index (CPI-U) for Minneapolis-Saint Paul new series index (1967=100) as published by the Bureau of Labor Statistics, United States Department of Labor. The CPI-U is incorporated by reference and is available from the Minitex interlibrary loan system. The CPI-U is subject to frequent change. By January 15 of each year, the commissioner must send a written notice of the maximum reimbursement rate to a local agency.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2445 REIMBURSEMENT FOR PREADMISSION SCREENING.

Subpart 1. **County of financial responsibility for preadmission screening of a recipient.** The county of financial responsibility for a recipient is as defined in Minnesota Statutes, chapter 256G.

Subp. 2. **Medical assistance reimbursement for preadmission screening of a recipient.** The medical assistance program must reimburse a local agency for the preadmission screening of a recipient if the local agency has complied with the time requirements of part 9505.2420. The local agency of the county of financial responsibility shall submit invoices for reimbursement of preadmission screening costs for a recipient to the department at the times and as required in part 9505.0450, subpart 2.

Subp. 3. **Reimbursement for preadmission screening of persons who are not recipients.** Reimbursement for the preadmission screening of persons who are not recipients must be made according to Minnesota Statutes, section 256B.091, subdivision 4.

Subp. 4. **Required local agency estimate of the cost and number of preadmission screenings of persons other than recipients.** Annually by February 15, a local agency must prepare and submit to the department an estimate for the following state fiscal year of the number and costs of preadmission screenings of persons who are not recipients and who will be applicants or nursing home residents for whom the county will provide preadmission screening.

Subp. 5. **Local agency's allocation of cost estimate to a nursing home.** Using the annual estimate of the number and costs of preadmission screenings required in subpart 4, a local agency must calculate the monthly amount to be paid by a nursing home to the local agency for preadmission screenings performed by the local agency for the following state fiscal year. The amount must be based on the nursing home's percentage of the number of licensed beds in nursing homes in the county of the local agency. The local agency must submit the amount to the nursing home by February 15.

Subp. 6. **Reconciliation of estimate required in subpart 4 with actual cost.** Annually by January 15, the department shall reconcile its estimated cost of a nursing home's number of preadmission screenings of persons who are not recipients as calculated under subpart 4 with the actual cost of preadmission screenings of these persons performed in the previous state fiscal year. The department shall notify the local agency of the amount of the overpayment or underpayment that the local agency must use in completing the calculation required under subpart 4.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2450 PENALTIES.

Subpart 1. **Penalty to nursing home for admission of an unscreened applicant.** A nursing home that admits an unscreened applicant who is subject to the preadmission screening requirement under part 9505.2400 or that fails to notify the preadmission screening team about an emergency admission as required under part 9505.2420, subpart 3, item B, is subject to the penalties in items A to C.

A. If the applicant is a recipient, the nursing home must not be reimbursed by medical assistance for the applicant's resident days that preceded the date of completion of the applicant's assessment by the preadmission screening team under part 9505.2425. Furthermore, the nursing home must not bill an unreimbursed resident day to the unscreened applicant who is a recipient.

B. If the applicant is not a recipient, the nursing home must not bill the applicant for the applicant's resident days that preceded the date of completion of the applicant's assessment by the preadmission screening team under part 9505.2420.

C. The nursing home must include an unreimbursed resident day in the nursing home's resident day total reported to the department for the purpose of rate calculation under parts 9549.0010 to 9549.0080.

Subp. 2. **Penalty to county of service for late screening.** A county of service required to act within the time requirements in part 9505.2420 that fails to act within the time requirements shall not receive reimbursement for the preadmission screening under part 9505.2445, subparts 2 and 3, from medical assistance in the case of a recipient or from the nursing home in the case of a person who is not a recipient. Under these circumstances, the county of service shall be solely responsible for the costs of the preadmission screening. Nevertheless, the county

of service must complete the preadmission screening as required in parts 9505.2400 and 9505.2425.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2455 ALTERNATIVE CARE GRANTS.

Subpart 1. **Preadmission screening determination of eligibility.** The preadmission screening team must determine if the applicant or nursing home resident is eligible for an ACG under the criteria in subpart 2. If the person being screened is eligible for an ACG, the preadmission screening team must:

A. determine the county of financial responsibility according to subpart 3;

B. determine the county of service; and

C. determine the amount of the fee to be paid by the person if the person would be eligible to receive medical assistance within 180 days after admission to a nursing home. The amount of the sliding fee must be determined according to the sliding fee schedule established by the commissioner under Minnesota Statutes, section 256B.091, subdivision 8, and on forms provided by the commissioner.

Subp. 2. **Eligibility criteria.** A person is eligible for an ACG if the person meets the criteria in items A to H:

A. the person has been screened by the preadmission screening team;

B. the person is 65 years or older;

C. the person is a recipient or is eligible for medical assistance under parts 9505.0010 to 9505.0150 or would be eligible to receive medical assistance within 180 days after admission to a nursing home;

D. the person would require nursing home care if community services were not available;

E. the person is an applicant who chooses to remain in the community and use community services or a nursing home resident who chooses to leave the nursing home and receive community services;

F. the person requires community services that cannot be provided by services funded by sources other than alternative care grants;

G. the person has completed an application for community services; and

H. the cost of an ACG is within the monthly limitation specified in subpart 8.

Subp. 3. **Determination of county of financial responsibility for alternative care grants.** The preadmission screening team must determine the county of financial responsibility for an ACG client according to item A or B.

A. The county of financial responsibility for an ACG client who is a recipient is the county as defined in Minnesota Statutes, chapter 256G.

B. When ACG services begin, the county of financial responsibility for an ACG client who would be eligible to receive medical assistance within 180 days after admission to a nursing home is the county of financial responsibility as defined in Minnesota Statutes, chapter 256G for medical assistance recipients.

Subp. 4. **Use of alternative care grants.** ACG services may be reimbursed through an ACG if the person is eligible under subpart 2 and if the services are identified as needed in the ACG client's individual service plan and if the services are subject to the rates established in part 9505.2490. However, reimbursement for respite care services is limited to payment for 30 days of service in one state fiscal year.

Subp. 5. **Supplies and equipment.** If the ACG client is a recipient and the supplies and equipment are covered services under part 9505.0310, the cost of

the supplies and equipment shall be paid as provided in the medical assistance program under parts 9505.0170 to 9505.0475 to the extent that reimbursement of the cost is not available from Medicare and a third party payer as defined in part 9505.0015, subpart 46. A local agency shall use ACG money to buy or rent care related supplies and equipment for an ACG client as specified in items A to C.

A. If the supplies and equipment are not covered services under part 9505.0310 or the ACG client is not a recipient and the cost of the supplies and equipment for the ACG client is not more than $100 per month, the local agency shall authorize the use of ACG funds.

B. If the supplies and equipment are not covered services under part 9505.0315 or the ACG client is not a recipient and the cost of the supplies and equipment exceeds $100 per month, the local agency must obtain prior authorization from the department to use ACG funds to pay the cost of the supplies and equipment. For purposes of this subpart, "prior authorization" means written approval and authorization given by the department to the local agency before the purchase or rental of the supply or equipment.

C. The department shall have the right to determine whether the supplies and equipment are necessary to enable the client to remain in the community. If the department determines that the supplies and equipment are necessary to enable the ACG client to remain in the community and if the cost of the supplies and equipment together with all other ACG services and skilled nursing services provided by public health nursing services is less than the limitation in subpart 8, the department shall authorize the use of the ACG funds to pay the cost.

Subp. 6. **Supervision costs.** The cost of supervising a home health aide or personal care assistant must be included in the rate for home health aide or personal care services, unless payment for the cost of supervision is included in the rate for skilled nursing service. If the cost of supervising a home health aide or personal care assistant is included in the rate for skilled nursing service, the cost must not be included in the payment for a home health aide or personal care assistant. The cost of supervising an alternative care grant service other than a personal care service or a health aide service must be included in the rate for the service.

Subp. 7. **Unallowable costs.** Alternative care grants must not be used:

A. to establish community services for which funding sources are available through other programs;

B. to pay for community services that can be reimbursed through other funding sources including Medicare and third party payers as defined in part 9505.0015, subpart 46;

C. to pay for room and board costs except for respite care provided outside of the ACG client's residence; or

D. to pay providers that are not under contract with the local agency under Minnesota Statutes, section 256B.091, subdivision 8.

Subp. 8. **Costs included within the monthly limitation of an ACG to an ACG client.** In a calendar month, the total cost of an ACG to an ACG client must not exceed the total statewide monthly average payment of the resident class to which the ACG client would be assigned under parts 9549.0050 to 9549.0059, calculated from the payments made for that resident class in the previous fiscal year. The following costs must be included in determining the total costs of an ACG:

A. cost of all ACG services;

B. cost of skilled nursing services provided by public health nursing services and reimbursable under parts 9505.0170 to 9505.0475; and

C. cost of supplies and equipment funded by an ACG.

Subp. 9. **Criteria for selection as an ACG provider.** A provider who provides ACG services must meet the criteria in items A and B.

A. The provider must be employed by or have contracted with the local agency to provide ACG services.

B. The provider must meet all licensure requirements and professional standards established in Minnesota Statutes, Minnesota Rules, and the Code of Federal Regulations that apply to the services provided.

Subp. 10. **Contract for ACG services.** If the local agency contracts with a provider under subpart 9, the contract must:

A. set beginning and ending dates for the term of the contract;

B. specify the duties and responsibilities of the local agency and the provider;

C. require the provider to comply with parts 9505.2390 to 9505.2500;

D. specify the amount that the local agency must reimburse the provider for the services;

E. specify reports and record retention required of the provider by the local agency;

F. specify the conditions under which the local agency shall terminate the provider's contract; and

G. specify documentation of an individual abuse prevention plan that complies with parts 9555.8000 to 9555.8500 if such a plan is required of the provider by Minnesota Statutes, section 626.557.

Subp. 11. **Reassessment of ACG clients.** A face to face reassessment of an ACG client must be conducted by the case manager at least once every six months after ACG services have begun. The case manager must also reassess an ACG client when the case manager determines that changes in the health and social needs or the financial status of the ACG client require revisions in the individual service plan. When an ACG client leaves the county of service and establishes residence in another Minnesota county, the case manager responsible for implementing the ACG client's individual service plan must notify the local agency of the other county about the client's change in residence and request the other county to assign a case manager and conduct a reassessment.

Subp. 12. **Record of reassessment.** At the time of an ACG client's reassessment, the case manager must complete an assessment form and give the ACG client an information form or forms supplied by the commissioner containing the information required in part 9505.2425, subpart 3, items C to E. The case manager must document in the ACG client's case record that the client received the required information. The ACG client's case record of reassessment shall contain at least the information in items A to G:

A. the completed assessment form;

B. the reason for the reassessment;

C. a redetermination of financial eligibility for the ACG client;

D. the names and relationship to the client of the persons consulted during the reassessment;

E. any revisions of the individual service plan that will occur in type, frequency, and cost of ACG services resulting from the reassessment;

F. a completed quality assurance and review (QA&R) form, as required by part 9549.0059, with an estimate of the client's resident class; and

G. a recomputed sliding fee for the client who would be eligible to receive medical assistance within 180 days after admission to a nursing home.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2458 CASE MANAGER ACTIONS TO ASSURE SAFETY AND HEALTH OF ACG CLIENT WHO IS A VULNERABLE ADULT.

A case manager who has reason to believe an ACG client who is a vulnerable adult is or has been subject to abuse or neglect as defined in Minnesota Statutes, section 626.557, subdivision 2, that occurs at the client's residence or the place where the client receives the ACG service shall immediately comply with the reporting and other actions required under Minnesota Statutes, section 626.557, and shall determine how to assure the client's health and safety during the local agency's investigation. The case manager shall determine whether to withdraw the services, work out another living arrangement for the client, or arrange for the services of another ACG provider. When the case manager receives the findings of the local agency's investigation, the case manager shall amend the ACG client's individual service plan as needed to assure the client's health and safety.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2460 LOCAL AGENCY SELECTION OF ACG PROVIDERS.

Subpart 1. **Public meeting to inform providers.** The local agency must hold an annual public meeting with possible providers of ACG services to inform providers about the criteria for provider selection as listed in subpart 4 and the date by which requests to be an ACG provider must be submitted to the local agency. The local agency may hold the annual public meeting at a time convenient to its schedule for completing service contracts to be included in its annual plan. The local agency must document that the notice required in subpart 2 was given and that the public meeting was held.

Subp. 2. **Notice of annual public meeting.** The local agency must place a notice of the public meeting required under subpart 1 in the newspaper that is the official newspaper designated by the county board of commissioners of the local agency under Minnesota Statutes, section 279.08. The notice must appear at least 14 days before the public meeting and must state the date, time, and place of the meeting, the type of services for which a need is anticipated, the criteria in subpart 3 for selection as an ACG provider, the date by which the local agency will complete its selection of ACG providers, and the name, telephone number, and address of the local agency's contact person who can provide information about the criteria for selection and contract terms.

Subp. 3. **Selection criteria.** The local agency must select providers for ACG contracts as required in Minnesota Statutes, section 256B.091, subdivision 8, using the criteria in items A to G and other criteria established by the local agency that are consistent with items A to G:

A. the need for the particular service offered by the provider;

B. the population to be served including the number of ACG clients, the length of time service will be provided, and the medical condition of the ACG clients;

C. the geographic area to be served;

D. the quality assurance methods to be used by the provider including compliance with required licensures, certifications, or standards and supervision of employees as required by parts 9505.2390 to 9505.2500;

E. the rate for each service or unit of service exclusive of county administrative costs;

F. evaluation of services previously or currently provided by the provider; and

G. the provider's previous compliance with contract provisions and future ability to comply with contract provisions including billing requirements, and terms related to contract cancellation and indemnification. The local agency

must evaluate the ACG services that it provides to ACG clients using the criteria in this subpart.

Subp. 4. **Written record of reason for not selecting a provider.** A local agency must keep a written record of the reason a provider who requests a contract to provide ACG services was not selected and must notify the provider of the reasons.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2465 STANDARDS FOR PERSONAL CARE SERVICES.

Subpart 1. **Definitions.** For purposes of this part, the following terms have the meanings given them.

A. "Personal care provider" means a home health agency that meets the requirements of subpart 5 and is under contract to the local agency to provide personal care assistants or a local agency licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47, or registered under Minnesota Statutes, section 144A.49.

B. "Personal care service" means a service listed in subpart 3 that is ordered by a physician and provided by a personal care assistant to an ACG client to maintain the ACG client in his or her residence.

Subp. 2. **Training requirements.** Personal care services must be provided by a personal care assistant who has successfully completed one of the training requirements in items A to E:

A. a homemaker or home health aide preservice training program using a curriculum recommended by the Minnesota Department of Health;

B. a nursing assistant training program or its equivalent for which competency as a nursing assistant is determined according to a test administered by the State Board of Vocational Technical Education;

C. an accredited educational program for registered nurses or licensed practical nurses;

D. a training program that provides the personal care assistant with skills required to perform the services specified in subpart 3; or

E. determination by the supervising registered nurse that the personal care assistant has, through training or experience, the skills required to perform the duties specified in subpart 3.

Subp. 3. **Personal care services.** The duties specified in items A to N are components of personal care services:

A. bowel and bladder care;

B. skin care done to maintain the health of the skin, including prophylactic routine and palliative measures such as exposure to air, use of nondurable medical equipment, application of lotions, powders, ointments, and treatments such as heat lamp and foot soaks;

C. range of motion exercises;

D. respiratory assistance;

E. transfers;

F. bathing, grooming, and hairwashing necessary for personal hygiene;

G. turning and positioning;

H. assistance with furnishing medication that is ordinarily self administered;

I. application and maintenance of prosthetics and orthotics;

J. cleaning equipment;

K. dressing or undressing;

L. assistance with food, nutrition, and diet activities;

M. accompanying an ACG client to obtain medical diagnosis or treatment and to attend other activities such as church if the personal care assistant is needed to provide personal care services while the recipient is absent from his or her residence; and

N. performing other services essential to the effective performance of the duties in items A to M.

Subp. 4. **Employment of personal care assistants.** A personal care assistant who provides personal care services under the ACG program is not an employee of the ACG client but must be employed by or under contract with a personal care provider. A personal care assistant employed by a personal care provider must meet the training requirements in subpart 2. The personal care provider shall terminate the personal care assistant's employment or assignment to an ACG client if the supervising registered nurse determines that the personal care assistant is not performing satisfactorily.

Subp. 5. **Personal care provider; eligibility.** Except as provided in subpart 11, a local agency that is not licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47 or registered under Minnesota Statutes, section 144A.49, and that wants to provide personal care services under the ACG program must contract with a personal care provider to provide the personal care services. To be eligible to contract with the local agency as a personal care provider, the provider must meet the criteria in items A to K. The local agency must assure the provider's compliance with the criteria in items A to K:

A. be licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47, or registered under Minnesota Statutes, section 144A.49;

B. possess the capacity to enter into a legally binding contract;

C. possess demonstrated ability to fulfill the responsibilities in this subpart and subpart 6;

D. demonstrate the cost effectiveness of its proposal for the provision of personal care services;

E. demonstrate a knowledge of, sensitivity to, and experience with the special needs, including communication needs, and the condition of the ACG client;

F. provide a quality assurance mechanism;

G. demonstrate the financial ability to produce a cash flow sufficient to cover operating expenses for 30 days;

H. disclose fully the names of persons with an ownership or control interest of five percent or more in the contracting agency;

I. demonstrate an accounting or financial system that complies with generally accepted accounting principles;

J. demonstrate a system of personnel management; and

K. if offering personal care services to a ventilator dependent ACG client, demonstrate the ability to train and to supervise the personal care assistant and the ACG client in ventilator operation and maintenance.

Subp. 6. **Personal care provider responsibilities.** The personal care provider shall:

A. employ or contract with personal care assistants to provide personal care services and to train personal care assistants as necessary;

B. supervise the personal care services as in subpart 9;

C. if the provider is not the local agency, submit a bill to the local agency for personal care services provided by the personal care assistant;

D. establish a grievance mechanism to resolve consumer complaints about personal care services;

E. keep records as required in parts 9505.1750 to 9505.1880;

F. perform functions and provide services specified in the personal care provider's contract under subpart 5;

G. comply with applicable rules and statutes; and

H. perform other functions as necessary to carry out the responsibilities in items A to G.

Subp. 7. **Employment prohibition.** A local agency that provides ACG services to an ACG client whether the services are provided by the local agency as a personal care provider or under contract with a personal care provider must prohibit the employment of a person to provide personal care services for an ACG client if the personal care assistant:

A. refuses to provide full disclosure of criminal history records as specified in subpart 8;

B. has been convicted of a crime that directly relates to the occupation of providing personal care services to a qualified recipient;

C. has jeopardized the health or welfare of a vulnerable adult through physical abuse, sexual abuse, or neglect as defined in Minnesota Statutes, section 626.557; or

D. is misusing or is dependent on mood altering chemicals including alcohol to the extent that the personal care provider knows or has reason to believe that the use of chemicals has a negative effect on the ability of the personal care assistant to provide personal care services or the use of chemicals is apparent during the hours the personal care assistant is providing personal care services.

Subp. 8. **Preemployment check of criminal history.** Before employing a person as a personal care assistant for an ACG client, the personal care provider shall require from the applicant for employment full disclosure of conviction and criminal history records pertaining to any crime related to the provision of health services under the medical assistance program or to the occupation of a personal care assistant.

Subp. 9. **Supervision of personal care assistant.** A personal care assistant must be under the supervision of a registered nurse. The supervising registered nurse shall not be a member of the family of the ACG client who is receiving personal care service from the personal care assistant under the registered nurse's supervision. The supervising registered nurse must:

A. ensure that the personal care assistant is capable of providing the personal care services required in the ACG client's individual treatment plan required by part 9505.2475 through direct observation of the assistant's performance or through consultation with the ACG client and the ACG client's primary caregiver when possible;

B. ensure that the personal care assistant is knowledgeable about the individual treatment plan before the personal care assistant performs the personal care services;

C. ensure that the personal care assistant is knowledgeable about essential observations of the ACG client's health, and about any conditions that should immediately be brought to the attention of either the nurse or the ACG client's physician;

D. evaluate the personal care services of an ACG client through direct observation of the personal care assistant's work or through consultation with the ACG client;

E. review the individual treatment plan with the ACG client and the personal care assistant at least once every 120 days and revise the individual treatment plan as necessary;

F. ensure that the personal care assistant and ACG client are knowledgeable about any change in the individual treatment plan; and

G. review all entries made in the ACG client's health care record showing the services provided and the time spent by the personal care assistant.

Subp. 10. **Evaluation of services.** The supervising registered nurse shall evaluate the personal care assistant's work under the schedule in items A to C.

The supervising registered nurse must record in writing the results of the evaluation and action taken to correct any deficiencies in the work of the personal care assistant.

A. Within 14 days after the placement of a personal care assistant with the ACG client.

B. At least once every 30 days during the first 90 days after the ACG client first begins to receive personal care services under the individual service plan developed by the screening team.

C. At least once every 120 days following the period of evaluations in item B.

Subp. 11. **Employment and reimbursement of a relative as a personal care assistant.** A relative of an ACG client, with the exception of the ACG client's spouse, shall be reimbursed for providing personal care services to an ACG client only if the relative and the local agency meet the requirements in items A to D.

A. The relative must be employed by or under contract with the local agency or a personal care provider. A local agency employing a relative under this subpart does not have to be licensed as a home health agency under Minnesota Statutes, sections 144A.43 to 144A.47.

B. The relative would suffer financial hardship as a result of providing the ACG client's personal care services or a personal care assistant who is not a relative is not available to perform the ACG client's personal care services. For purposes of this subpart, financial hardship refers to a situation in which a relative incurs a substantial reduction in income because he or she resigns from a full-time job, goes from a full-time to a part-time job paying considerably less compensation, takes a leave of absence without pay from a full-time job to care for an ACG client, or incurs substantial expenses in making arrangements necessary to enable the relative to care for an ACG client.

C. The relative and the local agency must meet the requirements of subparts 2, 3, and 7 to 10.

D. The local agency has obtained the department's prior approval.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2470 STANDARDS FOR HOME HEALTH AIDE SERVICES.

Subpart 1. **Employment of home health aide.** A home health aide who provides home health aide services under the ACG program to an ACG client must be an employee of a provider of home health aide services. The home health aide must be under the supervision of a registered nurse. Registered nurses and practical nurses licensed under Minnesota Statutes, sections 148.29 to 148.299 shall not be employed as home health aides under the ACG program.

Subp. 2. **Eligible providers.** To be eligible as a provider of home health aide services under the ACG program, a home health agency must be licensed under Minnesota Statutes, sections 144A.43 to 144A.46, and certified to participate under titles XVIII and XIX of the Social Security Act.

Subp. 3. **Approval and supervision of home health aide services.** A home health aide providing home health aide services in the ACG program must be approved by the supervising registered nurse to perform the medically oriented tasks written in the ACG client's individual treatment plan. The supervising registered nurse must be an employee of a home health agency that is providing the home health aide services.

Subp. 4. **Record of home health aide services.** A home health agency providing home health aide services to an ACG client must keep a record documenting the provision of home health aide services in the client's individual treatment plan. The documentation shall include the date and nature of the services provided and the names of the home health aide and the supervising registered nurse.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2473 STANDARDS FOR HOMEMAKER SERVICES.

Subpart 1. **Qualified homemakers.** The local agency shall assure that each ACG client receiving homemaker services is served by a homemaker qualified under part 9565.1200, subpart 2. A person who is providing a homemaker service under the ACG program to an ACG client who is the person's relative must meet the standards in part 9565.1200, subpart 2.

Subp. 2. **Contracting for homemaker services and supervision of a homemaker.** The local agency may directly provide or contract for homemaker services that are part of the ACG client's individual service plan. If the local agency provides homemaker services directly, the local agency must also provide supervision of the homemaker's activities. If the local agency contracts with a provider for homemaker services, the provider must meet the requirements of Minnesota Statutes, sections 144A.43 to 144A.46 or 144A.49.

Subp. 3. **Payment limitations; homemaker.** ACG payments shall be made only for the homemaker tasks specified in part 9505.2395, subpart 23, that are required by and indicated in the ACG client's individual service plan.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2475 ESTABLISHMENT OF INDIVIDUAL TREATMENT PLAN.

Subpart 1. **Requirement.** An individual treatment plan must be developed for an ACG client who receives home health aide services or personal care services. The ACG client's physician and the supervising registered nurse, together with the personal care assistant or the home health aide, the ACG client and the ACG client's representative, if any, must develop the individual treatment plan. The ACG client's physician and the supervising registered nurse must review the plan every 60 days and revise the plan if a revision is necessary to help the ACG client meet his or her needs. The supervising registered nurse must give a copy of the client's individual treatment plan to the ACG client's case manager and the home health agency that provides the home health or personal care services.

Subp. 2. **Contents of ACG client's individual treatment plan.** The ACG client's individual treatment plan must meet the requirements of Code of Federal Regulations, title 42, section 405.1223.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2480 ALLOCATION OF STATE ACG MONEY.

Subpart 1. **Formula for allocation of state ACG money.** Annually before July 1, the commissioner must allocate state money available for alternative care grants to each local agency. The allocation must include the state share of money for services provided to recipients under the waiver and the state share of money for services to persons who would be eligible to receive medical assistance within 180 days after nursing home admission. The allocation must be made according to Minnesota Statutes, section 256B.091, subdivision 8. State funds allocated by the commissioner to a local agency for ACG services provided under the waiver shall not be used for any purpose other than services under the waiver.

Subp. 2. **Review of allocation; reallocation of state ACG money.** The commissioner must review the local agencies' projected and expended state ACG money on a quarterly basis. The commissioner must reduce the allocation of state ACG money to a local agency if the commissioner determines that the local agency will not use the full state allocation during the state fiscal year. The commissioner must reallocate the unused portion of the local agency's allocation to a local agency that has or wants to have more ACG clients than were projected to be served in its biennial plan.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2485 ALLOCATION OF NUMBER OF ACG CLIENTS TO BE SERVED UNDER THE WAIVER.

Subpart 1. **Local agency allocation of ACG clients under the waiver.** At least annually, the commissioner must allocate the number of ACG clients who are recipients and for whom each local agency is financially responsible under the waiver. The commissioner must determine from the medical assistance eligibility data provided as of March 1 by the counties to the department each local agency's allocation according to the county's percentage of the statewide total number of recipients who are age 65 or older.

Subp. 2. **Review of allocation; reallocation of number of ACG clients under the waiver.** The commissioner shall review the projected and actual number of ACG clients served under the waiver by all local agencies on a quarterly basis. The commissioner may reduce the number of ACG clients allocated to a local agency if the commissioner determines that the local agency will serve fewer than its allocated number of ACG clients during the allocation period. The commissioner may reallocate the unused portion of the local agency's initial allocation to another local agency.

Subp. 3. **Notice to local agency.** The commissioner shall notify a local agency annually before May 15 of the number of recipients to be served as ACG clients under the waiver under subpart 1 and shall notify a local agency at least 15 days before the effective date of a change in the number of ACG clients allocated to the local agency under subpart 2.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2486 LOCAL AGENCY ESTIMATION OF NUMBER OF PERSONS OTHER THAN RECIPIENTS TO BE SERVED AS ACG CLIENTS.

A local agency must estimate the number of persons other than recipients to be served as ACG clients. The estimate shall depend on the extent that ACG funds allocated to the local agency as required by part 9505.2480 are available. The local agency must report the estimate in the biennial plan and revisions to the biennial plan required in part 9505.2495, subpart 2.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2490 RATES FOR ACG SERVICES.

Subpart 1. **Statewide maximum ACG service rate.** For years beginning on July 1 following the effective date of parts 9505.2390 to 9505.2500, the commissioner must annually set a statewide maximum rate allowed for payment of providing an ACG service. The statewide maximum rate must not exceed the prior fiscal year's rate by more than the percentage change between the two previous Januarys indicated by the all urban consumer price index (CPI-U) for Minneapolis-Saint Paul new series index (1967=100), as published by the Bureau of Labor Statistics, United States Department of Labor. The CPI-U is incorporated by

reference and is available from the Minitex interlibrary loan system. The CPI-U is subject to frequent change.

Subp. 2. **Local agency maximum ACG service rate set by commissioner; general.** The commissioner shall annually set the maximum rate that is available to a local agency for reimbursing an ACG provider for an ACG service. For years beginning on the first of July following the effective date of parts 9505.2390 to 9505.2500, the commissioner shall authorize an increase in the ACG rate available to a local agency for reimbursing an ACG provider equal to the percentage change between the two previous Januarys indicated by the all urban consumer price index (CPI-U) for Minneapolis-Saint Paul new series index (1967=100), as published by the Bureau of Labor Statistics, United States Department of Labor.

Subp. 3. **Local agency maximum ACG service rate set by commissioner; new ACG service.** A local agency that wants to contract for an ACG service that has not been provided before the effective date of parts 9505.2390 to 9505.2500 shall propose a maximum rate to the commissioner that does not exceed the statewide maximum ACG service rate established by the commissioner under subpart 1.

Subp. 4. **Notice to local agency.** Annually by May 15, the commissioner shall notify each local agency of the statewide maximum rate allowed for payment of providing an ACG service under subpart 1. Additionally, the commissioner shall notify the local agency m writing of the percentage increase allowed under subpart 2.

Subp. 5. **Local agency request to exceed county's maximum rate.** Notwithstanding the limitation on the local agency's maximum rate for an ACG service in subpart 2, a local agency that wants to increase an ACG service rate more than the percentage authorized by the commissioner under subpart 2 may submit a request for the increase to the commissioner. The local agency must justify the need for the greater increase by submitting evidence that documents an increase in costs, such as wages established under a union contract, taxes, utility costs, or transportation charges, that exceeds the percentage change or that shows that the higher rate is necessary to obtain the desired service within the local agency's local trade area. For purposes of this subpart, "local trade area" has the meaning given in part 9505.0175, subpart 22.

Subp. 6. **Local agency ACG service rate subject to audit and approval.** A local agency ACG service rate and a request to exceed the local agency's maximum ACG service rate are subject to audit and approval by the commissioner.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2495 LOCAL AGENCY REPORTS AND RECORDS.

Subpart 1. **Preadmission screening documents.** The local agency must complete and submit to the commissioner a preadmission screening document that summarizes the assessment and recommendations of the preadmission screening team on an applicant, nursing home resident, or ACG client for whom the local agency has completed a preadmission screening or a reassessment. The document must be submitted by the tenth of the month following the month in which a preadmission screening or reassessment was completed.

Subp. 2. **Local agency biennial plans.** The local agency must submit a biennial plan for preadmission screening and ACGs on forms prepared by the commissioner. The local agency must submit the biennial plan to the commissioner by July 1 of odd numbered years in order for the local agency to receive preadmission screening funds or ACG funds during the next two state fiscal years. The local agency must submit revisions to the biennial plan to the commissioner for approval before implementing the revisions. The biennial plan must include items A to F:

A. name and address of the local agency;

B. names and titles of the preadmission screening team;

C. names of ACG service providers;

D. identification of the types of ACG services the local agency will provide and the rates for the services;

E. an ACG budget and estimates of the number of recipients and other persons to be served as ACG clients for the first year of the biennium and an estimated budget and estimated number of clients to be served for the second year of the biennium. No later than July 1 of the second year of the biennium, each local agency must submit the actual budget and revised estimate of the number of clients to be served proposed for the second year of the biennium; and

F. assurances of compliance with Minnesota Statutes, section 256B.091, and parts 9505.2390 to 9505.2500.

Subp. 3. **Commissioner approval of local agency biennial plan.** The commissioner must approve or reject by August 15 a biennial plan submitted by the local agency as required in subpart 2, item E.

Subp. 4. **ACG provider records.** The local agency and each ACG provider under contract with the local agency must maintain complete program and fiscal records and supporting documentation identifying the ACG clients served, the services provided, and the costs incurred. The records must be identified and maintained separate from other provider records. The local agency's and provider's records including the local agency's contract with the ACG provider are subject to the maintenance schedule, audit availability requirements, and other provisions in parts 9505.1750 to 9505.2150.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2496 CRITERION FOR DELAY IN SENDING REQUIRED NOTICES.

If information that the commissioner needs to prepare and send the notices required under parts 9505.2390 to 9505.2500 is not provided in time for the commissioner to meet the time specified in these parts, the required notices shall be sent as soon as possible after the commissioner receives the needed information.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*

9505.2500 APPEALS OF SCREENINGS, RESCREENINGS, AND REASSESSMENTS.

Subpart 1. **Information about the right to appeal.** A preadmission screening team must provide a person being screened under part 9505.2400, rescreened under part 9505.2435, or reassessed under part 9505.2455, subpart 11, or the person's representative, information about the person's right to appeal the recommendation of the screening team. The information must be in writing and must be given to the person or the person's representative during the preadmission screening. The information must state the grounds for an appealable action and that ACG services will not be reduced, suspended, or terminated if the appeal is filed before the date specified in the information unless the person requests in writing not to receive continued ACG services while the appeal is pending.

Subp. 2. **Appealable actions.** A person being screened, rescreened, or reassessed may appeal if:

A. the recommendation of the preadmission screening team is to deny ACG services;

B. the preadmission screening team fails to determine with reasonable promptness whether the person is eligible for ACG services; or

C. the recommendation of the case manager based on a reassessment under part 9505.2455, subpart 11, is to reduce, suspend, or terminate ACG services.

Subp. 3. **Denial, reduction, suspension, or termination because of insufficient ACG funds or openings.** A denial, reduction, suspension, or termination of ACG services is not an appealable action if the county of financial responsibility has depleted the amount of money allocated under part 9505.2480 or assigned all the openings to serve ACG clients allocated under parts 9505.2485 and 9505.2486 or if the client's case manager withdraws ACG services as provided under part 9505.2458. Additionally, termination of an ACG service being provided to an ACG client under the waiver is not appealable if the termination results from termination of the waiver.

Subp. 4. **Submission of appeals.** The person being screened or the representative of the person being screened who wants to appeal the screening team's recommendation must submit the appeal in writing to the local agency of the county of service or to the department within 30 days after receiving written notice of the appealable action, or within 90 days of the written notice if a justified reason for delay can be shown.

Subp. 5. **Appeal of action.** An appeal of issues meeting the criteria under subparts 1, 2, and 4 shall be heard and decided in accordance with Minnesota Statutes, section 256.045.

Statutory Authority: *MS s 256B.091 subds 1 to 9*

History: *13 SR 258*