CHAPTER 9505
DEPARTMENT OF HUMAN SERVICES
HEALTH CARE PROGRAMS

9505.0175 DEFINITIONS.

[For text of subps 1 to 45, see M.R.]

Subp. 46. **Supervision.** "Supervision," except as specified in item E, means the process of control and direction by which the provider accepts full professional responsibility for the supervisee, instructs the supervisee in his or her work, and oversees or directs the work of the supervisee. The process must meet the following conditions.

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

E. Items A to D do not apply to supervision of physician assistants. Physician supervision of physician assistants must meet the standards set by Minnesota Statutes, chapter 147A, except that in rural health clinics and federally qualified health centers, physician supervision of physician assistants is governed by Code of Federal Regulations, title 42, chapter IV, subchapter E, part 491, subpart A, section 491.8.

[For text of subps 47 to 50, see M.R.]

Statutory Authority: *MS s 256B.04*

History: *21 SR 525*

9505.0326 FAMILY COMMUNITY SUPPORT SERVICES.

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

A. "Case management" means the activities specified in Minnesota Statutes, section 245.4871, subdivision 3, in the case of a child under age 18, or Minnesota Statutes, section 245.462, subdivision 3, in the case of a child at least age 18 but under age 21.

B. "Child" means a person under age 21 who is eligible for the early and periodic screening, diagnosis, and treatment program under parts 9505.1693 to 9505.1748 and who has been determined to be eligible for family community support services.

C. "Child with severe emotional disturbance" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 6, and includes a person at least age 18 but under age 21 who has serious and persistent mental illness as defined in Minnesota Statutes, section 245.462, subdivision 20, paragraph (c).

D. "Clinical supervision" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 7, for family community support services to a child under age 18, or Minnesota Statutes, section 245.462, subdivision 4a, for family community support services to a child at least age 18 but under age 21.

E. "Crisis assistance" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 9a. Crisis assistance does not mean necessary emergency services or

services designed to secure the safety of a child who is at risk of abuse or neglect. Crisis assistance, for a child, is an intense component of family community support services designed to address abrupt or substantial changes in the functioning of the child or the child's family evidenced by a sudden change in behavior with negative consequences for well being, a loss of usual coping mechanisms, or the presentation of danger to self or others. The services focus on crisis prevention, identification, and management. Crisis assistance may be used to reduce immediate personal distress and to assess factors that precipitated the crisis in order to reduce the chance of future crisis situations by implementing preventive strategies and plans. These are time-limited services designed to resolve or stabilize crisis through arrangements for direct intervention, support services to the child and family, and provisions for the utilization of more appropriate resources. Crisis assistance service components are crisis risk assessment, screening for hospitalization, referral and follow-up to suitable community resources, and planning for crisis intervention and counseling services with other service providers, the child, and the child's family.

F. "Diagnostic assessment" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 11, for a child under age 18, or Minnesota Statutes, section 245.462, subdivision 9, for a child at least age 18, but under age 21.

G. "Family" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 16.

H. "Family community support services" means those services in Minnesota Statutes, section 245.4871, subdivision 17, clauses (3) to (6). The services in Minnesota Statutes, section 245.4871, subdivision 17, clauses (1), (2), and (7) to (11), are not family community services eligible for medical assistance payment under this part.

I. "Individual family community support plan" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 19.

J. "Recipient" means a person who has been determined by the local agency to be eligible for medical assistance, and has been determined by a diagnostic assessment to be a child with a severe emotional disturbance, who has been determined eligible for family community support services by the local agency or the provider under contract to the local agency.

K. "Therapeutic support of foster care" has the meaning given in part 9505.0327.

Subp. 2. **Eligible providers of family community support services.** The entities in items A and B are eligible to provide family community support services if they meet the requirements of subparts 4 to 6:

A a county board; or

B. a provider under contract to a county board.

For purposes of this subpart, "county board" means the county board of commissioners or a board established under Minnesota Statutes, sections 402.01 to 402.10, or 471.59. A provider under contract to the county board to render family community support services must provide the required services and may not contract for family community support services with another party. The persons who provide the services must be employees of the provider under contract to the county board for the family community support services. Notwithstanding the definition in part 9505.0175, subpart 12, "employee" means a person employed by a provider who pays compensation to the employee and who withholds or is required to withhold federal and state taxes from the employee's compensation. An employee is not a self-employed vendor or independent contractor who has a contract with a provider.

Subp. 3. **Determination of eligibility to receive family community support services.** Family community support services are available to a child under age 18 who has been determined by diagnostic assessment to be a child with severe emotional disturbance, or if between the ages of 18 and 21, a person who has been determined to have a serious and persistent mental illness and needs family community support services. The diagnostic assessment may be a service under the early and periodic screening, diagnostic, and treatment services established in United States Code, title 42, chapter 7, subchapter XIX, section 1396d(r).

Subp. 4. **Eligibility for medical assistance payment.** To be eligible for medical assistance payment, the provider of family community support services as specified in subpart 2 must meet the requirements in items A to F. The mental health professional or practitioner

delivering family community support services must work with other persons rendering services to the child and shall ensure coordination and nonduplication of services consistent with county board coordination procedures established under Minnesota Statutes, section 245.4881, subdivision 5. Services must be provided in accordance with the following requirements:

A. The provider responsible for providing family community support services under subpart 2 must be able to recruit mental health professionals and practitioners, must have adequate administrative ability to ensure availability of services, and must ensure adequate pre–service and in–service training.

B. The mental health professional or practitioner delivering family community support services must be skilled in the delivery of mental health services to children with severe emotional disturbance and must be capable of implementing services which address the needs identified in the child's treatment plan.

C. The county board or provider under contract to the county board shall ensure that the mental health professionals involved in a child's care develop and sign the treatment plan and periodically review the necessity for treatment and the appropriateness of care. The individual treatment plan must become a subsection of the individual family community support plan.

D. Crisis assistance services for a child must be coordinated with emergency services as defined in Minnesota Statutes, section 245.4871, subdivision 14, for a child, and Minnesota Statutes, section 245.462, subdivision 11, for an adult. The provider under subpart 2 must render, or assist the child or the child's family in arranging emergency services for the child and the child's family. Emergency services must be available 24 hours per day, seven days a week.

E. If the recipient has no assigned case manager or refuses case management services, the county board or provider under contract to the county board shall ensure coordination of the components of family community support services.

F. The county board or provider under contract to a county board must ensure family community support services are given in a manner consistent with the core values set forth in Child Adolescent Service System Program (CASSP) in "A System of Care for Severely Emotionally Disturbed Children and Youth," which is incorporated by reference and published by the CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Road Northwest, Washington, D.C. 20007 (Washington, D.C., 1986). It is not subject to frequent change and is available at the Legislative Reference Library, 6th Floor, 100 Constitution Avenue, St. Paul, MN 55155.

Subp. 5. **Condition to receive medical assistance payment; clinical supervision required.** To be eligible for medical assistance payment, the mental health practitioner providing family community support services must receive clinical supervision from a mental health professional. However, medical assistance shall reimburse a mental health practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility and is present on–site for at least one observation during the first 12 hours in which the mental health practitioner provides the family community support services to the child with severe emotional disturbance or to the child's family. Thereafter, the mental health professional must be present on–site for observation as clinically appropriate when the mental health practitioner is providing individual family or group skills training to the child and the child's family. The observation must be a minimum of one clinical hour. The mental health professional accepting full professional responsibility must document the mental health professional's on–site presence in the child's record.

Subp. 6. **Components of family community support services.** A provider of family community support services as specified in subpart 2 is responsible to provide diagnostic assessments, if necessary, and the family community support components specified in a child's individual treatment plan. The components of family community support services are:

A. individual, family, or group skills training as specified in part 9505.0324, subpart 5, item C, subitems (1) and (2), and Minnesota Statutes, section 245.4871, subdivision 17, clauses (3) to (5), including assistance in developing independent living skills, assistance

in developing parenting skills necessary to address the needs of the child, and assistance with leisure and recreational activities; and

B. crisis assistance.

Subp. 7. **Excluded services.** The services specified in items A to N are not eligible for medical assistance payment:

A. client outreach for the purpose of seeking persons who potentially may be eligible for family community support services under this part;

B. family community support services provided to a child who at the time of service provision has not had a diagnostic assessment to determine if the child has a severe emotional disturbance, except that the first 30 hours of family community support services provided to a child who is later assessed and determined to have a severe emotional disturbance at the time services were initiated shall be eligible for medical assistance payment;

C. more than 68 hours of individual, family, or group skills training within any consecutive six-month period. The 68-hour limit may not be exceeded during any calendar year unless prior authorization is obtained;

D. more than 24 hours of crisis assistance within any consecutive six-month period. The 24-hour limit may not be exceeded during any calendar year, except in the case of an emergency, and prior authorization of the psychotherapy is obtained;

E. family community support services that exceed 92 hours in any combination of crisis assistance, and individual, family, or group skills training within any consecutive six-month period. The 92-hour limit may not be exceeded during any calendar year. Additional family community support services beyond 92 hours are eligible for medical assistance payment with prior authorization;

F. crisis assistance and individual, family, or group skills training provided by a person who is not at least qualified as a mental health practitioner as specified in Minnesota Statutes, section 245.4871, subdivision 26, and who does not maintain a consulting relationship with a mental health professional who accepts full professional responsibility as defined in subpart 5,

G. family community support services simultaneously provided with home-based mental health services;

H. family community support services simultaneously provided with therapeutic support of foster care services;

I. assistance in locating respite care and special needs day care, and assistance in obtaining potential financial resources, including those benefits listed in Minnesota Statutes, section 245.4884, subdivision 5,

J. medication monitoring;

K. family community support services not provided by a provider specified in subpart 2;

L. family community support services simultaneously provided by more than one mental health professional or mental health practitioner unless prior authorization is obtained;

M family community support services to a child or the child's family if the same services are provided to the child or child's family under part 9505.0323, 9505.0324, or 9505.0327; grants authorized according to Minnesota Statutes, section 245.4886; the Minnesota Family Preservation Act, Minnesota Statutes, section 256F.03, subdivision 5, paragraph (e), or the Minnesota Indian Family Preservation Act, Minnesota Statutes, sections 257.35 to 257.3579, except up to 60 hours of day treatment services under part 9505.0323 within a six-month period provided concurrently with family community support services to a child with severe emotional disturbance are eligible for medical assistance payment without prior authorization if the child is being phased out of day treatment services and phased into family community support services, or if the child is being phased out of family community support services and phased into day treatment services and the family community support services and day treatment services are identified with the goals of the child's individual treatment plan. Prior authorization may be requested for additional hours of day treatment beyond the 60-hour limit; or

N. family community support services provided in violation of subparts 1 to 6.

Subp. 8 **Required orientation and training.** A provider that employs a mental health practitioner to provide family community support services under this part must require the mental health practitioner to complete 20 hours of continuing education every two calendar years. The continuing education shall be related to serving the needs of a child with severe emotional disturbance in the child's home environment and the child's family. The topics covered in orientation and training must conform to part 9535.4068. The provider as specified in subpart 2 shall document completion of the required continuing education on an annual basis

Subp. 9. **Travel to the child's treatment site.** A mental health practitioner or professional shall receive payment for travel to and from the site where family community support services are provided. Travel shall be reimbursed at the hourly rate paid to a case manager for case management services under part 9505.0491, subparts 7 and 8 Only 40 hours of travel per recipient in any consecutive six–month period shall be reimbursed. The 40–hour limit may not be exceeded on a calendar year basis unless prior authorization is obtained. The commissioner's implementation of this subpart shall be subject to approval by the Health Care Financing Administration of the United States Department of Health and Human Services.

Subp. 10. **Coordination of family community support services with other programs.** Family community support services to recipients receiving community support services through a program other than medical assistance shall be coordinated as specified in items A and B.

A. If the child eligible for family community support services has a developmental disability, a substance abuse problem, or a physical condition that necessitates regular medical care, then a developmental disabilities specialist, substance abuse specialist, or medical specialist, respectively, must be solicited to be part of the planning team for the care of the child. The provider specified in subpart 2 must ensure the coordination of a child's care involving multiple agencies.

B. If applicable, the local provider specified in subpart 2 shall coordinate but not duplicate services under the adult community support programs for a child between the ages of 18 and 21 who is eligible for and is receiving family community support services. The individual treatment plan shall address an appropriate transition plan between family community support and community support services, if applicable.

Statutory Authority: *MS s 256B.04; 256B.0625*

History: *21 SR 582*

9505.0327 THERAPEUTIC SUPPORT OF FOSTER CARE.

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

A. "Case management" means the activities specified in Minnesota Statutes, section 245.4871, subdivision 3, for a child under age 18, or Minnesota Statutes, section 245.462, subdivision 3, for a child at least age 18 but under age 21.

B. "Child" means a person under age 21 who is eligible for the early and periodic screening, diagnosis, and treatment program under parts 9505.1693 to 9505.1748, and who is determined to be in need of therapeutic support of foster care.

C. "Child with severe emotional disturbance" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 6, and includes a person at least age 18 but under age 21 who has serious and persistent mental illness as defined in Minnesota Statutes, section 245.462, subdivision 20, paragraph (c).

D. "Clinical supervision" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 7, for therapeutic support of foster care to a child under age 18, or Minnesota Statutes, section 245.462, subdivision 4a, for therapeutic support of foster care to a child at least age 18 but under age 21.

E. "Diagnostic assessment" has the meaning given in Minnesota Statutes, section 245.4871, subdivision 11, for a child under age 18, or Minnesota Statutes, section 245.462, subdivision 9, for a child at least age 18 but under age 21.

F. "Family community support services" means services defined in Minnesota Statutes, sections 245.4871, subdivision 17, and 245.4884, subdivision 1.

G. "Family foster care" means direct 24–hour a day care provided to a child, out of the child's home, by a foster family.

H. "Foster family" means the foster child and adult caregiver or caregivers of foster family care who are responsible for the care of the foster children in the adult caregivers' homes.

I. "Recipient" means a child who has been determined by the local agency to be eligible for medical assistance, who has a severe emotional disturbance as determined by a diagnostic assessment, and who has been determined eligible for therapeutic support of foster care by the local agency or a provider under contract to the local agency.

J. "Residence," as defined in part 9505.0175, subpart 43, does not include a group home as defined in part 9560 0520, subpart 4; a residential treatment facility licensed under parts 9545.0900 to 9545.1090; an acute care hospital licensed under Minnesota Statutes, chapter 144; a regional treatment center or other institutional group setting; or a foster family home in which the foster parent is not the primary caregiver and does not reside with the child.

K. "Therapeutic support of foster care" has the meaning given in Minnesota Statutes, section 245 4871, subdivision 34. Therapeutic support of foster care is a set of intensive treatment services for foster families who care for children with severe emotional disturbances. The purpose of therapeutic support of foster care is to enable a child to improve or maintain emotional or behavioral functioning in order to reduce or prevent the reliance upon more intensive, restrictive, and costly services, or to reunify and reintegrate the child with the child's family after out–of–home placement. The services are provided primarily in the child's foster home but may also be provided in the child's school, the home of a relative or natural parent of the child, where the child works, a recreational or leisure setting, or the site where the child receives day care.

Subp. 2. **Eligible providers of therapeutic support of foster care.** The entities in items A and B are eligible to provide therapeutic support of foster care if they meet the requirements of subparts 4 to 6:

A. a county board; or

B. a provider under contract to a county board.

For purposes of this subpart, "county board" means the county board of commissioners or a board established under Minnesota Statutes, sections 402.01 to 402.10, or 471.59. A provider specified in item B under contract to the county board to render therapeutic support of foster care must provide the required services and may not contract for therapeutic support of foster care with another party. The persons who provide the services must be employees of the entity under contract with the county board for the therapeutic support of foster care. Notwithstanding the definition in part 9505.0175, subpart 12, "employee" means a person employed by a provider who pays compensation to the employee and who withholds or is required to withhold federal and state taxes from the employee's compensation. An employee is not a self–employed vendor or independent contractor who has a contract with a provider.

Subp. 3. **Eligibility to receive therapeutic support of foster care.** Therapeutic support of foster care is available to a foster family that provides foster care to a child with severe emotional disturbance who needs services to provide a therapeutic family environment or support for the child's improved functioning. The determination of a child's eligibility to receive therapeutic support of foster care under this part shall be based on a diagnostic assessment. The diagnostic assessment may be a service under the early and periodic screening, diagnostic, and treatment services established in United States Code, title 42, chapter 7, subchapter XIX, section 1396d(r).

Subp. 4. **Eligibility for medical assistance payment.** To be eligible for medical assistance payment, the provider of therapeutic support of foster care under subpart 2 must meet the requirements in items A to F.

A. Therapeutic support of foster care must be provided by mental health professionals and mental health practitioners who are skilled in the delivery of therapeutic support

services to foster families caring for children with severe emotional disturbance. The county board or provider under contract to a county board must ensure that mental health practitioners providing therapeutic support of foster care receive continuing training as defined in subpart 9.

B. The number of foster children in the family receiving therapeutic support of foster care shall not exceed two without department approval based on justification consistent with "Program Standards for Treatment Foster Care," which is incorporated by reference and published by the Foster Family–Based Treatment Association, 43 West 33rd Street, Suite 601, New York, New York 10001 (New York, New York, 1991). It is subject to frequent change and is available at the Legislative Reference Library, 6th Floor, 100 Constitution Avenue, St. Paul, MN 55155.

C. The caseload size of the mental health practitioners providing therapeutic support of foster care shall not exceed eight children.

D. The county board or provider under contract to the county board must provide, or assist the child or the child's foster family in arranging, mental health crisis services for the child and the child's foster family. Mental health crisis services must be available 24 hours per day, seven days a week.

E. The provider under subpart 2 must submit a letter to the Department of Human Services prior to rendering therapeutic support of foster care ensuring that it has adequate capacity to recruit mental health professionals and practitioners to provide therapeutic support of foster care, as specified in subparts 5 and 6.

F. The provider of therapeutic support of foster care under subpart 2 must ensure that services are rendered in a manner that is consistent with the core values set forth in "Program Standards for Treatment Foster Care."

Subp. 5. **Condition to receive medical assistance payment; individual treatment plan requirements.** Medical assistance payment is available only for services as provided in the recipient's individual treatment plan and items A to E.

A. Services must be designed by a mental health professional to meet the mental health needs of the child and the child's foster family as it relates to care of the child.

B. Mental health professionals and mental health practitioners shall work with the foster family and the child's other service providers to develop an individual treatment plan.

C. Mental health professionals and practitioners shall train and support the child's foster family through the child's length of stay in the foster family as long as determined necessary in the individual treatment plan. The foster family and, unless clinically inappropriate, the child must be invited to participate in all treatment planning for the child.

D. The individual treatment plan shall be updated by a mental health professional as needed. However, treatment plan reviews to assess the child's progress and to ensure that services and treatment goals continue to be necessary and appropriate to the child and the child's foster family shall be conducted at least every three months.

E. The development and updating of a recipient's individual treatment plan by a mental health professional shall be coordinated with, and become a subsection of, the recipient's individual family community support plan, if any.

Subp. 6. **Condition to receive medical assistance payment; clinical supervision required.** To be eligible for medical assistance payment, a mental health practitioner providing therapeutic support of foster care must receive clinical supervision. However, medical assistance shall reimburse a mental health practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility and is present on–site for at least one observation during the first 12 hours in which the mental health practitioner provides the individual, family, or group skills training to the child with severe emotional disturbance or the child's foster family. Thereafter, the mental health professional must be present on–site for observation as clinically appropriate when the mental health practitioner is providing individual family or group skills training to the recipient and the recipient's foster family. The observation must be a minimum of one clinical hour during the first 12 hours. The mental health professional must document on–site presence by signing the child's record.

Subp. 7. **Components of therapeutic support of foster care.** An eligible provider of therapeutic support of foster care specified in subpart 2 is responsible to provide diagnostic assessments and the therapeutic support of foster care components specified in a recipient's individual treatment plan. The components are:

A. individual psychotherapy, family psychotherapy, group psychotherapy, and multiple-family group psychotherapy as specified in part 9505.0323; and

B. individual, family, or group skills training to foster families as specified in part 9505.0324, subpart 5, item C. The individual, family, and group skills training shall be designed to enhance the therapeutic family environment by assisting foster families to improve their understanding of normal child development and the nature of the foster child's severe emotional disturbance; training foster families in interventions designed to meet the special and individual needs of the child; educating foster families regarding the availability of support networks for foster families; and facilitating integration and reunification goals through visitation and other activities.

Subp. 8. **Excluded services.** The services specified in items A to J are not eligible for medical assistance payment:

A. therapeutic support of foster care provided to a foster family with a child who at the time of the service has not had a diagnostic assessment to determine if the child has a severe emotional disturbance. However, the first 30 hours of therapeutic support of foster care provided to a foster family with a child who is later assessed and determined to have a severe emotional disturbance at the time services were initiated shall be eligible for medical assistance payment;

B. more than 192 hours of individual, family, or group skills training within any consecutive six-month period. The 192-hour limit may not be exceeded during any calendar year, without prior authorization;

C. more than a combined total of 48 hours within any consecutive six-month period of individual psychotherapy, family psychotherapy, group psychotherapy, and multiple-family group psychotherapy. The 48-hour limit may not be exceeded during any calendar year, except in the case of an emergency if prior authorization of the psychotherapy is obtained;

D. therapeutic support of foster care that exceeds 240 hours in any combination of the psychotherapies and individual, family, or group skills training within any consecutive six-month period. The 240-hour limit may not be exceeded during any calendar year. Additional therapeutic support of foster care beyond the 240 hours are eligible for medical assistance payment with prior authorization;

E. psychotherapy provided by a person who is not a mental health professional as defined in part 9505.0175, subpart 28;

F. individual, family, or group skills training provided by a person who is not at least qualified as a mental health practitioner as defined in Minnesota Statutes, section 245.4871, subdivision 26, and who does not maintain a consulting relationship with a mental health professional who accepts full professional responsibility as specified in subpart 6;

G. therapeutic support of foster care provided by an entity specified in subpart 2 if the entity is not capable of providing all the components required in subpart 7;

H. therapeutic support of foster care simultaneously provided by more than one mental health professional or mental health practitioner unless prior authorization is obtained;

I. therapeutic support of foster care to a foster family if the same services are provided to the family under part 9505.0323, 9505.0324, or 9505.0326; grants authorized according to Minnesota Statutes, section 245.4886, the Minnesota Family Preservation Act, Minnesota Statutes, section 256F.03, subdivision 5, paragraph (e); or the Minnesota Indian Family Preservation Act, Minnesota Statutes, sections 257.35 to 257.3579, except as provided in subitem (1) or (2):

(1) up to 60 hours of day treatment services under part 9505.0323 within a six-month period provided concurrently with therapeutic support of foster care to a child with severe emotional disturbance are eligible for medical assistance payment without prior authorization if the child is being phased out of day treatment services and phased into thera-

peutic support of foster care, or if the child is being phased out of therapeutic support of foster care and phased into day treatment services and therapeutic support of foster care and day treatment services are identified within the goals of the child's individual treatment plan. Therapeutic support of foster care must be coordinated with the provision of day treatment services. Prior authorization may be requested for additional hours of day treatment beyond the 60–hour limit; or

(2) if the mental health professional providing the child's therapeutic support of foster care anticipates the child or the child's family will need outpatient psychotherapy services upon completion of the therapeutic support of foster care, then one session of individual psychotherapy per month for the child or one session of family psychotherapy per month for the child's family is eligible for medical assistance payment during the period the child is receiving therapeutic support of foster care. For purposes of the child's transition to outpatient psychotherapy, the child may receive two additional psychotherapy visits per six–month episode of therapeutic support of foster care if the mental health professional providing the therapeutic support of foster care requests and obtains prior authorization. The mental health professional providing therapeutic support of foster care shall work with the provider of outpatient psychotherapy to facilitate the child's transition from therapeutic support of foster care to outpatient psychotherapy services and to coordinate the child's mental health services as required under part 9505.0323, subpart 32; or

J. therapeutic support of foster care that does not comply with subparts 1 to 7.

Subp. 9. **Required orientation and training.** A provider that employs a mental health practitioner to provide therapeutic support of foster care under this part must require the mental health practitioner to complete 20 hours of continuing education every two calendar years The continuing education shall be related to serving the needs of a child with severe emotional disturbance in the child's home environment and the child's family. The topics covered in orientation and training must conform to part 9535.4068. The provider shall document completion of the required continuing education on an annual basis.

Subp. 10. **Travel to the child's treatment site.** Travel by a mental health professional or practitioner to and from the site where the mental health professional or practitioner provides therapeutic support of foster care is eligible for medical assistance payment. Medical assistance payment to a mental health professional or practitioner who travels to and from the site where the professional or practitioner provides therapeutic support of foster care shall not exceed payment for more than 128 hours of travel per recipient in any consecutive six–month period. These limits apply on a calendar year basis as well. The commissioner's implementation of this subpart shall be subject to approval by the Health Care Financing Administration of the United States Department of Health and Human Services. Payment for travel under this subpart shall be at the hourly rate paid to a case manager for case management services under part 9505.0491, subparts 7 and 8.

Subp. 11. **Coordination of therapeutic support of foster care with other programs.** The mental health professional or practitioner delivering therapeutic support of foster care must work with other providers rendering services to the child and foster family and shall ensure coordination and nonduplication of services consistent with county board coordination procedures established under Minnesota Statutes, section 245.4881, subdivision 5. If the child has other services for a developmental disability, a substance abuse problem, or a physical condition that necessitates regular medical care, or receives other services through a county social worker, then the county social worker, developmental disabilities specialist, substance abuse specialist, and medical specialist, respectively, must be invited to take part in planning for the services.

Statutory Authority: *MS s 256B.04; 256B.0625*

History: *21 SR 582*

9505.0395 RURAL HEALTH CLINIC SERVICES AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.

Subpart 1. **Definition.** "Rural health clinic service" and "federally qualified health center service" are health services provided in a clinic or center defined in Code of Federal Regulations, title 42, chapter IV, subchapter B, part 405, subpart X, and meeting the conditions set forth in Code of Federal Regulations, title 42, chapter IV, subchapter E, part 491, subpart A.

Subp. 2. **Covered services.** All health services provided by a rural health clinic or a federally qualified health center are covered services within the limitations applicable to the same services under parts 9505.0170 to 9505.0475 if the clinic's or center's staffing requirements and written policies governing health services provided by personnel other than a physician are in compliance with Code of Federal Regulations, title 42, chapter IV, subchapter E, part 491, subpart A, section 491.8. The limitations on supervision specified in part 9505.0175, subpart 46, do not apply to supervision of physician assistants working in a clinic or a center. Supervision of physician assistants m clinics or centers is governed by the standards in Code of Federal Regulations, title 42, chapter IV, subchapter E, part 491, subpart A, section 491.8.

Statutory Authority: *MS s 256B.04*

History: *21 SR 525*

9505.0500 DEFINITIONS.

[For text of subps 1 to 4, see M.R.]

Subp. 4a. [Repealed, 20 SR 2405]

[For text of subps 5 to 17, see M.R.]

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

[For text of subp 19, see M.R.]

Subp. 19a. [Repealed, 20 SR 2405]

[For text of subps 20 to 26, see M.R.]

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

Subp. 28. [Repealed, 20 SR 2405]

[For text of subp 29, see M.R.]

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.0520 INPATIENT ADMISSION CERTIFICATION.

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

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

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

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

[For text of subitems (1) to (7), see M.R.]

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

C. Inform the hospital of the certification number.

D. For purposes of billing, enter the certification number and any required prior authorization number on invoices submitted to the department for payment.

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

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

B. Within 48 hours after the occurrence of an event described m subitem (1), and within 72 hours of the event described in subitem (2), excluding weekends and holidays, inform, by telephone, the medical review agent of the event and provide the information required in subpart 3, item B, if applicable.

(1) An admission that is an emergency admission as specified in subpart 2.

(2) The admission of a pregnant woman that does not result in the delivery of a newborn or a stillbirth within 24 hours of her admission, as specified in subpart 2, item B.

For purposes of this subitem, the time limit for notifying the medical review agent is calculated beginning with the time of the admission of the pregnant woman.

If the hospital fails to notify the medical review agent within the required time limit, the hospital shall submit, at its own expense, a copy of the complete medical record to the medical review agent within 30 days after the recipient's discharge. Failure to submit the record within the 30 days shall result in denial of the certification number.

C. For billing purposes, enter the certification number and any required prior authorization number on all invoices submitted to the department for payment.

[For text of subp 5, see M.R.]

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

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

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

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

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

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

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

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

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

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

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

[For text of subp 7, see M.R.]

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

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

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

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

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

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

F. If the admitting physician does not request a second physician adviser's opinion, the medical review agent shall deny the admission certification, shall not issue a certification number, and shall notify the admitting physician, the hospital, and the recipient of the denial. The notice to the recipient shall be in writing and shall state the reasons for the denial and the recipient's right to appeal under Minnesota Statutes, section 256.045, and part 9505.0522. The notices to the admitting physician and the hospital shall be in writing, shall state the reasons for the denial, and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

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

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

H. If the second physician adviser is unable to determine that the admission is medically necessary, the medical review agent shall deny the admission certification, shall not issue a certification number, and shall notify the admitting physician, the hospital, and the recipient of the denial. The notice to the recipient shall be in writing and shall state the reasons for the denial and the recipient's right to appeal under Minnesota Statutes, section 256.045, and part 9505.0522. The notices to the admitting physician and the hospital shall be in writing and shall state the reasons for the denial and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

Subp. 9. **Reconsideration.** The admitting physician or the hospital may request reconsideration of a decision to deny or withdraw an admission certification number under subpart 8, item F or subpart 11. The admitting physician or the hospital shall submit the request in writing to the medical review agent together with the recipient's medical record and any additional information within 30 days of the date of receipt of the certified letter denymg or withdrawing an admission certification number. Upon receipt of the request, the medical record, and any additional information, the medical review agent shall appoint at least three physician advisers, none of whom shall have been involved previously in the procedure for the recipient's admission certification number, to hear the reconsideration. The reconsideration may be conducted by means of a telephone conference call. The physician advisers may seek additional facts and medical advice as necessary to decide whether the admission is medically necessary. The reconsideration shall be completed within 45 days of the receipt of the information necessary to complete the reconsideration. The outcome of the reconsideration shall be the one chosen by the majority of the physician advisers appointed to consider the request. The admitting physician or the hospital may appeal the determination of the physician advisers according to the contested case provisions of Minnesota Statutes, chapter 14, by filing a written notice of appeal with the commissioner within 30 days of the date of receipt of the certified letter upholding the denial or withdrawal of admission certification number. However, an admitting physician or hospital that does not request reconsideration or appeal under the contested case procedures of Minnesota Statutes, chapter 14, within 30 days after the denial or withdrawal of an admission certification number is not entitled to an appeal under Minnesota Statutes, chapter 14.

[For text of subp 9a, see M.R.]

Subp. 10. **Medical record review and determination.** As specified in the contract between the department and the medical review agent, upon the request of the department, or upon the initiative of the medical review agent, the medical review agent shall conduct a concurrent, continued stay, or retrospective review of a recipient's medical record to validate the diagnostic category and to determine whether the admission was medically necessary, whether the inpatient hospital services were medically necessary, whether a continued stay will be medically necessary, and whether all medically necessary services were provided. The procedure for concurrent, continued stay, and retrospective reviews shall be as in items A to F.

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

F. If the clinical evaluator is unable to determine from the documentation in the recipient's medical records the reasons for the recipient's discharge and readmission, the clinical evaluator shall submit the medical records of the recipient's discharge and readmission to a physician adviser. The physician adviser shall review the records and determine the nature of the discharge and readmission according to the criteria in part 9505.0540, subparts 3 to 5, and if the determination of the medical review agent is different from that of the admitting physician or hospital, then the medical review agent shall notify the admitting physician or hospital by certified letter mailed within five days, exclusive of weekends and holidays, of the determination. The notice shall state the right of the admitting physician and hospital to request a reconsideration under subpart 9.

Subp. 11. **Consequences of withdrawal of admission certification number; general.** The department or the medical review agent shall withdraw the certification number and may take action as specified in items A to E if the medical review agent determines any of the following: (1) that the admission was not medically necessary; (2) that all medically necessary inpatient hospital services were not provided; (3) that some or all of the inpatient hospital services were not medically necessary; or (4) that within 20 days, exclusive of weekends and holidays, the hospital has failed to comply with the department's or the medical review agent's request to submit the medical record or other required information to support that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, or that some or all of the inpatient hospital services provided were medically necessary; or, that the information submitted by the hospital was inadequate to support that the admission was medically necessary, that all medically necessary inpatient hospital services were provided, or that some or all of the inpatient hospital services provided were medically necessary.

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

E. If within 20 days, exclusive of weekends and holidays, the hospital failed to comply with the department's or the medical review agent's request to submit the medical record or other required information to support (1) that the admission was medically necessary; (2) that all medically necessary inpatient hospital services were provided; or (3) that some or all of the inpatient hospital services provided were medically necessary; or, if the information submitted by the hospital was inadequate to support clauses (1) to (3), all or part of the payment shall be denied or recovered as provided in items A to D.

Subp. 12. **Reconsideration of denial or withdrawal of admission certification number.** The denial or withdrawal of an admission certification number may be reconsidered under subpart 9.

[For text of subp 13, see M.R.]

Subp. 14. **Retroactive admission certification.** If the admitting physician fails to request admission certification by contacting the medical review agent prior to an admission for an inpatient hospital service other than a service under subpart 2, the admitting physician may retroactively request admission certification. The admitting physician shall submit at his or her own expense the recipient's complete medical record to the medical review agent within 30 days of the recipient's discharge. The medical record must contain the information required in subpart 3, item B, and any other facts necessary to establish that the recipient's admission was medically necessary. The procedure outlined in subpart 8 shall also be followed in the case of retroactive admission certification. The denial of retroactive admission certification and the withdrawal of retroactive admission certification may be appealed to the medical review agent through the reconsideration process in subpart 9.

Subp. 15. **Recovery of payment after withdrawal of admission certification number.** An admitting physician or hospital that receives a notice of withdrawal of a certification number and that does not request reconsideration under subpart 9 or appeal under Minnesota Statutes, chapter 14, shall be subject to recovery of payment without further notice or right to appeal. If a reconsideration results in the denial or withdrawal of a certification number, and the admitting physician or hospital does not appeal within the time permitted pursuant to other remedies, the department shall recover payment without further notice to the admitting physician and hospital. If an appeal results in the denial or withdrawal of a certification number, the department shall recover the payment without further notice to the admitting physician and the hospital.

Recovery of overpayments may be made by:

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

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.0521 PROHIBITION OF RECOVERY FROM RECIPIENT.

The provider may not seek payment from the recipient for inpatient hospital services provided under parts 9505.0500 to 9505.0540 if the certification number is not issued or is withdrawn.

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.0522 RECIPIENT'S RIGHT TO APPEAL.

A recipient who is denied inpatient hospital services because of the medical review agent's determination that the services are not medically necessary may appeal the medical review agent's determination under Minnesota Statutes, section 256.045.

Statutory Authority: *MS s 256.0625; 256.991, 256D.03*

History: *20 SR 2405*

9505.0540 CRITERIA TO DETERMINE MEDICAL NECESSITY OR APPROPRIATENESS.

Subpart 1. **Determination for admission for purpose other than chemical dependency treatment.** The medical review agent shall follow the Appropriateness Evaluation Protocol and Criteria for Inpatient Psychiatric Treatment of Blue Cross and Blue Shield of Minnesota in determining whether a recipient's admission is medically necessary, whether the inpatient hospital services provided to the recipient were medically necessary, whether the recipient's continued stay will be medically necessary, and whether all medically necessary inpatient hospital services were provided to the recipient.

[For text of subps 2 to 6, see M.R]

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.1100 MR 1995 [Obsolete]

9505.1110 MR 1995 [Obsolete]

9505.1120 MR 1995 [Obsolete]

9505.1130 MR 1995 [Obsolete]

9505.1140 MR 1995 [Obsolete]

9505.1150 MR 1995 [Obsolete]

9505.1160 MR 1995 [Obsolete]

9505.1170 MR 1995 [Obsolete]

9505.1180 MR 1995 [Obsolete]

9505.1190 MR 1995 [Obsolete]

9505.1200 MR 1995 [Obsolete]

9505.1210 MR 1995 [Obsolete]

9505.1220 MR 1995 [Obsolete]

9505.1230 MR 1995 [Obsolete]

9505.1240 MR 1995 [Obsolete]

9505.1250 MR 1995 [Obsolete]

9505.1260 MR 1995 [Obsolete]

9505.1270 MR 1995 [Obsolete]

9505.1280 MR 1995 [Obsolete]

9505.1290 MR 1995 [Obsolete]

9505.1300 MR 1995 [Obsolete]

9505.1310 MR 1995 [Obsolete]

9505.1320 MR 1995 [Obsolete]

9505.1330 MR 1995 [Obsolete]

9505.1340 MR 1995 [Obsolete]

9505.1350 MR 1995 [Obsolete]

9505.1360 MR 1995 [Obsolete]

9505.1370 MR 1995 [Obsolete]

9505.1380 MR 1995 [Obsolete]

9505.1718 SCREENING STANDARDS FOR AN EPSDT CLINIC.

[For text of subps 1 to 14a, see M.R.]

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.

[For text of subp 15a, see M.R.]

NOTE This subpart is shown to correct an error in Minnesota Rules 1995 A column from subpart 15, item D, was inadvertently omitted

9505.5005 DEFINITIONS.

[For text of subps 1 to 11, see M R.]

Subp. 12. **Medical assistance or MA.** "Medical assistance" or "MA" means the Medicaid program established by title XIX of the Social Security Act and Minnesota Statutes, chapter 256B. For purposes of parts 9505.5035 to 9505 5105, medical assistance also refers to general assistance medical care and MinnesotaCare unless otherwise specified.

Subp. 12a **Medical appropriateness or medically appropriate.** "Medical appropriateness" or "medically appropriate" refers to a determination, by a medical review agent, that the recipient's need for a surgical procedure requiring a second medical opinion meets the criteria in Minnesota Statutes, section 256B.0625, subdivisions 1, 4a, and 24.

Subp. 12b **Medical review agent.** "Medical review agent" means the representative of the commissioner who is authorized by the commissioner to make decisions about second medical opinions under parts 9505.5035 to 9505.5100.

[For text of subps 13 and 13a, see M.R.]

Subp. 14. **Physician.** "Physician" means a person licensed to provide services within the scope of his or her profession as defined in Minnesota Statutes, chapter 147. For purposes of the second medical opinion requirement in parts 9505.5035 to 9505.5105, physician shall also mean a person licensed to provide dental services within the scope of his or her profession as defined in Minnesota Statutes, section 150A.06, subdivision 1.

Subp. 14a. **Physician adviser.** "Physician adviser" means a physician who is qualified to render an opinion about the surgical procedure as evidenced by the physician's certification or eligibility for certification from the appropriate specialty board if, according to the community standard, the certification or eligibility for certification is required of physicians performing the surgical procedure.

Subp. 14b. **Recipient ID number.** "Recipient ID number" means the unique 8–digit identification number assigned to a recipient who has been determined eligible for MA, GAMC, or MinnesotaCare.

[For text of subps 15 to 17, see M.R.]

Subp. 17a. **Reconsideration.** "Reconsideration" means a review, as set forth in part 9505.5078, of a second physician adviser's opinion that a surgical procedure is not medically appropriate.

[For text of subp 18, see M.R.]

Subp. 18a. **Second opinion or second medical opinion.** "Second opinion" or "second medical opinion" means the determination by the medical review agent under parts 9505.5035 to 9505.5105 that a surgical procedure requiring a second medical opinion is or is not medically appropriate.

Subp. 18b. [Repealed, 20 SR 2405]

[For text of subp 19, see M.R.]

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.5035 SURGICAL PROCEDURES REQUIRING SECOND MEDICAL OPINION.

Subpart 1. **General requirements.** Second medical opinions shall be required for medical assistance, general assistance medical care, and MinnesotaCare recipients for inpatient and outpatient elective surgical procedures according to the list published in the State Register under Minnesota Statutes, section 256B 0625, subdivisions 1, 4a, and 24. Publication shall occur in the last issue of the State Register for the month of October if there has been a revision in the list since the last October. In addition, the department shall publish any revision of the list at least 45 days before the effective date if the revision imposes a second medical opinion requirement. The department shall send each provider a copy of the published list or a revision of the published list.

Subp. 2. **Requirements prior to eligibility determination.** The requirements of parts 9505.5035 to 9505.5105 shall apply to individuals who have applied for MA or GAMC, but whose applications have not yet been approved or denied at the time the surgical procedure is performed.

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.5040 [Repealed, 20 SR 2405]

9505.5041 SURGICAL PROCEDURE ELIGIBLE FOR MEDICARE PAYMENT.

A provider who performs a surgical service requiring a second medical opinion on a recipient eligible for Medicare must bill Medicare as specified in part 9505.0440. If Medicare denies payment or makes a partial payment for the service, the provider may request the medical review agent to issue an authorization number for medical assistance billing purposes. The provider's claim for medical assistance payment must comply with part 9505.0440 and the time limit specified in part 9505.0450, subpart 4, item A.

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.5045 CRITERIA TO DETERMINE WHEN SECOND MEDICAL OPINION IS REQUIRED.

The commissioner shall use the criteria in items A to D to determine which surgical procedures shall be subject to the second medical opinion requirement.

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

Statutory Authority: *MS s 256.0625, 256.991; 256D.03*

History: *20 SR 2405*

9505.5046 CRITERIA TO DETERMINE MEDICAL APPROPRIATENESS.

The criteria and standards to determine the medical appropriateness of a surgical procedure for which a second medical opinion is required shall be as required in Minnesota Statutes, section 256B.0625, subdivisions 1, 4a, and 24.

Statutory Authority: *MS s 256 0625; 256.991; 256D 03*

History: *20 SR 2405*

9505.5050 [Repealed, 20 SR 2405]

9505.5055 [Repealed, 20 SR 2405]

9505.5060 [Renumbered 9505.5091]

9505.5065 [Repealed, 20 SR 2405]

9505.5070 [Repealed, 20 SR 2405]

9505.5075 PHYSICIAN RESPONSIBILITY.

When a surgical procedure is subject to a second medical opimon, the physician offering to provide the surgical procedure must contact the medical review agent for a determination of whether the surgical procedure is medically appropriate. The physician must request the determination of whether the surgical service is medically appropriate before submitting a claim for medical assistance payment. The claim for payment must have the authorization number given by the medical review agent and must comply with the requirements of part 9505.0450.

The physician must give the medical review agent the following information by telephone:

A. the recipient's name, ID number, and date of birth;

B. the admitting physician's name and provider number;

C the primary procedure code according to the most recent edition of Physicians' Current Procedural Terminology published by the American Medical Association or the International Classification of Diseases — Clinical Modification, published by the Commission on Professional and Hospital Activities, Green Road, Ann Arbor, Michigan 48105, which is incorporated by reference and available through the Minitex interlibrary loan system and is subject to change;

D. the expected date of the surgical procedure;

E. the recipient's diagnosis by diagnostic code according to the most recent edition of the International Classification of Diseases — Clinical Modification;

F. information from the recipient's medical record sufficient to enable the medical review agent to determine if the surgical procedure meets the criteria in part 9505.5046;

G whether the surgical procedure is in response to an emergency;

H. whether the surgical procedure is a consequence of, or a customary and accepted practice incident to, a more major surgical procedure; and

I. the name and provider number of the inpatient or outpatient hospital where the surgical procedure was or will be performed.

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.5076 MEDICAL REVIEW AGENT DETERMINATION.

Subpart 1. **Qualified staff.** The medical review agent shall provide professional and technical expertise to conduct the second medical opinion program for medical assistance, general assistance medical care, and the MinnesotaCare programs. Unless otherwise specified in parts 9505.5035 to 9505.5100, the professional and technical expertise shall consist of persons who are physicians or who are registered nurses licensed under Minnesota Statutes, sections 148.171 to 148.285, to practice professional nursmg and qualified by training and experience to review the appropriateness of surgical procedures

Subp. 2. **Medical review agent's determination upon receipt of required information.** The medical review agent must obtain and review the information required from the physician under part 9505.5075. If the medical review agent determines that the requested surgical procedure is medically appropriate, the medical review agent shall certify that the requirements of parts 9505.5035 to 9505.5105 are met and shall issue an authorization number. If the medical review agent determines that the requested surgical procedure is not medically appropriate, the medical review agent shall deny an authorization number. In either event, within 24 hours of receipt of the required information, exclusive of weekends and holidays, the medical review agent shall provide the notices required under part 9505.5082.

Subp. 3. **Medical review agent unable to determine medical appropriateness.** If the medical review agent is unable to determine if a surgical procedure requiring a second opinion is medically appropriate, the medical review agent shall consult a physician adviser as specified in part 9505.5077.

Subp. 4. **Retrospective review of medical record.** The medical review agent may conduct an on-site retrospective review of a recipient's inpatient hospital records on a surgical procedure to obtain information needed to make or verify a determination of medical appropriateness. If, after the review of the medical records, the medical review agent determines that the surgical procedure was not medically appropriate, the medical review agent shall deny an authorization number or, if an authorization number was issued, withdraw the authorization number. Upon completing the review, the medical review agent shall notify the physician as specified in part 9505.5082.

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.5077 DETERMINATION BY PHYSICIAN ADVISER.

Subpart 1. **Physician adviser opinion.** Upon the request of an admitting physician or the medical review agent according to part 9505.5076, subpart 3, a physician adviser shall determine if a surgical procedure requiring a second medical opinion is medically appropriate. If the physician adviser determines that the surgical procedure requiring a second opinion is medically appropriate, the medical review agent shall issue an authorization number and notify the admitting physician and the recipient of the determination. If the physician adviser determines that the surgical procedure requiring a second opinion is not medically appropriate, the medical review agent shall deny an authorization number and notify the admitting physician and the recipient according to part 9505.5082. If the physician adviser is unable to determine if the surgical procedure is medically appropriate, the medical review agent shall notify the admitting physician by telephone, and the admitting physician may request a second physician adviser's opinion. If the admitting physician does not request a second physician adviser's opinion, the medical review agent shall deny the authorization number and shall notify the admitting physician and the recipient of the denial according to part 9505.5082.

Subp. 2. **Second physician adviser's opinion.** If the admitting physician requests a second physician adviser's opinion under subpart 1, the medical review agent shall contact a second physician adviser. If the second physician adviser determines that the surgical procedure requiring a second medical opinion is medically appropriate, the medical review agent shall issue an authorization number. If the second physician adviser is unable to determine if the surgical procedure is medically appropriate, or determines that the procedure is not medically appropriate, the medical review agent shall deny an authorization number and notify the recipient and the admitting physician of the denial under part 9505.5082.

Statutory Authority: *MS s 256.0625, 256 991; 256D.03*

History: *20 SR 2405*

9505.5078 RECONSIDERATION.

Subpart 1. **Reconsideration requested by physician.** If a second physician adviser determines a surgical procedure is not medically appropriate, an admitting physician requesting the second medical opinion may request reconsideration. The admitting physician who wants reconsideration must submit a written request to the medical review agent within 30 days of the date of receipt of the notice in part 9505.5077. The request must have the recipient's name and health care program identification number, the disputed surgery, the reason for the dispute, the medical record or part of the medical record needed to make a determination of medical appropriateness, any other relevant information, and the name, address, and telephone number of the physician.

Subp. 2. **Reconsideration; three physician advisers.** Upon receipt of a reconsideration requested under subpart 1, the medical review agent shall appoint at least three physician advisers who did not take part in the determination leading to a denial of an authorization number. Each physician adviser shall determine the medical appropriateness of the surgical procedure. The reconsideration decision shall be the opinion of the majority of the physician

advisers. The reconsideration must be completed within 60 days of the receipt of the information required under subpart 1.

Subp. 3. **Reconsideration; medical review agent.** Upon completion of the reconsideration, the medical review agent shall notify the admitting physician by telephone within 24 hours of the decision, exclusive of weekends and holidays. Additionally, the medical review agent shall send, by certified mail, the admitting physician and the recipient the written notices required under part 9505.5082 no later than ten days following the decision, exclusive of weekends and holidays. The notice to the recipient must state the right of the recipient to appeal under part 9505.5105 and Minnesota Statutes, section 256.045. If the admitting physician has already performed the surgery, the notice to the admitting physician must state the right of the admitting physician to appeal under the contested case procedure under Minnesota Statutes, chapter 14.

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.5079 INELIGIBILITY TO SERVE AS PHYSICIAN ADVISER.

A physician shall not be eligible to serve as a physician adviser if:

A. the physician is the admitting physician or the physician who will provide the surgical procedure;

B. during the previous 12 months, the physician issued treatment orders or participated in the formulation or execution of the treatment plan for the recipient for whose surgical procedure a determination of medical appropriateness is required;

C. the physician or the physician's spouse, child, grandchild, parent, or grandparent has an ownership interest of five percent or more in the hospital where the surgery was or will be performed; or

D. the physician can obtain a financial benefit from the performance of the surgical procedure on the recipient.

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.5080 FAILURE TO OBTAIN REQUIRED OPINIONS.

Subpart 1. **Opinion of medical review agent.** Failure of the physician who offers to provide a surgical procedure requiring a second opinion to obtain a required second medical opinion from the medical review agent shall result in denial of payment for all costs, direct and indirect, associated with the surgery, including costs attributable to other providers and hospitals.

Subp. 2. [Repealed, 20 SR 2405]

Subp. 3. [Repealed, 20 SR 2405]

Statutory Authority: *MS s 256.0625, 256.991; 256D.03*

History: *20 SR 2405*

9505.5082 NOTICE ABOUT DETERMINATION OF MEDICAL APPROPRIATENESS.

Subpart 1 **Notice approving authorization number.** If a surgical procedure requiring a second medical opinion is determined to be medically appropriate and the medical review agent issues an authorization number for the surgical procedure, the medical review agent must inform, by telephone, the physician requesting the procedure and mail the recipient and the physician a notice of the determination within 24 hours of the determination, exclusive of weekends and holidays.

Subp. 2. **Notice denying authorization number.** If a surgical procedure requiring a second medical opinion is determined not to be medically appropriate or a decision about whether the surgical procedure is medically appropriate cannot be reached, the medical review agent shall deny an authorization number for the surgical procedure and notify by telephone within 24 hours of the denial the physician requesting the procedure. Additionally, the medical review agent must mail written notices as specified in items A to D within 24 hours of the denial or failure to reach a decision, exclusive of weekends and holidays.

A. A notice to a recipient must state that the recipient may appeal the denial of the service under part 9505.5105 and Minnesota Statutes, section 256.045.

B. A notice to a physician must state the reason for the denial of the authorization number. Additionally, the notice must state that, as appropriate, the physician may request the opinion of a physician adviser under part 9505.5077, subpart 1, a second physician adviser under part 9505.5077, subpart 2, or a reconsideration under part 9505.5078. The notice must also state that the admitting physician who requests the opinion of a physician adviser or a second physician adviser, as appropriate, may submit additional information to document the medical appropriateness of the surgical procedure.

C. If on reconsideration a determination is made that the surgical procedure is not medically appropriate, notice to the physician must state the reason for the denial and must state that if the surgery has already been provided, the physician may appeal the denial under the contested case procedure under Minnesota Statutes, chapter 14, unless another procedure is required by statute. The notice must also state that the physician who appeals may submit additional information to document the medical appropriateness of the surgical procedure.

D. If the medical review agent withdraws an authorization number under part 9505.5076, subpart 3, the notice must state the reason for the withdrawal and must state that the physician may request the opinion of a physician adviser under part 9505.5077.

Statutory Authority: *MS s 256.0625; 256.991, 256D.03*

History: *20 SR 2405*

9505.5085 PROHIBITION OF PAYMENT REQUEST.

A physician, hospital, or other provider who is denied payment because of failure to comply with parts 9505.5035 to 9505.5105 shall not seek payment from the recipient of the service and the recipient shall not be liable for payment for the service for which payment was denied.

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.5090 [Repealed, 20 SR 2405]

9505.5091 PENALTIES.

The penalties for failure to comply with parts 9505.5000 to 9505.5100 shall be imposed in accordance with parts 9505 2160 to 9505.2245 in addition to parts 9505.0145, 9505.0465, and 9505 0475.

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *10 SR 842, 13 SR 1688; 20 SR 2405*

9505.5096 [Repealed, 20 SR 2405]

9505.5100 [Repealed, 20 SR 2405]

9505.5105 FAIR HEARINGS AND APPEALS.

Subpart 1. **Appealable actions.** A recipient may appeal any of the following department actions:

A. the department has failed to act with reasonable promptness on a request for prior authorization as established under part 9505.5020, subpart 1, or the medical review agent has failed to act on an authorization request under the second medical opinion program, within the time specified in parts 9505.5035 to 9505.5091;

B. the department has denied a request for prior authorization under part 9505.5020, subpart 1;

C. the medical review agent has denied an authorization request under the second medical opimon program subsequent to a reconsideration conducted according to part 9505.5078; or

D. the department has proposed a reduction in service as an alternative to authorization of a proposed service for which prior authorization under part 9505.5020, subpart 1, was requested.

Subp. 2. **No right to appeal.** The right to appeal shall not apply to the list of surgical procedures established according to Minnesota Statutes, section 256B.0625, subdivisions 1, 4a, and 24.

Subp. 3. **Request for fair hearing.** When a recipient requests assistance from a local agency in filing an appeal with the department, the local agency shall provide the assistance.

The request for a hearing must be submitted in writing by the recipient to the appeals unit of the department. The request must be filed either:

A. within 30 days of the date notice of denial of the request for prior authorization under part 9505.5020, subpart 1, or request for authorization of a surgical procedure was received; or

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

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

Statutory Authority: *MS s 256.0625; 256.991; 256D.03*

History: *20 SR 2405*

9505.5230 [Repealed, L 1996 c 451 art 5 s 39]