9505.0210 COVERED SERVICES; GENERAL REQUIREMENTS.

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

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

(1) be medically necessary;

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

(3) meet quality and timeliness standards;

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

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

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

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

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

Statutory Authority: *MS s 256B.04*

History: *12 SR 624; 17 SR 1279*

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