CHAPTER 9505
DEPARTMENT OF HUMAN SERVICES
HEALTH CARE PROGRAMS

9505.0075 RESPONSIBILITY OF RELATIVES.

Subpart 1. **General requirements; financial obligation of responsible relative.** A responsible relative has an obligation to contribute partial or complete repayment of medical assistance given to a recipient for whom he or she is responsible. The financial obligation of a responsible spouse must be determined under subpart 3 and the financial obligation of parents must be determined according to parts 9550.6200 to 9550.6240 if the responsible spouse or parents provide the information needed to make the determination. The responsible spouse who refuses to provide information needed to determine the financial obligation under subpart 3 is obligated to reimburse the local agency for the full amount of medical assistance paid for health services provided to the recipient. Refusal of responsible parents to provide information needed to determine financial obligation shall result in notification to the parents that the department or county board may institute civil action to recover the required reimbursement under Minnesota Statutes, sections 252.27, subdivision 3, and 256B.14, subdivision 2. The local agency may reduce the amount to be paid on the financial obligation determined under subpart 3 if payment of the financial obligation will cause the responsible spouse undue hardship. Undue hardship to responsible parents is governed by part 9550.6230. In no case shall the financial obligation determined under subpart 3 for the responsible spouse exceed the amount of medical assistance provided the recipient.

[For text of subps 2 and 3, see M.R.]

Subp. 4. [Repealed, 16 SR 2780]

Subp. 5. **Consideration of parental income.** The income of parents must be considered available in determining a child's eligibility for medical assistance as provided in items A to G. For purposes of this subpart, parents shall be responsible for a parental fee determined under part 9550.6220, unless excluded under part 9550.6200, subpart 2.

A. If the child is under age 18 and lives together with the parents, the parents' income and assets must be considered available in determining the child's eligibility, unless the child is under 18 and living together with the parents and the child's eligibility for medical assistance was determined without consideration of the parents' income and assets as:

(1) part of a home- and community-based waiver under Minnesota Statutes, section 256B.092, 256B.49, or 256B.491; or

(2) a disabled child under Minnesota Statutes, section 256B.055, subdivision 12.

The income of parents whose child's eligibility for medical assistance was determined without consideration of the parents' income and assets must be considered in regard to an obligation under parts 9550.6200 to 9550.6240.

B. If a child under age 18 lives together with the parents and is an eligible recipient of supplemental security income, parental income must be considered available in determining the child's eligibility.

C. If the child is under age 18 and living with one parent, the child's eligibility must be based on the child's income and assets and the income and assets of the parent living with the child. The parent not living with the child is obligated to provide medical support under Minnesota Statutes, section 518.171.

D. If the child is under 18 and not living together with either parent, the child's eligibility must be based on the child's income and assets. The parents' income must be considered only in regard to a financial obligation to contribute under parts 9550.6200 to 9550.6240.

E. If the child is between 18 and 21 years of age, and is living together with the parents or not living together with the parents to attend a high school, college, university, postsecondary technical college, or private business, trade, vocational, or technical college accredited, licensed, or approved under state laws and rules, and is a dependent of the parents for federal income tax purposes, the child is considered to live together with the parents. The parents' income and assets must be considered available in determining the child's eligibility.

F. If the child is age 18 or older, is living together with the parents and is determined to be disabled under Minnesota Statutes, section 256B.055, subdivision 7, or is not living together with the parents, and is not claimed as a tax dependent while attending a high school, college, university, postsecondary technical college, or a private business, trade, vocational, or technical college accredited, licensed, or approved under state laws and rules, the parents have no financial obligation.

Subp. 6. **Parental financial obligation.** When the parents have a financial obligation under subpart 5, the parents' financial obligation to reimburse the medical assistance program for the costs of services provided by medical assistance to the child recipient must be determined according to parts 9550.6200 to 9550.6240.

Subp. 7. **Change in living arrangement.** Spousal or parental income and assets must be considered available in the month after the month in which the spouses or parents and child begin living together. Consideration of spousal or parental income and assets must end in the month after the month in which the spouses or parents and child stop living together. A change in living arrangement must be reported as required in part 9505.0115, subpart 1.

Subp. 8. **Notice to responsible spouse or parent.** When making an initial determination of eligibility, the local agency shall give written notice to the responsible spouse within 30 days of the date of notice of the person's eligibility.

Further, the local agency shall notify the responsible spouse 30 days before the effective date of an increase in the obligation to be paid by the responsible spouse. A decrease in the obligation to be paid by the responsible spouse is effective the month following the month of the change in the cost of care or the responsible spouse's income or household size. The notice shall state the amount of the obligation to be paid, to whom the payment shall be made, the time a payment is due, penalties for refusing or failing to pay, and the right to appeal.

At the time eligibility is being determined, notice to the responsible parents shall be given according to part 9550.6220, subpart 1. Review and redetermination of parental fees are governed by part 9550.6228. Notice to the responsible parents of an increase or a decrease in the amount of the parental fee must be given according to part 9550.6229.

Subp. 9. **Appeals.** A responsible spouse has the right to appeal the determination of an obligation to pay under Minnesota Statutes, section 256.045. The appeal must be made in writing to the local agency within 30 days of the date of the notice required in subpart 8. Appeals by responsible parents are governed by part 9550.6235.

Subp. 10. **Refusal or failure to pay.** If a responsible spouse refuses or fails to pay the obligated amount within 30 days of the date specified in the notice under subpart 8, a cause of action exists against the responsible spouse for the portion of medical assistance granted after the date of the notice to a responsible relative of a payment obligation. The county of financial responsibility shall refer the refusal or failure to pay to the county attorney for action to enforce payment of the obligation.

Unless the responsible spouse's income and assets is deemed available to the applicant or recipient, the refusal or failure of a responsible spouse to pay the obligated amount does not affect the recipient's medical assistance eligibility. If the medical assistance payment to the long-term care facility has been reduced by the expected amount of the responsible spouse's obligation and the relative fails to pay within 60 days, the local agency shall adjust the payment to the long-term care facility so that the facility is paid the facility's per diem rate less the recipient's monthly spend down from the time of the responsible relative's refusal or failure to pay. Refusal or failure of responsible parents to pay the obligated amount is governed by part 9550.6226, subpart 5.

Statutory Authority: *MS s 252.27; 256B.14*

History: *16 SR 2780*

9505.0180 SURVEILLANCE AND UTILIZATION CONTROL PROGRAM.

Subpart 1. [Repealed, 15 SR 2563]

Subp. 2. **Duty to implement.** The department shall carry out a program of a surveillance and utilization review under parts 9505.2160 to 9505.2245 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 9505.2160 to 9505.2245.

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*

History: *15 SR 2563*

9505.0290 HOME HEALTH AGENCY SERVICES.

[For text of subps 1 and 2, see M.R.]

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

[For text of items A to C, see M.R.]

D. Rehabilitative and therapeutic services under part 9505.0390, and including respiratory therapy under part 9505.0295, subpart 2, item E.

[For text of subps 4 and 5, see M.R.]

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0295 HOME HEALTH SERVICES.

[For text of subpart 1, see M.R.]

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

[For text of items A to E, see M.R.]

F. rehabilitative and therapeutic services that are defined under part 9505.0390, subpart 1;

[For text of items G and H, see M.R.]

[For text of subps 3 to 5, see M.R.]

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0323 MENTAL HEALTH SERVICES.

[For text of subps 1 to 30, see M.R.]

Subp. 31. **Medical assistance payment for mental health services by mental health practitioner.** Notwithstanding other provisions of this part, a mental health service provided by a mental health practitioner is a covered service if the mental health practitioner has the qualifications in items A to C and the service is provided under the clinical supervision of a mental health professional. Medical assistance for services performed according to this subpart shall be paid at one-half the medical assistance payment rate for the same service provided by a mental health professional.

A. The mental health practitioner holds at least a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university.

B. The mental health practitioner is employed by a private nonprofit entity specializing in mental health services to low-income children under age 15.

C. The mental health practitioner has provided outpatient mental health services with a primary emphasis on family-oriented mental health services, to children under age 15, under clinical supervision for at least ten years after receiving a bachelor's degree.

For purposes of this subpart, "low-income children under age 15" refers to

children under age 15 in a family having a gross family income equal to or less than 185 percent of the federal poverty guidelines for the same family size.

Statutory Authority: *MS s 256B.04; L 1990 c 568 art 3 s 97*

History: *16 SR 59*

9505.0385 REHABILITATION AGENCY SERVICES.

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

A. "Physical impairment" means physical disabilities including those physical disabilities that result in cognitive impairments.

B. "Rehabilitation agency" means a provider that is certified by Medicare to provide restorative therapy and specialized maintenance therapy as defined in part 9505.0390, subpart 1, items J and K, and to provide social or vocational adjustment services under the Code of Federal Regulations, title 42, section 405.1702, paragraph h.

Subp. 2. **Covered services.** To be eligible for medical assistance payment, the services specified in items A and B that are provided by a rehabilitation agency must be ordered by a physician, must be related to the recipient's physical impairment, and must be designed to improve or maintain the functional status of a recipient with a physical impairment:

A. physician services under part 9505.0345; and

B. rehabilitative and therapeutic services as in part 9505.0390.

Subp. 3. **Eligibility as rehabilitation agency service; required site of service.** To be eligible for medical assistance payment, a rehabilitation agency service must be provided at a site that has been surveyed by the Minnesota Department of Health and certified according to Medicare standards; or at a site that meets the standards of the State Fire Marshal as documented in the provider's records; or at the recipient's residence. If the federal government denies reimbursement for services at non-Medicare certified sites, because the sites are not Medicare certified, then the eligibility for rehabilitation agency services shall be restricted to sites which meet the Medicare certification standards.

Subp. 4. **Social and vocational adjustment service provided by rehabilitation agency.** A social or vocational adjustment service provided by a rehabilitation agency must meet the requirements of Code of Federal Regulations, title 42, section 405.1702, must be provided as an unreimbursed adjunct to the covered services specified in subparts 2 and 3, and is not eligible for payment on a fee for service basis.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0386 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES.

Subpart 1. **Definition.** For purposes of this part and part 9505.0410, "comprehensive outpatient rehabilitation facility" means a nonresidential facility that is established and operated exclusively to provide diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons, at a single fixed location, by or under the direction of a physician and that meets the conditions of participation specified in Code of Federal Regulations, title 42, section 485, subpart B.

Subp. 2. **Eligibility for payment.** To be eligible for medical assistance payment as a provider of rehabilitative and therapeutic services, a comprehensive outpatient rehabilitation facility must meet the requirements of parts 9505.0385 and 9505.0390. Additionally, mental health services provided by the comprehensive outpatient rehabilitation facility according to part 9505.0323 shall be eligible for medical assistance payment.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0390 REHABILITATIVE AND THERAPEUTIC SERVICES.

Subpart 1. **Definitions.** For purposes of parts 9505.0390 to 9505.0392 and 9505.0410 to 9505.0412, the following terms have the meanings given them in this part.

A. "Audiologist" means a person who has a current certificate of clinical competence in audiology from the American Speech-Language-Hearing Association and, when it is applicable, who holds the specific state licensure and registration requirements for the services the person provides.

B. "Direction" means, notwithstanding any other definition of direction in parts 9505.0170 to 9505.0475, the actions of a physical or occupational therapist who instructs the physical therapist assistant or the occupational therapy assistant in specific duties to be performed, monitors the provision of services as the therapy assistants provide the service, is on the premises not less than every sixth treatment session of each recipient when treatment is provided by a physical therapist assistant or occupational therapy assistant, and meets the other supervisory requirements of parts 5601.1500 and 5601.1600.

C. "Functional status" means the ability of the person to carry out the tasks associated with daily living.

D. "Occupational therapist" means a person who is currently registered by the American Occupational Therapy Association as an occupational therapist.

E. "Occupational therapy assistant" means a person who has an associate degree in occupational therapy and is currently certified by the American Occupational Therapy Certification Board as an occupational therapy assistant.

F. "Physical therapist" means a person who is a graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent and, when it is applicable, licensed by the state.

G. "Physical therapist assistant" means a person who is qualified as specified in part 5601.0100, subpart 3.

H. "Rehabilitative and therapeutic services" means restorative therapy, specialized maintenance therapy, and rehabilitative nursing services.

I. "Rehabilitative nursing services" means rehabilitative nursing care as specified in part 4655.5900, subparts 2 and 3.

J. "Restorative therapy" means a health service that is specified in the recipient's plan of care by a physician and that is designed to restore the recipient's functional status to a level consistent with the recipient's physical or mental limitations.

K. "Specialized maintenance therapy" means a health service that is specified in the recipient's plan of care by a physician, that is necessary for maintaining a recipient's functional status at a level consistent with the recipient's physical or mental limitations, and that may include treatments in addition to rehabilitative nursing services.

L. "Speech-language pathologist" means a person who has a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association and, when it is applicable, meets the specific state licensure and registration requirements for the services the person provides.

Subp. 2. **Covered service; occupational therapy and physical therapy.** To be eligible for medical assistance payment as a rehabilitative and therapeutic service, occupational therapy and physical therapy must be:

A. prescribed by a physician;

B. provided by a physical or occupational therapist or by a physical therapist assistant or occupational therapy assistant who, as appropriate, is under the direction of a physical or occupational therapist;

C. provided to a recipient whose functional status is expected by the physician to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare.

Subp. 3. **Covered service; speech-language service.** To be eligible for medical assistance payment as a rehabilitative and therapeutic service, a speech-language service must be:

A. provided upon written referral by a physician or in the case of a resident of a long-term care facility, on the written order of a physician as specified in Code of Federal Regulations, title 42, section 483.45;

B. provided by a speech-language pathologist. A person completing the clinical fellowship year required for certification as a speech-language pathologist may provide speech-language services under the supervision of a speech-language pathologist but shall not be eligible to be enrolled as a provider under part 9505.0195;

C. provided to a recipient whose functional status is expected by the physician to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare.

Subp. 4. **Covered service; audiology.** To be eligible for medical assistance payment as a rehabilitative and therapeutic service, an audiology service must be:

A. provided upon written referral by a physician;

B. provided by an audiologist. A person completing the clinical fellowship year required for certification as an audiologist may provide audiological services under the supervision of an audiologist but shall not be enrolled as a provider under part 9505.0195;

C. provided to a recipient whose functional status is expected by the physician to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; and

D. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's attending physician at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare.

Subp. 5. **Covered service; specialized maintenance therapy.** To be eligible for medical assistance payment, specialized maintenance therapy must be:

A. provided by a physical therapist, physical therapy assistant, occupational therapist, or occupational therapy assistant;

B. specified in a plan of care that is reviewed, and revised as medically necessary, by the recipient's physician at least once every 60 days unless the service is a Medicare covered service and is to a recipient who also is eligible for Medicare. If the service is to a recipient who also is eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or by the physician delegate as required by Medicare; and

C. provided to a recipient who cannot be treated only through rehabilitative nursing services because of a condition in subitems (1) to (5):

(1) spasticity or severe contracture that interferes with the recipient's activities of daily living or the completion of routine nursing care;

(2) a chronic condition that results in physiological deterioration and that requires specialized maintenance therapy services or equipment to maintain strength, range of motion, endurance, movement patterns, activities of daily living, or positioning necessary for completion of the recipient's activities of daily living;

(3) an orthopedic condition that may lead to physiological deterioration and require therapy intervention by an occupational therapist or a physical therapist to maintain strength, joint mobility, and cardiovascular function;

(4) chronic pain that interferes with functional status and is expected by the physician to respond to therapy; or

(5) skin breakdown that requires a therapy procedure other than a rehabilitative nursing service.

Subp. 6. **Payment for rehabilitative nursing service in long-term care facility.** Medical assistance payment for a rehabilitative nursing service in a long-term care facility is subject to the conditions in parts 9549.0010 to 9549.0080 and 9553.0010 to 9553.0080.

Subp. 7. **Payment limitation; therapy assistants and aides.** To be eligible for medical assistance payment on a fee for service basis, health services provided by therapy assistants must be provided under the direction of a physical or occupational therapist. Services of a therapy aide in a long-term care facility are not separately reimbursable on a fee for service basis. Services of a therapy aide in a setting other than a long-term care facility are not reimbursable.

Subp. 8. **Excluded restorative and specialized maintenance therapy services.** Restorative and specialized maintenance therapy services in items A to K are not eligible for medical assistance payment:

A. physical or occupational therapy that is provided without a prescription of a physician;

B. speech-language or audiology service that is provided without a written referral from a physician;

C. services provided by a long-term care facility that are included in the costs covered by the per diem payment under parts 9549.0010 to 9549.0080 and 9553.0010 to 9553.0080 including:

(1) services for contractures that are not severe and do not interfere with the recipient's functional status or the completion of nursing care as required for licensure of the long-term care facility;

(2) ambulation of a recipient who has an established functional gait pattern;

(3) services for conditions of chronic pain that does not interfere with the recipient's functional status and that can be managed by routine nursing measures;

(4) services for activities of daily living when performed by the therapist, therapist assistant, or therapy aide; and

(5) bowel and bladder retraining programs;

D. arts and crafts activities for the purpose of recreation;

E. service that is not medically necessary;

F. service that is not documented in the recipient's health care record;

G. service specified in a plan of care that is not reviewed, and revised as medically necessary, by the recipient's attending physician as required in subparts 2 to 5;

H. service that is not designed to improve or maintain the functional status of a recipient with a physical impairment;

I. service that is not part of the recipient's plan of care;

J. service by more than one provider of the same type of rehabilitative and therapeutic services, for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan under Minnesota Statutes, section 256B.0625, subdivision 26; and

K. service that is provided by a rehabilitation agency as defined in part 9505.0385, subpart 1, item B, and that takes place in a sheltered workshop, in a developmental achievement center as defined in part 9525.1210, subpart 8, or service at a residential or group home which is an affiliate of the rehabilitation agency.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0391 THERAPISTS ELIGIBLE TO ENROLL AS PROVIDERS.

A physical therapist, an occupational therapist, an audiologist, or a speech-language pathologist is eligible to enroll as a provider if the therapist complies with the requirements of part 9505.0195 and maintains an office at the therapist's or pathologist's own expense. Additionally, a physical therapist or occupational therapist must be certified by Medicare. However, a service provided by an independently enrolled therapist or pathologist is not eligible for medical assistance payment under the therapist's or pathologist's provider number on a fee for service basis if the service was provided:

A. while the therapist or pathologist functioned as an employee of another provider; or

B. by another therapist or pathologist employed by the independently enrolled therapist unless the employee is a speech-language pathologist or an audiologist completing a clinical fellowship year.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0392 COMPLIANCE WITH MEDICARE REQUIREMENTS.

Notwithstanding requirements of parts 9505.0385, 9505.0386, 9505.0390, and 9505.0391, a rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements shall not be eligible for medical assistance reimbursement.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0410 LONG-TERM CARE FACILITIES; REHABILITATIVE AND THERAPEUTIC SERVICES TO RESIDENTS.

Subpart 1. **Eligible providers.** The providers in items A to F are eligible for medical assistance payment on a fee for service basis for restorative therapy and specialized maintenance therapy that is provided according to part 9505.0390 and that is provided at the site of a long-term care facility to a recipient residing in the long-term care facility:

A. a long-term care facility as defined in part 9505.0175, subpart 23;

B. a rehabilitation agency as defined in part 9505.0385;

C. a comprehensive outpatient rehabilitation facility as defined in part 9505.0386;

D. a physical therapist as defined in part 9505.0390;

E. an occupational therapist as defined in part 9505.0390; and

F. a speech-language pathologist or audiologist as defined in part 9505.0390, subpart 1, item E.

Subp. 2. **Payment limitation.** To be eligible for medical assistance payment, rehabilitative and therapeutic services provided to recipients residing in a long-term care facility must comply with the requirements of parts 9505.0170 to 9505.0475.

Subp. 3. **Payment for restorative therapy and specialized maintenance therapy.** Medical assistance payment for restorative therapy and specialized maintenance therapy may be made according to part 9505.0445, item O, or as provided in parts 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080, or as specified in the contract between the department and a prepaid health plan according to part 9505.0285.

Subp. 4. **Payment for rehabilitative nursing services.** Medical assistance payment for rehabilitative nursing services shall be as provided in parts 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080, as applicable. However, payment for a rehabilitative nursing service shall not be made on a fee for service basis.

Subp. 5. **Reporting of fees for service by long-term care facility.** A long-term care facility that receives medical assistance payment on a fee for service basis for the provision of restorative and specialized maintenance therapy to a resident shall report the therapy income in accordance with parts 9549.0010 to 9549.0080 or 9553.0010 to 9553.0080, as applicable. This subpart applies to medical assistance payments made to the long-term care facility for therapy services provided by an employee or by a related organization. For purposes of this subpart, "related organization" has the meaning given it in Minnesota Statutes, section 256B.433, subdivision 3, paragraph (b).

Subp. 6. **Prohibited practices.** If medical assistance payment is made to a provider other than a long-term care facility for restorative therapy and specialized maintenance therapy, the long-term care facility in which the recipient resides must not request or receive payment from the provider in excess of the limit on charges specified in Minnesota Statutes, section 256B.433, subdivision 3, paragraph (c).

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0411 LONG-TERM CARE FACILITIES; REHABILITATIVE AND THERAPEUTIC SERVICES TO NONRESIDENTS.

Rehabilitative and therapeutic services provided by and at the site of a long-term care facility to a recipient who is not a resident of a long-term care facility are eligible for medical assistance payment if the facility is certified by Medicare as an outpatient therapy provider, under Code of Federal Regulations, title 42, part 405, subpart Q, if the service is a covered service, and if the requirements of parts 9505.0390 to 9505.0412 are met.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

9505.0412 REQUIRED DOCUMENTATION OF REHABILITATIVE AND THERAPEUTIC SERVICES.

A rehabilitative or therapeutic service provided under parts 9505.0385, 9505.0386, 9505.0390, 9505.0391, 9505.0395, 9505.0396, 9505.0410, and 9505.0411 must be documented as specified in items A to D.

A. The service must be specified in the recipient's plan of care that is reviewed and revised as medically necessary by the recipient's physician at least once every 60 days. However, if the service is to a recipient who is also eligible for Medicare and the service is a Medicare covered service, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by a physician or by the physician delegate as required by Medicare.

B. The recipient's plan of care must state:

(1) the recipient's medical diagnosis and any contraindications to treatment;

(2) a description of the recipient's functional status;

(3) the objectives of the rehabilitative and therapeutic service; and

(4) a description of the recipient's progress toward the objectives in subitem (3).

C. The recipient's plan of care must be signed by the recipient's physician.

D. The record of the recipient's service must show:

(1) the date, type, length, and scope of each rehabilitative and therapeutic service provided to the recipient;

(2) the name or names and titles of the persons providing each rehabilitative and therapeutic service;

(3) the name or names and titles of the persons supervising or directing the provision of each rehabilitative and therapeutic service; and

(4) a statement, every 30 days, by the therapist providing or supervising the services, other than an initial evaluation, that the therapy's nature, scope, duration, and intensity are appropriate to the medical condition of the recipient in accordance with Minnesota Statutes, section 256B.433, subdivision 2.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2404*

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 U.

[For text of items A to L, see M.R.]

M. For EPSDT services, the rate shall be the lower of the provider's submitted charge or the 75th percentile of all complete EPSDT screening charges submitted for complete EPSDT screenings during the prior state fiscal year, July 1 to the following June 30. The adjustment necessary to reflect the 75th percentile shall be effective annually on October 1.

[For text of items N to U, see M.R.]

Statutory Authority: *MS s 256B.0625*

History: *16 SR 2518*

9505.1693 SCOPE AND PURPOSE.

Parts 9505.1693 to 9505.1748 govern the early and periodic screening, diagnosis, and treatment (EPSDT) program.

Parts 9505.1693 to 9505.1748 must be read in conjunction with section 1905(a)(4)(B) of the Social Security Act, as amended through December 31, 1981, and the Code of Federal Regulations, title 42, part 441, subpart B, as amended through October 1, 1987, and section 6403 of the Omnibus Budget Reconciliation Act of 1989. The purpose of the EPSDT program is to identify potentially

handicapping conditions in children eligible for medical assistance, to provide diagnosis and treatment for conditions identified, and to encourage parents and their children to use health care services when necessary.

Statutory Authority: *MS s 256B.0625*

History: *16 SR 2518*

9505.1718 SCREENING STANDARDS FOR AN EPSDT CLINIC.

[For text of subpart 1, see M.R.]

Subp. 2. **Health and developmental history.** A history of a child's health and development must be obtained from the child, parent of the child, or an adult who is familiar with the child's health history. The history must include information on sexual development, lead and tuberculosis exposure, nutrition intake, chemical abuse, and social, emotional, and mental health status.

[For text of subps 3 to 8, see M.R.]

Subp. 9. **Development.** A child must be screened for the following according to the screening provider's standard procedures: fine and gross motor development, speech and language development, social development, cognitive development, and self-help skills. Standardized tests that are used in screening must be culturally sensitive and have norms for the age range tested, written procedures for administration and for scoring and interpretation that are statistically reliable and valid. The provider must use a combination of the child's health and developmental history and standardized test or clinical judgment to determine the child's developmental status or need for further assessment.

[For text of subps 10 and 11, see M.R.]

Subp. 12. **Immunizations.** The immunization status of a child must be compared to the "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition. Immunizations that the comparison shows are needed must be offered to the child and given to the child if the child or parent of the child accepts the offer. The "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition, is developed and distributed by the Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440. The "Recommended Schedule for Active Immunization of Normal Infants and Children," current edition, is incorporated by reference and is available at the State Law Library, Judicial Center, 25 Constitution Avenue, Saint Paul, Minnesota 55155. It is subject to frequent change.

Subp. 13. **Laboratory tests.** Laboratory tests must be done according to items A to F.

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

B. A child aged one to five years must initially be screened for lead through the use of either an erythrocyte protoporphyrin (EP) test or a direct blood lead screening test until December 31, 1992. Beginning January 1, 1993, a child age one to five must initially be screened using a direct blood lead screening test. Either capillary or venous blood may be used as the specimen for the direct blood lead test. Blood tests must be performed at a mmimum of once at 12 months of age and once at 24 months of age or whenever the history indicates that there are risk factors for lead poisoning. When the result of the EP or capillary blood test is greater than the maximum allowable level set by the Centers for Disease Control of the United States Public Health Service, the child must be referred for a venous blood lead test. A child with a venous blood lead level greater than the maximum allowable level set by the Centers for Disease Control must be referred for diagnosis and treatment.

[For text of items C to F, see M.R.]

[For text of subp 14, see M.R.]

Subp. 14a. **Health education and health counseling.** Health education and health counseling concerning the child's health must be offered to the child who is being screened and to the child's parent or representative. The health education and health counseling are for the purposes of assisting the child or the parent or representative of the child to understand the expected growth and development of the child and of informing the child or the parent or representative of the child about the benefits of healthy lifestyles and about practices to promote accident and disease prevention.

Subp. 15. **Schedule of age related screening standards.** An early and periodic screening, diagnosis, and treatment screening for a child at a specific age must include, at a minimum, the screening requirements of subparts 2 to 14 as provided by the following schedule:

Schedule of age related screening standards

A. Infancy:

Standards	Ages					
	By 1 month	2 months	4 months	6 months	9 months	12 months
Health History	X	X	X	X	X	X
Assessment of Physical Growth:						
Height	X	X	X	X	X	X
Weight	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X
Physical Examination	X	X	X	X	X	X
Vision	X	X	X	X	X	X
Hearing	X	X	X	X	X	X
Development	X	X	X	X	X	X
Health Education/ Counseling	X	X	X	X	X	X
Sexual Development	X	X	X	X	X	X
Nutrition	X	X	X	X	X	X
Immunizations/Review		X	X	X	X	X
Laboratory Tests:						
Tuberculin		if history indicates				
Lead Absorption		if history indicates				X
Urinalysis	←	←	←	X	←	←
Hematocrit or Hemoglobin	←	←	←	←	X	X
Sickle Cell		at parent's or child's request				
Other Laboratory Tests		as indicated				
Oral Examination	X	X	X	X	X	X

X = Procedure to be completed.

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

B. Early Childhood:

Standards	Ages				
	15 months	18 months	24 months	3 years	4 years
Health History	X	X	X	X	X
Assessment of Physical Growth:					
Height	X	X	X	X	X
Weight	X	X	X	X	X
Head Circumference	X	X	X	X	X
Physical Examination	X	X	X	X	X
Vision	X	X	X	X	X
Hearing	X	X	X	X	X
Blood Pressure				X	X
Development	X	X	X	X	X
Health Education/Counseling	X	X	X	X	X
Sexual Development	X	X	X	X	X
Nutrition	X	X	X	X	X
Immunizations/Review	X	X	X	X	X
Laboratory Tests:					
Tuberculin	if history indicates				
Lead Absorption	if history indicates		X	if history indicates	
Urinalysis	←	←	X	←	←
Bacteriuria (females)					X
Hematocrit or Hemoglobin	←	←	←	←	←
Sickle Cell	at parent's or child's request				
Other Laboratory Tests	as indicated				
Oral Examination	X	X	X	X	X

X = Procedure to be completed.

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

C. Late childhood:

Standards	Ages				
	5 years	6 years	8 years	10 years	12 years
Health History	X	X	X	X	X
Assessment of Physical Growth:					
Height	X	X	X	X	X
Weight	X	X	X	X	X
Physical Examination	X	X	X	X	X
Vision	X	X	X	X	X
Hearing	X	X	X	X	X

Blood Pressure	X	X	X	X	X
Development	X	X	X	X	X
Health Education/Counseling	X	X	X	X	X
Sexual Development	X	X	X	X	X
Nutrition	X	X	X	X	X
Immunizations/Review	X	X	X	X	X
Laboratory Tests:					
Tuberculin		if history indicates			
Lead Absorption		if history indicates			
Urinalysis	←	←	X	←	←
Bacteriuria (females)	←	←	X	←	←
Hemoglobin or Hematocrit	←	←	X	←	
Sickle Cell		at parent's or child's request			
Other Laboratory Tests		as indicated			
Oral Examination	X	X	X	X	X

X = Procedure to be completed.

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

D. Adolescence:

Standards	Ages 14 years	16 years	18 years	20 years
Health History	X	X	X	X
Assessment of Physical Growth:				
Height	X	X	X	X
Weight	X	X	X	X
Physical Examination	X	X	X	X
Vision	X	X	X	X
Hearing	X	X	X	X
Blood Pressure	X	X	X	X
Development	X	X	X	X
Health Education/Counseling	X	X	X	X
Sexual Development	X	X	X	X
Nutrition	X	X	X	X
Immunizations/Review	X	X	X	X
Laboratory Tests:				
Tuberculin		if history indicates		
Lead Absorption		if history indicates		
Urinalysis	←		X	
Bacteriuria (females)	←		←	
Hemoglobin or Hematocrit	←		X	
Sickle Cell		at parent's or child's request		

Other Laboratory Tests	as indicated	
Oral Examination	X	X

X = Procedure to be completed.

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

Subp. 15a. **Additional screenings.** A child may have a partial or complete screening between the ages specified in the schedule under subpart 15 if the screening is medically necessary or a concern develops about the child's health or development.

Statutory Authority: *MS s 256B.0625*

History: *16 SR 2518*

9505.1748 CONTRACTS FOR ADMINISTRATIVE SERVICES.

Subpart 1. **Authority.** A local agency may contract with a county public health nursing service, a community health clinic, a Head Start agency, a community action agency, or a school district for early and periodic screening, diagnosis, and treatment administrative services. Early and periodic screening, diagnosis, and treatment administrative services include outreach; notification; appointment scheduling and transportation; follow-up; and documentation. For purposes of this subpart, "community action agency" means an entity defined in Minnesota Statutes, section 268.53, subdivision 1, and "school district" means a school district as defined in Minnesota Statutes, section 120.02, subdivisions 13 to 15.

[For text of subps 2 and 3, see M.R.]

Subp. 4. **Approval.** A contract for administrative services must be approved by the local agency and submitted to the department for approval by November 1 of the year before the beginning of the calendar year in which the contract will be effective. A contract must contain items A to L to be approved by the department for reimbursement:

[For text of items A to F, see M.R.]

G. a clause that stipulates that the contracting parties will provide program and fiscal records and maintain all nonpublic data required by the contract according to the Minnesota Government Data Practices Act and will cooperate with state and federal program reviews;

H. a description of the services contracted for and the agency that will perform them;

I. methods by which the local agency will monitor and evaluate the contract;

J. signatures of the representatives of the contracting parties with the authority to obligate the parties by contract and dates of those signatures;

K. a clause that stipulates that the services provided under contract must be performed by or under the supervision of skilled medical personnel; and

L. a clause that stipulates that the contracting parties will comply with state and federal requirements for the receipt of medical assistance funds.

Statutory Authority: *MS s 256B.0625*

History: *16 SR 2518*

9505.1750 [Repealed, 15 SR 2563]

9505.1760 [Repealed, 15 SR 2563]

9505.1770 [Repealed, 15 SR 2563]

9505.1780 [Repealed, 15 SR 2563]
9505.1790 [Repealed, 15 SR 2563]
9505.1800 [Repealed, 15 SR 2563]
9505.1810 [Repealed, 15 SR 2563]
9505.1820 [Repealed, 15 SR 2563]
9505.1830 [Repealed, 15 SR 2563]
9505.1840 [Repealed, 15 SR 2563]
9505.1850 [Repealed, 15 SR 2563]
9505.1860 [Repealed, 15 SR 2563]
9505.1870 [Repealed, 15 SR 2563]
9505.1880 [Repealed, 15 SR 2563]
9505.1890 [Repealed, 15 SR 2563]
9505.1900 [Repealed, 15 SR 2563]
9505.1910 [Repealed, 15 SR 2563]
9505.1920 [Repealed, 15 SR 2563]
9505.1930 [Repealed, 15 SR 2563]
9505.1940 [Repealed, 15 SR 2563]
9505.1950 [Repealed, 15 SR 2563]
9505.1960 [Repealed, 15 SR 2563]
9505.1970 [Repealed, 15 SR 2563]
9505.1980 [Repealed, 15 SR 2563]
9505.1990 [Repealed, 15 SR 2563]
9505.2000 [Repealed, 15 SR 2563]
9505.2010 [Repealed, 15 SR 2563]
9505.2020 [Repealed, 15 SR 2563]
9505.2030 [Repealed, 15 SR 2563]
9505.2040 [Repealed, 15 SR 2563]
9505.2050 [Repealed, 15 SR 2563]
9505.2060 [Repealed, 15 SR 2563]
9505.2070 [Repealed, 15 SR 2563]
9505.2080 [Repealed, 15 SR 2563]
9505.2090 [Repealed, 15 SR 2563]
9505.2100 [Repealed, 15 SR 2563]
9505.2110 [Repealed, 15 SR 2563]
9505.2120 [Repealed, 15 SR 2563]
9505.2130 [Repealed, 15 SR 2563]

9505.2140 [Repealed, 15 SR 2563]

9505.2150 [Repealed, 15 SR 2563]

9505.2160 SCOPE AND APPLICABILITY.

Subpart 1. **Scope.** Parts 9505.2160 to 9505.2245 govern procedures to be used by the department in identifying and investigating fraud, theft, or abuse by providers or recipients of health services through the medical assistance, general assistance medical care, consolidated chemical dependency treatment, children's health plan, catastrophic health expense protection programs, home and community-based services under a waiver from the Health Care Financing Administration of the United States Department of Health and Human Services, or any other health service program administered by the department, and for the imposition of sanctions against providers and recipients of health services. Additionally, parts 9505.2160 to 9505.2245 establish standards applicable to the health service and financial records of providers of health services through medical assistance, general assistance medical care, consolidated chemical dependency treatment, children's health plan, or catastrophic health expense protection programs.

Parts 9505.2160 to 9505.2245 must be read in conjunction with titles XVIII and XIX of the Social Security Act; Code of Federal Regulations, title 42; Minnesota Statutes, chapters 62E, 145, 245, 245A, 252, 253, 254A, 254B, 256, 256B, 256D, 256E, and 609.

Subp. 2. **Applicability.** Parts 9505.2160 to 9505.2245 apply to local agencies, providers participating in a program, and recipients of health services through a program.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2165 DEFINITIONS.

Subpart 1. **Scope.** The terms in parts 9505.2160 to 9505.2245 shall have the meanings given them in this part and in part 9505.0175, the medical assistance definitions.

Subp. 2. **Abuse.** "Abuse" means:

A. in the case of a provider, a pattern of practices that is inconsistent with sound fiscal, business, or health service practices, and that result in unnecessary costs to the programs, or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health service. The following practices are deemed to be abuse by a provider:

(1) submitting repeated claims from which required information is missing or incorrect;

(2) submitting repeated claims using procedure codes which overstate the level or amount of health service provided;

(3) submitting repeated claims for health services which are not reimbursable under the programs;

(4) submitting repeated duplicate claims for the same health service provided to the same recipient;

(5) submitting repeated claims for health services that do not comply with part 9505.0210 and, if applicable, part 9505.0215;

(6) repeated submission of claims for services that are not medically necessary;

(7) failing to develop and maintain health service records as required under part 9505.2175;

(8) failing to use generally accepted accounting principles or other accounting methods which relate entries on the recipient's health service record

to corresponding entries on the billing invoice, unless another accounting method or principle is required by federal or state law or rule;

(9) failing to disclose or make available to the department the recipient's health service records or the provider's financial records as required by part 9505.2180;

(10) repeatedly failing to properly report duplicate payments from third party payers for covered services provided to a recipient under a program and billed to the department;

(11) failing to obtain information and assignment of benefits as specified in part 9505.0070, subpart 3, or to bill Medicare as required by part 9505.0440;

(12) failing to keep financial records as required under part 9505.2180;

(13) repeatedly submitting or causing repeated submission of false information for the purpose of obtaining prior authorization, inpatient hospital admission certification under parts 9505.0500 to 9505.0540, or a second surgical opinion as required under part 9505.5035;

(14) knowingly and willfully submitting a false or fraudulent application for provider status;

(15) soliciting, charging, or receiving payments from recipients or nonmedical assistance sources, in violation of Code of Federal Regulations, title 42, section 447.15, or part 9505.0225, for services for which the provider has received reimbursement from or should have billed to the program;

(16) payment by a provider of program funds to a vendor whom the provider knew or had reason to know was suspended or terminated from program participation;

(17) repeatedly billing a program for services after entering into an agreement with a third-party payer to accept an amount in full satisfaction of the payer's liability; or

B. in the case of a recipient, the use of health services that results in unnecessary costs to the programs, or in reimbursements for services that are not medically necessary. The following practices are deemed to be abuse by a recipient:

(1) obtaining equipment, supplies, drugs, or health services that are in excess of program limitations or that are not medically necessary and that are paid for through a program;

(2) obtaining duplicate services for the same health condition from a multiple number of providers. Duplicate service does not include an additional opinion that is medically necessary for the diagnosis, evaluation, or assessment of the recipient's condition or required under program rules, or a service provided by a school district as specified in the recipient's individualized education plan under Minnesota Statutes, section 256B.0625, subdivision 26;

(3) continuing to engage in practices that are abusive of the program after receiving the department's written warning that the conduct must cease;

(4) altering or duplicating the medical identification card for the purpose of obtaining additional health services billed to the program or aiding another person to obtain such services;

(5) using a medical identification card that belongs to another person;

(6) using the medical identification card to assist an unauthorized individual in obtaining a health service for which a program is billed;

(7) duplicating or altering prescriptions;

(8) misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services, or drugs;

(9) furnishing incorrect eligibility status or information to a provider;

(10) furnishing false information to a provider in connection with health services previously rendered to the recipient which were billed to a program; or

(11) obtaining health service by false pretenses.

Subp. 3. **Federal share.** "Federal share" means the percent of federal financial participation in the cost of the state's medical assistance program.

Subp. 4. **Fraud.** "Fraud" means medical assistance fraud as defined in Minnesota Statutes, section 609.466.

Subp. 5. **Health services.** "Health services" has the meaning given in part 9505.0175, subpart 14.

Subp. 6. **Health service record.** "Health service record" means written or diagrammed documentation of the nature, extent, and evidence of the medical necessity of a health service provided to a recipient by a provider and billed to a program.

Subp. 6a. **Medically necessary or medical necessity.** "Medically necessary" or "medical necessity" has the meaning given in part 9505.0175, subpart 25.

Subp. 6b. **Pattern.** "Pattern" means an identifiable series of more than one event or activity.

Subp. 7. **Primary care case manager.** "Primary care case manager" means a provider designated by the department who is a physician or a group of physicians, who is employed by or under contract with the Department of Human Services, and who is responsible for the direct care of a recipient, and for coordinating and controlling access to or initiating or supervising other health care services needed by the recipient.

Subp. 8. **Program.** "Program" means the Minnesota medical assistance program, the general assistance medical care program, catastrophic health expense protection program, children's health plan, consolidated chemical dependency program, home and community-based services under a waiver from the Health Care Financing Administration of the United States Department of Health and Human Services, or any other health service program administered by the department.

Subp. 9. **Provider.** "Provider" has the meaning given in part 9505.0175, subpart 38.

Subp. 10. **Recipient.** "Recipient" means an individual who has been determined eligible to receive health services under a program.

Subp. 11. **Restriction.** "Restriction" means:

A. in the case of a provider, excluding or limiting the scope of the health services for which a provider may receive a payment through a program for a reasonable time; or

B. in the case of a recipient, limiting the recipient's participation in a program for a period of 24 months, to only health services which have been prior authorized, or to health services from a designated primary care case manager or other designated health service providers. The restriction of a recipient must be indicated on the recipient's medical identification card or other form of program identification, under part 9505.0145, subpart 4. For purposes of restriction, designated health service providers do not include long-term care facilities.

Subp. 12. **Suspending participation or suspension.** "Suspending participation" or "suspension" means making a provider ineligible for reimbursement by a program for a stated period of time.

Subp. 13. **Suspending payments.** "Suspending payments" means stopping any or all program payments for health services billed by a provider pending resolution of the matter in dispute between the provider and the department.

Subp. 14. **Terminating participation.** "Terminating participation" means making a provider ineligible for reimbursement by a program.

Subp. 15. **Theft.** "Theft" means the act defined in Minnesota Statutes, section 609.52, subdivision 2, clause (3)(c).

Subp. 16. **Third-party payer.** "Third-party payer" means the term defined in part 9505.0015, subpart 46, and, additionally, Medicare.

Subp. 17. **Withholding payments.** "Withholding payments" means reducing or adjusting the amounts paid to a provider to offset overpayments previously made to the provider.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563; 16 SR 960*

9505.2175 HEALTH SERVICE RECORDS.

Subpart 1. **Documentation requirement.** As a condition for payment by a program, a provider must document each occurrence of a health service provided to a recipient. The health service must be documented in the recipient's health service record as specified in subpart 2 and, when applicable, subparts 3 to 6. Program funds paid for a health service not documented in a recipient's health service record shall be recovered.

Subp. 2. **Required standards for health service records.** A provider must keep a health service record as specified in items A to I.

A. The record must be legible at a minimum to the individual providing care.

B. The recipient's name must be on each page of the recipient's record.

C. Each entry in the health service record must contain:

(1) the date on which the entry is made;

(2) the date or dates on which the health service is provided;

(3) the length of time spent with the recipient if the amount paid for the service depends on time spent;

(4) the signature and title of the person from whom the recipient received the service; and

(5) when applicable, the countersignature of the provider or the supervisor as required under parts 9505.0170 to 9505.0475.

D. The record must state:

(1) the recipient's case history and health condition as determined by the provider's examination or assessment;

(2) the results of all diagnostic tests and examinations; and

(3) the diagnosis resulting from the examination.

E. The record must show the quantity, dosage, and name of prescribed drugs ordered for or administered to the recipient.

F. The record must contain reports of consultations that are ordered for the recipient.

G. The record must contain the recipient's plan of care, individual treatment plan, or individual program plan. For purposes of this item, "plan of care" has the meaning given in part 9505.0175, subpart 35; "individual treatment plan" has the meaning given in part 9505.0477, subpart 14; and "individual program plan" has the meaning given in part 9535.0100, subpart 15.

H. The record must report the recipient's progress or response to treatment, and changes in the treatment or diagnosis.

I. The record of a laboratory or X-ray service must document the provider's order for service.

Subp. 3. **Requirements for pharmacy service records.** A pharmacy service

record must comply with the requirements of subparts 1 and 2 and Minnesota Rules, part 6800.3110, relating to pharmacy licensing and operations, and Minnesota Rules, part 6800.3950, relating to electronic data processing of pharmacy records. However, the pharmacy service record must be a hard copy made at the time of the request for service and must be kept for five years as required under part 9505.2190, subpart 1.

Subp. 4. **Requirements for medical transportation service records.** A medical transportation record must meet the requirements of subparts 1 and 2 and must document:

A. the origin, destination, and distance traveled in providing the service to the recipient;

B. the type of transportation; and

C. if applicable, a physician's certification for nonemergency, ancillary, or special transportation services as defined in part 9505.0315, subpart 1, items A and F.

Subp. 5. **Requirements for medical supplies and equipment records.** A medical supplies and equipment record must meet the requirements of subparts 1 and 2 and:

A. must document that the medical supply or equipment meets the criteria in parts 9505.0210 and 9505.0310; and

B. except as provided in part 9505.2190, subpart 1, must contain a hard copy of the provider's order or prescription for the medical supply or equipment and the name and amount of the medical supply or equipment provided for the recipient.

Subp. 6. **Requirements for rehabilitative and therapeutic services.** Rehabilitative and therapeutic service records must meet the requirements of subparts 1 and 2 and must meet the criteria in part 9505.0412.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2180 FINANCIAL RECORDS.

Subpart 1. **Financial records required of providers.** The financial records of a provider who receives payment for a recipient's services under a program must contain the material specified in items A to H:

A. payroll ledgers, canceled checks, bank deposit slips and any other accounting records prepared for the provider;

B. contracts for services or supplies that relate to the provider's costs and billings to a program for the recipient's health services;

C. evidence of the provider's charges to recipients and to persons who are not recipients, consistent with the requirements of Minnesota Statutes, chapter 13;

D. evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to third-party payers or programs;

E. the provider's appointment books for patient appointments and the provider's schedules for patient supervision, if applicable;

F. billing transmittal forms;

G. records showing all persons, corporations, partnerships, and entities with an ownership or control interest in the provider as defined in Code of Federal Regulations, title 42, section 455.101; and

H. employee records for those persons currently employed by the provider or who have been employed by the provider at any time within the previous five years which under the Minnesota Government Data Practices Act would be considered public data for a public employee such as employee name, salary,

qualifications, position description, job title, and dates of employment; and in addition employee records shall include the current home address of the employee or the last known address of any former employee.

Subp. 2. **Additional financial records required for long-term care facilities.** A long-term care facility must maintain:

A. the records required under subpart 1;

B. purchase invoices; and

C. records of the deposits and expenditure of funds in the recipients' resident fund accounts as required under part 9505.0425.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2185 ACCESS TO RECORDS.

Subpart 1. **Recipient's consent to access.** A recipient of medical assistance is deemed to have authorized in writing a provider or others to release to the department for examination according to Minnesota Statutes, section 256B.27, subdivision 4, upon the department's request, the medical assistance recipient's health service records related to services under a program. The medical assistance recipient's authorization of the release and review of health service records for services provided while the person is a medical assistance recipient shall be presumed competent if given in conjunction with the person's application for medical assistance. This presumption shall exist regardless of whether the application was signed by the person or the person's guardian or authorized representative as defined in part 9505.0015, subpart 8.

Subp. 2. **Department access to provider records.** A provider shall grant the department access during the provider's regular business hours to examine health service and financial records related to a health service billed to a program. Access to a recipient's health service record shall be for the purposes in part 9505.2200, subpart 1. The department shall notify the provider no less than 24 hours before obtaining access to a health service or financial record, unless the provider waives notice.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2190 RETENTION OF RECORDS.

Subpart 1. **Retention required; general.** A provider shall retain a health service and financial record related to a health service for which payment under a program was received or billed for at least five years after the initial date of billing. Microfilm records satisfy the record keeping requirements of this subpart and part 9505.2175, subpart 3, in the fourth and fifth years after the date of billing.

Subp. 2. **Record retention after provider withdrawal or termination.** A provider who withdraws or is terminated from a program must retain or make available to the department on demand the health service and financial records required under subpart 1.

Subp. 3. **Record retention under change of ownership.** If the ownership of a long-term care facility or provider service changes, the transferor, unless otherwise provided by law or written agreement with the transferee, is responsible for maintaining, preserving, and making available to the department on demand the health service and financial records related to services generated before the date of the transfer as required under subpart 1 and part 9505.2185, subpart 2.

Subp. 4. **Record retention in contested cases.** In the event of a contested case, the provider must retain health service and financial records as required by subpart 1 or for the duration of the contested case proceedings, whichever period is longer.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2195 COPYING RECORDS.

The department, at its own expense, may photocopy or otherwise duplicate any health service or financial record related to a health service for which a provider makes a claim or receives payment under a program. Photocopying shall be done on the provider's premises unless removal is specifically permitted by the provider. If a provider fails to allow the department to use the department's equipment to photocopy or duplicate any health service or financial record on the premises, the provider must furnish copies at the provider's expense within two weeks of a request for copies by the department.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2200 IDENTIFICATION AND INVESTIGATION OF SUSPECTED FRAUD AND ABUSE.

Subpart 1. **Department investigation.** The department shall investigate providers or recipients to monitor compliance with program requirements for the purposes of identifying fraud, theft, or abuse m the administration of the programs.

Subp. 2. **Contacts to obtain information.** The department may contact any person, agency, organization, or other entity that is necessary to an investigation under subpart 1. Among those who may be contacted are:

A. government agencies;

B. third-party payers, including Medicare;

C. professional review organizations as defined in Mmnesota Statutes, section 145.61, subdivision 5, or their representatives;

D. a professional services advisory committee established under part 9505.0185 or its representative;

E. recipients and their responsible relatives;

F. providers and persons employed by or under contract to providers;

G. professional associations of providers and their peers;

H. recipients and recipient advocacy organizations; and

I. members of the public.

Subp. 3. **Activities included in department's investigation.** The department's authority to investigate extends to the examination of any person, document, or thing which is likely to lead to information relevant to the expenditure of funds, provision of services, or purchase of items identified in part 9505.2160, subpart 1, provided that the information sought is not privileged against such an investigation by operation of any state or federal law. Among the activities which the department's investigation may include are as follows:

A. examination of health service and financial records;

B. examination of equipment, materials, prescribed drugs, or other items used in or for a recipient's health service under a program;

C. examination of prescriptions for recipients;

D. interviews of contacts specified in subpart 2;

E. verification of the professional credentials of a provider, the provider's employees, and entities under contract with the provider to provide health services or maintain health service and financial records related to a program;

F. consultation with the department's peer review mechanisms; and

G. determination of whether a health service provided to a recipient meets the criteria of parts 9505.0210 and 9505.0215.

Subp. 4. **Determination of investigation.** After completing its investigation under subparts 1 to 3, the department shall determine whether:

A. the provider or the recipient is in compliance with the requirements of a program;

B. insufficient evidence exists that fraud, theft, or abuse has occurred; or

C. the evidence of fraud, theft, or abuse supports administrative, civil, or criminal action.

Subp. 5. **Postinvestigation action.** After completing the determination required under subpart 4, the department shall take one or more of the actions specified in items A to F:

A. close the investigation when no further action is warranted;

B. impose administrative sanctions according to part 9505.2210;

C. seek monetary recovery according to part 9505.2215;

D. refer the investigation to the appropriate state regulatory agency;

E. refer the investigation to the attorney general or, if appropriate, to a county attorney for possible civil or criminal legal action; or

F. issue a warning that states the practices are potentially in violation of program laws or regulations.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2205 COMMISSIONER TO DECIDE IMPOSITION OF SANCTION.

The commissioner shall decide what sanction shall be imposed against a provider or recipient under part 9505.2210. The commissioner shall consider the recipient's personal preferences in the designation of a primary care case manager. In addition, the commissioner shall consider the following factors in determining the sanctions to be imposed:

A. nature and extent of fraud, theft, or abuse;

B. history of fraud, theft, or abuse;

C. willingness of provider or recipient to comply with program rules;

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

E. in the case of a recipient, the local trade area and access to medically necessary services in the designation of a primary care case manager or other restrictions.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2210 IMPOSITION OF ADMINISTRATIVE SANCTIONS.

Subpart 1. **Authority to impose administrative sanction.** The commissioner shall impose administrative sanctions or issue a warning letter if the department's investigation under part 9505.2200 determines the presence of fraud, theft, or abuse in connection with a program or if the provider or recipient refuses to grant the department access to records as required under part 9505.2185.

Subp. 2. **Nature of administrative sanction.** The actions specified in items A and B are administrative sanctions that the commissioner may impose for the conduct specified in subpart 1.

A. For a provider, the actions are:

(1) referral to the appropriate peer review mechanism;

(2) transfer to a provider agreement of limited duration;

(3) transfer to a provider agreement which stipulates specific conditions of participation;

(4) suspending or terminating the provider's participation;

(5) requiring attendance at provider education sessions provided by the department;

(6) requiring prior authorization of the provider's services;

(7) review of the provider's claims before payment; and

(8) restricting the provider's participation in a program.

B. For a recipient, except as provided in subpart 3, the actions are:

(1) referral for appropriate health counseling to correct inappropriate or dangerous use of health care services;

(2) restriction of the recipient; and

(3) referral to the appropriate adult or child protection agency.

Subp. 3. **Emergency health services excepted from restrictions.** Emergency health services provided to a restricted recipient by a provider shall be eligible for payment by a program if the service provided is otherwise eligible for payment by a program. The department may require the provider to provide documentation of the emergency circumstance with the emergency service payment claim.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2215 MONETARY RECOVERY.

Subpart 1. **Authority to seek monetary recovery.** The commissioner shall seek monetary recovery:

A. from a provider, if payment for a recipient's health service under a program was the result of fraud, theft, or abuse, or error on the part of the provider, department, or local agency; or

B. from a recipient, if payment for a health service provided under a program was the result of fraud, theft, or abuse, or error on the part of the recipient absent a showing that recovery would, in that particular case, be unreasonable or unfair.

Subp. 2. **Methods of monetary recovery.** The commissioner shall recover money described in subpart 1 by the following means:

A. permitting voluntary repayment of money, either in lump sum payment or installment payments;

B. using any legal collection process;

C. deducting or withholding from program payments money described in subpart 1; and

D. withholding payments to a provider under Code of Federal Regulations, title 42, section 447.31.

Subp. 3. **Interest charges on monetary recovery.** If the department permits the use of installment payments to repay money described in subpart 1, the department may assess interest on the funds to be received at the rate established by the Department of Revenue under Minnesota Statutes, section 270.75. Interest may accrue from the effective date of recovery, as specified in part 9505.2230, subpart 2.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2220 USE OF RANDOM SAMPLE EXTRAPOLATION IN MONETARY RECOVERY.

Subpart 1. **Authorization.** For the purpose of part 9505.2215, the commissioner shall be authorized to calculate the amount of monetary recovery from a provider of money erroneously paid based upon extrapolation from systematic

random samples of claims submitted by the provider and paid by the program or programs. The department's random sample extrapolation shall constitute a rebuttable presumption regarding the calculation of monetary recovery. If the presumption is not rebutted by the provider in the appeal process, the department shall use the extropolation as the monetary recovery figure specified in subpart 3.

Subp. 2. **Decision to use samples.** The department shall decide whether sampling and extrapolation are to be used in calculating a monetary recovery according to the following criteria:

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

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

Subp. 3. **Sampling method.** The department shall use the methods in items A to D in calculating the amount of monetary recovery by random sample extrapolation.

A. Samples of a given size shall be selected in such a way that every sample of that size shall be equally likely to be selected.

B. Samples shall only be selected from claims for health services provided within the interval that coincides with the interval during which money allegedly was erroneously provided and for which recovery will be made.

C. The sampling method, including sample size, sample selections, and extrapolation from the results of the sample, shall be according to statistical procedures published in the following text: W. Cochran, Sampling Techniques, John Wiley and Sons, New York 3rd Ed. (1977). Sampling Techniques is incorporated by reference and is available through the Minitex interlibrary loan system.

D. The sample size will be sufficiently large so that the estimate of the amount which would be recovered by a full audit will be within five percent of that amount with 95 percent confidence. A two-sided 95 percent confidence interval for that amount will be computed. The department's calculated monetary recovery is the lower end of that confidence interval.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2225 SUSPENSION OF PROVIDER CONVICTED OF CRIME RELATED TO MEDICARE OR MEDICAL ASSISTANCE.

The commissioner shall suspend a provider who has been convicted of a crime related to Medicare or medical assistance as provided in Minnesota Statutes, sections 256B.064 and 256D.03, subdivision 7, clause (b). The procedures in part 9505.0475 shall be followed in the suspension process.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2230 NOTICE OF AGENCY ACTION.

Subpart 1. **Required written notice.** The department shall give notice in writing to a provider or recipient of a monetary recovery or administrative sanction that is to be imposed by the department. The notice shall be sent by first class mail. The department shall place an affidavit of the mailing in the provider's or recipient's file as an indication of the date of mailing and the address. The notice shall state:

A. the factual basis for the department's determination according to part 9505.2200, subpart 4;

B. the actions the department plans to take;

C. the dollar amount of the monetary recovery, if any;

D. how the dollar amount was computed;

E. the right to dispute the department's determinations and to provide evidence; and

F. the right to appeal the department's proposed action under part 9505.2245.

Subp. 2. **Effective date of recovery or sanction.** For providers, the effective date of the proposed monetary recovery or sanction shall be the first day after the last day for requesting an appeal as provided in part 9505.2245, subpart 1, item B. For recipients, the effective date of the proposed action shall be 30 days after the recipient's receipt of the notice required under subpart 1. If an appeal is made under part 9505.2245, the proposed action shall be delayed pending the final outcome of the appeal, except as provided by part 9505.2231. Implementation of a proposed action following the resolution of an appeal may be postponed if in the opinion of the commissioner the delay of action is necessary to protect the health or safety of the recipient or recipients.

Subp. 3. **Effect of department's administrative determination.** Unless a timely and proper appeal made under part 9505.2245 is received by the department, the administrative determination of the department shall be considered final and binding.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2231 SUSPENSION OR WITHHOLDING OF PAYMENTS TO PROVIDERS BEFORE APPEAL.

Subpart 1. **Grounds for suspension or withholding.** The commissioner is authorized to suspend or withhold payments to a provider before an appeal provided in part 9505.2245, if:

A. there is substantial likelihood that the department will prevail in an action under parts 9505.2160 to 9505.2245;

B. there is a substantial likelihood that the provider's practice, which is the basis for the department's determination made under part 9505.2200, subpart 4, will continue in the future;

C. there is reasonable cause to doubt the provider's financial ability to repay the amount determined to be due; or

D. suspending participation or withholding payment is necessary to comply with Minnesota Statutes, section 256B.064, subdivision 2.

Subp. 2. **Exception to prehearing suspension or withholding.** The commissioner shall not order a prehearing suspension or withholding of payments to a nursing home or convalescent care facility.

Subp. 3. **Federal share.** When an overpayment has been made by the department, the commissioner is authorized to recover from a provider the federal share when it is due to the federal government under federal law and regulations.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2235 SUSPENSION OR TERMINATION OF PROVIDER PARTICIPATION.

Subpart 1. **Effect of suspension or termination as provider.** The provider agreement of a vendor who is under suspension or terminated from participation shall be void from the date of the suspension or termination. A suspension or termination from medical assistance does not mean suspension or termination from another program unless the suspension or termination is extended to that program. The vendor who is under suspension or terminated from participation shall not submit a claim for payment under a program, either through a claim as an individual or through a claim submitted by a clinic, group, corporation, or profes-

sional association except in the case of claims for payment for health services provided before the vendor's suspension or termination from participation. No payments shall be made to a vendor, either directly or indirectly, for services provided under a program from which the vendor had been suspended or terminated.

Subp. 2. **Reinstatement of vendor as provider.** A vendor who is under suspension or terminated from participation is eligible to apply for reinstatement as a provider at the end of the period of suspension or when the basis for termination no longer exists. The department shall review a vendor's application to determine whether the vendor is qualified to participate as specified by the provider participation requirements of part 9505.0195 and Code of Federal Regulations, title 42, sections 1002.230 to 1002.234.

Subp. 3. **Prohibited submission of vendor's claims.** A clinic, group, corporation, or other professional association shall not submit a claim for a health service under a program provided by a vendor who is under suspension or terminated from participation unless the health service was provided before the vendor's suspension or termination. If a clinic, group, corporation, or other professional association receives payment under a program for a health service provided by a vendor after the vendor's suspension or termination from participation, the department shall recover the amount of the payment and may impose administrative sanctions against the clinic, group, corporation, or other professional association if the commissioner determines that the provider knew or had reason to know of the suspension or termination.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2236 RESTRICTION OF PROVIDER PARTICIPATION.

Subpart 1. **Effect of restriction on a provider.** The provider agreement of a provider who is restricted from participation shall be amended by the restriction specified in the notice of action to the vendor provided under part 9505.2230. The provider who is restricted from participation shall not submit a claim for payment under a program for services or charges specified in the notice of action, either through a claim as an individual or through a claim submitted by a clinic, group, corporation, or professional association, except in the case of claims for payment for health services otherwise eligible for payment and provided before the restriction. No payments shall be made to a provider, either directly or indirectly, for restricted services or charges specified in the notice of action.

Subp. 2. **Reinstatement of restricted provider.** A provider who is restricted from participation is eligible to apply for reinstatement as an unrestricted provider at the end of the period of restriction. The department shall review a provider's application to determine whether the provider is qualified to participate without restrictions as specified by the provider participation requirements of part 9505.0195 and Code of Federal Regulations, title 42, sections 1002.230 to 1002.234.

Subp. 3. **Prohibited submission of restricted provider's claims.** A clinic, group, corporation, or other professional association shall not submit a claim for a health service furnished under a program by a provider who is restricted from furnishing the health service or submitting a charge or claim, unless the health service was provided before the provider's restriction. If a clinic, group, corporation, or other professional association receives payment for a health service furnished under a program by a provider restricted from participation, the department shall recover the amount of the payment and may impose administrative sanctions against the clinic, group, corporation, or other professional association if the commissioner determines that the clinic, group, corporation, or other professional association knew or had reason to know of the restriction.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2240 NOTICE TO THIRD PARTIES ABOUT DEPARTMENT ACTIONS FOLLOWING INVESTIGATION.

Subpart 1. **Notice about providers.** After the department has taken an action against a provider as specified in part 9505.2210, subpart 2, item A, and the right to appeal has been exhausted or the time to appeal has expired, the department shall issue the notices required in items A and B.

A. The department shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made, sanctions imposed, appeals made, and the results of any appeal.

B. The department shall notify the general public about action taken under part 9505.2210, subpart 2, item A, subitem (4) or (8), by publishing the notice in a general circulation newspaper in the geographic area of Minnesota generally served by the provider in the majority of its health services to Minnesota program recipients. The notice shall include the provider's name and service type, the action taken by the department, and the effective date or dates of the action.

Subp. 2. **Information and notice about recipients.** After the department has taken an action against a recipient as specified in part 9505.2210, subpart 2, item B, subitem (2), and the recipient's right to appeal has been exhausted or the time to appeal has expired, the department must notify the recipient's primary care case manager and other health care providers about the restriction imposed on the recipient and the circumstances leading to the restriction. Notice shall include the recipient's name and program, the nature of the restriction imposed on the recipient, a list of providers to whom the recipient is restricted, and the beginning and ending dates of the restriction.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.2245 APPEAL OF DEPARTMENT ACTION.

Subpart 1. **Provider's right to appeal.** A provider may appeal the department's proposed actions under parts 9505.2210, 9505.2215, and 9505.2220, under the provisions of Minnesota Statutes, section 14.57 to 14.62.

A. The appeal request shall specify:

(1) each disputed item, the reason for the dispute, and estimate of the dollar amount involved for each disputed item;

(2) the computation that the provider believes is correct;

(3) the authority in the statute or rule upon which the provider relies for each disputed item; and

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal.

B. An appeal shall be considered timely if written notice of appeal is received by the commissioner as provided by statute.

Subp. 2. **Recipient's right to appeal.** A recipient may appeal any sanction proposed by the department under Minnesota Statutes, section 256.045, and part 9505.0130.

Statutory Authority: *MS s 256B.04*

History: *15 SR 2563*

9505.5010 PRIOR AUTHORIZATION REQUIREMENT.

Subpart 1. **Provider requirements.** Except as provided in part 9505.5015, a provider shall obtain prior authorization as a condition of reimbursement under

the medical assistance and general assistance medical care programs for health services designated under parts 9505.0170 to 9505.0475 and 9505.5025; and Minnesota Statutes, section 256B.0625, subdivision 25. Prior authorization shall assure the provider reimbursement for the approved health service only if the service is given during a time the person is a recipient and the provider meets all requirements of the medical assistance or general assistance medical care programs.

[For text of subps 2 to 4, see M.R.]

Statutory Authority: *MS s 256.991; 256D.03*

History: *16 SR 2102*

9505.5015 AFTER THE FACT AUTHORIZATION.

Subpart 1. **Exceptions.** As provided in subparts 2 to 4, medical assistance or general assistance medical care programs reimbursement shall be given for a health service for which the required authorization was requested after the health service was delivered to the recipient. The provider of the health service shall submit the request on form DHS-1856 or DHS-1855 as required in part 9505.5010, subpart 3, and shall submit materials, reports, progress notes, admission histories, or other information that substantiates that the service was necessary to treat the recipient.

Subp. 2. **Emergencies.** A health service requiring prior authorization shall retroactively receive authorization in an emergency if the provider submits the request for authorization after providing the initial service and the provider documents the emergency. Billing for emergency services must comply with part 9505.0450.

Subp. 3. **Retroactive eligibility.** When the health service was provided on or after the date on which the recipient's eligibility began, but before the date the case was opened, a health service requiring prior authorization shall be authorized retroactively if the health service meets the criteria in part 9505.5030, and if an authorization request is submitted to the department within 180 days of the date the case was opened.

Subp. 4. **Third party liability.** A provider of a health service originally billed to Medicare or a third-party payer as defined in part 9505.0015, subpart 46, for which Medicare or the third-party payer denied payment or made a partial payment may retroactively submit a request for authorization if the provider wants to receive payment of the difference between the medical assistance or general assistance medical care payment rate for the service and the payment by the third-party payer. The service is eligible for medical assistance or general assistance medical care reimbursement if it meets the criteria in part 9505.5030 and if the authorization request is submitted to the department along with a copy of the notice explaining the denial or partial payment within 180 days of the date of the notice.

Subp. 5. **Authorization of dental prostheses.** A dental services provider who wants to obtain after the fact authorization of a removable dental prosthesis for which authorization is required under part 9505.0270, subpart 4, must submit the request on form DHS-1856 before submitting an invoice for the removable prosthesis. To obtain after the fact authorization, the removable prosthesis must meet a criterion specified in part 9505.0270, subpart 4, items A to C.

Subp. 6. **Authorization of medical supplies or equipment for recipient being discharged from hospital or long-term care facility.** Medical supplies or equipment requiring prior authorization under part 9505.0310, subpart 3, or Minnesota Statutes, section 256B.0625, subdivision 25, shall receive after the fact authorization in the case of a recipient being discharged from a hospital or long-term care facility if:

A. the provider submits a request for authorization after providing the initial service;

B. the provider documents the date of the recipient's discharge from the long-term care facility or hospital;

C. the recipient's discharge plan specifies the medical supplies or equipment as medically necessary and appropriate for the recipient's home care; and

D. the medical supplies and equipment are eligible for medical assistance payment under part 9505.0310.

Statutory Authority: *MS s 256.991; 256D.03*

History: *16 SR 2102*